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Article abstract

This paper examines the use of health care alternatives by a culturally-conservative Canadian Indian man who suffers from statis ulcers, a disorder he has attributed to both natural and unnatural origins. A case study is presented that utilizes a conceptual framework from medical anthropology. This case study illustrates the cultural and social determinants of health seeking; the perceived etiology, degree of impairment, and the efficacy of the treatment and its cultural relevance are all found to be significant factors in the selection of therapeutic resources. Ritualized performances of Native shamans are found to be an integral part of the healing process.

The Quest For A Cure: A Case Study in the Use of Health Care Alternatives

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This paper examines the use of health care alternatives by a culturally-conservative Canadian Indian man who suffers from statis ulcers, a disorder he has attributed to both natural and unnatural origins. A case study is presented that utilizes a conceptual framework from medical anthropology. This case study illustrates the cultural and social determinants of health seeking; the perceived etiology, degree of impairment, and the efficacy of the treatment and its cultural relevance are all found to be significant factors in the selection of therapeutic resources. Ritualized performances of Native shamans are found to be an integral part of the healing process.

Cet article s'intéresse aux soins que pratique un homme d'origine indienne du Canada. Cet homme, qui respecte des usages 'traditionnels', souffre d'ulcères, fait qu'il attribue autant à des facteurs naturels qu'à d'autres. En présentant cette étude de cas, nous suivons un cadre conceptuel propre à l'anthropologie médicale. Sont mis à jour les déterminants culturels et sociaux intervenant dans la cure; l'étiologie retenue, le degré de maladie, l'efficacité du traitement choisi et les interférences culturelles apparaissent comme autant de facteurs significatifs lors du processus de sélection des thérapies. Les rituels des chamans indiens font aussi partie de ce processus de guérison.

Introduction

The shocking statistic that Native Indians use hospital facilities two to two and one half times more than the Canadian national population average (Indian Affairs, 1980:20) might suggest that this segment of our society does not share the popular dissatisfaction with Western institutionalized medicine. How wrong such a conclusion would be! Despite Health and Welfare Canada's annual expenditure of approximately one hundred million dollars (Indian Affairs, 1980:119) for the delivery of Indian health care services, Indians continue to reach beyond the professional sector of the medical system for their health care needs; they seek additional therapeutic procedures from other resources—those of the so-called folk and popular sectors of the health care system.

The Canadian medical system can be thought of as a tripartite paradigm composed of the professional, the folk and the popular sectors. The professional sector consists of that group of highly-trained experts who administer biomedicine to attack the organic cause of illness. Indians augment the services of these medical personnel with resources of the folk sector, most notably the vestiges of traditional Indian beliefs and practices that still exist. These aspects of Native culture attracted

much attention from early anthropologists and medical personnel who tended to view healing rituals as manipulative conjuring rites that would be superseded by Western medicine, once science had triumphed over superstition. Yet, the efficacy of indigenous folk healers has ensured their survival (e.g., Kew and Kew, 1981). The folk sector of the medical system offers services of other folk healing traditions. Practitioners of everything from Chinese herbalism to iridology are available for consultation. However, the most widely used component of the medical system is the popular sector and its self-treatment therapy, including; herbal remedies, popular home remedies and commercial patent remedies. Indian people, like everyone else, rely substantially on their own knowledge of healing procedures to combat illness.

Each sector of the medical system attempts to understand and treat illness and therefore develops what Kleinman (1975a; 1975b; 1978) has called an "explanatory model." The explanatory model addresses five major questions: 1) the etiology or cause of the sickness; 2) the time and mode of the onset of the symptoms; 3) the pathophysiology or nature of the sickness; 4) the expected course and prognosis; and 5) the treatment. Different sectors of the medical system possess distinct explanatory models which may co-exist, complement or compete with one another. As explanatory models are held by practitioners and patients in all health care sectors, and are socially and culturally determined, they can be formally elicited and used to examine the differential use of health care services among any segment of the population.

Through a case study of an elderly Indian man's responses to illness, this paper examines his differential use of medical resources, some of the factors determining his selection, and the major conflicts that arose in his transactions with the various sectors of the medical system.[1] The data used were compiled from interviews and correspondence with the informant over an eight-year period. Emphasis was placed on eliciting the informant's personal explanation about his illness and how he chose and evaluated treatment. The data are organized chronologically, starting before the informant entered the sick role. Unfortunately, it has not been possible to interview the practitioners whom the patient consulted.

Okanagan-Colville Concepts of Illness

HR, born in 1900, is an Okanagan (Interior Salish) man living on an Indian Reserve in south-central British Columbia. Amongst the Okanagan-Colville, HR is recognized as being culturally conservative and is regarded as one of the last tradition-bearers of his people. HR, like other elderly Okanagan-Colville people, holds to a belief system that classifies illness by etiology—illnesses are caused either naturally or unnaturally.

