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MEDICAL PRACTICES AND BELIEFS OF EVERYDAY LIFE IN A MIDWESTERN COMMUNITY

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of the Ohio State University

By
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The Ohio State University
1986

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Approved by
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1986
To My Mother,

Estella Johnson Taylor
ACKNOWLEDGMENTS

The subject matter of this study is somewhat controversial. Consequently, the participants of this study have been given pseudonyms. Most of them would not consider themselves as specialists in a technical sense nor what they do as even bearing any resemblance to the practice of medicine. However, someone reading this text might want to differ with this notion and make a claim that they are practicing medicine. To avoid any negative repercussions the participants might experience if such a claim were to be made and used against them, their voices and the local community in which they live will remain anonymous.

I am deeply grateful to the fourteen participants who shared a part of their lives with me, those in the community who led me to the appropriate resources, and all, including the couple I stayed with while collecting the data, who helped to make my fieldwork experience pleasurable.

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IN\[2pt]TRODUCTION

In recent years, the biomedical model has been under attack and proved inadequate in terms of its disease focus and health management ineffectiveness. According to this model, ideally physicians are trained to isolate and identify non-health agents such as viruses and bacteria in the patient's body, to examine his health problems in physiological terms and offer him relief from bodily symptoms. The socio-cultural aspects of the patient are rarely, if ever, recognized as having a direct bearing on how he may respond to the disease and the treatment process. The biomedical model assumes that health problems merely have physiological properties and are resolvable primarily through technological procedures.

While no one can deny the scientific breakthroughs in modern medicine, many question the usefulness (from a conceptual and pragmatic standpoint) of its objective approach in the treatment of individuals since responses to disease are interconnected to psychosocial and cultural forces. Studies have shown that those with similar degrees of organ pathology may present remarkably different complaint patterns depending upon the culture and setting in which
those medical conditions arise (Zola, 1966; Zborowski, 1952). Scholars make a semantic distinction between disease and illness (Eisenberg, 1977; Kleinman, 1980; Fabrega, 1973). Disease, according to the scientific medical framework, refers to the malfunction of body organs and systems, while illness represents the personal and social adaptive response to the disease. Illness is the process one undergoes to make the disease and its manifestations personally meaningful. For example, when one takes on the sick role, her lifestyle is altered. She may give up certain rights and responsibilities and her interactions with others; particularly family and social network may be modified. As Eisenberg states, disease is what physicians diagnose and treat while illness is what a patient suffers (1977).

The misassumptions and limitations of the biomedical model have led researchers to look for other conceptualizations of health. Investigators from diverse fields such as the natural sciences, social sciences, clinical sciences, and public health have explored various dimensions of health including disease, illness that results from the disease or disorder, health seeking behavior, health management, the healing process, etc. From this extensive body of materials, models of health have emerged, indicating the complexity of health behavior and its amenability to diverse fields of inquiry.
In his attempt to examine health and illness behavior, Talcott Parsons made a pioneering attempt to steer the sociology of health field away from the disease oriented biomedical model by his formulation of the sick role concept. In terms of health assessment of the criteria, Parsons uses the level of social functioning capacity of the individual while ignoring the notion of abnormalities of body organs and systems as health indicators. One who is dysfunctional and unable to perform her expected tasks remains a liability for the social system until she gets well. Society recognizes the potential for humans to become ill; therefore, the sick role is a legitimate role when handled properly in the system. According to Parsons, this institutionalized role consists of the following features: (1) those who are sick are not to blame for their ill health. The sickness is beyond their control and that some form of therapy is essential for recovery. (2) Those who are sick may be exempted from certain role and task obligations; (3) those who are sick are obligated to society to get well; (4) those who are sick must seek out the appropriate health resources (physicians) for assistance to regain their health and return to optimum functional capacity in the system. Parsons made a fundamental attempt to examine the notion of health and illness in relation to the American social system. A criticism against his model is that his sick role description assumes that illness behavior
is a socially and culturally learned response that is uniformly adopted by all those who are sick in society. In response to Parsons' predictable role set, Mechanic individualizes illness behavior in his Coping Response Theory (1962). He suggests that the sick role is a negotiated procedure between the individual and his social network. Mechanic's model indicates that a great deal of illness behavior involves evaluating and interpreting symptoms. Locating treatment resources is the last step taken in this negotiation process. Mechanic's model fails to include the evaluation of treatment resources in terms of whether they benefit the one who uses them. People not only want to know what resources are available, where they are located, and how much they will cost but also whether they will aid them in the recovery process. Suchman expands upon Mechanic's model by describing illness behavior beyond the symptoms stage (1965). Beyond this initial stage, the individual assumes the sick role, seeks medical care, becomes a dependent patient, and then recovers. Suchman contends that some who are sick will not experience all of these stages. This model only includes recovering persons and not those that suffer with persistent ailments or incurable disorders such as arthritis or asthma.

Another way of conceptualizing health behavior is to view all health-related activities as organized responses to disease that form a cultural system with interrelated
parts (Kleinman, 1980; Seijas, 1973). Disease exists in any society and every society makes some kind of provisions for combating it. Individuals experiencing and treating a disease look for ways to cope with the illness that can result from it. Each of these components including illness, patients, healers, social relationships and roles, institutions, beliefs and attitudes about sickness, and choice and evaluation of treatment are systematically interconnected and constitute what Kleinman calls the health care system. As a cultural system with symbolic meanings embedded in patterns of human behavior, a health care system, Kleinman contends is something to be examined much like language, religion and kinship systems. Viewing medicine as a social and cultural system, this model is concerned with the actors' response to sickness in a cultural setting in terms of how they identify symptoms, interpret and treat sickness, and evaluate treatment. Kleinman further asserts that the internal structure of the health care system consists of three sectors: scientific, folk, and popular. The scientific sector comprises the organized healing professions, that is modern scientific medicine in Western society. The folk sector contains a variety of sacred and secular practitioners and healing strategies which are often at odds with the scientific medical sector. The popular sphere is where the bulk of health management takes place, where health care activities
are handled by the lay population, and where illness is initially defined, self-treatment procedures implemented, and coping strategies formulated. Each of these three spheres contains different systems of meaning, beliefs, and norms that govern behavior (Kleinman, 53). In this sense, each sector of the health care system may be considered a separate culture.

While Kleinman's model attempts to examine the complexity of a number of components of health behavior, it omits health maintenance and prevention behaviors concentrating on the illness aspect of health care. According to Kleinman, the bulk of health management which takes place in the popular sector is preoccupied with preventive and health maintenance procedures. The actors' health behaviors consist of much more than organized responses to disease. Many of them utilize self-help and alternative medical strategies (including folk and popular) with the primary goal being wellness enhancement and not the treatment of disease.

This study unlike Kleinman's, focuses on people who consider themselves well. It examines the ramifications of wellness and health activities in a local health system. By the term local health system, I am referring to a cultural system composed of the folk, popular and professional sectors as described above located in a specific geographical community, a small, rural, predominantly white,
midwestern town that I will refer to as Johnson City (a fictitious name to protect the respondents' identities). The notion of a town denotes some sort of boundary, a distinct place with a name and a population. In some sense, this line of demarcation is artificial. Medical beliefs and practices often times know no boundaries particularly since information may be transmitted via technological devices such as the telephone, television and radio. For example, one may learn of a cold remedy from a telephone conversation with a friend or from a show on the health channel of cable television.

This study is primarily exploratory and is by no means exhaustive. It is not a complete ethnography of a community nor an examination of all of the components of a health system. It attempts to uncover the cultural terms of a select group (people selected randomly via ethnography who considered themselves well) of a local health system; to examine the compatibility and incompatibility of medical beliefs; to examine the ways in which medical knowledge is transmitted, and to explore the complexities of social networks and how they are used in the local health system.

Many studies on health behavior have tended to focus on the sick and illness aspects implying that actors in the system only use health resources including the network, self-treatment procedures, and alternative practitioners to correct some sort of organ malfunction they may be
experiencing. Certainly these activities may take place when one attempts to overcome a medical crisis. However, most of the health management process is concerned with health maintenance and prevention. This area of health behavior needs to be examined from a microscopic perspective. The health prevention studies that have been done are large scale and have focused on motivational factors such as education and socioeconomic aspects that cause people to take action (Tyroler, et al., 1965; Suchman, 1967).

This study is an exploration of what people know about health and the context in which this knowledge is transmitted. Such a problem lends itself to ethnomethodology and is concerned with what Garfinkel refers to as the self-organizing properties of social activities, namely, for this study, what actors do to organize their everyday health-related activities in the way that they do. My task as a researcher is to investigate the health-related ideological frameworks of the respondents and report their perceptions of their world. The questions chosen (see Appendix A) for this study limit what can be known about their world. It is generally known that some people have accidents; some get sick and quickly recover, while others appear to remain in ill health for long periods of time and even a lifetime. Still there are those, like my informants, who maintain that they are well and in good health
even though they experience medical crises. Many of them appear to live in a world in which much of what goes on is perceived within a medical context. The notion of wellness is part of their self-concept. They value specific health resources (many would be considered unconventional) and believe them to be essential to their daily lives. What do these people represent? This question is a difficult one to answer. I cannot be certain at this point, whether I am examining people who exhibit typical forms of health behavior. Self-help groups seem to be growing rapidly in this country. Perhaps in some way, these people and their attitudes are indicative of this phenomenon.

The design of the study is as follows: Chapter one explains my methodological procedures; Chapter two looks at the historical problematic relationship between the three medical systems, namely scientific, folk, and popular; Chapter three examines some problematic notions of alternative medicine along with how alternative medicine as a body of medical strategies and beliefs is meaningful in the lives of the respondents. Chapter four explores the network concept and how it is involved in the distribution of medical information; Chapter five discusses some problematic terms of this local health system, while Chapter six addresses the notion of how the respondents' self-concept might be connected to wellness. This is an ongoing study and only attempts to examine some useful ways of looking at health behavior.
NOTES


2 For a description of Mechanic's ten negotiation factors, see Wolinsky, 1980, 78.
CHAPTER I

METHODOLOGY

Problem Description

Medical knowledge exists in any society. How this knowledge gets distributed is related to power. In western society, there is the scientific medical knowledge that is controlled by a select group. This group, through legislated laws and the support of powerful institutions has been given charge over health care management and consists of the legitimate medical practitioners of the society. The knowledge these practitioners possess is given out in very specific ways for very specific problems. One major way a layperson gains access to this knowledge is by taking on the role of patient. When assuming this role, one encounters specialists who in utilizing this knowledge will follow a specific set of procedures in an attempt to bring about effective treatment results. During these transactions, the patient may encounter medical beliefs that are in conflict with his own.

A concern of this study involves examining the compatibility and incompatibility of these medical beliefs. What are some criteria natives use to determine whether a
practitioner's treatment methods have met their expectations? What kinds of problems is the specialist expected to solve? More specifically, what kinds of problems are the scientific specialist's domain and what kinds of problems do the natives themselves treat? Self-treatment by the individual and her significant others is the first strategy implemented in one's attempt to resolve a medical crisis or to prevent one from occurring. This kind of medical knowledge is difficult to study for several reasons.

Firstly, unlike scientific medical knowledge consisting of a unified body of information and applied to a very precise set of procedures, self-treatment medical knowledge (also may be referred to as folk, popular, unconventional, natural, or alternative medicine) is diffuse, non-integrated, and not centered around any one theory or group of theories about health or disease. The origin of many of these self-help procedures is uncertain, but some may be traced to ancient traditions. For example, the health food approach which is part of the popular medical system has its roots in ancient Native American herbalism.

Secondly, this form of knowledge is related to powerlessness. In this society, one does not gain status once one becomes a specialist in a certain area of these medical procedures as one would if she were to become a physician or surgeon specializing in a particular area of scientific medicine. Alternative practitioners and their medical
systems are often perceived in pejorative terms. Consequently, much of their medical knowledge must be given out in very discreet ways. Often these practitioners make use of their unconventional medical beliefs and procedures secretively, not wanting to be discovered by those who in the local community maintain conflicting medical beliefs. For example, a psychic therapist may not want others in the local vicinity who may disapprove of this medical system to know she possesses this skill. In this respect, this information is given out in a very limited way.

Thirdly, the natives use these unconventional medical systems interchangeably and simultaneously with scientific medicine. From the layperson's perspective, the boundaries are not distinct. One might solicit help from a physician, chiropractor, herbalist, and faith healer respectively for the same medical problem or for different ones she may be experiencing simultaneously. Every medical system has its terminology and notions of reality. Symptoms labelled and diagnosed in one medical system may be conceptualized as something else in another. For example, problems involving acute loss of memory, mental deterioration, disorientation, and inability to formulate sentences may be perceived as manifestations of Alzheimer's disease in the scientific medical system while they may be identified as signs of demon possession in the faith healing medical system. Each medical system has its problem frames, ways of looking at
health-related phenomenon and its solution frames, ways of attending to those problems.

Apart from the medical systems one turns to for health management, there are socio-cultural factors that influence one's notion of health and how to handle health-related problems. A person experiences states of health based upon his personal beliefs and orientation towards medical frames, as well as the state in which his significant others perceive him to be. A person who is tired, lethargic and unhappy most of the time may begin to feel sick if he or his family perceives this state as threatening and labels it as "sickness" (Kleinman, 1980:76). There are a host of terms natives use to differentiate their health-related experiences. What is the meaning of "cured" versus "healed" and "sick" as opposed to "well" for example. One of the aims of this study is to discover these terms and their range of possible meanings.

Self-treatment procedures may include a host of unconventional medical systems. In a sense, this medical knowledge may be thought of as the underground health resource, a medical network preoccupied with health prevention and maintenance. Such a notion implies that medical knowledge is not static but something that is out there in the world being distributed among a group of people in the network of the local health system. How does one use her network to acquire this knowledge? Certainly one would not
have confidence in every alternative medical system. While an herbalist may be satisfied with the results she obtains from herbalism, iridology, fasting, and health food strategies, she may be vehemently opposed to psychic therapies, yoga, scientology, etc. How does one locate the medical knowledge that more appropriately meets her needs and expectations? Another dimension of this study explores this issue. In examining the social networks of the informants, this study is concerned with how medical knowledge is transmitted and how network ties have an impact on one's health-related behavior. Sometimes one may go to a physician in following a friend's advice. If the friend is a nurse, this may have a greater influence on her decision to go. Milroy states that networks in rural areas lean towards density (many persons linked to ego are also linked to each other) and multiplexity (members interact with each other on several levels, e.g., a man's boss might be his father, neighbor, and minister), factors that act as norm enforcement mechanisms (1980:137). Other factors of social network that may influence behavior are the affective value placed on the relationship—whether it is an intimate one, or one that is somewhat distant; and how one in the linkage is perceived by the individual—whether she is someone to look up to, trust, or not take very seriously. This study is concerned about social networks to the extent of what medical knowledge relations share with each other.
Selectivity

Johnson City with a population under 20,000 was selected as the local community (meaning place of settlement) in which to conduct this study. This relatively small community, I felt, would contain a wide range of existing alternative medical resources. Visibly present were a faith healing ministry, a local health food store, a food co-op, some self-help groups such as Alcoholics Anonymous and Help Anonymous, and several drugstores.

