

Doctors and retribution: the hospitalisation of compensation claims in the Highlands of Papua New Guinea

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Abstract

The cultures in the Papua New Guinea Highlands are characterised by a tradition of retribution. Compensation is part of an elaborate system of exchanging gifts, goods and services. Compensation is paid to those who have suffered some kind of loss for which others are held responsible. Such incidents include death or injury caused by fighting, a road accident or domestic violence, theft, rape, gossip, and property damage. Fear of revenge is an important motive for paying compensation.

The hospital has become an increasingly important institution for retribution. It provides medical reports to support compensation claims of physical damage in cases involving violence or an accident. Case material, collected by one of the authors who conducted fieldwork in a hospital in the Southern Highlands, shows that the hospital has established itself as an authoritative actor in the local compensation culture. Doctors spend about one afternoon per week writing medical reports for compensation claims. These reports have become an attractive extra source of income for the hospital. The article describes and analyses a number of cases to illustrate the hospital's role in the production and legitimisation of retribution.

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Introduction

In 1976 Dunn suggested the term 'cosmopolitan medicine' to indicate that so-called 'Western' medicine had outgrown its geographical boundaries and could now be found anywhere. It had become nearly indigenous in most societies of the world. In a large table Dunn contrasted the cosmopolitan medical system with 'local' and 'regional' ones. His main purpose was to provide a better, more acceptable name for what was commonly called 'modern', 'Western', or 'scientific medicine' (Dunn, 1976, pp. 138–140). Dunn's medical system was not 'cosmopolitan' in the usual sense of the word. It did not accommodate cultures from the whole world; it was still the universal type of system, which

now could be found anywhere, without giving up its original character: a transplant, as Dunn remarked. Honesty compels us, however, to quote Dunn where he emphasised that cosmopolitan medicine is *not* the same worldwide: "Obviously, cosmopolitan medicine is subject to considerable regional and local variation—it is not globally homogeneous" (Dunn, 1976, p. 136). The article did not take up this issue, however, and mainly dealt with the regional medical traditions such as Ayurveda and Unani and contrasted these with the implanted medical system as if this was—after all—monolithic.

In his introduction to the classic reader in which Dunn's article appeared, Leslie (1976, pp. 5–8) adopted Dunn's term and argued why the word was better than the other misleading and ethnocentric names. Cosmopolitan, it appeared, was just another word, more convenient (although longer) and culturally more correct. The adaptive nature of cosmopolitan medicine,

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its capacity for acculturation, was mentioned, for example, in the title of Dunn's contribution, but not discussed, let alone supported by ethnographic evidence.

Almost twenty years later, Mary-Jo DelVecchio Good (1995) published a programmatic article calling for cultural studies of 'biomedicine' (which by then had become the favourite name). She gave it the subtitle of 'an agenda for research'. More than any previous author she pointed out that biomedicine was not a monolithic entity but an institution that was strongly affected by its local contexts:

Although biomedicine is fostered by an international political economy and global community of medical educators and bioscientists, it is taught, practiced, organized and consumed in local contexts (DelVecchio Good, 1995, p. 461).

She insisted that cultural studies of biomedicine should focus on "the dynamic relationship between local and international worlds of knowledge, technology and practice." She then continued to illustrate this approach by studying clinical narratives in oncology and how these are influenced by local and global factors such as international scientific research and production of medical technology and pharmaceuticals. The cultural variety she observed in her own research made her conclude that we should speak about "a plurality of biomedicines that are socially and culturally situated rather than about a single unified body of knowledge and practice" (DelVecchio Good, 1995, p. 462).

This paper continues on the path she set out, but moves further away from the strictly medical topics that figure in her argument. We want to draw attention to wider, more mundane and extraneous issues which have an impact on style and culture in Non-Western biomedical practices. If DelVecchio Good focuses on Geertz's concept of 'local (medical) knowledge, we want to look at local *politics* and local *commerce* and how these affect the supposedly clinical work in hospitals.

We have been inspired to do so following an intriguing article by Mark Nichter (1986) in which he portrays 'the' rural health centre in South India and Sri Lanka as a social system with all its typical characteristics of competition, conflict, and concerns about status and power; in short: a place for local politics.

Another source of inspiration was the study by Shahaduz Zaman (2003) of a huge hospital ward in a university hospital in a Bangladeshi city. Zaman's aim was to describe how conditions in Bangladesh society such as poverty, violence, extreme hierarchy and complicated gender relationships are played out in the ward between patients, their relatives, doctors, nurses and 'ward boys'.