Those disorders believed to be natural or secular include headaches, colds, cuts, toothaches, sores, injuries from accidents and the like. Unnaturally-induced illnesses include: injuries inflicted by animate beings other than humans; diffuse internal illnesses including fever and contagious diseases; afflictions of the mind caused by shamanistic action; spirit-illness; and magical poisoning or sorcery (Ray, 1932:202; Cline, 1938:162-165). Of course, the manifestations of an unnaturally-induced illness can be identical to those of natural origin. Consequently, an ailment is readily designated as unnatural when therapy does not produce immediate relief. In such cases, a shaman or "Indian doctor" is consulted for a diagnosis.

Some Okanagan-Colville people believe that many diseases are brought about by the presence of "small worms" crawling underneath the skin. Other diseases are said to be caused by "poisons," some of which can make the blood weak, requiring the help of tonics to "change the blood."

In Okanagan-Colville society today it appears the greatest number of unnatural or prolonged illnesses are thought to be caused by magical "poisoning" or sorcery, known by the Native term *p̓tax̓*. The majority of those still practising *p̓tax̓* are women of post-menopausal age whose knowledge has been learned in earlier life from mothers and grandmothers. The power of *p̓tax̓* allows those women who practice it to alter and manipulate events both for good and evil ends. For example, *p̓tax̓* can be used as a "love charm" to bring two people together, as a "good luck medicine" to make a horse win a race, or as an amulet for protection from ghosts. On the other hand, *p̓tax̓* is also used to cast spells and to curse people to have bad luck or even to die. *P̓tax̓* is seldom discussed but readily acknowledged amongst the Okanagan-Colville—its mention brings on nervous laughter.

It was in the context of this cultural framework that HR perceived his illness and selected treatment.

Case Study

From 1916 to 1942, HR developed numerous minor leg ulcers which he attributed to contact with certain poisonous plants growing in hay fields. HR treated himself with poultices of Canada mint *(Mentha arvensis),* a natural source of menthol

which is both germicidal and antiseptic (Osol and Pratt, 1973:670). Initially, HR did not consider himself to be ill, nor did he recognize any symptoms of disease—ulcers were bothersome but part of his life as a cowboy. When the sores persisted, he augmented his herbal treatments with a home remedy suggested by a local White rancher. But by 1942 the ulcers were affecting his ability to work, so HR treated them with the latex of a poisonous plant, milkweed *(Asclepias speciosa),* in the belief that a poison was needed to kill the poison in his leg. The treatment proved unsuccessful.

In 1942, for the first time in his life, HR sought assistance outside the popular sector of the medical system. A White physician was the most readily available medical resource. The ulcers responded to the physician's treatment and remained healed for nearly thirty years. When the problem sores recurred, however, HR then interpreted the White doctor's therapeutic procedure from thirty years earlier as a causative factor. In describing the physician's earlier treatment, HR recalls that an unidentified "black liquid" was injected into his left hip and then into his right hip. He remembers feeling the liquid travel a short distance down his left leg and stop precisely at the spot where his leg later became ulcerated again.

The poison that HR believed to be responsible for the ulcerated leg was now attributed to the black liquid, not to the plants in the hayfields. HR was no longer working actively in the hayfields, and therefore was no longer in contact with the plants which he had believed to be the cause of his leg ulcers. The unfamiliar therapy administered thirty years earlier was outside of the community-held belief system and continued to be misunderstood by HR.

Early in 1970, HR sought further medical advice from friends and from other people recognized as knowledgeable in Interior Salish Indian communities, and consulted a known shaman. Because HR classified the ulcers as a naturally-caused disorder, this "Indian doctor" was not requested to make a diagnosis. He did, however, prescribe a herbal treatment, but HR did not receive any symptomatic relief.

Later in 1970, HR's concern for effective control of the symptoms made him resort, once again, to a White physician. Pills were prescribed. If the pills would cure him, HR could not understand why he was not given a larger bottle so that he could take them more frequently than was recommended. When the results of this drug therapy were not immediately evident, HR's misunderstanding led to non-compliance and he switched to another practitioner in another sector of the medical system.

HR's quest for a cure led him to a local Chinese cafe-owner. Bearing a note to inform any Cantonese-speaking person of his destination, HR travelled to Vancouver to seek aid from a Chinese practitioner who used biomedicine in his practice. The diagnosis offered by the Chinese healer was in accordance with HR's current theory of the etiology—the healer set about to "kill the poisons that were working together in his body." As well as supplying HR with a larger quantity of pills than the White doctor was willing to dispense, the Chinese healer administered four injections—one in each shoulder and one in each hip. Apparently HR perceived some symptological response, for he complied with the prescription.

Early in 1971, HR once again sought advice from a local White doctor. Varicose veins were now impeding his movement. HR recalls that this condition was explained to his satisfaction as being the result of "a few poisons working together." The familiar diagnosis and the physical relief that HR obtained as a result of the therapy restored HR's faith in Western medicine.