From a historical standpoint, the community has been a place where alternative medical procedures, namely water therapy were used. During the nineteenth century and early part of this century, the county area was nationally renown for its sulphur springs and attracted tourists interested in the springs for what was believed to be their medicinal qualities. At the time, advertisement materials were printed up and distributed describing the springs and their location. The following is an example of those descriptions taken from a copy (obtained from a local resident) of what was one of the originally printed announcements:

MEDICINAL PROPERTIES: The large number of permanent cures which have been effected during the past two seasons establish beyond doubt, the rare and valuable medicinal qualities of these waters.
During the course of my research, I found people who remembered the springs from their childhood and how at one time they generated a thriving business for the area.

Another reason Johnson City was chosen as a place to study self treatment and alternative medical behavior was that this kind of behavior, in a predominantly white, college community needs to be examined. Much of the scholarship on folk and alternative medicines has concentrated on ethnic and religious groups and/or lower classes of people in western communities, and non-industrial societies. The implication is that these types of medical beliefs and practices are something to be associated with distinctively different groups or with those in remote areas where scientific health systems have had little impact. While such nonmainstream groups often involve themselves in medical belief practices that may be labelled "unconventional" or "nonscientific," this form of medical behavior need not necessarily be restricted to these groups. Self-treatment procedures represent the major type of health management in any local health system. Thus mainstream groups are likely to utilize these unconventional medical forms as well. How such medical strategies operate in the health management process must be explored within these groups.

Locating an informant within the local community required some method of selectivity since everyone could not be interviewed. Selectivity was governed by those who could
give me the most information and help me uncover the patterns of that culture. This study examines specialized knowledge in a local health system. Therefore, I only interviewed specialists who could and were willing to supply me with information.

The term "specialist" not only includes those who are formally trained in some aspect of health care such as the pharmacist (see Appendix B) and county health nurse, but also those who have acquired some type of medical knowledge from experiencing traumatic health crises; doing extensive reading; being an apprentice to a practitioner such as an herbalist; or receiving the gift or power of healing from metaphysical sources. I used this term in making distinctions between those I needed to interview and those I did not. Natives in the local health system might not necessarily use the term "specialist" as I did. For example, a pharmacist would probably not consider a faith healer or one who has had a bout with cancer a specialist. A health food store owner might ask a friend of hers who also believes in natural cures whether dolomite is good for kidney stones but might not call her a specialist. However, a public health nurse would probably be considered a health specialist by most members of the community. Health figures such as the pharmacist and public health nurse are visible, and they serve some type of need by performing their roles in the local health system. People expect them to be able
to handle certain types of problems. However, there are those in the health system whose services are utilized in a much more restricted sense. For example, the librarian with a mastectomy tells a very restricted group of women how to detect breast cancer. The psychic therapist does not want people in the local vicinity to know she has this skill. Most of her clients are from out of town. The fact that people go to them for assistance (in the librarian's case, she sometimes gave information about breast cancer voluntarily) may be some indication that they are a specialist in some area of health.

The initial stage of the fieldwork concerning alternative health behavior began by my casually talking to the owners of the local health food store to find out how health-related information was transmitted. Posted on the bulletin board were health-related pamphlets on topics such as breastfeeding and diet. There was a small leaflet with a map indicating how to get to a local herb farm designed like a chalet. There was information on the local fluoridation issue. Anne, one of the owners who eventually became one of my primary informants (those selected as respondents to the interview questionnaire), was very much opposed to the water being fluoridated. She had been attending opposition meetings trying to prevent it from happening. Dates indicating when the next meetings would be held were posted on the board. Also, there were some popular medical books such as
Jethro Kloss' *Back to Eden* on a rack on display. Besides the visible forms of information, verbal types of information were exchanged between owner and customer. Testimonials (i.e., the personal endorsement of a product) or the repeating of some other person's endorsement (e.g., "A friend of mind said that she tried this...and it works") seemed to have been persuasive devices that were used in disseminating information.

The owners introduced me to a number of resource persons they thought I would be interested in talking to, including the owner of an herb farm, a local doctor involved in home births, a woman involved in Shiatsu (acupuncture without needles) and a list of others. I became known as someone who was interested in health attitudes and practices in Johnson City. Prior to an informant's participation in the formal interview, she was given a statement outlining the objectives of the study in nontechnical language (see Appendix C).

Much of my attempt to locate appropriate oral resource persons came about through my networking. It was similar to going into a new community, describing the kind of hairdresser I preferred, and inquiring as to whether there were any there to fit the description. If the person to whom the question was addressed did not know of any hairdressers fitting the description, she might lead me to someone whom she felt did know. My informants consisted of persons in the
community that were thought to be knowledgeable about self
treatment procedures and concerned about health. In explain­
ing my objectives to various persons in the community such
as the health food store owners, several food co-op members,
and an herb farm owner, I was referred to several people
who were experiencing or had undergone a medical crisis, to
women who had had home births, and to alternative practi­
tioners (this term was not used by the informants). One
of the customers in the health food store was telling the
owner about how the tenants at one of the local senior
citizens building where she worked used aloe vera juice for
their stomachs. In my checking out this lead at the build­
ing, several of the residents referred me to Jim W (see
Appendix B), the man whom they thought dug roots and con­
cocted old home remedies. The former editor of the local
newspaper led me to the psychic therapist. He made mention
of her psychic abilities to me. When I told her he had sent
me to her, she stated that he did not know what she did.
Only a select few in the community knew specifically what
she did. What was important about this approach in locating
informants was that I became exposed to peoples' perceptions
of others. Often these perceptions were different from the
individual's self concept. For example, all of my selected
fourteen informants felt that they were well. Yet two of
them had been referred to me in relation to "sickness."
"You should see Jean R because she just had a mastectomy and
is undergoing chemotherapy." The herb farm owner was referred to me because she grows herbs. However, she herself felt that she did not cultivate the herbs for medicinal purposes but more as seasoning agents to sell to people. These herbs had little to do with her health; yet, the notion of health was inextricably connected to her self concept and identity. Each of these fourteen informants were selected because the notion of health was connected with much of what they did; it was a significant aspect of their self concept, and all felt that they were well. All felt that their health was a commodity; something to protect and not take for granted. While this notion might appear trite, it is significant because six of them had undergone some sort of conversion experience in terms of how they viewed themselves in relation to their health. Jim stated how he abused his body by drinking alcohol and smoking when he was a young man but that he no longer did that. Anne talked at length about how she abused her body in terms of drugs and cigarettes when she was a teenager. Her health changed when she moved to Oregon and stopped the harmful habits. She stated:

My health did a big turnabout. I gained like thirty pounds. But my system was exhausted after what I had done to it.... And my glands weren't functioning. I fasted for five days and gained two pounds.
Some of the individuals knew each other, and some did not. To protect the identity of the participants, each is referred to in the study by a pseudonym (see Appendix B). Some asked to remain anonymous, while others did not seem concerned one way or the other. One person in particular was very disappointed her identity would not be disclosed. She indicated to me that she had been wanting to share her health program with the entire world and originally thought her participation in this study might be an avenue to fame.

The questionnaire attempted to elicit responses that would indicate the medical terms of the local health system, as well as how the natives rely on their stock of knowledge in problem-solving situations related to health. For example, what is a self-treatable health problem? What types of self-help techniques are used (e.g., utilizing folk and/or popular approaches, waiting it out with the assumption that the problem will clear up by itself, following a friend's advice based upon her personal experience, etc.)? What role does the scientifically trained physician play in the health management process? What types of practitioners other than scientifically trained physicians are available in the local health system? What role(s) do they play in the health management process? What type of health-related knowledge exists in the community? How and to whom is this knowledge transmitted?
Part of the interview questionnaire (see Appendix A) contains what James Spradley calls, "descriptive questions" to get a sample of the natives' repertoire of symbols. He emphasizes the importance of the investigator getting the natives' terms to discover the inner meaning of that culture (1979:73). He also states that the ethnographer should be cognizant of at least one setting in which the informant performs typical activities in order to ask the informant significant questions (1979:85). For example, the question, "describe something you always treat at home" allows for the possibility of the informant's home being an appropriate setting for handling some health crises.

Some health-related knowledge appeared to be highly context specific, and the formal ethnographic interview was a somewhat ineffective tool in eliciting this information. For example, questions 9, 11, 14, 19, and 37 (see Appendix A) were designed to generate what folklorists refer to as "home remedies." These homemade medications may involve household materials such as baking soda, turpentine, or whiskey and/or natural environment materials coming from plants, as well as mineral and animal substances including herbal teas, human urine, chickens, eggs, mud, etc. This type of medical information is often transmitted in very traditional ways such as mothers to daughters and friends to friends. The interview generated very few of these medical practices; however, it became evident that such
medical practices were still in existence in this community when my allergy began to show some visible signs of discomfort. Some told me home remedies that they had heard about for this type of problem or things they had tried themselves. For instance, one woman told me to "sniff at a mixture of part salt and soda." She insisted that it really works. The extent of the respondents' use of home remedies could not be established due to the natural context needed to elicit this type of information. The ethnographic interview was the major tool used to obtain data and it could not provide the necessary environment.

Apart from conducting a formal interview with the fourteen respondents, several contextual settings including the food co-op, the health food store, two pharmacies, and an Alcoholics Anonymous meeting were observed to see how health-related information was exchanged. For example, how might a pharmacist recommend a product to a customer and friend who is experiencing very painful leg cramps? What might customer and practitioner talk about during this exchange? The intention was to investigate naturally occurring exchanges of information, specifically those related to health. My observation of the contexts for the transmission of allergy information was purely incidental and something that evolved extemporaneously with my severe hay fever episodes.
Data

The methodology yielded two types of data. The tape-recorded interview material introduced me to the patterns of symbolic structures within this local health system. It elicited responses that were an indication of how the natives perceive and categorize their health-related experiences—e.g., a health problem that is self-treatable versus one that requires the attention of a practitioner, the notion of sick versus well, the notion of what knowledge is transmittable and what is not. Health crises are commonplace occurrences in the local health system and are often resolvable through self treatment and lay specialists' efforts. How one goes about resolving them is personal to the extent that one is allowed to make choices about the medical option(s) he will utilize. The resolution often involves one's reliance upon the social relations of his interpersonal network for advice, understanding, support, and/or tangible rewards such as running errands, watching the children, and giving financial support.

The other type of data resulted from ethnographic observation of health-related resources such as a local discount drugstore, health food store, and an Alcoholics Anonymous (AA) meeting. These settings yielded natural occurrences of exchanges between various actors in their social networks. How one goes about getting information will depend upon the type of information he is requesting
and from whom. For example, a customer in the health food store stated to the owner and others gathered around the counter that she heard from a friend who works at Harvey's (fictitious name for senior citizens' complex) about the residents taking aloe vera juice for their stomachs. "Is it good for your stomach," she asked. "What about it?"

These facilities provide a setting where the information one gets from friends, associates, strangers, and the media is tested. The transmittor of the information often states the source of his information in some kind of way—"A friend of mine said," or may not name the source but only indicate the information was picked up somewhere—"I heard that." People may go to these resources to validate their information with a possible intent of trying the product for themselves. They also may publicly endorse a product they have tried with the intent of persuading someone to try it or of merely spreading the "good news" that the health problem was resolved or is under control, and out of satisfaction for the product's effectiveness. They may also publicly denounce a product if after trying it they were dissatisfied with its results.

The Setting

According to the 1980 census, Johnson City has a population of 18,780. Whites make up 93 percent of the population, while blacks and other non-whites make up 7 percent.
The city covers an area of 9.5 square miles. The average per capita income is $6,491; median family income is $20,159, and median household income is $17,197. Johnson City is a part of what is considered the fastest growing county in the state. The city is ranked among the top three for the highest employment rate in the state. While there are 75 local industries, 40 percent of the workers in the community commute to work outside the city.  

The history of the local university is rich in medicinal lore. Situated in the southern part of the city, the university was founded in 1844. Its location is due to the sulphur spring that once attracted many tourists and those interested in what they called the spring's medicinal properties. A hotel was built in 1833 near the spring to accommodate the tourists. Local histories point out how the area's Indians, before the university was established, called the spring "medicine water."

In 1841, when the proprietor abandoned the natural health project, plans were made to convert the area into a university. Today the spring's function has changed somewhat from that of its early days. It often serves as a center for initiatory rites for the students. Those engaged and those who reach their twenty-first birthday get thrown into its odoriferous waters.

There are five pharmacies in the city: two located
in the downtown area, one on the south end (contains heavy concentration of black population) of the city, and two on the west end near one of the town's two senior citizens' complexes. Lorie, the pharmacist included in the study, works at one of the drugstores near the senior citizens' complex. This particular drugstore is one of the businesses that make up a mini shopping center and is a few yards north of the local hospital. Besides the pharmacies, there are at least five health-related businesses in the city, including a health food store, food co-op, weight loss center with a smoking clinic, karate studio, and an exercise center.

Both the health food store and the food co-op are situated in the downtown area, and both were included in the study. The health food store recently got a new owner (Anne, one of my informants, is the former owner). Signs about high-protein drinks, tropical drinks, juices, and herbal ice tea are hung on a big, blue movable poster board stand that is placed on the sidewalk in front of the store every morning to attract customers. Although the store contains a juice bar, it does not have seating facilities. Thus customers usually purchase their drinks and drink them somewhere else outside the store. Customers often stand and chat with the owner or other customers while browsing through the store or purchasing various products. While the food co-op is located in the downtown area, it is not directly accessible from the sidewalk of the main street.
One must go through a glass door, then up a big flight of stairs, and towards the back of the building to get to it. One time when I was there, hardly any customers came in. The volunteer stated that Thursdays are usually slow. For both businesses, the influx of customers is unpredictable.

A large number of county residents utilize Johnson City's medical facilities. The hospital with 136 adult and pediatric beds and 20 bassinets is located in Johnson City and serves the entire county. The number of medical personnel at the hospital is as follows: 31 physicians (M.D.s) on the active staff, 34 on consulting staff, 3 emergency room physicians, and 3 honorary physicians; 92 registered nurses, 36 LPNs, and 66 nursing assistants, male and female. The hospital has a completely staffed and fully-equipped laboratory. It contains x-ray facilities and a coronary and intensive care unit. In 1976, a $6 million expansion project was completed that provided new laboratory and x-ray facilities and an out-patient clinic.5

The Public Health Department consists of three divisions: nursing, environmental health, and vital statistics. The department offers the standard health services such as health screening programs, school health programs, Women, Infant, Children Supplemental Feeding Program (WIC), immunization programs, preventive health education programs, and health care to the elderly and disabled for the county area. According to Vital Statistics, the five leading
causes of death in the county for the last three years are cardiac-heart, cancer, respiratory, cardiovascular, and accidents and suicides.

There are a number of social agencies in the community that are health related. Help Anonymous, founded in 1973, is an information and referral service for the county. The agency handles as many as 6,000 cases in one year. Once a client's needs are assessed, Help Anonymous refers the client to the proper agency located in the community or the surrounding area. Some of the local agencies include the Mental Health Center, LaLeche League, Planned Parenthood, Project Rainbow (a pre-natal clinic sponsored by the County Health Department), Alcoholics Anonymous, Easter Seal (organization of community people who provide help for the handicapped), Lions Club (for eyeglasses), Hospice, Speech and Hearing Center, and People in Need (provides food for the desperate). Help Anonymous also has a crisis intervention program whereby telephone counselling is offered to those in need. If a client requires some on-going counselling, then she is referred to the Mental Health Center.