Our case will be the acting out of local politics on the premises of a hospital in Papua New Guinea: the role of

the doctor in legitimising compensation claims, or when viewed from the opposite angle, a case of 'medicalisation', the application of medical knowledge and technology to settle matters which are strictly speaking outside the medical field. The process of medicalisation was passionately presented—and resented—by Ivan Illich (1976) as a key development in present-day society. It portrays the ever-continuing exchange between medicine and society that affects both society and hospital, in this case, a hospital in the Highlands of Papua New Guinea.

Fieldwork

The first author, who is both a physiotherapist and anthropologist, worked for three years in the hospital of Mendi. The intention was to combine his work as a physiotherapist with anthropological fieldwork in the hospital. The advantages of this combination were obvious: his presence in the hospital was 'natural'. He took part in the care of patients, joined doctors during their 'rounds', attended meetings and got to know both patients and staff. The intention seemed ideal as far as it enabled him to carry out participant observation without the usual limitations that anthropologists face. He kept track of his observations in an elaborate diary.

In actual practice, however, the combination of the two roles proved cumbersome. He found it difficult to work as a physiotherapist, involved in practical matters such as treating patients and doing exercises with them, and at the same time to observe what was going on and play the role of ignorant outsider. At first, when he *was* ignorant and an outsider, the roles were reconcilable, but it gradually became more difficult as he assumed greater responsibilities and became a relative insider, directly involved in hospital work. In the last half year of his stay he decided to concentrate more on anthropological research *outside* his working periods. He studied annual reports, patient records and conducted formal interviews with patients and staff members.

The thesis that he wrote on the basis of the research focused on two types of context and their impingement on the hospital culture. One was the scarcity of resources, which seriously affected the quality of services in the hospital. The second was the *wantok* (pidginisation of 'one talk') system, which could be best defined as cultural, social and political identity. For patients, as well as staff, their ethnic identity and clan membership almost determined their action. Recruitment of personnel and quality of care depended on whether the people involved were *wantoks* (Van Amstel, 1994).

In this article we concentrate on one particular aspect of the *wantok* system in the hospital: the staff's involvement in compensation claims between different *wantoks*.

The hospital

Mendi is the capital of the Southern Highlands Province of Papua New Guinea. Most of the approximately 50,000 inhabitants of the province live in valleys with an elevation of 1400–2400 m. The province hosts 16 different ethnic groups, but about two-thirds of the population speak a language called Wola or Angal Heneng and today nearly everybody also speaks Pidgin (or *Tok Pisin*).

The Mendi area was the last province to be put under Australian administration in 1950–1951. Until 1976 its only connection with the nearest commercial centre, Mount Hagen, was an unpaved road. When the Highlands Highway was extended to Mendi, the area began to attract a large number of economic enterprises.

The Mendi area has been studied by various anthropologists: Ryan (1959, 1969), Sillitoe (1979) and Lederman (1986). Early visitors to the area were impressed by the inhabitants' intensive agricultural activity and their keen involvement in exchange relations. The Highlanders were found to be egalitarian, "entrepreneurs with a flair for oratory and for political organizing" (Lederman, 1986, p. 3). Lederman, who studied social and political relations among Mendi people characterises them with three key terms: materialism, individualism and competitiveness (p. 5). The subject of this article confirms that typification.

Mendi Hospital was opened in 1974 on a hill about 2 km from the centre of Mendi town. It occupied an area of 100 × 160 m and was fenced off by barbed wire. Initially the hospital had a serious shortage of personnel. In 1974 it had two physicians, one qualified nurse and three nursing aids. The number of admissions ranged between ten and twenty per month. Electricity was a big problem at the time and the hospital suffered frequent blackouts.

In 1990 when Van Amstel did his research, the hospital had 160 beds and between 300 and 400 admissions per month. There were 52 nurses and 26 nursing aides but only two doctors (plus three vacancies for doctors). Nurses were doing most of the work meant to be carried out by doctors. In 1991, 22% of all admissions were for obstetrics and almost 20% were patients with pneumonia. Accidents and violence (8.6%) constituted the third largest group of admissions. The high rate of pneumonia was probably caused by the fact that people lived in houses full of smoke and by exposure to cold and draught. The local approach to health, according to one informant, is the idea that a child who cannot survive naked will not grow to become strong. The reasons for violence will be discussed later.