At the time HR returned to a White physician two years later, when the problem recurred, he was told he had a circulation problem and was admitted to a hospital for surgery; skin transplants were undertaken from his hip to the ulcers that had developed in his lower leg. This procedure failed, although the swelling subsided once the varicose veins were stripped. With additional treatment, the leg healed eventually and the ulcers did not reappear for several years.

The early 1970s marked a profound transition in HR's life. His wife died, leaving him to perform tasks, such as cooking and cleaning, that Indian men normally regard as "women's work." He could no longer manage his ranch, and difficulties he was having concerning his land resulted in litigation with his own relatives. He left his ranch and moved to another house on the other side of the river, but not long after this he was the victim of a freak accident—a rock and mud slide narrowly missed destroying the new house he had moved into. His emotional state at this time was summarized in a letter he wrote to me:

Now days I got no friends, no body would not talk to me, no body likes me, everybody against me, everybody tried to make me mad in some ways...

In this depressive state, HR revised his explanatory model when the ulcers recurred in 1975. The social discord in his life led to a suspicion that his misfortune stemmed from ill will; he believed he was the victim of *ptax* (sorcery). He no longer

classified the illness as naturally caused. HR's response to this shift in cognition was then consistent with his perception of the etiology—he consulted a shaman.

HR's visit to the shaman was arranged through an Indian friend who accompanied him on the appointed night. This particular shaman was an Upper Skagit (Coast Salish) man from Washington State, but his curing techniques followed Interior Salish custom, where such healers work for four consecutive nights, beginning their rituals after the last ray of light has faded from the evening sky.

In the course of the ritual, which lasted about one hour, the shaman used a basin of water, a fancy handkerchief that he asked HR to sit on, and a blanket that he hung over the back of HR's chair. The techniques used were like those of other shamans whom HR had witnessed, starting with the healer singing his personal "doctoring" songs. Occasionally, the shaman danced. Others who were present in the room, including HR himself, joined in the singing, but the starting and stopping of the song was determined by the shaman alone. During the pauses he blew forcefully on the back of HR's neck and down the centre of his chest. (This was done, HR explained, to "blow the sickness out of the body".) Then, standing in front of the patient, the shaman moved his hands, one on either side of HR's body but not touching it, down from the head to the feet. All the while the shaman made short patting motions to "chase the sickness from the body." Later they had a meal together and the session ended. This was all in keeping with HR's expectations of what the diagnosis would entail.

HR describes the first night of doctoring as an "inquest," where the shaman "just looks around and examines the evidence." The resolution of the first night of doctoring came later that night in the shaman's dream.

On the second night, the shaman presented his understanding of HR's illness and its treatment—his personal explanatory model—a culturally-relevant, highly-personal account suggesting social discord in HR's community. He confirmed HR's suspicion that sorcery was the cause of his troubles. Instrumental in this "dirty work," the shaman said, were two women and a male accomplice whose work had begun "quite some time ago." The shaman explained that a man had entered HR's house while he was out and cut small pieces of material from the seams of his clothes. He stored them in a gray sock that had a red mark on it. These bits of cloth were said to have been given to the two women who then added some bloodied and pus-coated hair that had been clipped from a cow's injured leg and left on the ground. They took this evil bundle away with them. The shaman informed HR that the women went to a graveyard, where they pushed a long stick into a freshly-covered grave so that the end of the stick reached the gap between the top of the coffin and the side of the grave. They wiggled the stick back and forth to make a passageway into the grave. Next, they inserted HR's specially-treated sock down into the bottom of this passageway. While the women were refilling the hole, they spoke to the sock, saying, "HR will have sores like the injured cow. He will suffer like the cow and no doctor, Indian or White, will be able to cure him." Then, the women walked a short distance away, turned back to face the grave, and laughed. This was the cause of HR's ulcerated leg, the shaman announced.

The prognosis given as part of this shaman's explanatory model absolved him of any obligation to cure. Yet he spent the third and fourth nights performing ritual therapy. This involved drawing the sickness down the full length of HR's body and capturing it in his hands. The strength of the sickness caused the healer to flail his arms about wildly, as if he were holding a live object. Then he thrust his hands into the basin of water to weaken the sickness and drown it. Now, with his hands still clasped, the shaman walked to an open door and, as if releasing a captured bird, he threw the sickness into the night air.

The shaman explained to HR that it would be at least ten days before he noticed any change in his condition, for he was not simply working on HR's symptoms but also trying to withdraw the curse. Nevertheless, no change occurred. In recalling this period of his illness episode, HR remarks that the therapy was ineffective because the shaman feared the strength of the women's *ptax*. HR does not acknowledge any failing in the healer's abilities.