Apart from the more formalized health services and practitioners, there are various alternative health practitioners including a manual therapist with a degree in naturopathy and one in mechino therapy (use of diathermy, muscle stimulation, contraction, etc. as treatment techniques); a psychic therapist with a Master's degree in social
work whose services focus more on helping people "get in touch with themselves" than giving them a reading; a medical technologist and massage therapist whose treatment program integrates Shiatsu, Hatha Yoga, massage therapy, polaric therapy and reflexology; the owner of an herb farm that serves as a haven and a source of comfort, particularly for people with stress; herbalists or those who are very knowledgeable of and rely upon herbs for curative and preventive purposes; and a faith healer with a nationally acclaimed ministry that is being run temporarily by his assistant while he is away. This list is not intended to imply that the above alternative practitioners are the only ones in town. These are the ones that were involved in my study.

Some of these practitioners charge a fee for services rendered, and some do not. The manual therapist charges a flat fee of $15 in cash per office visit. The psychic does not have a required fee. Some clients pay her while others are unable to. She equates the miracles that happen in her life with God's rewarding her or making up for the differences in pay she receives from her clients. In terms of the herb farm, clients may buy products from the store there. But picnicking on the grounds, feeding the ducks, or just sitting around in the fresh air are activities done free of charge. The herbalists (although these people are very knowledgeable about herbs and utilize them in self treatment practices, they may not call themselves herbalists) use
their medical knowledge to help family and friends who may be going through a health crises and/or who want to use herbs as preventive medicine. The faith healing minister does not require a fee when he prays for his clients. However, those connected with the church, either members or persons on the mailing list, are encouraged to give "freely" to the ministry. The church sends out (via mail) or gives prayer cloths and blessed water to clients, encouraging some type of monetary donation in return.

Another aspect of alternative health practices in the local health system includes homebirthing. Nurse midwifery (certified R.N. midwife) is legal in the state while lay midwifery (non-certified) is not. Choice, a group concerned about people's right to choose where to have their babies, is located nearly thirty miles from Johnson City, serving several counties. The group's two birth attendants (nurse midwives) always attend a birth together. They feel that they come as friends to work with the mother on an emotional level and are opposed to interventionist techniques during the birthing process. They believe that they are there to support the mother through labor and to insure that her wishes (e.g., not having an IV) are met. They stress the use of oil massage and warm compresses to aid in the birthing process, whereas a physician might have an episiotomy done. Choice handles only low risk cases and has what they call a good backup system in case of an emergency. The
birth attendants are registered nurses and are employed at
their respective local hospitals. An obstetrician in
Johnson City attends home births as well. He also was
instrumental in getting the birthing room at the local
hospital. Two of my informants have had home births;
however, figures for the number of home births in the last
five years in the city were unavailable at the time this
study was conducted.
NOTES

1For an examination of how two different ethnic groups describe their symptoms differently when the diagnosed disorder is the same, see Irving Kenneth Zola, "Culture and Symptoms—An Analysis of Patients' Presenting Complaints," American Sociological Review, Vol. 31 (1966), 615-633. Zola argues that a sign indicating problems is related to its prevalence and correspondence with major value-orientations of a specific culture. This study contends that the epidemiological differences observed between and within societies might be due to the selective process a patient uses in expressing his symptoms to the physician and not so much of an etiological one.

2Spradley uses the term "verbatim principle" in reference to the conflict that is present between investigator and native because of their different perceptions of the cultural scene. To make these differing perspectives less of a problem, the investigator should "make a verbatim record of what people say" (1979:73).

3Information obtained from the local chamber of commerce and one of their brochures.

4Titles of local histories are not given to protect the identity of my informants.

5Information taken from local chamber of commerce brochure.

6Figure quoted by Help Anonymous office.
CHAPTER II

THE RELATIONSHIP BETWEEN SCIENTIFIC, FOLK, AND POPULAR MEDICINES

Medicine (meaning treatment practices relative to the art of healing) and health care, including prevention and maintenance, are controversial in the sense that authoritarianism is often in conflict with individualism. Prior to the institutionalization of medicine, anyone whether farmer, merchant, lawyer, or housewife could practice it with little or no concern for legal ramifications. The line of demarcation between doctor and medical lay person was not distinct, and in some cases, practically nonexistent primarily since physicians had no real body of medical knowledge they could call their own. The art of healing was basically domestic in nature and something done by family and friends rather than by a physician with formal medical training (Risse, et al., 1977:1). Presently, however, the medical profession (namely physicians) maintains a monopoly on healing practices from a legal standpoint. This authority is being challenged by the public at large.

Many remain somewhat skeptical towards "orthodox" medicine for various reasons, some denouncing it completely.
A number of "unorthodox" medical therapies and techniques are being used. With so many medical options available, how can one know which one is the most effective for what type of problem? Which one is the most reliable or the least reliable? Who should or should not be allowed to practice medicine? Medical control seems a necessary evil often impinging upon the right of the individual to play a more active role in medicine. Where does the medical doctor's domain begin and end? Who should do what in terms of maintaining one's health and/or preventing a medical crisis from occurring? To what extent are health practices private? How much medical knowledge can the lay person obtain and use effectively without having a formal medical education? Is one practicing medicine when one administers treatment such as the laying on of hands to one with osteoarthritis who believes in faith healing? What are the limitations of modern medicine? How might nonbiological factors such as socio-cultural, psychological, and religious elements affect illness behavior?

The above questions are indicative of the ongoing contention between modern, folk and popular medicines. To gain insight into this dynamic relationship, it would be helpful to examine these three forms of medicine within an historical context. This discussion is meant to serve as a backdrop for the ethnographic material of this study. Many of the respondents may possess no knowledge of the
historical tensions between these different medical forms, and in a sense, one could argue that this is not their history. Yet, common themes exist in what appears to be two disparate types of data. For example, the notions of the application of self help medical practices for curative as well as preventive purposes and the desire for individuals to be major participants of their health care program have roots in the nineteenth century health reform movement. Indeed, the medical consciousness of many of the respondents is similar to that during this earlier health movement. This brief medical history will outline some of the major themes and problems in its consideration of the historical relationship between the three medical forms.

Neither scientific, folk, or popular medicine is without its successes, failures, and quacks. And none of the three forms is without controversy. Witness the increase in the number of malpractice lawsuits against physicians; the numerous devices on the market to cure arthritis or to increase the size of women's breasts; the many "natural" nostrums to help make women young and beautiful; or the number of faith healers who sell various items such as prayer cloths, pins, crosses, blessed oil, water, or some type of solution to those "in need" in the name of God, prosperity, and good health. The different controversies are too numerous to mention here, and many are nowhere close to resolution.
Scientific Medicine's Evolution

The history of scientific medicine (also referred to as modern, Western, allopathic, conventional, orthodox, and materialistic medicine) is usually presented in evolutionary terms, i.e., something that grew away from folk medicine as a result of a series of scientific discoveries connected with the alleviation of suffering and/or the prolongation of life (Duffy, 1976; Rothstein, 1972; Shryock, 1977; and Youngson, 1979). Therefore, discovery is equated with progress, enlightenment, and change. During premodern times, health conditions were poor, and the performance quality (based upon effective treatment techniques and whether the doctor could save the patient's life) of practitioners was less than desirable (judging by modern standards). Up until the mid eighteenth century, there were no educational standards for doctors in this country. Religion and medicine were somewhat inseparable, and many priests were medical practitioners. In prelicense days, it was not uncommon for anyone to supplement his/her income by serving as a doctor.

The boundaries between folk and early western medicine were practically nonexistent prior to the onslaught of technological discoveries. The treatment practices of most doctors, whether formally trained or not, were grounded in non-scientific theories about disease and empiricism. Many practitioners held to a humoral concept of disease
which assumed that an imbalance of the four basic humors (i.e., blood, phlegm, yellow bile, and black bile) caused sickness. The imbalance was the result of either an excess, or a fermentation or putrefaction, or an alteration in movement of a particular humor (Duffy, 27). Thus, practitioners treated body states such as fevers and fluxes rather than disease (Shryock, 1977:40).

Treatments consisting of excessive bleeding, purging, sweating, and blistering were harsh to say the least and based on theory rather than result. Along with these painful techniques, doctors used nauseating substances in treating patients. For example, a small pox cure "consisted of bleeding, a soft diet, and the administration of a variety of drugs including syrup of white poppies and sheep's 'Purles' in water," along with a poultice made up of cow's dung, milk, and bread applied to the throat and used inwardly for "defluxion" (Duffy, 28-29). The fecal material of both animals and humans was often used as medical remedies. As a result of "heroic" medicine, patients were more often harmed than helped. Numerous complaints of patients dying from excessive bleeding and regurgitation continued even after the professionalization of medicine. For many regular physicians (those with a medical degree) were committed to "heroic" medicine regardless of the consequences.
The distinction between physician and folk practitioner and/or medical lay person became much more pronounced once the practice of medicine became professionalized. Twaddle characterizes a profession as "having some formal occupational organization, community recognition (usually in the form of licensing), and autonomy in the definition and organization of work" (1977:162). With autonomy, the medical profession could set its own standards of medical education and training, control the licensing of practice, and the recruitment process of its members, define the scope of its work, and monitor its standards of practice (Twaddle, 1977:162). Practitioners outside of the profession (i.e., irregulars including apprentice-trained practitioners, folk healers, and quacks) were considered unqualified from the elitist viewpoint of the medical profession, whether their treatments were effective or not.

Historically, the medical profession has been an institution of exclusivism, promoting sexism, racism, and classism. For example, the AMA refused to admit women M.D.s with the same qualifications as those of white male M.D.s in 1868. Delegates from racially integrated medical societies were refused a seat in 1870 (Weil, 1983:22). And the clientele of most regulars consisted of people from the middle and upper classes.

Along with professionalization came a higher standard of medical education in terms of entrance requirements and
medical examinations. Scientific investigation became a dominant part of medical training, and gradually the practice of medicine became centered around the application of scientific knowledge for the purposes of controlling health problems and eliminating diseases. Scientific discoveries (too numerous to mention here) had a place in the practice of medicine. For example, the medical world's acceptance of the germ theory created a major interest in eradicating disease through massive immunization programs. Prevention approaches consisted of manipulating features of the environment such as upgrading sanitation conditions, maintaining immunization programs, and isolating infectious cases. This concentration on the biological aspects of illness has literally eradicated the contagious diseases mentioned earlier.

While the practice of medicine moved towards technology, a whole new set of problems emerged. Talcott Parsons states that the conditions of scientific advance consist of "first the abstraction and generalization of knowledge, and second, the development of investigative procedures" (1951:33). Many of the technological advances in medicine were due to discoveries that materialized in other fields such as physics, botany, and biology, and in the course of time came to be applied to medicine. For example, while the first bacteria were discovered in the seventeenth century by Anton Van Leeuwenhoek, a Dutch microscope maker, the
linkage of bacteria with the theory of contagion did not occur until the mid nineteenth century (Twaddle, 12). With each discovery, a very specific kind of knowledge was required for the practicing of medicine. The new set of procedures that were required for the application of this knowledge was upsetting to various interest groups, namely the irregulars made up of various subsets of practitioners, from the apprentice, herbalist, to the mid-wife. Progress in modern medicine has meant a move towards specialization, and in the process, medical procedures have become incomprehensible to the masses and something to be accepted on blind faith.

Self-Help and Health Reform

Historically, the general public has resisted the authoritarianism of scientific medicine, refusing to depend totally upon a physician for health strategies. The self-help notion that was the backbone of the popular health reform movement in the nineteenth century encouraged everyone to control her own destiny by improving her life and health through personal efforts. While historians usually associate the self-help ideology with the Jacksonian Democratic era, the concept in some form was in existence long before then, particularly when folk medicine was the dominant form of medicine and was used to handle major and minor health problems. As stated earlier, the art of
healing was something that belonged to the community and not something that took place in an impersonal environment as we know a sterile hospital or clinic to be. However, as scientific medicine gained so much control, the medical rights of the individual were being redefined and in some cases violated.4

The notion of self-help is very complex, particularly the way it is expressed beginning in the nineteenth century during the health reform movement up until the present. Medical historians date the beginning of the movement at around 1830, a time in which concern for personal health and hygiene intensified. The movement's major purpose was to prevent disease by educating the masses about the laws of physiology and hygiene. This massive education program was very important during the time, especially since infectious diseases and death were so rampant. In spite of this life-threatening environment, good health was thought to be attainable if one adhered to natural laws. Good nutrition was a key factor, as well as a clean environment, and proper rest. Sickness was no longer something one had to endure stoically, or something that was placed in the hands of a vindictive god (Morantz, 1977:75).

Obtaining and maintaining good health through self-help means had important feminist ramifications. Physiological societies for women were established in various parts of the country in which women could talk openly about
female health issues with others (including female physi­
cians) who understood their concerns. Morantz discusses
how the movement attempted to prepare the woman for her
important role as manager of children and household. There
were lectures on bathing, infant care, cookery, childhood
sexuality, female anatomy, etc. There were lectures
against the corset and tight lacing.

It is important to note that some health reformers
attacked the white male medical power structure in their
treatment of pregnancy and childbirthing as something
inherently pathological and abnormal. While regular
physicians utilized harsh interventionist methods in handling
pregnancy and childbirthing, health reformers saw both
processes as natural, requiring fresh air, proper diet,
exercise, and hygiene. Mothers were encouraged to bathe
infants daily and to dress them in loose garments so as not
to restrict movement. Sweet oil was used for chafing
problems. Drugs were forbidden for mother and child
(Morantz, 87). These actions certainly indicated some
opposition towards obstetrics, a branch of scientific
medicine utilizing procedures that sometimes did not
benefit mother and child. This non-interventionist approach
to childbirthing remains a vital part of the ideology of the
homebirthing movement today. Essentially, the self-help
notion of the nineteenth century health reform movement
raised the female consciousness with regards to the
importance of female health issues while teaching women how to live in a male dominated society. Medical historian, Richard Shryock, has pointed out the link between the health reform movement and the women's movement. He states that while the health movement was basically concerned with women's rights in general, the women's movement was specifically concerned with health and women gaining access to medical institutions (from Ehrenreich and English, Witches, Midwives, and Nurses, 1973:26). Certainly the two movements represent an organized effort to combat institutionalized sexism and classism upheld by the white male medical profession.

Another concern of the self-help concept was tied in with massive consumerism, that is the process of making medicine available to the public through popular medical guides. The purpose of many of these self-help manuals was to inform the general public about hygiene, prevention of medical crises to maintain good health, and how to treat common complaints without the aid of a physician. As early as the eighteenth century, William Buchan (an M.D. from the Royal College of Physicians at Edinburgh) in Domestic Medicine clearly expressed the following rationale for writing a self-help manual: (1) One should have some medical knowledge as part of her general knowledge. (2) This knowledge would serve as a deterrent against quackery, promote more effective nursing and child care in the home,
and enhance the relationship between the lay person and her physician. (3) Scientific medical concepts would be made available and intelligible to the public at large (Risse, et al., 1977:2).