There was little communication between patients and staff. Patients were barely informed about their diagnosis and treated in an authoritarian way but they seemed hardly disturbed by it.

The hospital's buildings were spread out over a large area with lawns between some of the wards. When the weather was favourable patients would spend most of the day on the lawns. The outpatient department, wards, operating rooms and administration were separated and visitors were not allowed in the wards during the morning.

Wantoks

Wantok is a key concept in Papua New Guinea society. Literally it refers to people who speak the same language. It is sometimes translated as 'clan' or 'tribe', but the concept is used in a more flexible way, depending on the particular situation in which it is applied. *Wantoks* are members of any group with a sense of communality vis-à-vis another group. People from the same district, even though they do not speak the same language and who are enemies 'back home', can be *wantoks* vis-à-vis people from other districts. The same goes for provinces and regions. People migrating to urban centres face various problems. "Thus it is quite natural that they seek out others of their home community, or surrounding area, who have arrived before.... [These] are expected to share their facilities and acquaintances in order to care for and to help establish the new arrivals" (Shaw, 1981, pp. 193–194). A Papua New Guinean overseas would regard all other countrymen as *wantoks* in comparison to those in the host community. They might even include expatriates such as missionaries or 'development workers' living in Papua New Guinea. The very people who call themselves *wantoks* while in Port Moresby, the capital, may find themselves in different camps at home. "*Wantok* groups are defined in relation to the situation in which people find themselves" (Ballard, quoted in Shaw, 1981, p. 194). Acts of reciprocity and hostility, as we will see, follow this changing character of *wantok*, or rather constitute it.

Retribution/reciprocity

Melanesian societies, according to Trompf (1994) are characterised by a retributive logic. *Bekin* (to pay back) constitutes the main principle of social and political interaction. Paying back is demanded in a positive as well as in a negative sense.

There is a large body of ethnographies on societies in the Papua New Guinean Highlands that focus on retribution in the context of social structure, exchange and gender relations. Some of them, as we have seen, describe communities in the Southern Highlands where Mendi is located (e.g. Lederman, 1986; Sillitoe, 1979). Elsewhere Sillitoe (1998, p. 162) characterises

compensation as an attempt by those embroiled in disputes “to balance the score between them; handing over valuables makes good the loss suffered by the plaintiff.” Retribution, one could say, is one of the principal ‘mechanics’ that hold communities and groups of communities together. At the same time, however, (as we will see) compensation claims are the seed of conflict and additional violence since claims are often met by fierce denial and hard bargaining.

The strong sense of reciprocity in the practice of compensation works both within the group of *wantoks* and between different groups of *wantoks*. *Wantoks* have compelling mutual obligations to each other that can be described in Sahlin’s concept of generalised reciprocity, long-term diffuse relationships, which imply mutual claims on each other’s goods and services. It goes without saying that *wantoks* help each other and share what they possess among each other. Giving brings respect and prestige and buys the support of the receivers in the near or more distant future. Money and affection are closely interlinked.

Strathern (1978) pointed out three main motives for these exchanges of goods and services: enhancement of status, improvement of political relations with other clans, and prevention of war. All these objectives are directed towards peace and stability in and between communities and occupy most the minds of *wantoks*. One conspicuous form of reciprocity and retribution, usually indicated with the English term ‘compensation’ is, however, more negative. Any loss, inflicted by another *wantok* has to be repaid. If repayment does not occur, strong sanctions in the form of revenge can be expected. There is, therefore, considerable pressure to pay compensation; it prevents further trouble and bloodshed.

Compensation is paid for different kinds of loss: deaths during conflicts between clans, victims of road accidents and other kinds of accidents, domestic violence victims, theft and destruction, rape, offence and libel.

Various factors influence the amount of compensation that needs to be paid. First of all the cause of the loss must be considered. For example, an accident requires less compensation than an intentional, damaging act. The relationship between the victim’s clan and that of the perpetrator is a second factor taken into account. The claim will be higher if the relationship is more distant and/or hostile. The economic position of the guilty party is a third consideration: the more well-to-do, the higher the claim. Workers may, for example, claim very high compensation from their employer. Other qualities that influence the compensation claim are the gender, the social position and the age of the victim. One person emphasised that the price for a young and strong man is bound to be high: “A young man, well built is a potential for

the clan; how many children would he have had if he were still alive?”