Continuing to seek help, HR resorted to the Shaker Church. [Shakerism is an indigenous Western North American religious movement whose followers believe that their religion was provided by God to Indian people in their time of need in the 1880s (Barnett 1957).] Shaker ceremonies combine both Christian and aboriginal Indian beliefs. When filled with God's spirit (a state similar to being in contact with one's guardian spirit power), Shakers are believed to prophesy, heal the sick and exorcise evil. HR's friendship with a Shaker follower, in addition to his personal faith in God and also in Indian spirit power, prompted him to attend a Shaker group curing ceremony. Despite dramatic rituals involving the ringing of bells, lighting of candles and "speaking in tongues," the therapy did little to address HR's individual concerns, except in

symbolic terms. As the healing ceremony was a social event, it did serve to reunite HR with a community of friends.

HR's symptoms worsened over the next few months. But now, having gained an understanding of what he perceived to be the etiology of the illness, he again resorted to treatment from the popular sector of the medical system. He confidently employed his own extensive knowledge of herbal therapy, washing the afflicted area with a decoction made from the tops of young tamarack *(Larix occidentalis)* trees, and drinking a similar decoction. The wash acted as a counter-irritant because of the natural presence of turpentine (Osol and Pratt, 1973:1250). Despite the appropriateness of his home remedy, HR's condition worsened. Again, his recourse was to a professional physician. Following a skin transplant in the summer of 1976, HR had only minor outbreaks of leg ulcers which he treated himself using both Native and commercial medicines.

HR's evaluation of the physician's therapy in 1976 was that it was partially effective; the physical symptoms of the disorder were controlled, though the illness was not cured. In a letter to me dated December 1976, HR stated:

HR gathering tops of young tamarack *(Larix occidentalis)*.

The Doctor says I'm okay but I do not know. The Doctor he doesn't know what was ron [sic] with me but I do. Only thing is nothing I can do about it but only an Indian doctor he help.

Western medicine did not alleviate the psychosocial aspects of the illness. HR underwent little behavioral change and continued to seek out shamans to treat other somatic complaints. His anxiety was still present. The minor recurrences of his leg ulcers were a reminder that he was still a victim of *ptax*.

In the spring of 1981 the ulcers became large and painful. Once again HR selected a professional physician and once again he was admitted to a hospital for skin transplant surgery. The operation failed; by this time the circulation in his lower leg had become so constricted that a graft was not possible. He was discharged, well supplied with ointments and bandages for self-treatment at home.

HR's simultaneous use of healers from the professional, the folk and the popular sectors of the medical system began in mid-1981. At this time his faith in all healers was tempered by a practical skepticism. Although he believed that professional physicians were most efficient at controlling his symptoms, his most recent hospital treatment had not been successful. And he believed that the shamans whom he had hired did not possess guardian spirit powers strong enough to remove the curse which he perceived to be the cause of his problems. Also, he realized that there had been little change in his symptoms following the Indian healer's therapy.

HR continued applying the ointments prescribed by a local White physician. He supplemented this therapy with attendance at a curing ceremony held at a relative's home, with a Blackfoot shaman from Montana as host. The presence and the supportive role of HR's relatives during the ceremony helped to meet his needs, with the result that he felt better. His evaluation of the shaman's capabilities for reducing his physical complaints was equally positive. While he believes that the herbal medicine given to him by this Blackfoot doctor may have eventually healed his leg, HR was not left with what he considered enough medicine to complete the treatment.

By the spring of 1982, HR's leg ulcers had again deteriorated. At this time a White woman, belonging to a local church, was organizing groups to visit a faith healer in the Philippines. Stories of the healer's abilities in expelling cancerous organs and in other feats resulting in miraculous cures enticed HR to sign up for the trip. However, when the date of departure was delayed several times and a number of HR's friends asked him to reconsider his

decision, he concurred that there were too many indications that he should not go.

Continuing his quest for a cure, HR again turned to self-treatment. He prepared poultices from the peeled and pounded roots of chocolate tips *(Lomatium dissectum),* a plant considered so poisonous by the Okanagan-Colville that it was used in former times to make an infusion for killing fish in streams. But it is also well known as an effective medicine for treating cuts, sores, boils and dandruff (Turner, Bouchard and Kennedy, 1980:66-68).

The herbal treatments were supplemented with visits to a local White physician. When HR was hospitalized for six weeks in June 1982 he certainly did not expect a culturally-meaningful explanation of his disorder from the Western medical personnel. He also did not expect that their therapy would cure his illness, although he did believe that they could bring his physical symptoms under control. He commented on this in an interview with me following his departure from the hospital:

Whiteman doctors can help it, but they can't cure it. It fools them. It looks like it gets better, but it doesn't, it comes out again. Whiteman doctors can't cure it because they don't understand what caused it.