The ideology of the popular health movement was conducive to the medical sects that sprang up during this time. Perhaps one of the most radical definitions of the self-help notion came to be called Thomsonianism, named after its leader and founder, Samuel Thomson, an irregular who capitalized on public opposition to "heroic" medicine of the regulars. Unlike Buchan who wanted his reader to develop an ample degree of health awareness, Thomson wanted "to make every man his own physician."

Thomson, an itinerant practitioner, formulated his own medical system while publically denouncing the medical profession. His protestation was significant for several reasons. Firstly, it showed that one could openly denounce the treatment practices of the profession and effect a change. Thomson blamed his mother's death on mercurials and other harsh drugs administered to her by an orthodox physician. Consequently, Thomson was strongly opposed to mineral remedies. As an herbal practitioner, he utilized steam baths and botanic emetics, purgatives, diuretics, and sudorifices.

Most important were the political ramifications of his medical philosophy. He advocated the rights of the common
people to practice in their own homes. This belief had some practical implications particularly since poor people might have to resort to home remedies or a folk healer if they were unable to afford a physician's fees, or if they lived in a remote area where physicians were unavailable. Of course, the problem of misdiagnosis must be taken into consideration and whether the lay person could handle a major medical crisis by following a generalized medical guide.

Tied in with the success of a popular movement (which is what Thomsonianism came to be called) is commercialization. Thomson patented his system in order to sell the rights to practitioners. By 1839, Thomson's *New Guide to Health; or Botanic Family Physician* had gone into its thirteenth edition (Duffy, 112). Ironically, the Thomsonian movement acquired such a following until the leader became a victim of his own movement. Some of his disciples organized medical schools and began to institutionalize Thomson medicine, an act contrary to the basic principles of the movement. Some manufacturing companies made a profit by borrowing his name and products. Such unscrupulous actions indicate the need of some kind of governing agency to control a large scale operation.

Thomsonianism certainly restricted the role of the professional healer in the home; in fact, its ultimate aim was to rid the physician of healing tasks completely.
Thomson's movement also pointed out the importance of a medical approach's having a popular appeal and public support, which is something scientific medicine did not have. Not only was the public opposed to the excessive treatment practices of orthodox physicians, but also the seemingly unlimited power the profession had over medicine. State medical licensing laws aimed at barring unorthodox healers from practice were passed in thirteen states by 1830 (Bermosk and Porter, 1979:24). For example, the state of New York passed a law in 1807 that fined an unlicensed doctor five dollars for every month he practiced medicine. In 1827, New York passed a law that gave only licensed physicians access to the courts in recovering unpaid fees (Weil, 1983:20).

To some health reformers, the regulars' monopoly over medicine was seen as antidemocratic, an enemy of the people. Perhaps it can be said that the ultimate goal of the popular health movement was to usurp the medical profession's authority and put the practice of medicine back in the hands of the common people (Weil, 21). The movement was successful, at least temporarily, in its endeavors. By the end of the 1840s, many state licensing laws were repealed and for awhile the practice of medicine was not exclusive to elitist regulars.

Aside from Thomsonianism, homeopathy founded by the German physician, Samuel Christian Hahnemann (1755-1843),
who was vehemently against heroic medical practices, and in
favor of small dosages of drugs, moderate exercise, fresh
air, and proper diet (Duffy, 113) gained a respectable
following while its founder gained international recognition.
For some time, regular physicians considered homeopaths
unorthodox and tried to discourage them from practicing
medicine. For example, the American Medical Association in
drawing up its code of ethics in 1847 stated thusly in its
famous "consultation clause":

No one can be considered a regular
practitioner, or a fit associate in
consultation, whose practice is based
upon an exclusive dogma, to the re-
jection of the accumulated experience
of the profession (Quoted from Weil,
22).

In 1855, the AMA demanded that state medical societies
expel any homeopathic members from their ranks. Homeopaths
were denied hospital privileges. However, they had enough
political clout to start their own hospitals.

While homeopathy did not obtain the popular appeal
that Thomsonianism did, it remained a serious threat to the
medical profession because its early membership primarily
consisted of orthodox physicians who were dissatisfied with
heroic medicine. They could not be ignored or dismissed as
quacks. Certainly homeopaths with their small dosages of
drugs were more successful in treating some of the serious
diseases of the time such as cholera and yellow fever.
Many of their patients were from the ranks of the middle and upper classes, the major source of income for the regulars (Duffy, 117). In the end, homeopaths were absorbed into the medical profession, a problem we will later discuss when examining the compatibility and incompatibility of healing systems.

The Scientific Medical Model

Modern medicine has its roots in the scientific laboratory, a non-social environment. At the basis of modern medicine is the notion that non-health entities such as bacteria, viruses, and parasites are seen as causes of disease. They are objectified, are capable of being isolated and identified. This approach assumes that the causes of complex health conditions can be known with certainty and that knowledge of a patient's beliefs, feelings, values, and economic background is of little or no importance in restoring her health, which in this case means destroying the non-health entities. Under this mechanistic approach, the conditions in which "A" causes "B" can be specified, and once those conditions have been specified, the scientific investigator can account for and control all possible causal factors (Harold Bursztajn, et al., 1981:25).

Indeed the above model is an oversimplification of the complexities of a health crisis. A patient's condition may
be due to multi-causal factors (i.e., environmental, psychological, and social); it may be impossible to correlate the efforts of each cause; and the same observed condition may be affected by different causes at different times (Bursztajn, 59). For example, a certain type of rash may occur from consistent loss of sleep, hypertension, improper diet, allergic reactions to the environment, etc. It might be difficult to determine how the causes relate to the condition individually or collectively. A probabilistic model in medicine might place more emphases on physician observation and patient-physician interaction during the diagnostic stages rather than on running so many tests to determine a single cause of the medical problem. The mechanistic model encourages diagnostic overkill where physicians are committed to isolating a single cause of a problem.

Indicators of non-health entities are usually apparent in some form in the human body. Hence the signs of a medical problem can be detected, measured, felt, in some cases smelled or heard by an examining physician. Patients notice symptoms by experiencing some sort of pain such as headaches, ringing in the ears, leg cramps, or a change in feeling or mood such as despondency, nervousness, or a change in capacity level such as inability to concentrate or lack of energy. Persistent symptoms will make the average person turn to a physician to determine what is
wrong and to relive him/her of symptoms.

Scientific medicine's move toward technology has resulted in a very defined set of procedures in treating the patient. Treatment is determined by a diagnosis which is based upon the patient's medical history, physical examination, and laboratory test results. Diagnosis can be costly, inconvenient, and invasive depending upon how it is implemented. Weil states that technological advancement in diagnosis came about with the following four types of inventions and/or procedures during the latter part of the nineteenth century: (1) instruments such as the ophthalmoscope and x-ray that provided means for visualizing gross anatomical structures; (2) the microscope to determine specific germs and tissue changes caused by specific disease; (3) devices such as the electrocardiogram to measure body functions in numerical and graphical form; and (4) chemical tests of tissues and body fluids (1983:92).

The system encourages diagnostic overkill and allows little room for uncertainty. Therefore physicians may be less reluctant to rely on their intuition and common sense in making a diagnosis. Since malpractice litigation is on the rise, physicians, rightfully so, feel that they must exhaust all avenues in handling a medical problem, and thus the need to rely upon technology. For example, in the United States alone, there were about 2 billion laboratory diagnostic tests done in 1971; 3 billion in 1974, and 4.5
billion in 1976. (Figures in Weil, 93, quoted from Stanley Reiser, 1978:159). Certainly a percentage of these tests was necessary, particularly in detecting early forms of degenerative diseases. However, over testing presents a paradox. Patients may be harmed by some tests and suffer from an iatrogenic illness. For example, over exposure to diagnostic x-rays, injection of radiopaque dyes into arteries, or use of powerful drugs for diagnosis rather than treatment will injure or kill a certain percentage of patients (Weil, 94). Physicians seem to have become victims of their own technological procedures. It is ironic to think that one devoted to relieving pain experienced from symptoms could cause serious pain and injury in the problem-solving process.

Conceptualizations of Folk Medicine

While scientific medicine has a clearly defined set of procedures in handling a medical problem (the procedures may be unclear to the patient, however), those of folk medicine are often less definable, and sometimes appear mystifying, to both natives and non-natives, particularly when belief is a major factor. How does one prove that s/he was healed by God or that his/her wart fell off when s/he rubbed the wart with a cut potato and buried the potato in a fork in the road? Indeed folk medicine covers a wide range of beliefs and what appears to be irrational explanations
concerning disease etiologies, preventive and curative practices.

Folk medicine is complex on several levels. From a scholarly standpoint, there is the problem of definition. Does one define it by content of medical practice, namely belief and other elements involved such as herbs and/or magic? Is it something defined strictly by the context and culture in which it is performed?

Scholars often define folk medicine as a body of traditional knowledge existing among the members of the community apart from the community's professional or scientific medical system. This definition, however, is inadequate in that it can apply to popular medicine as well. What is traditional (something passed on through time in variable forms) within one group may be current to another. For example, Yoga, an age old, preventive health form (dating around the first century A.D.) of the Indian and Chinese Buddhists is very popular in this country now. Yoga exercises can be seen at times on the Cable Health Channel and read about in popular magazines. Emphasis is placed on developing the ability to relax the back and control one's breathing which will lead to self control and a greater mental calm (Frances Kennett, 1976:44). The recent interest in herbalism, the ancient pharmacopoeia is another example. Numerous herbalism guides are available at the public library and bookstores.
The term folk medicine is used by scholars to refer to substances from the natural environment and old remedies grandmother concocted around the house to combat common ailments such as fevers, colds, or rheumatism, as well as the performance of simple rituals such as tossing something over one's shoulder or over another object, including a gate, a tree limb, or a house to eradicate diseases and evil forces. Don Yoder sees folk medical practices consisting of two varieties: "natural" and "magico-religious" (Dorson, ed., 1972:192).

According to Yoder, natural folk medicine includes materials from the natural environment, such as herbs, plants, mineral and animal substances, as well as old home remedies or kitchen medicines transmitted from generation to generation. For example, mud (yet recommended by some doctors) and warm human urine were used to draw out poison from insect bites and stings. Women, the chief practitioners of home remedies, concocted poultices and homemade medications from herbs and household substances such as turpentine, coal oil, baking soda and vinegar. Many of these practices still exist; therefore, the context in which they occur must be examined. Major beliefs associated with the "natural" variety of folk medicine are that nature's capacity to heal is unlimited and anything "natural" is pure and good for anyone. God has provided, in the vast herbaceous woodlands and fields, a storehouse of remedies for any ailment.
Yoder's magico-religious category covers a wide range of folk beliefs about disease, prevention and healing. Sickness or misfortune may be the result of divine retribution inflicted upon an impious person by a supernatural power. For example, in the Mexican culture, *sacra*, that is supernatural beings, sacred places and objects usually neutral to man, might become malevolent if they are worshipped inappropriately or insufficiently (Velimirovic, ed., 1978:35). Tying a piece of garlic around one's neck or wearing an old, dirty sock around one's neck can ward off disease. The belief associated with an offensive object is that anything with a hideous smell has the power to prevent a disease from spreading.

In the magico-religious category, sacred and secular supernatural powers are utilized for curative and preventive purposes. Practitioners, from faith healers to witch doctors, and material objects such as an Irish potato, a dirty sock, and a stone at a crossroad can function as mediators of that power. Wayland Hand states that there is complete syncretism of the two powers to insure the success of a cure (1980:xxv). Healers engaged in magico-religious acts often think of themselves as mediators of the divine. Some may operate independently and not be affiliated with a church, while others' healing practices may be very much a part of the church structure to which they belong. For example, healers may utilize elements of witchcraft and
Christian faith healing and conduct healing services in a part of their home that is a sanctuary with a pew and pulpit. Although they may not be connected with a church in the community, local, as well as non-local people may utilize their services for specific kinds of health-related problems. Churches within organized religion may have little or no toleration for their beliefs and view their work in antagonistic terms, labelling it "the devil's work," a form of quackery, and something to shun. Those healers connected with a church may place just as much emphasis on "being saved" and daily righteous living as on being healed. In fact, the two may be inseparable. It is difficult to determine why some healers are accepted in a community and others are not. Those healers operating within the confines of a religion may utilize very similar procedures, including magical practices, as those healers who are not accepted by the church. Church healers may advise their clients to jump up and down seven times while being prayed for or to drink olive oil that has been "blessed" by them three times a day. While these healers may denounce witchcraft as the devil's work, they may utilize materials from the natural environment in similar ways that a conjurer or curandero would.

Yoder recognizes the tendency of natural and magical medicine to overlap. For example, a shaman may use many herbs to heal his patients; a faith healer may prophesy to
someone to eat certain herbs every day for a month to get healed; an herbalist may chant certain formulae over his garden to ensure its success. It is difficult to determine what is magic and what is not. It is almost impossible to determine where the boundary of the natural ends and the magico-religious begins.

Certainly, folk medicine is something that seemingly defies classification. For a long time, researchers tended to focus on the traditions of folk medicine while overlooking it as an experience real to those who believe. Therefore, some assumptions have been made that are misleading. (1) Folk medicine is something inferior to scientific medicine and is utilized by inferior (meaning something other than mainstream, educated, white middle class) persons. Along with this notion, one sees the labels "primitive," "marginal," "ethnic," "unorthodox," and "non-scientific" medicine used as substitutes for the term folk medicine, all having some pejorative implications. (2) The folk accept these beliefs blindly without any experimental testing, particularly in cases where practitioners with certain types of magical powers such as the shaman, conjurer, or powwower are involved. Believers are unable to move from subjective to objective reality. Their medical practices may be labelled as irrational beliefs, making the efficacy of a belief system difficult to challenge or refute.
Herein lies the mystery for scientific practitioners. The practice of folk medicine is so heavily contingent upon beliefs which are neither verifiable nor disprovable by scientific procedures grounded in material reality. Imagine trying to prove whether a curandero was a medium for spirits while in a trance, and whether his cures involving corrientes espirituales (spiritual currents) and vibraciones mentales (mental vibrations) were the reason a client was relieved of asthma attacks brought on by evil spirits. Scientific medicine feels more comfortable with a healing system that can be scientifically and empirically validated or invalidated. If the system is nontestable, then scientific medicine will more than likely see it as something to ignore and not take seriously, or as something grounded in ignorance and superstition or quackery. It should be noted that those utilizing a healing technique are not as meticulous as scientists are in isolating causal factors that bring about effects and specifying the conditions in which this cause-effect relationship exists. Often those who are sick and concerned about getting well and/or functioning at normal capacity will use several healing techniques simultaneously. If they get better, then they are likely to feel that these strategies worked, particularly if they have had success with them on several occasions or know of someone who has. These healing strategies become meaningful to them on a pragmatic level when they have had some success with them.
Belief in a folk healing approach such as the notion that witchcraft can cause people to become ill is somewhat different from the belief that meteorological factors cause rain. First of all, the rainfall theory is the product of laboratory testing, an idealized environment in which multi-causal factors can be isolated and shown to produce an effect. Just because cures involving the body and mind relationship (such as witchcraft) cannot be measured in scientific terms, it does not follow necessarily that these healing techniques are not real to believers and do not have distinct properties. Much research needs to be done in the area of belief and its relationship to health and healing. Folk medicine is an excellent area to examine in this respect.