Representatives of both parties may meet to reach an agreement about the amount to be paid. If, as often happens, the parties do not reach a common decision, a neutral third person or institution will be called in to decide. This can be a village magistrate or village council.

The introduction of modern money has fanned the culture of compensation to an almost commercial level. Strathern and Steward (2000a, pp. 158–162) and several others have sketched this ‘inflation’ of compensation demands. The money system also allows for a more precise calculation of debits and credits to be applied in a compensation claim. Another, less expected, vehicle facilitating compensation payments is the hospital, as we will see.

Illness, accident and compensation

Surprisingly little has been written on the role of retribution in the explanation and management of illness in the various studies of local medical practice in Papua New Guinea (e.g. Frankel & Lewis, 1989; Glick, 1967; Keck, 1992; Lewis, 1975; Obrist van Eeuwijk, 1992; Welsch, 1982). An exception is Frankel (1986), who studied illness behaviour among the Huli people nearby Mendi. Frankel devotes considerable attention to the role of compensation in the Huli response to illness. They tend to link each incidence of illness to human responsibility, for example, sorcery (*tomia*; or *poisin* in Pidgin) or physical violence. Diseases as different as dysentery, bronchitis, malaria and Parkinson’s, to use biomedical terminology, are commonly ascribed to blows or injuries the victim incurred, recently or long ago. Women, in particular, have the tendency, according to Frankel, to attribute even relatively minor health problems to physical violence inflicted on them.

Huli people seek relief from their symptoms in the health centre or hospital but their main preoccupation is to resolve the social implications of their problem. Frankel:

When asked what is wrong with them, people who explain their illnesses in terms of injury give full accounts of the background of the fight, the number of blows they received with what weapon, but will volunteer little about the symptoms they have (p. 131).

Frankel comments that ‘illness’ sometimes constitutes little more than “a ruse to gain compensation for an injury” (p. 131) but apart from this social justice aspect, compensation also has therapeutic meaning. It is believed that compensation directly influences the

healing process. Symptoms ‘grow’ as long as compensation has not been paid and stop growing as soon as compensation has been given. One woman remarked: “When you get paid, your illness disappears”. Another woman, who did not want to request compensation for a particular reason, asked for just one pig for therapeutic reasons. Frankel’s study shows that attributing illness to human agency provides people with a tool to deal with the problem, medically and socially.

Of the 57 cases presented by Frankel, 43 cases involved claims for compensation. Seven of those who did not claim it, abandoned the claim on Christian grounds (Christian churches strongly criticise the compensation culture) and seven others did not make a claim because they said they would be ‘ashamed’ as close relatives were involved.

An interesting complication is that it may be advantageous to the accused party to settle a case while the plaintiffs prefer to drag it out. Once a compensation case has been settled it is almost impossible to reopen it if the illness becomes more serious or the victim dies. In most of the cases reported by Frankel discussions on the compensation went on while the plaintiffs were watching the gravity of the illness (Frankel, 1986, p. 133).

The 14 cases in which no compensation was claimed represent a trend that has led to some discussion between specialists in Papua New Guinean cultures. Goldman (1993) criticises the widespread idea that every ‘accident’ involves human agency. If ‘pure’ accidents do not exist, then each event involving loss of property, honour or health requires retribution. Goldman takes a more nuanced stand and argues that liability and responsibility are not the same. ‘Compensation’ may have different rationales. He shows, for example, that there is room to manoeuvre in the establishment of liability. Strathern and Steward (2000b) stress the same point and provide various examples of negotiating agency and accident. Elders, they write, may sometimes label an event as an ‘accident’ in order to reduce or prevent more violence such as interethnic fighting. (Strathern & Steward, 2000b, p. 279).

In one of the cases discussed by Frankel a man comes to the health centre to be treated for “what medically was osteomyelitis” but which the man claimed had been caused by an arrow wound. After the man had related the social and political history behind his complaint, he concluded: “You [the doctor] must give me a letter for me to show him [his enemy] when I take him to court. I want eight pigs compensation from him” (p. 131).

This leads us to the role of the hospital in the production and negotiation of compensation, which constitutes “the most explicit extension of the medical system into other areas of social organization” (Frankel, 1986, p. 133).