The explanatory models held by the hospital personnel and HR were quite dissimilar. In fact, the hospital routine was antithetical to HR's personal view of appropriate therapy. HR was assigned to a large hospital room with five other men, none of whom was Indian. The elderly patient occupying the next bed had difficulties with his bowels, which meant that the nursing staff often had to attend to his needs. HR was very much aware of the smell of feces permeating his room. But the window could not be opened because of another patient's condition, so there was no fresh air. In addition, the filled bedpans were apparently left in the adjoining washroom, where HR believed the hospital staff "were drying the dirt so that they could examine it." Weeks passed and the smell continued. Finally, HR left a note on one of the filled bedpans in the washroom, requesting the staff to remove the cause of the "stink." What was perceived as merely unpleasant to other patients was very offensive indeed to HR, whose culture views all human wastes as potential "poisons" that are severely detrimental too healing and, worse still, can be used in *ptaχ*. There was no acknowledgement of HR's request.

HR's depressive feelings began to have the biological concomitants of lack of appetite and insomnia. He spent longer and longer periods of time withdrawn in the smoking lounge (where the windows could be opened) until past curfew, when he had to be ordered to go to bed. But from HR's cultural perspective, the time when he was ordered to bed was precisely the time when healing is believed to occur—late at night. (In Okanagan-Colville society, many medicines are taken in secrecy, either late at night or early in the morning, and often in association with steambathing to cleanse and ritually purify the body.)

Because of the medical staff's lack of knowledge of HR's explanatory model, they were unable to respond with culturally-appropriate therapy. For example, the leg ulcers were washed daily with a diluted solution of hydrogen peroxide, even though HR urged them to use it full strength. His request stemmed from the culturally-conditioned assumption that only the visual evidence of the peroxide's foaming action would indicate that the sickness was being drawn from his leg. This concretized symbolism is a common feature of shamanic performances.

When HR asked to be moved to an empty room that he knew existed on the same floor of the hospital, his request was neither discussed nor acted upon. He then took his complaint to the head nurse. Three days later, when no decision had been made, HR announced that he was leaving the hospital. His doctor was called in to speak with him but HR explained that he would "soon be dead" if he stayed because "the hospital is too dirty for an old Indian." Unfortunately, the physician-patient communication came too late. Disappointed and distrustful, HR went home, vowing never to return again.

While in the hospital, HR had received an Indian visitor who told him about another Blackfoot shaman in Montana. Stories of this shaman's ability to cure Indian people's disorders that Western medicine had "given up on" only served to reinforce HR's decision to leave the hospital.

In September 1982, HR travelled to Browning, Montana for the Blackfoot shaman's healing ceremony. Certain advance preparations were necessary —HR was instructed to purchase special foods to be eaten at the midnight feast. Also, he was told to bring certain coloured ribbons that the healer later fashioned into long sashes.

HR maintained that he was a victim of *ptaχ*, so this Blackfoot shaman was not asked to give a diagnosis. Instead, he proceeded directly to the mechanics of exorcism, brushing his hands up and down HR's body while singing his personal doctoring songs. Those present joined in the singing and danced where they stood. The ceremony took place in a mountain cabin and the actual curing ritual was performed in total darkness, according to Blackfoot custom.

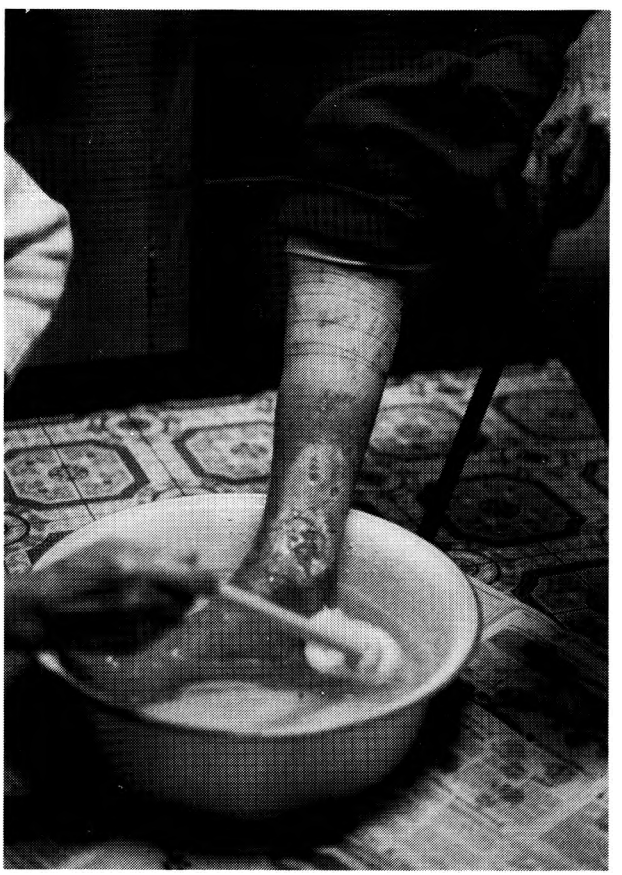
Before the second and final night of the curing

ceremony, HR was asked for some gas money so that the shaman could visit a particular mountain where he would gather a certain root for HR's ulcerated leg. The root, unfamiliar to HR, was to be pounded and used as a poultice. But after HR had applied the root for several days, his leg became swollen and painful and he discontinued the procedure.