Conceptualizations of Popular Medicine

As stated earlier, the boundary between folk and popular medicine is sometimes indistinguishable. Medical knowledge once in oral circulation among a specific group of people may become popularized and reach the masses. For example, herbalism once so prevalent in early Native American culture has been lost to a great extent. However, numerous popular medical guides have attempted to disseminate this ancient botanical knowledge among the masses by presenting various pictures of the plants and describing their medicinal effects. Of course, these books do not and
perhaps cannot present the most important information, i.e., dosage proportions. How might one define popular medicine?

In attempting to arrive at a definition, one might say that on one level, popular medicine is a body of countless treatment techniques and therapies such as acupuncture, yoga, vitamin and mineral therapy, herbal remedies, and reflexology made available to the public at large on a massive scale to promote health, healing, and self-help strategies. These therapies are presented in medical guides, on the cable health channel, TV talk shows, and in numerous health-related newspaper columns. Many have been utilized for centuries in less technological societies and their point of origin is often unknown. In the last couple of decades, these therapies have been considered by many in this country to be alternative medical strategies in comparison to scientific medicine. Unlike the scientific medical model that promotes patient passivity and dependency on various aspects of the system, including the physician, hospital, medication, and technology, these alternative medicines encourage the self-help approach and active participation in one's health management.

Another way of looking at popular medicine is to see it as a product which originates in the popular sector of a local health care system. First of all, we must examine what activities take place in this segment of the health care system.
Kleinman identifies the components of the popular sector as follows: beliefs, choices and decisions, roles, relationships, interaction settings, and institutions (1980: 50). Within this sphere, illness is first defined and health care initiated by the non-professional population on the individual, familial, social, and community levels. Much of what goes on here has to do with health maintenance and less with sickness. Decisions are made about which practitioner to see and for what purpose (e.g., Should I have a physical to see if my heart is all right? Should I see a manual therapist to loosen up my joints?), and which health regimen to follow (e.g., vitamin therapy, aerobics, meditation, fasting, etc.). Most medical concerns are dealt with in this sector, and popular medical products are available to accommodate these diverse needs, interests, and beliefs.

Kleinman's model of the internal structure of a local health care system is useful in that he identifies its components and points out the importance of the popular sector as a place for health management. A limitation of his model, however, is that the terms he uses in identifying the components are static. Consequently, health care management is not represented as the dynamic process it is. For example, his use of "role" as a component implies a function in the health care system, whereas if the term "role enactment" were used, it would imply a dynamic process
in which specific types of behavioral forms emerge.

More specifically, "patient" is a role in the local health care system. Certain forms of behaviors emerge when the individual adopts this role and interacts with others. What are these behavioral patterns and what is the context in which they are expressed? A more useful model it seems would address these issues by indicating a process of orientation of a local health care system, representing the complexities involved in health management. I prefer to modify Kleinman's model and identify the components of a local health care system in the following manner: belief reinforcement, decision making, role enactment, relationship management, performance interaction, and institutionalization. Each of these terms indicates activities or forms of dynamic processes consisting of sets of rules and transactions that go to make up the local health care system. How is popular medicine involved here?

Since the popular sector is the place where the greatest amount of health care activities take place, we can assume that knowledge is being transmitted which aids or in many instances cripples health management. Knowledge and information is disseminated on a massive level via products ranging from exercise equipment, to blood pressure kits, to numerous over-the-counter drugs, to hundreds of health-related manuals on topics such as how to stop smoking, how to handle a normal pregnancy, and how to reap the benefits of
Transcendental Meditation. This information may be bought and sold to aid the non-professional in his/her health management process. In this regard, popular medicine may be thought of as a marketable product, information transmitted on a massive scale to a consuming public preoccupied with health management, and in this society, "getting the most out of life". What kind of process is involved that makes such products appealing on the massive level? How do these products serve as transmitters of information, and is such information always health related?

In western society, there is an entire mythology that advertisers and manufacturers make use of in an attempt to sell health-related items including literature, health foods and supplements, shampoos, cosmetics, fitness paraphernalia, etc. Products are often presented as "improved," "new," and "better" sometimes in comparison to the old brand or the current competing brand. Oftentimes though, a faulty claim is made and these terms in reality are meaningless because it is unclear as to what if anything is being compared. With a health-related product, an ideology such as "back to Eden" may be associated with it, depending on the terms used in reference to the product and claims being made. The folk/natural medical guides are examples of a product projecting a "back to Eden" ideology through the repeated use of familiar phrases such as the "old country way" or "pure and simple."
Some of the popular health literature today is an attempt to sound the alarm against western society relying too heavily on physicians and their prescribed drugs to solve its health problems. This implied notion seems contradictory to that of research indicating that the bulk of health management involves self-treatment practices and is done at the lay, non-specialist level. Like Buchan's self-help manual of the eighteenth century, an underlying idea of this self-help literature is that people are logical and responsible, they should be knowledgeable of their bodies and capable of handling many health crises without the aid of a physician. This information is presented in a semi-technical style, as well as a popular style of writing. The Physician's Desk Reference for NonPrescription Drugs and Long's The Essential Guide to Prescription Drugs present somewhat technical descriptions of various over-the-counter drugs along with their intended therapeutic effects. David Carroll, herbalist, masseur, and accupressurist presents numerous natural healing programs for everyday, less serious ailments such as toothaches, bug bites, and rashes. He immediately warns the reader that more complex ailments such as tuberculosis and apoplexy should be handled by an experienced natural physician. The literature is written by people and institutions with various health interests such as drug companies, practicing physicians, science editors of popular magazines, and
natural healing advocates.

Various health materials use rhetorical strategies to explain medical concepts (scientific or alternative) to a lay audience and/or to show them how to use the scientific medical system more discriminatively, primarily by warning them of its inherent dangers and shortcomings. All of these materials attempt to make the reader a more informed and responsible consumer, and to aid him/her in the health-related decision-making process. Some health guides use dramatic and shocking images in an attempt to destroy the undue godlike pedestal that scientific medicine and its practitioners have been placed upon. It is ironic, however, that this all-out war against the scientific medical system is being waged frequently by those who know it best, the physicians themselves. For example, Robert S. Mendelsohn begins his "non credo" in his *Confessions of a Medical Heretic* by stating strongly, "I do not believe in Modern Medicine. I am a medical heretic. My aim in this book is to persuade you to become a heretic too." Mendelsohn goes on to criticize the extreme treatments modern medicine uses in everyday situations and states that it would benefit our health if "more than ninety percent of modern medicine would disappear from the face of the earth (xi)." Such chapter titles as "Ritual Mutilations" and "Devil's Priests" are indicative of the strong emotional appeal this book has while appealing to common sense reasoning of the reader with
use of personal exempla and statistics. Assuming the reader becomes a skeptic towards the end of the book, thus denouncing faith in modern medicine, Mendelsohn encourages him to embrace a new faith, one committed to life and the celebrants of the religion of life: the self, family, and community (160). Mendelsohn implies that the self-help approach in taking care of mind and body is essential in protecting this life. Once one embraces this new philosophy, one will live a happy and healthy life.

In terms of images projected, throughout the literature, scientific medicine is portrayed in several ways. It may be presented as an evil tyrant one should try to avoid altogether, or as a health system having something worthwhile to offer in terms of preventive and curative techniques, provided that the readers become more discriminating consumers, developing an understanding about its products and techniques. Or it may be exemplified as an authoritative watchdog that is there to protect the consumer, to put all health-related myths to rest, to demystify modern medicine, and to serve as a cultural interpreter for the layperson. This image seems to be projected in the Harvard Medical Letter.

While scientific medicine is portrayed in very predictable terms in the popular sector, so too is folk medicine. It appears to be something that is ancient, mystical, quaint, inexpensive, natural, entangled in superstition and simplicity. For example, in Carlson Wade's book entitled
Natural and Folk Remedies, herbal emollients for the skin are presented as "beauty secrets" that Helen of Troy lived by. This information is presented in anecdotal form, with bits of common sense observations intermixed with ancient remedies and folk medical beliefs.

Another example in which folk medicine is presented in mystical terms can be found in D. C. Jarvis' bestseller, Folk Medicine: A Vermont Doctor's Guide to Good Health. Jarvis, an M.D., recognizes the limitations of his scientific training in handling the medical problems of rural Vermonter whose preventive medical approaches appear to be heavily influenced by age-old folk beliefs within the community. Through observation and having direct contact with patients governed by this system of beliefs, Jarvis concludes that those who live closest to the soil (rural Vermonter) and maintain diets consisting of natural foods such as fruits, berries, and roots are healthier than those who live in urban environments tainted by human hands. As an example of the anecdotal format in which the material is presented, the chapter entitled "Potassium and Its Uses" contains numerous stories about the multi-uses of apple cider vinegar (which has a high potassium level), including combating food poisoning, chronic fatigue, and sore throat. In describing these folk medical practices, Jarvis gives hasty generalizations by presenting the honey and apple cider vinegar as some sort of cure-all for good health. He does
not caution the reader about the problems that can result from having too much of a potassium intake. This book, along with many other folk medicine books at the popular level, portrays health prevention and maintenance as something possible with the use of inexpensive "natural" materials and with the use of simple techniques such as drinking apple cider daily.

Paul Atkinson in his discussion of mythic thought sees Jarvis' text on folk medicine struggling with the problem of man being alienated from nature from an individual and collective standpoint (in *Culture and Curing*, Peter Morley and Roy Wallis, eds. 1978:177-8). Individually he grows up apart from nature and her laws. The process of civilization also causes him to lose his awareness of natural processes, hence the rational versus the instinctive. Children and animals are presented as instinctive, meaning they follow the natural laws. Children naturally like sour plants, berries and raw foods such as clay. Animals refuse to eat when they are sick, thus creating within the body a new biochemical state that hastens a recovery. To regain the Edenic status, man, a rebel and "deserter from the animal kingdom," must find his way back to nature. Jarvis places great emphasis on man's observing and learning from the animals' behavioral patterns to rediscover this health and fitness that nature provides (which is what Vermonters have done). The polarities of man/nature might be resolved
through diet and medication, hence the use of natural remedies.

Many of the popular books on folk medicine such as Jethro Kloss' *Back to Eden* and Robin Page's *Cures and Remedies the Country Way* seem to exhibit this type of mythology. Some faith healers state that the cures to all disease, including cancer are in the Bible. Health and healing remain shrouded in mystery. Natural materia medica remain at our fingertips but yet inaccessible because of our loss of innocence (natural knowledge). Aside from making a profit, the numerous folk medical guides are attempts to regain this medical Eden. Health food stores and food co-ops with their organically grown products are all-out efforts to achieve some sort of Edenic health in a world where technology and its hazards are imminently present.

The above examples are indications of what happens when information becomes a product that is transmitted on a massive scale. In terms of popular medicine, this information may be medically related such as explanations involving self treatment strategies. On another level, non-medical information may be transmitted when certain images and ideologies are projected that are in some way a reflection of the culture for which the information is intended.
Interchangeability of Medical Systems

This topic is crucial to understanding how health management is realized in a local health care system. Kleinman sees the popular sector as a point of entrance, exit and interaction between the folk and scientific sectors. One may utilize these health options interchangeably to combat a health crisis or to prevent one from occurring. In terms of the patient/client, he can make the adjustments needed to utilize these systems simultaneously. For the patient/client's ultimate aim is health centered, whether preventive or curative. Let us consider this hypothetical situation as an example.

When one develops a skin problem, the individual's concern for physical appearance, belief in divine healing, and link in the social network may all be factors in determining her method in overcoming the crisis. She may see herself as disfigured and needing to avoid public exposure. Once she accepts this sick role, she is too embarrassed to go to work. She may go to a physician while staying home from work after a friend insists she see a doctor. The individual may already be doing what the doctor advises her to do—get plenty of rest, fresh air, and sun. Perhaps she has little intention of taking the doctor's prescribed medicine. The doctor's advice merely sanctions her self-treatment practices which in turn gives her an added sense of confidence. She may also be relying on divine power and
a home remedy consisting of a baking soda bath or the juice from an aloe vera leaf to clear up the disorder. The individual sees herself with a health problem serious enough to isolate her from certain relationships but not ill enough to take the doctor's medicine. In this particular case, the doctor sees her as a patient in need of some medicine to get rid of the rash symptoms. When an individual enters and exits these healing sectors, she encounters a different set of beliefs about illness categories and treatment techniques.

From the practitioner's perspective, a modus vivendi with practitioners of opposing systems may not be possible, particularly in the case of physicians where the handling role is somewhat connected with power and dominance. What determines the compatibility and incompatibility of health systems? Why can physicians work with an osteopath or possibly a chiropractor but not with an herbalist or a shaman?

The term "orthodox" medicine is indicative of the institutionalized power that scientific medicine has acquired in this country. Orthodox practitioners have the support of the AMA, colleges of medicine, private foundations concerned with medical research, the pharmaceutical industry, the U.S. Public Health Service, the examining and licensing boards of the fifty states (Wardell in *Marginal Medicine*, 1976:61). They ultimately have the endorsement
of the federal government with the various medical supplement programs that will provide some financial support to various groups in the society for the use of scientific medical facilities.

Scientific medicine includes a diverse range of practitioners with physicians being at the top of the hierarchical structure, therefore having the broadest scope of practice rights and privileges; there are what Wardell calls the ancillary practitioners, those who practice as assistants to the physician and are directly under her supervision such as nurses, prosthetists, physical therapists, and hospital pharmacists; then there are those who practice independently of medical supervision but who have a limited practice, concentrating on specific conditions and/or parts of the human body such as dentists, orthodontists, optometrists, clinical psychologists, and speech therapists (62).

Historically, those practitioners who were not allopaths or regulars but considered threats to the orthodox medical profession by the establishment have had an outright political battle with it. Those who treat a wide range of medical problems and have a different theory of health from allopaths may be viewed in antagonistic terms particularly when their theory challenges some fundamental notions of allopathic medicine. Those who have formed a group, are united, have some autonomy and political power
and public support will certainly pose a threat to the scientific medical establishment. The demands the group makes on the profession also are partly determined by whether the group wants to operate independently of the profession or desires to be recognized as legitimate practitioners and to be tolerated as such, or incorporated into it (Wardell in *Marginal Medicine*, 1976:64). The group's fundamental health notions and treatment techniques must have some compatibility with those of orthodox medicine before the group can become a part of the scientific medical profession. In the absorption process, the irregular group may have to surrender its independence as practitioners by submitting to orthodox medical supervision, or by limiting the scope of its practice (i.e., have a clearly defined set of problems that it handles) or by giving up at least some of its basic notions of health to the point that the establishment's fundamentals are no longer being challenged.