Hospital and compensation

In their discussion of changes in ideas and practices around moral responsibility and retribution, Strathern and Steward (2002a) look at various historical developments in Papua New Guinea society such as colonial administration, Christian missionaries, the introduction of modern money, and state building, but they overlook the presence of biomedical institutions. Using the example of Mendi hospital we will briefly sketch how the professional facilities of the hospital impinge on the compensation culture and, vice-versa, how compensation enters and changes the hospital culture.

Sickness or injury may lead to compensation claims if the person responsible for it is known, for example, in the case of a traffic accident or violence (domestic or otherwise). The case below, reported to the hospital, is an example.

Two men tried to steal sugar cane from the garden of A. A caught them and started a fight with them. The thieves fought back and beat him up. When he was taken to the hospital it was found that his spleen had been injured and he had to be admitted to the surgical ward.

Three days later, A’s brother went to visit the clan of the two thieves to request a *bel-kol* (prepayment). The other clan refused to pay anything so the brothers took with them a pig (worth about 1000 kina, US\$900). A new conflict arose, but the police office decided that the brothers could keep the pig as long as the exact amount of the compensation had not yet been determined.

The exact amount of compensation in the case of bodily damage depends of the injury, which only the hospital can establish. For this reason the hospital has achieved an increasingly important position in the compensation business. People claiming compensation can buy a medical report for 20 kina (almost US\$ 20 at the time).

There are three types of medical reports. The first and most common type is a report made at the request of the victim or the police. The second is a medical report based on the Workers Compensation Act (WCA). When someone suffers bodily damage while working for an insured employer, he/she can receive compensation in line with the Worker Compensation Act (WCA). The doctor must complete a form indicating the nature and gravity of the injury and state whether or not it will lead to a lasting handicap. The third type is the Motor Vehicle Accident report needed by the motorist’s insurance company (MVA).

In 1991 the hospital wrote 254 medical reports, 78% of which concerned compensation claims by individuals.

Table 1
Medical reports 1991 Mendi hospital

	Violence		WCA		MVA		Other		Total	
	M	F	M	F	M	F	M	F	M + F	
Fractures	21	21	9		18	8	7	1	85	33%
Internal diseases	5	2	4		2	—	11	11	35	14%
Big injuries	32	34	4		4	1	4		79	31%
Small injuries	8	4			5	1			18	7%
Rape	—	25							25	10%
Backache	1						1		2	1%
Burns	1	1	1						3	1%
Sexually transmitted diseases								2	2	1%
Other							1	3	4	2%
Total (M/F)	68	87	18		30	10	24	17	254	100%
Total	155 (63%)		18 (7%)		40 (15%)		41 (15%)		254	100%

Table 1 provides a detailed overview of all the reports from that year. The large number of big injuries resulting from violence or rape is striking.

It is not always clear how those who request a medical report use it in their compensation claim. It is often doubtful that anyone in the community is able to interpret the report correctly. Moreover, some are in such a hurry that it is hardly possible for the doctor to provide a reliable prognosis.

Apparently, the fact that the victim has a medical report is in itself a factor that can result in a higher damage payment. *What* has been written may be less important. The fact that many people with very light injuries also come to the hospital to obtain a report supports that interpretation. Even if the doctor concludes that there is “nothing wrong”, there *is* a medical report. The report, finally, also functions as kind of neutral referee that helps the two parties reach an agreement. An example:

B discovered that pumpkins were being stolen from his garden. He went in the night to keep watch and caught a boy from a neighbouring village. B attacked the boy with a bush knife and caused a deep wound in his leg. Crawling, the boy managed to reach his home, where his clan members reacted in rage. They attacked B's village and set two houses, a store and a pigsty afire. Seven pigs died in the fire. They further shot three arrows into the back of one of B's clansmen, J. This incident resulted in a big fight between the two clans in which about two hundred men took part but only one man, of the boy's clan, was injured. He was treated in the hospital for a chest injury but his condition was not serious. At that moment, the two clans decided it had been enough and the boy's clan offered compensation. The others accepted the offer.

The case was still in progress when the researcher left but he discussed the matter with J when he came to the hospital for a medical report. The report, he said, was necessary to show his injury in black and white and to take away any uncertainty about the damage during the negotiations. J expected to receive about 1000 kina (US\$ 900) in compensation. B, the man who had injured the boy, would also have to pay compensation, he said, but to his own clan. He was accused of being the *as bilong pait* (cause of the fight). He should not have attacked the boy with his bush knife. The injury of the boy proved not serious after all.