A ribbon sash made for him by the Blackfoot shaman was hung above the headboard of HR's bed, where, he was told, he should "look every day to see if the ribbons have moved." The shaman told him his guardian spirit power would, through the power imbued in the sash, protect HR from evilly-disposed spirit powers of other shamans. (This sash is still hanging above HR's pillow, with a rosary and a picture of Christ.)

The Blackfoot shaman cautioned HR that three additional visits would be required before he would be cured, yet HR is hesitant to resume the sessions and risk the chance of adverse reactions to the unidentified herbal poultices.

Not long after returning from Montana, HR pursued still further treatment. In October, 1982, on the recommendation of a friend, an anthropologist with whom he had collaborated, HR visited a Chinese herbalist in Vancouver. The herbalist, an old man of 91, had been trained in China by master herbalists. In his basement he kept a large supply of various preparations he had imported from his homeland. This herbalist showed HR "before and after" photographs of leg ulcers he had treated successfully.



HR being treated by Chinese herbalist, November 1982.

Visits to this herbalist were to be made at two-day intervals for six weeks. The regular treatment procedure included washing the ulcers and applying a powder, followed by a fresh herbal poultice. The Chinese herbalist recommended abstinence from certain foods believed to be critical to the healing process, and dietary modifications that HR strictly complied with while undergoing the therapy. A friendship developed between HR and the herbalist and his wife, with HR often delaying his departure to sit and smoke with the couple. But three weeks after the treatment had begun, the elderly Chinese herbalist died.

A full six weeks' supply of poultices had been prepared, so the widow was able to continue the treatments, as she had assisted her husband on numerous occasions. Feeling better and perceiving some alleviation of his symptoms, HR returned home to the interior of British Columbia in November, 1982.

Upon his return, HR began a program of self-treatment. Friends and relatives suggested several different home remedies, including mega-vitamin therapy, drinking tonics made from *Aloe vera* and parsley, and applying *Aloe vera* to the ulcers and covering them with parsley poultices. HR also drank a total of 31 quarts of a tamarack decoction he made at home. The tamarack decoction, HR explains, "heals the sores from the inside of the body."

During this period, HR also hired a Colville shaman from Washington State whose healing abilities had only recently been acknowledged. This man's doctoring was similar to other shamans HR had called upon. This shaman left HR with two large handkerchiefs which were tied together to form a loop that was placed over his head and under one arm. These he was to continue wearing for one month's time, after which he was to put them underneath his bed pillow. HR followed this shaman's advice, despite being dissatisfied with the explanation given by him for the cause of the problem—he suggested that HR was the victim of the *pťax* of two people, one of whom he could see and the other of whom he could not see. The shaman informed HR that the hair from the tail of an ornamental China horse,that HR has hanging on his wall, had been used by an old woman to put a curse on him. The old woman was someone HR knew, lived on the west side of the river not too far away, and would now be

ill herself. Although HR was very much aware that an old woman living nearby would probably like to make him suffer (because of a land dispute in which he was the victor), he dismissed the explanation on the basis that this particular woman was healthy. Also, the shaman was unable to "see" the incident that had been described by the Upper Skagit shaman in 1975. The Colville shaman encouraged HR to continue with whatever home remedies he was using and cautioned him not to expect any immediate change in his condition for about eight weeks.

Ten weeks passed before HR asked the Colville shaman to return. Again, he performed his exorcism ceremony. He told HR to call him in another four weeks, but when the ulcerated leg worsened, HR decided to seek other courses of treatment.

HR's self-treatment program now consisted of using large quantities of hydrogen peroxide which he poured liberally over the sores. This he purchased at the local pharmacy. HR's purchases of hydrogen peroxide grew so large that the pharmacist began to ask what he was using it for. When HR showed the pharmacist his badly-ulcerated leg, he suggested immediately that HR consult the town's new physician, a young female general practitioner.

In the following few weeks HR's condition deteriorated rapidly. He was found bedridden, in pain and without medicine of any description when his anthropologist friend subsequently visited him. He was too ill to visit the new female physician and too distrustful to go to a hospital, so the doctor went to see him at his home. She initiated therapy involving white sugar poultices (see Knutson et al., 1981, for a report on this treatment of chronic leg ulcers), a form of treatment similar to the poultice treatments which HR himself had been using. And most importantly, she instructed Indian health workers, women from HR's own community and speakers of HR's native language, how to apply these poultices. Other women from his community were hired to visit HR daily to prepare him a nutritious meal and tidy his house.

By the summer of 1983, the results of this therapy were apparent, but still, HR felt the treatment was incomplete. In an interview I had with him at that time concerning the White doctor's treatments, HR stated:

Even if she gets them better—if they get better I can be good enough to go someplace. I will *go to an Indian doctor. Even if she gets them better. She get them better, but they'll come back again.*

In the fall of 1983, however, HR's established routine was interrupted when the town doctor announced she was leaving, his Indian health worker went on vacation, and the substitute worker applied the poultices in a slightly different manner. HR was very distraught; he augmented the sugar treatments with his own home remedies. He obtained the services of yet another shaman, a Coast Salish man from the Lummi tribe in Washington State. As a result of this man's therapy, HR again felt better. But the condition of his leg ulcers did not improve.