Before absorption is possible, the group must battle with the AMA (formed in 1846) that has maintained consistently an exclusionist policy towards irregular practitioners. For example, homeopathy was not considered a medical heresy when Hahnemann first introduced its principles in his *Organon of Rational Healing* in 1810. Hundreds of physicians deserted allopathic medicine to follow Hahnemann's teachings for what proved to bring about more positive therapeutic results. Two of his fundamental principles, the Law of
Similars and the Law of Infinitesimals are yet recognized by homeopaths today. Hahnemann felt that a drug that produced a set of symptoms in a healthy person could cure a sick person manifesting those same symptoms. He was one of the first to seriously examine the therapeutic effects of drugs on health. His single remedy rule forbade physicians to use two or more drugs simultaneously on a patient. This theory was certainly a challenge to the allopathic polypharmacological assumption that if one drug was effective in a medical crisis, then a combination of drugs would be even more beneficial. Hahnemann felt that drugs should be examined under a very controlled set of circumstances and drew up a list of rules to monitor drug experimentation (some of which are impractical and unrealistic for today's scientific medical system). Some of these rules yet challenge modern drug testing procedures today. For example, Hahnemann was concerned with patient variability in terms of how one person might react to a drug as opposed to another person. He felt that sex might be a variable in determining a drug's effect on health. Therefore, a drug should be tested on both men and women. Today governmental regulations practically exclude women as drug research subjects (Weil, 16). Consequently, we do not know how drugs might affect the sexes differently. Hahnemann's diluted doses of remedies were less likely to make patients worse than the excessive treatment procedures of allopaths.
Homeopathy became a threat once it began to attract so many allopaths; as stated earlier, homeopaths could not be labelled as ignorant folk practitioners and quacks. There was enough unity among homeopaths to organize, in 1844, the American Institute of Homeopathy, the first medical organization at the national level (Duffy, 115). Also the spread of homeopathy resulted in an economic loss for the regulars because this form of medicine appealed to the middle and upperclass levels of society, the major source of income for the regulars. Consequently, when the AMA was established, hostilities between the regulars and homeopaths became much more pronounced and open fire continued well into the twentieth century until homeopathy joined the ranks of the regulars.

Gaining Acceptance of the Medical Orthodoxy

What happens when an irregular healing sect moves towards medical orthodoxy and is absorbed by the medical establishment? How is this process even possible when its fundamental theories about health, disease, and therapeutic treatment differ from those of the medical establishment? What will both gain or lose by this merger?

In examining the above questions, one must consider why the healing sect wants to be accepted by the orthodoxy. There are the obvious reasons of obtaining additional power and prestige. More specifically, the irregular practitioners
want to limit the constraints on their practice placed upon them by the medical establishment. Without acceptance, they are stigmatized, and constantly viewed with suspicion. Perhaps they want to expand their practice, to have privileges and financial support the establishment has, to consult with allopaths and vice versa. A healing sect is not monolithic. There are bound to be some dissidents among the ranks. In the case of homeopaths, by 1880 the profession split into two groups: the Hahnemannians, those who strictly adhered to the master's tenets; and the larger group, those who wanted to utilize allopathic medicines along with homeopathic treatment (Weil, 23). The larger group expressed the desire to be free of the laborious constraints Hahnemann placed on the practice. For example, homeopaths were to test a drug on themselves before administering it to a patient in order to understand the drug's effects. No drug could be given simultaneously with another. Then too, scientific process revolutionized allopathy with its triumphs over infectious diseases, miraculous discoveries of wonder drugs such as antibiotics and life-giving hormones. Its boundaries seemed almost limitless while those of homeopathy seemed to remain stagnant (Weil, 24). It should be noted that homeopathic treatment had some impact on allopathic medicine. For example, specific drugs such as nitroglycerin for relief of anginal pain and metallic gold for the treatment of
rheumatoid arthritis were first used by homeopaths and were later used by allopaths (Weil, 33).

To a large extent, the compatibility of practitioners in different health systems is dependent upon whether their respective systems possess some sort of common ground in terms of theories about health, disease, and therapeutic treatment. If a system recognizes a material reality of drugs and disease, then perhaps some degree of compatibility is possible with scientific medicine. For example, while curanderos in the Mexican-American culture recognize social, psychological, and spiritual components of health and illness, scientific regulars primarily consider the physiological. Only after the possibility of physical causation is ruled out do they give serious attention to the psychological. Curanderos recognize natural illnesses (e.g., hypertension, diabetes, and mental retardation) as being caused by natural agents. To patients with these problems, they recommend that they seek the aid of a physician (Trotter II and Chavira: 1981, 61). Curanderos will see a physician themselves if they have what they call a natural illness. Since the biomedical framework does not include the notion that illness may be caused by supernatural forces, the cultural illness, susto, would not be treated successfully by regulars. In Madsen's study entitled The Mexican-American of South Texas, an informant makes the following comment:
A curer (curandero) admits there are things he cannot cure and helps you find someone to treat it. Have you ever had a doctor send you to a curer because your sickness was susto? Doctors know they can't treat susto. But they say it is some other disease and give you worthless medicine until you die. And you pay right to the end. Then they sign a certificate saying some disease killed you and they think they are free of blame (93).

It is questionable as to whether regulars could work side-by-side with folk healers. First of all, they would have to recognize irregulars as healers capable of handling certain types of health problems, an idea that most have not begun to even consider. The wholistic health model might possibly resolve the problem of fractionalized or incomplete medical care. At least in theory, it recognizes the importance of the self-help process such as meditation, relaxation, and Autogenic Training, as well as the importance of the spiritual resources such as the priest or shaman in the healing process. Ideally, this model considers every person as an individual with vastly untapped potentials, capable of playing an active role in his health care. Unlike scientific medicine that has a tendency to dehumanize a person by focusing on the treatment of an organ, wholistic medicine helps the person treat himself and takes into account not only the physiological, but also the social, emotional, mental, spiritual, and environmental aspects of the individual and his relationship to health. Now whether
this model actually is being implemented remains to be seen.

The Oral Roberts Medical Complex has made some attempt to combine faith healing and scientific medicine, but research needs to be done to see how this system works, particularly on the level of practitioners. In other words, what would be the function of scientific medicine; what would be the function of faith healing; and how might these two systems interact in the healing process? Would the faith healing minister be on the level, in terms of prestige and power, of medical doctor, or a notch below or above? Could a physician outside of this belief system practice successfully here or is the faith of all involved in the healing process necessary for this model to work? These are questions that need to be explored. Wardell states that organized medicine can tolerate faith healing since it offers no real threat to its epistemological foundations or to the economic base of its physicians (in *Marginal Medicine*, 1976:63). Historically, while faith healers have believed that healing ultimately comes from God, they have also recognized the physician as God's instrument and utilized her services when they felt it necessary. Conversely, some physicians perhaps have felt personally that God or some higher power is the ultimate factor in determining their success in handling a medical crisis. It would be helpful to examine how doctors talk about their successes
and failures, particularly in comparison with how their respective patients would. While some physicians on a personal level might recognize the supernatural as being a factor in the healing process, the scientific model by which they practice does not. It is doubtful that many would encourage their patients to pray for God's healing.

Conclusion

What we have been examining thus far is the historical problematic relationship between scientific medicine and other medical systems. What came to be known as scientific medicine has maintained an exclusionist policy towards those practitioners not a part of its rank and file and in the name of "professionalization" utilized legislative and financial resources to strip them of their right to practice medicine. A major force that made this medical takeover possible was the technological knowledge the regulars obtained apart from other healers. Without a body of medical knowledge that was exclusively theirs, scientific regulars would not have acquired the power they have today. The notion of specialization poses some problems concerning ownership and power. There are different kinds of specialists in a local health care system. Should one be valued over another and given exclusive rights to practice medicine? Why are the unconventional specialists' skills considered less valuable by the society particularly if their clients
feel that they have benefitted from these skills?

Many would agree that scientific medicine is better equipped to handle certain medical problems such as acute infections associated with bacteria, parasites, and fungi, medical emergencies such as myocardial infarction (heart attack), and severe burn injuries than any other medical system. Because of scientific medicine's control over the practice of medicine, one is less likely to find the quacks of the eighteenth, nineteenth, and early twentieth centuries out on the street selling Indian medicines and cure-all drugs that make all sorts of claims. Yet, some form of medical-related quackery remains a real problem in this country. There are a number of formally untrained persons with bogus degrees pretending to be licensed doctors; and the sale of unscrupulous health-related items via mail and perhaps the old door-to-door approach is still a problem. One wonders how a person could practice as an anaesthesiologist in several hospitals for thirteen years without being discovered (this story reported on the CBS news broadcast, "Sixty Minutes," April 4, 1985). How much of the practice of medicine is based on actual medical skill and knowledge, and how much is contingent upon convincing others you possess these things?

While one cannot overlook the scientific breakthroughs in modern medicine, one cannot deny the problems of misuse and abuse of this medical knowledge. Women have certainly
been oppressed under this medical system given the excessive number of hysterectomies and radical mastectomies as proof. It should be noted that when white male medical doctors took over childbirthing from midwives, women were not given the personal attention and support so very much a part of the midwife-home delivery method. Unnecessary interventionist methods have often caused more harm than good. When a person takes on the role of patient, the scientific medical system may be used against him. The patient is made to feel helpless and dependent upon a very expensive, bureaucratic and inefficient system.

All surviving medical systems serve some useful purpose and someone benefits from them. Some medical problems appear to be handled more effectively by one approach than the other. A folk illness such as demon possession or witch-riding may be mislabelled by scientific medicine as a psychosomatic illness with little or no attention given to the belief system of the patient and the ramifications of that system. Conversely, one suffering from a medically treatable stroke may be told by a faith healer that in order to get well, he must ask God's forgiveness for some sin he committed. Whatever the case may be, a patient evaluates the treatment practices of any practitioner based upon various criteria (e.g., disappearance of symptoms or gaining of physical energy though physical symptoms remain present, ect.) and may utilize practitioners from different systems
for the same problem. Thus, the patient has some sense of what he would like the practitioner to accomplish and whether her medical techniques are fulfilling those expectations.

Another important notion that must be stressed is that it is ultimately the people who determine whether a healing system is valid or invalid, is effective or ineffective, even though the laws might be contrary to their beliefs. A healing system survives only if it is functional for a group of people. The fact that alternative healing methods are important to people is an indication of their personal involvement in the health management process. The following chapters will examine this complex process and its ramifications.
Medical historian, Richard H. Shryock, sees Cotton Mather's involvement in preventive medicine, namely the smallpox vaccination as the chief medical contribution made by Americans to modern medicine prior to the nineteenth century. It should be noted that inoculation was practiced in the rural areas of Great Britain and the Continent in the seventeenth century. Later, from 1714 to 1716, the inoculation procedure was reported in detail in a series of letters addressed to the Royal Society from Constantinople (Duffy, 1979:35), causing widespread interest in the procedure. Mather, having read the accounts in the Royal Society's Transactions and having heard personal accounts about inoculation from his black slave, Anesimus, who said the procedure was a common practice in his tribe, urged Dr. Zabdiel Boylston, a leading physician in Boston to inoculate when a smallpox epidemic broke out in April, 1721. At Mather's request, Dr. Boylston inoculated 240 people with smallpox virus, the first large scale test of this kind in modern medicine (Shryock, 1977:57). Physicians with a medical degree were opposed to Mather's involvement in this matter. While the clergy tended to support inoculation, physicians of the emerging profession, at first, were opposed. At the root of the controversy was whether lay persons should be involved in the practice of medicine on this level or whether something as dangerous as a smallpox epidemic should be handled only by those of the emerging medical profession. After all, inoculation was in the experimental stages; thus, Dr. William Douglass questioned whether it should be implemented on such a large scale since there were many unanswered questions about its danger and usefulness. Mather felt that the clergy had the right to control the life of the community, including the medical aspects.

For a discussion of Mather's concepts on medicine, see O. T. Beall, Jr. and R. H. Shryock, Cotton Mather: First Significant Figure in American Medicine (Baltimore, 1954).

Some Latin American folk illnesses have a humoral etiology. For example, bilis is believed to be brought on by prolonged anger and fear. A person becomes tense and irritable, loses his/her appetite, has constipation, and may suffer with migraine headaches when excessive bitter
bile flows into the person's system as a result of his/her extreme anger or fears. Treatment includes cleansing the stomach of excess bile by taking either commercial laxatives such as epsom salts or purgative herbs such as Cassia sagrada, a "sacred bark" (in Trotter II and Chavira, 1981: 93-94).

3The control of the environment by hygienous measures was one of the major influential factors in the decline of mortality. Prior to the germ theory or any knowledge about infectious agents, various effective methods were used to control disease. For example, John Snow investigating a London cholera epidemic in 1824 localized the epidemic to a specific neighborhood and felt that the water supply from the Broad Street pump was the source of contamination. Upon investigation, he discovered that those with cholera used the pump and those who were not affected by the disease used alternative water sources. The epidemic subsided after the handle was removed from the pump (Twaddle and Hessler, 1977: 11). It should be noted that the early public health movement grew out of a concern for social welfare and an awareness to make the physical environment more comfortable for its citizens. Departments of public health were established in many large cities in the latter part of the nineteenth century. These departments were responsible for monitoring sanitation facilities and epidemics.

4Robert S. Mendelsohn, M.D., in Confessions of a Medical Heretic in a somewhat cynical tone discusses how allopathic physicians with their tyrannical attitudes and technological equipment debilitate patients while denying them any control in handling a health crisis mainly when patients are on their turf (i.e., the hospital, doctor's office, etc.). He uses the example of a pregnant woman clearly stating her wishes to her obstetrician concerning how to handle her birthing process (e.g., no shaving, episiotomy, analgesia, induced labor, etc.); nevertheless, in her final moments of labor, the doctor may not respect the woman's requests. Of course, Mendelsohn generalizes about physicians and fails to see them as individuals who do not handle all things alike. What he is actually describing is a medical paradigm that encourages a self-help philosophy and patient input concerning the health problem and how to go about handling it.

Another problem that has evolved out of scientific medicine's heavy reliance upon hi-tech treatment procedures is that of "informed consent" by the patient prior to the use of such procedures. To apprise the prospective patient of all risks involved might trigger psychological reactions in him/her that could impede the success of the therapy. Medical advance has created some very complex ethical
questions such as the "death with dignity" issue. The old idea that the physician's duty is to prolong life as much as possible is certainly being challenged by the public at large. For a discussion of medical ethics and an examination of basic moral premises relative to the profession, see Maurice B. Visscher, M.D., Humanistic Perspectives in Medical Ethics (New York): Prometheus Books, 1972).

5 For a history of maternity care, see Barbara Katz Rothman, In Labor: Women and Power in the Birthplace (New York: W. W. Norton & Co., 1982). Rothman examines how women who originally controlled maternity care were dethroned from their position by white male regulars. She argues that once surgeons were considered experts in the use of instrumentation such as the forceps for abnormal births, midwives (women who tended births long before men did) lost control over normal births. Rothman points out how formal training programs concerning human anatomy and the reproduction processes conducted by surgeons in the 1700s excluded women from their ranks.

6 While scientific medicine recognizes a psychological component of health, the institution considers it separately from the physiological. The subdivision of orthodox practitioners into psychiatrists and physicians is indicative of this separation. Andrew Weil, M.D., talks about how healing is a natural response to illness or injury. When this process is blocked, the source of trouble is likely to be the non-physical aspect of the human mind-body and attention to the physical will not produce a cure. He goes on to discuss how mind cures must be given more attention by physicians (20). It should be noted that many physicians do not adhere completely to the biomedical model in the treatment of patients. I am describing a model and am referring to its extreme aspects.