Sometimes it is not the victim but the perpetrator who requests a medical report. This happens when the victim is believed to claim too much and the other hopes to prove this with the medical report. It is also possible that the medical report has no or little effect, because it is overruled by other arguments. An example:

Some years ago, C, who is a cleaner in a government institute, brought her little son to the hospital with serious arthritis. The boy was admitted and treated with cortico-steroids. Four years later, the boy died of meningitis, probably as a side effect of the medicines. The boy's father, who had left the mother and the child a long time ago, accused the woman of being responsible for the child's death and claimed a high amount of compensation. His clan supported his claim. The doctor wrote a medical report in which he explicitly emphasised that the mother could not be blamed for the boy's death. Nevertheless, the mother's clan paid a large amount of compensation. The medical report had no effect.

In this case we can see that in the local perception misfortune is attributed to persons independent of the hospital diagnosis. In the same way, a medical report proving that a person died a natural death will not

remove the accusation of sorcery (*poisin*). Personalistic explanations of illness and death (for example, sorcery) serve the tradition of compensation. Blaming a particular person for illness or death falls, however, outside the competence of the hospital and takes place in the traditional milieu. If a young boy dies, whatever his disease may be, people believe someone should be held responsible. The medical diagnosis turns into politics and those who have power are able to decide who is to be blamed and should pay compensation.

Until now, our description of the hospital's role in compensation claims has concentrated on what the medical reports meant to patients and clients of the hospital. We will now turn to how the compensation business affected the hospital.

Writing medical reports constituted a substantial source of income for the hospital. In a nearby hospital, medical reports were the main source of income! When that hospital raised the price of medical reports to 40 kina it did not result in a decrease in requests.

The medical director of that hospital also used the compensation income to solve particular problems in the hospital. When there was a shortage of blood, he made people pay for their medical reports with 20 kina and a half litre of blood.

The financial advantages of the compensation claims enjoyed by the hospital had another side as well. In spite of a serious shortage of medical doctors in the area, doctors spent a lot of time writing medical reports while other, probably more urgent tasks, were delegated to nurses. On average, one afternoon per week was devoted to compensation cases.

Finally, it is remarkable that the hospital was never itself implicated in compensation claims. Contrary to developments in "the West", doctors and nurses were not blamed for medical mistakes. Ultimate responsibility for medical problems was consistently given to people outside the hospital. We cannot exclude the possibility however that the globalising movement of hospital culture will eventually also lead to claims against medical professionals in Papua New Guinea, as is now common in North America and gaining momentum in Europe.

Conclusion

The aim of this article was to sketch the influence of the local culture on the functioning of the hospital in the Highlands of Papua New Guinea. We concentrated on one particular aspect: the hospital's involvement in compensation claims. Anthropological research in the hospital of Mendi has shown how the local preoccupation with retribution has entered daily practice in the hospital and how the hospital has grown into an influential actor in the compensation business.

The revenues generated from writing medical reports constitute a welcome addition to the hospital's meagre financial situation and have led to doctors to spend considerable amounts of time on an activity that has no medical urgency. The hospital has indeed skilfully joined the culture of retribution for its own financial advantage.

The hospital's willingness to write medical reports for compensation claims could be regarded as an example of doctors' compliance with patients' requests. This compliance could be seen as leaving, as a consequence, a cultural imprint on the hospital as an originally 'Western' institution.

It also represents a typical example of medicalisation: the growing influence of biomedical knowledge and practice on daily life in Papua New Guinea. But, as we have seen, that influence is limited. Participants in the compensation transactions do not recognise the hospital's authority over mystical explanations such as sorcery and other types of personification in the attribution of physical damage.

Comparable developments of 'localisation' of the biomedical hospital have been presented in other contributions found within this issue on hospital ethnography. Another particularly striking example of a hospital's involvement in local requests with attractive financial rewards is the rise of mortuaries in hospitals of Ghana. The elaborate culture of funerals in Southern Ghana increasingly calls for dead bodies to be stored in mortuaries so that relatives have more time to prepare for a prestigious funeral celebration. This new trend in the funeral tradition has boosted the income of the hospitals which, at present, are the only institutions allowed to run a mortuary. For one private hospital the revenues from the mortuary constituted almost half of the hospital's total income (see [Van der Geest n.d.](#)).