Discussion

At a time when Western medical personnel are lamenting their inability to treat certain Native disorders, there is a need to evaluate how and why Indian people like HR are using such diverse health care alternatives. Indeed, the most striking feature of HR's "illness trajectory" is its pluralism. He has selected and combined therapy from the popular, the folk and the professional sectors of the Canadian medical system, switching from one resource to another. HR's pathway through medical options should not be viewed as naive, speculative, or irrational, but as a pragmatic search for symptom relief in a milieu in which he maintains control. HR's case study demonstrates how his explanatory model underwent alteration as he received new information, negotiated with friends, and utilized alternative resources. But does this illness trajectory, as illustrated in figure 1, suggest a pattern of health care use? What was the process of his interaction with the various health care sectors? What were the major determinants in HR's health-seeking behaviour?

A number of models have been proposed to examine the "processual" approach to illness—the stages typically passed through by a person who believes himself or herself to be ill. One such model formulated by Chrisman (1977) distinguishes five elements of the health-seeking process: symptom definition, illness-related shifts in behaviour, lay consultation and referral, treatment actions, and adherence. Chrisman (1977:353) suggests that "the ability to relate conceptual elements with [illness] chronology should increase our capacity to explicitly link sociocultural factors such as health beliefs... to behaviors during sickness."

HR's case study shows that the presence of symptoms may not necessarily be sufficient to precipitate help-seeking beyond the popular sector of the medical system. It appears that HR has been afflicted with the same circulatory disorder, varying in its severity, since 1916. Primary treatment was, and continued to be throughout his illness episode,

Figure 1
Chronology of resort for HR's illness episode

Year	Perceived Etiology	Health Care Sector	Resource
1916-42	poisonous plants	popular	self-treatment: herbal, home remedies
1942	poisonous plants	professional	White physician: injections
1970	poisoned by physician's treatment in 1942	folk	Indian doctor: herbal
1970	poisons	professional	White physician: drugs
1970	poisons	professional	Chinese physician/healer: drugs, injections
1971	poisons	professional	White physician: ointment
1973	poisons impeding circulation	professional	hospital: skin transplant
1975	sorcery	folk	Indian doctor: diagnosis, exorcism
1975	sorcery	folk	Shakerism: exorcism, prayer
1975	sorcery	popular	self-treatment: herbal
1976	sorcery	professional	hospital: skin transplant
1976	sorcery	popular	self-treatment: herbal, commercial remedies
1981	sorcery	professional	hospital: skin transplants
1981	sorcery and poisons	popular	self-treatment: ointments
1981	sorcery and poisons	folk	Indian doctor: exorcism, herbal
1982	sorcery and poisons	popular	self-treatment: herbal
1982	sorcery and poisons	professional	hospital: ointments, washes
1982	sorcery and poisons	folk	Indian doctor: exorcism, herbal
1982	sorcery and poisons	folk	Chinese healer: herbal
1982	sorcery and poisons	popular	self-treatment: home remedies, herbal, commercial remedies
1983	sorcery and poisons	popular	self-treatment: commercial remedies
1983	sorcery and poisons	folk	Indian doctor: exorcism
1983	sorcery and poisons	popular	self-treatment: commercial
1983	sorcery and poisons	professional	White physician and Indian health workers: sugar poultices
1983	sorcery and poisons	popular	self-treatment: home remedies
1983	sorcery and poisons	folk	Indian doctor: exorcism

self-medication, first using familiar herbal remedies, "home remedies," or over-the-counter medicines from the local pharmacy. Yet HR did not perceive himself to be in a state of illness until 1942, when the pain associated with the ulcers impeded his activity and his ability to work—this supports Apple's (1960) thesis that it is the social disruption caused by symptoms that triggers the health-seeking process.

In HR's case, cultural factors had a distinct influence on symptom definition, the first step of the health-seeking process. Initially, HR assigned his problem to the category of natural illness. The most appropriate therapeutic procedure for a disorder of this etiology is self-medication, which HR tried. When this approach was not successful, HR resorted to a local White physician, not to a shaman whose therapy for a natural illness would be too closely aligned to self-treatment. The options that HR considered appropriate to combat the "poisons" which he believed had invaded his body, consisted most often of biomedicine available through White physicians, Chinese healers and a nearby hospital. These were chosen after consulting with friends (some of whom had comparable problems in the past) to determine the severity of the disorder and the necessary action to be taken.