7 Studies have indicated the importance of nonbiological factors affecting the patient's labelling and defining a bodily state as a symptom or a problem. Zola's study points out the difficulty of conceptualizing and measuring chronic disorders primarily because of the socio-cultural factors of the patient, such as one's value-orientation towards sickness and pain. What may be perceived as signs or indicators of a medical problem in one population may be ignored in another. For example, diarrhea, sweating, and coughing are considered typical everyday experiences among many Mexican-Americans in the southwestern United States. Lower back pain among lower-class women is a common condition, an expected everyday experience, and they do not perceive it as a symptom of any disease or disorder (Koo's study referred
If a condition is prevalent among a population, it may be perceived as a normal state, something inevitable that one must endure. Zola emphasizes that there are systematic differences in the way people present and react to their complaints. Also, people describe the pain from the same condition in different ways. Since the scientific medical approach does not recognize socio-cultural factors as significant components of disease, diagnosis may be mispronounced and treatment techniques ineffective.

While the practitioner-patient interactions are dyads in the scientific biomedical model, in non-western societies, the practitioner-patient interactions within the folk medical model involve the sick person and family members. In other words, the afflicted individual may not be the focus of therapeutic treatment and may not be present during transactions between the practitioner and family members. Many folk healers believe that illness may influence family and social relationships; therefore, they respond to a medical crisis by administering treatment to those relationships and family members. For a more detailed discussion of this model, see Arthur Kleinman, Patients and Healers in the Context of Culture (Berkeley: University of California Press, 1980) pp. 203-258.

Attempts are being made to study the laying on of hands phenomena from a biological perspective. Apparently, the heat intensity of a healer's hands is measurable and supposedly higher than that of non-healers. Under controlled conditions, experiments were conducted on mice and barley seeds to see if they would respond to the laying on of hands by a healer (i.e., one who claims to have the gift of healing) in biologically recognizable ways. Based on the results of these experiments, the researcher concluded that a transfer of energy occurs from the therapist to the patient, and the healer has to possess a psychological attitude so that s/he can receive the energy from God and/or some sort of higher energy source. For a detailed discussion of these experiments, see Bernard R. Grad, "Some Biological Effects of the Laying on of Hands and Their Implications" in Dimensions in Wholistic Healing: New Frontiers in the Treatment of the Whole Person, Herbert A. Otto, Ph.D., and James W. Knight, M.D., eds. (Chicago: Nelson-Hall, 1979) pp. 199-212.

Scientific medicine's tendency to focus on the biological aspects of the healing process may be impeding discovery about how the nature of mind and brain affect the healing process. Certainly physicians recognize the mind as having some part to play here; witness the placebo dimension in testing the effectiveness of a drug. However,
they tend to assign negative significance to the placebo effect and see it as something to rule out by double blind testing in the controlled evaluation of a new drug. If patients indicate relief from placebos, physicians tend to believe that the sickness has no physiological basis. Dr. Andrew Weil argues that all treatments have the potential to elicit a placebo response depending upon the beliefs of the practitioner and patient. Therefore, the treatment's effectiveness may be indirectly enhanced by a placebo response. He states that it is impossible to determine whether the placebo response or the treatment in and of itself contributes the most in the final outcome. For a more in-depth discussion of this controversy, see Weil's "Mind and Body" in Health and Healing (Boston: Houghton Mifflin Co., 1983) pp. 199-254.

It should be noted that according to Weil, in Health and Healing, the two broad divisions of allopathy are medicine and surgery; both are distinct approaches to handling a medical crisis, i.e., surgeons practice surgery and physicians medicine. Medicine as a subdivision of allopathy includes such specialties as cardiology, dermatology, gastroenterology, internal medicine, neurology, and psychiatry. Surgery as a subdivision of allopathy involves such specialties as orthopedics, obstetrics, gynecology, plastic surgery, neurosurgery, etc. (84). These two divisions generate two distinctive types of doctors. For a historical account of this division, see John Duffy, The Healers (Urbana: University of Illinois Press, 1979).

There is a discrepancy in the literature concerning the date when the AMA was formed. For example, Ehrenreich and English in Witches, Midwives, and Nurses list the date as 1848; Duffy in The Healers as 1847; Weil as 1846.

It appears to be a common practice for practitioners of a healing sect to stray away from the founder's tenets in the course of time. For example, the disciples of Thomsonianism began institutionalizing medicine and forming medical schools, an act in itself contrary to Thomson's notion that medicine belonged to the common man. Andrew Taylor Still (1928-1917) founder of Osteopathy (bone manipulation), gave up the use of drugs completely and felt that his techniques alone could be used to treat any medical problem. During the early part of this century, osteopaths (D.O.s), contrary to the master's teachings, were using the same drugs as allopaths in handling medical problems.

twentieth century, American physicians were seldom attacked by mass and highbrow media. Medical discoveries and surgical successes helped to generate favorable publicity about science and the medical profession in general. The public viewed medical care as both essential and desirable. However, physicians' high ideals and stance against socialized medicine brought criticism against the priestly, and technical functions of the profession. Public confidence in the profession was shaken.
CHAPTER III

ALTERNATIVE MEDICINE: ADVANCING MEDICAL PLURALISM

The origin of the term "alternative medicine" is somewhat ambiguous. Some of the literature on this topic seems to imply that alternative medicine is a fairly recent phenomena, something that evolved within the last several decades from patient dissatisfaction with scientific medicine (Hulke, ed., et al., 1979; Inglis and West, 1983). Common complaints are that it is too expensive, too impersonal, and too dependent upon dangerous drugs and unnecessary interventionist procedures. One argument is that while so many technological advances were being made in pharmacology, surgery, anaesthesiology, and bacteriology, many diseases were eradicated; thus, many people came to venerate the "godlike" physician and to depend upon him to resolve any health care crisis they might have had. During this period of time (primarily from the latter nineteenth century to the 1860s), non-allopathic or irregular practitioners were virtually wiped out of business because nearly everyone turned to scientific medicine for fundamental health care and/or rigid laws were passed to discourage them from practicing. Conservative allopathic
institutions such as the AMA and the Royal College of Physicians in London have a long history of combating medical pluralism in an effort to monopolize the treatment of all human diseases. To achieve this objective, scientific practitioners had to be recognized by the general public as having a body of medical knowledge superior to that of any practitioner not formally trained in scientific medicine. This knowledge would involve their knowing how to administer the appropriate treatment in a medical crisis effectively.

The assumption that people in the Western world within the last several decades have begun to use alternative medical systems is unfounded. Historically, our society has always been medically pluralistic and resisted a complete surrender to the authoritarianism of scientific medicine. However, there does seem to be a proliferation of interest in medical systems, particularly Eastern forms such as acupuncture, yoga, and Shiatsu. Certainly, these forms are receiving more attention from the media which may be due in part to the self-help/fitness movement in this society. More health professionals are exploring alternative health forms which again may be the result of this self-help humanistic movement that tends to exalt humanism over technology.

One cannot discuss alternative medicine and its implications without first considering the notion of a dominant group of practitioners, in this case, the orthodox
medical profession. After all, the term "alternative" suggests something that exists outside an established system. Alternative practitioners will undoubtedly have different beliefs about the causes of human illnesses and the appropriate treatment thereof from those of the scientific medical establishment. The reasons for their marginal or peripheral status are complex and may vary from culture to culture.

Wallis and Morley state that the following conditions must be present for the notion of orthodox and hence non-orthodox medicine to exist in a society: (1) there has to be an occupational group whose job consists of administering therapeutic treatment to the sick; (2) members of this group display a high level of consensus relative to disease etiologies and appropriate treatment procedures for most medical problems; and (3) the practitioners are perceived by the client group as legitimate and uniquely competent to treat the sick (1976:9). Wallis and Morley go on to state that throughout history, condition number one has been met while two and three have been characteristic of some traditional societies, as well as the industrialized Western world since the latter part of the nineteenth century. Perhaps condition number three is the most problematic. Legitimacy and competency may be ideal properties of orthodoxy—hence scientific healers; yet, a significant portion of the client group may see them as ineffective
practitioners. While competency denotes adequate training and the proper credentials, it does not necessarily indicate client satisfaction.

How does one group of practitioners come to be recognized as being uniquely competent relative to the entire spectrum of human sicknesses and diseases when medical competition is a reality? Studies have shown that in a medically pluralistic society, a certain group of practitioners is perceived as handling specific types of medical problems more efficaciously than another group of practitioners and vice versa. For example, Kleinman in his research concerning the responses of lower and middle class families of Taiwan to sickness episodes found that Western-style practitioners usually were selected to handle acute medical problems such as infections, diarrhetic or respiratory disorders, while chronic medical problems such as hypertension or hemiparesis from a cerebrovascular accident were more often handled by indigenous (Chinese-style physicians and folk healers) practitioners. Selectivity of practitioners was heavily influenced by popular beliefs of how the actual treatments work and what they purport to do. Patients maintained an entirely different set of expectations when they were treated by Western-style doctors as compared to their being treated by indigenous healers. For instance, patients changed doctors if Western-style physicians did not relieve their symptoms in several days with a
maximum of two to three office appointments. However, Chinese medicine was believed to act slowly since it treats the "underlying cause" rather than symptoms. Therefore, patients waited for a considerable period of time even though symptoms might persist before they concluded that the treatment had been unsuccessful (1980:179-374).

Another study which specifically addresses the notion of a group's preference for a marginal practitioner over an orthodox one is that of Arthur B. Shostak, entitled Blue-Collar Life. In examining various dimensions of the lifestyle of the working class in Western culture (specifically the white male blue-collarite and his dependents), Shostak includes a section on health and illness. He concluded that the chiropractor was favored over the allopathic practitioner for the following reasons: treatment by a chiropractor was less expensive and more available in blue-collar neighborhoods; treatment was simple and direct—no drugs or surgery utilized; clients felt less incapacitated during treatment and returned to work more quickly; and the chiropractor was perceived as an unusually personable medical type rather than an impersonal, arrogant type.

The above studies indicate that people obviously evaluate and compare practitioners, both orthodox and unorthodox; they often have a set of preconceived ideas as to what practitioners actually can and cannot do. People expect positive results which could range anywhere from
disappearance of symptoms, to being able to go back to work whether they are completely healed or not, to a complete recovery. What Wallis and Morley indicate is that orthodox status of practitioners is contingent upon the degree of legitimacy the client group gives them based upon their specialized knowledge and their efficiency in handling a medical crisis. While one group of practitioners may be labelled as "orthodox" (which means in Western culture that they have the backing of powerful institutions such as the government, insurance companies, etc.), it may be perceived as a body of ineffective healers by the public at large or by certain segments of the public in relation to its treatment of certain types of medical problems. "Orthodoxy" is a slippery term and very difficult to analyze. One must take into consideration variability from culture to culture. For example, while chiropractors are still considered "marginal" practitioners in this country (this negative label is changing for them, however) by scientific practitioners, according to Shostak, blue collar workers of his study for the most part preferred chiropractors over allopathic practitioners, and therefore saw them as legitimate healers. In my own research, Dr. G, a manual therapist (something similar to a chiropractor) who handled lower back, cervical, lumbarsatic and headache problems, said that many of his clients were industrial workers with industrial injuries. In Taiwan, although only Western-style medicine having the
orthodox status received direct financial support from the government (Kleinman, 12), a certain segment of the client population yet felt that scientific practitioners were limited in their ability to handle certain medical problems effectively. In some traditional societies, it is orthodox medicine that is viewed with suspicion by the population and in some sense is considered marginal.

While the term "orthodox medicine" in Western society denotes superiority, prestige, autonomy, and is synonymous with scientific medicine, this status is not static and something to be taken for granted. Witness how allopaths dissatisfied with the results of scientific medicine are becoming more receptive to less conventional approaches to healing. It is not uncommon for various physicians and allied professionals to attend seminars and symposia on frontier areas of healing. For example, from September 30 through October 3, 1972, the Academy of Parapsychology and Medicine made up of physicians and allied health professionals conducted a four-day symposium entitled "The Dimensions of Healing" at Stanford University. The academy co-sponsored a similar symposium at the University of California, Los Angeles, in October where 1300 professionals became acquainted with healing modalities such as biofeedback, acupuncture, and spiritual healing (Otto and Knight, 1979:21). Series of conferences exploring unorthodox healing practices appear to attract professionals from
various fields.

Some scholars feel that the holistic health movement will probably have a significant impact on the medical profession in this country in the next several decades. Holistic healing centers are emerging, and in May of 1978, 225 physicians from the United States and Canada came together in Denver to form the American Holistic Medical Association. This organization offers programs to medical schools while providing research, education, and supplementary resources for medical professionals and non-professionals interested in holistic medicine (Otto and Knight, 24).

Just what is holistic medicine? What does it have to offer that the conventional scientific medical model does not? Is it just another term used synonymously with "alternative," "fringe," or "marginal" medicine, and something not to be taken seriously by conventional practitioners?

The term "holistic medicine" refers not only to a comprehensive treatment program that takes into consideration the mental, psychological, physical, social, and spiritual aspects of the person, but also some fundamental notions of health that involve positive wholeness and well being. Unlike the biomedical model that focuses on eradicating the disease and its symptoms, ideally, the holistic medical model attempts to take in a much broader and more positive concept
of health. Health is not merely the absence of disease but consists of a balance in the energy spheres "of our emotional, rational, spiritual, physical, and social selves" (Harold Stone, 1979:32). An imbalance of these energy spheres is an indication that some form of healing is needed.

Proponents of this model feel that a number of factors affect the outcome of the healing process including self awareness, i.e., everyone taking responsibility for her own health, learning all about nutrition, learning how to handle stress and learning how to be the leading decision maker in regards to her health. A person is presented with choices in terms of treatment modalities (including those not commonly accepted such as acupuncture, yoga, psychic therapy and faith healing) leading to health and she must decide what course of action to follow. The physician is not viewed as the ultimate voice of authority and the one responsible for making the person well. The person's impressions and knowledge of the causes and nature of the pathology or dysfunction are recognized as valuable and are taken into consideration by the medical personnel during the diagnostic and treatment stages.

Holistic medicine advocates believe that the environment, including the psychological and the physical, in which recovery takes place is important in healing. Medical personnel are key figures in expressing love and emotional
support for the client. Ideally, there is no hierarchy among medical personnel; all have a significant part to play, are seen as facilitators of healing, and together make up a team. The healing team should know the client well enough to encourage him to tap his inner resources, including the psychological, spiritual, and mental in order to move towards health and vitality. They feel that properly controlled group sessions with non-medical persons can provide an environment that fosters the emotional stimuli necessary for helping participants discover the underlying forces that impede healing. Also, they believe that such groups can diminish participants' anomie and alienation by generating friendships consisting of a caring bond that promotes healing.

At the core of this model are some ancient Greek medical notions. One is that when a person is ill, the entire person needs to be treated, the psyche and soma (mind and body). The mind-body dichotomy that exists today in allopathic medicine was nonexistent in ancient Greek medicine and any treatment at the temple was directed towards the whole person not just an organ or limb.