In the Papua New Guinea Highlands concerns about compensation today are even stronger than in the beginning of the nineties when Van Amstel's research took place. The expansion of the money economy into the most remote villages of the area is likely to facilitate also a further expansion of the compensation culture (in the same way as it has pushed the funeral culture in Ghana to become more commercial). The involvement of the hospital in providing medical reports is, therefore, likely to continue and increase.

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References

- DelVecchio Good, M.-J. (1995). Cultural studies of biomedicine: An agenda for research. *Social Science & Medicine*, 41(4), 461–474.
- Dunn, F. L. (1976). Traditional Asian medicine and cosmopolitan medicine as adaptive systems. In Ch. Leslie (Ed.), *Asian medical systems: a comparative study* (pp. 133–158). Berkeley: University of California Press.
- Frankel, S. (1986). *The huli response to illness*. Cambridge: Cambridge University Press.
- Frankel, S., & Lewis, G. (Eds.) (1989). *A continuing trial of treatment: medical pluralism in Papua New Guinea*. Dordrecht: Kluwer.
- Glick, L. B. (1967). Medicine as an ethnographic category. *Ethnology*, 6(1), 31–56.
- Goldman, L. (1993). *The culture of coincidence*. Oxford: Oxford University Press.
- Illich, I. (1976). *Limits to medicine. Medical nemesis: the expropriation of health*. Harmondsworth: Penguin.
- Keck, V. (1992). *Falsch gehandelt—schwer erkrankt. Kranksein bei den Yupno in Papua New Guinea aus ethnologischer und biomedizinischer Sicht*. Basel: Verlag Wepf & Co.
- Lederman, R. (1986). *What gifts engender*. Cambridge: Cambridge University Press.
- Leslie, Ch. (1976). Introduction. In Ch. Leslie (Ed.), *Asian medical systems: a comparative study* (pp. 1–12). Berkeley: University of California Press.
- Lewis, G. A. (1975). *Knowledge of illness in a Sepik society*. London: Athlone Press.
- Nichter, M. A. (1986). The primary health center as a social system: PHC, social status and the issue of team-work in South Asia. *Social Science & Medicine*, 23(4), 347–355.
- Obrist van Eeuwijk, B. (1992). *Small but strong. Cultural contexts of (mal-)nutrition among the Northern Kwanga (East Sepik Province, Papua New Guinea)*. Basel: Verlag Wepf & Co.
- Ryan, D. A. (1959). Clan formation in the Mendi Valley. *Oceania*, 29, 257–290.
- Ryan, D. A. (1969). Marriage in Mendi. In R. Glasse, & M. Meggitt (Eds.), *Pigs, pearlshells and women: marriage in the New Guinea Highlands* (pp. 159–175). Englewood Cliffs, NJ: Prentice-Hall.
- Shaw, R. D. (1981). The *wantok* system: Local principles and expatriate perspectives. *Catalyst*, 11(3), 190–203.
- Sillitoe, P. (1979). *Give and take*. Canberra: Australian National University Press.
- Sillitoe, P. (1998). *An introduction to the anthropology of Melanesia: Culture and tradition*. Cambridge: Cambridge University Press.
- Strathern, A. J. (1978). Tambu and Kina: Profit, exploitation and reciprocity in two New Guinea exchange systems. *Mankind*, 11(3), 253–264.
- Strathern, A. J., & Stewart, P. J. (2000a). *Arrow talk. Transaction, transition, and contradiction in New Guinea Highlands history*. Kent: Kent State University Press.
- Strathern, A. J., & Stewart, P. J. (2000b). Accident, agency, and liability in New Guinea Highlands compensation practices. *Bijdragen tot Taal- Land- en Volkenkunde*, 156(2), 275–295.
- Trompf, G. W. (1994). *Payback: the logic of retribution in Melanesian societies*. Cambridge: Cambridge University Press.
- Van Amstel, H. (1994). *Mijn wantok gaat voor. De invloed van cultuur en armoede op het functioneren van het Mendi ziekenhuis in Papoea Nieuw Guinea*. Master's Thesis, University of Amsterdam.
- Van der Geest, S. (n.d.). Mortuaries and dead bodies in Ghana: A new funeral trend. Unpublished ms.
- Welsch, R.L. (1982). *The experience of illness among the Ningerum of Papua New Guinea*. Unpublished Ph D. Dissertation, University of Washington.
- Zaman, S. (2003). *Broken limbs, broken lives: Ethnography of a hospital ward in Bangladesh*. Unpublished Ph.D. Dissertation, University of Amsterdam.