The health-seeking process was most dynamic following HR's re-assessment of his symptoms to the category of unnatural illness. Again, cultural and social factors were instrumental in his perception of the disorder, which recurred during a time when he felt surrounded by social discord. *Ptax* (sorcery) was suspected immediately. HR sought confirmation not from his community of friends but from a shaman whose responsibility it was to identify the person(s) whose evil intentions were causing HR's misfortune. HR's explanatory model then reflected a retrospective assessment of the years' events as causal agents for his illness. His re-evaluation of the symptoms and their meaning

became a critical determinant in selecting alternative resources from that point onwards.

The question of "why" he was afflicted was now as important as "how" the illness was manifested. The disorder was now given meaning within his Native community, allowing HR to call upon those who shared his health beliefs and practices for suggestions about treatment and recommendations of healers. Thus, he first chose practitioners who shared his primary etiological assumption. But when the problem persisted, his explanatory model fluctuated enough to allow his etiological explanation to become multi-factorial, encouraging an amplified use of resources. He consulted a greater number of people for advice and acquired a greater number of options from which to choose appropriate therapy.

Once HR perceived his illness to be of unnatural origin, the nature of his transactions with practitioners altered. He no longer expected a cure to be administered by any one healer. He also moved from the role of "patient" to the role of "patron," selecting specific services from specific practitioners. He understood his problem to be an "Indian illness" for which the efficacy of biomedicine was limited. While recognizing that Western medicine is proficient at temporary symptom control but neglects the psychosocial needs of a patient, HR considered the therapeutic procedures of shamans to be especially capable of fulfilling the latter.

HR's pattern of using professional physicians and Western medical resources suggests that the severity of the problem was his major determinant in selecting that sector of the medical system. His adherence to the prescribed regime was greatest when there existed some commonality between the explanatory models held by HR and his practitioners, when there was immediate visible improvement in his condition, and when there was personal support from members of his community. However, once the symptoms were under control, HR sought amelioration of what he perceived to be the cause of the illness by attending Indian healing ceremonies. His expectations regarding this form of therapy and the practitioner's beliefs and function were always satisfied as his illness was given meaning within his own cultural framework. Inasmuch as these ceremonies were social events focusing on HR, he generally experienced significant behavioural changes following the treatment—quite simply, he felt better. He was, therefore, reluctant to deny the efficacy of the herbal remedies prescribed by the shamans. Instead, he rationalized the lack of symptom response while using such remedies by stating that he was not given enough of them, that he broke a cultural taboo while using them, or that Native cures require a long period of time before the results can be evaluated. This contrasts sharply with his view of Western drug therapy for which he has higher expectations, including quicker results. On one occasion, when HR perceived no immediate symptom response while undergoing drug therapy, he stopped treatment and switched to an alternative medical resource. On another occasion he stopped treatment because he perceived it to be antithetical to his expectations of appropriate therapy and, consequently, potentially harmful.

The greatest conflicts arose when there were major discrepancies between the explanatory models of HR and the practitioners. Foremost was the discrepancy in expectations of HR and of the medical personnel during his 1982 hospital stay. Apparently no attempt was made by the attending nurses or HR's physician to gain any understanding of the cultural influences governing HR's response to his illness. Yet both HR and the hospital personnel viewed the nature of his disorder, its cause, and its treatment and eventual outcome, quite differently. Thus, a problem in communication ultimately resulted in poor patient care, and HR left the hospital with a renewed need for the services of a shaman.

Conclusion

HR is a fiercely independent individual but he is not unique amongst Indian people in his multiple use of treatment alternatives.

It is generally agreed that the demands of Canada's Indian population are not being met by Western medicine. A recent editorial (1982) by John Last, an Ottawa physician and editor of the *Canadian Journal of Public Health,* laments, "we must confess our failures to diagnose and treat the disorders that exist here [among Indian people]." Yet despite this, only a few medical projects in Canada have attempted to integrate the available medical resources into a syncretic system offering more culturally-relevant health care to Indian people. Here in British Columbia, mental health research by Drs. Jilek, Jilek-Aall and Todd demonstrates the effectiveness of some Native therapeutic procedures (for example, in the treatment of anomic depression) and has prompted these medical people to co-operate closely with the few remaining Coast Salish Indian healers (Jilek, 1980:130; cf. Jilek and Todd, 1974; and Jilek and Jilek-Aall, 1978). Unfortunately, such a sensitive concern with Indian patients' psychosocial needs, as is taken by Jilek and associates, has not been forthcoming from the larger body of general medical

practitioners. Indeed, the Jilek approach has been criticized as being "anti-western, pro-nativist and anti-positivist" (Hippler, 1980:192).

The extent to which Indian people like HR are using alternative medical resources, and the knowledge and logic that are operative in their selection, await further clarification.

It is perhaps timely for Western medical personnel and anthropologists alike to address the issue of discrepancy between patients and practitioners and to focus upon the actual transactions between the two. Only when we gain an understanding of the cultural dimensions of health care within our pluralistic medical system will people like HR be assured of better health care.

In the meantime, HR's quest for a cure continues.

NOTES

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