Another fundamental of the model found in ancient Greek medical thought is that every patient is to take an active part in the healing process mainly through releasing the latent transpersonal energy which stems from his interacting subsystems. Holistic healing advocates feel that
everyone has the inner capacity or inner authority to heal. Practitioners and therapists alike serve as health facilitators to help those in need tap their inner healing resources such as belief, will and intuition. Ancient Greek healers also encouraged the sick to take an active role in their treatment and to utilize their inner resources. After going through various healing rituals with the patients, practitioners of ancient Greece who were actually priests of the temple would encourage them not to be afraid, to remain quiet, and to go to sleep. During the night, often patients reported having healing dreams in which the healing god, Asklepios, appeared and cured them of their illness; sometimes, the illness would be gone the next day (Stone, 1979:32). Some psychotherapists of today would refer to a dream that has a healing effect on the patient as a medium for tapping this transpersonal energy spoken of earlier. There are a number of ways to tap this energy, including through suggestology, meditation, chanting, fasting, color therapy, etc. This model emphasizes the importance of making a person well and whole and stresses that the most appropriate healing modality, be it unorthodox or otherwise, may be used to accomplish this aim.

In reference to the question raised earlier concerning the relationship between holistic medicine and alternative marginal medicine and whether these forms are something to be taken seriously by conventional practitioners, first
of all, it seems that the term "alternative medicine" as used in the literature refers to any type of healing modality, be it diagnostic, preventive, or therapeutic, not utilized or accepted in a general sense by scientific medicine. The term almost always refers to a non-synthetic chemical remedy or non-surgical technique, which would probably include hundreds of medical strategies such as radionics, herbalism, psychic surgery, dianetics, hypnotism, chromotherapy, hydrotherapy, zone therapy and reflexology, chiropractic, jogging, fasting plans, faith healing, vitamin therapy, yoga, iridology, macrobiotics, acupuncture, etc. (Carroll, 1980:17), and any non-interventionist healing technique that acts as a catalyst to help the body heal itself. Alternative medicine is a somewhat relative term. For what represents a viable solution or alternative to a medical problem to one person may be totally unacceptable to another. For example, a faith healer may be strongly opposed to the curanderismo healing system and view it as the work of Satan. Some allopasts use some manipulation, acupuncture, or herbalism as treatment therapies, while others are completely resigned to using only the more conventional therapies. More accurately though, alternative medicine is a term that indicates choice in approaches to health for a general public that seems preoccupied with obtaining a "wellness" state.
While alternative medicine is a term that refers to numerous nonconventional medical strategies collectively, holistic medicine itself is alternative medicine representing a healing system with a conceptual framework that is applicable to a wide variety of nonconventional treatment programs attending to the psychological, physical, social and spiritual dimensions of the person. Therefore, it consists of a variety of practices and schools of thought that attempt to consider the physical and nonphysical aspects of health and illness. Holistic medicine is a system that employs any therapy, preferably an alternative/unconventional form, that stimulates the person's inner healing resources. The fact that conventional scientific diagnostic/treatment methods are used only after alternative forms have been exhausted, probably is some indication of the former's incompatibility with holistic medicine. While many alternative medical forms have emphasized an integrated treatment of the whole person historically, scientific medicine has moved more and more towards a particularized treatment program. Witness the 57 specialized fields of scientific medicine, and the number continues to grow.

Actually, holistic medicine can be viewed as a psychosomatic medicine in that it recognizes the effect the complex interaction of mind, body and environment can have upon one's health in similar ways as the latter does.
"Psychosomatic" is a term overused by both professionals and lay persons. Unfortunately, for some it has come to mean an "imaginary" illness (i.e., symptoms of the disorder persist in spite of the absence of organic pathology); therefore, the disorder has no real basis. Yet more and more research, particularly the stress literature, is linking the psychogenesis of chronic disorders such as hypertension, cardiovascular disease, bronchial asthma, and arthritis to psychological and environmental factors (Dohrenwend and Dohrenwend, eds., 1974). In spite of this evidence, this "imaginative/hypochondriacal status of psychosomatic disorders impedes the clinical use of psychosomatic concepts (Hufford, 1984:31).^6

At the heart of the holistic/alternative medicine versus scientific medicine (or humanism versus technology) controversy are some very complex problems that are far from resolution. First of all, should the major emphasis of medicine shift from disease to health? If so, what is the role of physicians in a more humanistic medicine versus the present highly technology-based medicine? Should lay persons have a greater role in health care?

It is very difficult to talk about medical systems collectively; however, it is probably safe to say that a fundamental goal of most medical systems is to improve the welfare of human beings. How one goes about accomplishing this task is debatable. Underlying philosophical questions
about our earthly existence are relative to this debate. For example, is there some sort of predetermined lot of suffering (for our purposes suffering refers to sickness and any form of medical or psychological trauma) that everyone must experience? If suffering is inevitable, should we make some effort to alleviate it or become resigned to it and try to make the best of it? The Christian eschatological vision of the kingdom of God is that of a Utopia—a time when all believers will have a perfect state of health, when suffering is no longer a reality, when perfect harmony, peace, and justice are unending. Thus, many fundamental Christians would see suffering (sickness) as a necessity to inhabit this non-earthly, perfect kingdom. Some fundamentalists feel that God has given us resources such as doctors, ministers and individual faith to get through these "trying times." They also believe in divine intervention during a medical crisis, and hope and belief in this ultimate energy makes healing always possible even when scientific medicine has labelled a medical problem "hopeless" and "terminal."

There is a secular humanism in both the scientific and holistic/alternative medical approaches. The ultimate goal of secular humanism, i.e., the perfection of society through human efforts, presupposes that an individual shall have full responsibility for her thoughts and deeds (Braunthal, 1979:275). Progress is not something to be
taken for granted nor something that will automatically happen without the will and deeds of human beings. Scientific medical discoveries, on one hand, can be viewed as a human effort to obtain that perfect society. After all, some diseases have been eradicated; the infant mortality rate is down, and the life expectancy of both men and women has increased. On the other hand, some might believe that we have become too dependent upon these man-made inventions. As stated in chapter two, some physicians are fearful of making a diagnosis without running unnecessary tests, tests that can cause more harm than good. Chemotherapy is abused and overused. Secular humanism is the celebration of human beings and excludes any dependence upon external powers.

The holistic approach at best can be seen as an attempt to demystify medicine by focusing on the psychosocial aspects of healing while de-emphasizing the technical. The patient is encouraged to undertake a rigid introspection process in an effort to control the outcome of her health. Indeed this part of the system contains one of the most humanistic elements in that the individual uses her inner resources to control her destiny. According to this model, members of the healing team help to aid this process.

While the holistic approach appears to be the medical model that many have been waiting for, there are some questions as to what this model can and cannot do. Most would
agree that nonspecialists, particularly the patient, should play a greater role in his health care in the scientific medical system. But what becomes the physician's task with all of her technological knowledge once the nonspecialist is given more recognition? Realistically, can a nonspecialist be considered her equal during a medical crisis or as a supplementary resource? Some think that under the holistic model, the physician will take on a comforter role. She will be one who knows very little specifically and will more than likely refer patients to specialists (Gardner, 1983:40). Just how much of the patient's insight during the diagnostic and treatment states is helpful? While the treating of symptoms is not the major focus in this model, at some point the patient would have to describe how he feels to the health facilitators. Certainly a description of the symptoms would come up some time or another. In reference to the holistic health center model (where the healing team consists of lay persons and technically trained persons), would one talk about his symptoms to a minister in the same way he would to a physician or to a psychotherapist?

The question of specialization is problematic and one that some doctors feel is crucial to the holistic model's soundness and validity. In other words, what is to be gained by moving away from scientific specialization? Many doctors are in favor of the rapid increase in the number of
specialized areas in scientific medicine and feel that there should be more. The underlying notion here is that specialization is a means to an end. Progress for the whole will come about when the tiniest segment is known completely. Perhaps holistic medicine should be another specialty (Gardner, 39). After all, no medical model can handle everything. The clinical and research literature on holistic/alternative medicine seems to indicate that its strongest elements are prevention of stress-related disorders, health maintenance, and the healing process of the whole person. While there is no focus on disorders per se, it has gotten very positive results in handling stress-related disorders such as hypertension, angioneurotic edema, peptic ulcers and arthritis. Empirical evidence indicates that with the use of meditative therapy, including biofeedback, Transcendental Meditation (TM), and yoga, patients can consciously regulate the autonomic nervous system and attain heightened awareness and unique physiological states including a reduced breathing rate from twelve to fourteen breaths per minute to four to six, a significant reduction in blood pressure, etc. Research findings also indicate that the meditative process is more effective at relieving nervous-system stress than either sleeping or dreaming.

Empirical evidence concerning the effects of alternative medical forms is necessary to convince nonbelievers
of their clinical validity. The psychological and physiological transformations that patients experience because of altered states of consciousness in meditative therapies can be measured with scientific equipment. However, much is yet to be discovered about the mind as a potential healing modality. Clairvoyance, telepathy, and extrasensory perception remain mysteries since the scientific means have not been formulated to determine how they work. Besides our lack of scientific instrumentation to study certain healing forms, certain practitioners acquire their abilities and knowledge in an esoteric manner, for example through divine revelation, from a near-death experience, or from belief in certain complex transmission processes (such as the miracle of string measurement can only be passed on from a female to a male or a male to a female, never from members of the same sex). 8

Ever since the World Health Organization defined health as "a state of complete physical, mental, and social well-being," many health professionals have viewed this rather ambiguous statement as useless in terms of scientific standards. What are the properties of the term "well-being," and how does one achieve this state? Are we referring to a relativistic concept, or is this one that has general applicability? Researchers are struggling with these kinds of questions as they try to discover other means by which to determine the health of a society besides the mortality
rate and the number and kinds of disease of a given population. Clearly we are dealing with different forms of reality. There are those who accept the notion of health and well being as having very complex socio-psychological and metaphysical properties. Thus certain kinds of therapies are appropriate in an attempt to obtain the ideal of "living life to the fullest." On the other hand, there are those who believe that health is something objectifiable, and health management is contingent upon understanding and eradicating this quantifiable entity—disease.

Description of Sample

Problem: What health care practices exist in Johnson City? In what context are they utilized and for what purpose?

I began with the hypothesis that alternative health practices exist in any community. By alternative, I refer to self-help procedures the natives use without the guidance of a physician. I am also including diagnostic, maintenance, and treatment techniques they use that have not been accepted by the scientific medical profession. These practices could include some things done on a regular basis, occasionally, or perhaps once in a lifetime. For the most part, these practices will not involve drugs made from synthetic chemicals or surgical techniques (see Table 1, p. 118). Alternative medicine should not be viewed as a replacement for scientific medicine but as a possible
resource to aid in the resolution of certain kinds of medical crises. Sometimes these unorthodox forms work and sometimes not. Natives use alternative medical forms simultaneously with the conventional medical system usually without their physician's knowledge of their doing so.

There is a level of predictability in health behavior. Often the first step taken in a medical situation that is perceived as a crisis is the diagnosis which may include only the individual in question, or could involve friends, family, strangers, and/or medical professionals. The next step involves choice—the course of action one decides to take to resolve the problem, e.g. wait it out, intervene with medication, use vitamins and other natural healing methods, etc. In terms of health maintenance and preventive cases, sometimes there is no need for a diagnosis and rigorous procedures may be followed to avoid future medical problems.

There were several questions that focused on the notion that the home is the center for specific kinds of health care practices. The questions designed to generate information about medical practices in the home were as follows:

(1) Describe what you do when there is an accident around the house.

(19) Describe something you always treat at home.

(33) What kind of health problems should be treated at home?
(12) What do you do to stay as well as possible?  

In terms of an accident, evaluating the immediate situation is vital. All of the informants indicated this importance in one way or another. For example, 43 percent prefaced their answer with a statement such as "depends on what it is." Many expressed the need to remain calm. Anne, (informant one, see Appendix B for a brief description of participants) stated:

Usually very little—I'm trying to think of accidents we've had. My one year old fell off of the picnic table the other day, and you know bit his tongue real bad and cut his gums. Those mouth accidents are always profuse bleeding. You know, I really didn't do much but give him a drink of water. Unless it's some terrible accident, I feel like I react calmly. Well, like with that I just gave him some ice, rinsed his mouth, comforted him basically.

The data revealed two categories of accidents: minor ones which were self-treatable such as burns and wounds that were not too deep; and major ones such as broken bones from a car wreck, wounds that needed stitches, heart attack, spider bite, etc. which required outside assistance of the emergency squad, doctor, etc. Immediate responses to an accident were governed by several factors including whether the victim was a high-risk individual, the degree of responsibility one involved felt for the victim, and the diagnosis which would attempt to identify the level of severity of
the injuries sustained. For example, Nancy, informant two who was very much opposed to the drug therapy scientific medicine uses, seemed much more susceptible to taking her grandchildren and a friend (who began to get very excited over a bee sting) injured at her chalet to the hospital than herself (a nurse friend who happened by had to persuade her to go in when she thought Nancy had broken her leg).

Margaret, informant thirteen who cares for her invalid mother, very succinctly stated, "I would call the squad immediately" in response to question one. Dianne, informant twelve, a Public Health Nurse who at the time of the interview was involved in the home health care program, called the emergency squad when an elderly patient of hers fell with a walker. Cases perceived to be at high-risk were thought to require outside help often when one felt responsible for the outcome and therefore less hesitant about risking any uncertainty. Such cases involved children, grandchildren, the disabled and the elderly.

The prevailing attitude among the informants was that most medical problems will run their course. Unless it was a major accident or an accident involving a high-risk person, outside professional help usually was not sought. In cases where a medical professional was a friend of the injured person or the injured person's family member, the medical professional's assistance (usually advice and reassurance that things would be all right) was solicited in a
non-work environment. Anne, informant one, made the following statement:

A couple of weeks ago, he (her one year old son) fell down the stairs, did two back flips down the stairs. So that was a little scary. He got real pale, didn't cry, which I interpret as a bad sign for a kid to do that and not cry. But just so happen right at that moment some friends were coming over, well he's a doctor. So he was able to assure me too.... He (her son) got real pale, but he seemed to move all right and respond. So that passed within an hour.

Lorie (informant eleven), the pharmacist, stated that whenever her roommates had an accident, she usually handled it unless it was something serious like a broken bone. It is difficult to say whether these people would have sought outside professional help if these medical professionals had not been around at the time of the accident. Pam, informant six, did state that she would have called the emergency squad if her family doctor had not been her next-door neighbor when her daughter fell out of the swing and landed on her back. Whether Anne, informant one, would have called her doctor if he did not happen to be over to her house when her son fell backwards down the stairs was questionable. She did say that she herself checked his responses. Even though he was listless, "he seemed to move all right and respond." She indicated that she would have
watched him very closely for an hour or so for any unfamiliar symptoms. Had they developed, perhaps then she would have called the doctor, a friend of hers. Many of the accident stories indicated that people used the home to treat most accidents which were normally a temporary disruption. Major accidents did not occur often, but when they did, professional medical help usually was solicited.

Besides minor accidents, there were other self-treatable medical problems such as ailments (a persistent disorder or disease that tended to cause discomfort to the person periodically and something the doctor could do little, if anything for) and a short-term medical problem such as an infection, a cold, etc. Four of my informants (29 percent) suffered with arthritis. Two of them (Dianne and Jim) took aspirin for relief, while the other two (Barbara and Mary) used what would be considered unorthodox methods. For example, Barbara (informant ten) who used cherries for her rheumatoid arthritis (see Table 1, p. 118) stated:

People who've had rheumatism, arthritis or gout problems. Just the idea of cherries has worked for them. Just six to eight cherries a day. Any type of cherry, any color. Dried, fresh, frozen. And I guess it changes their uric acid in their body. The idea, the problem, is you have too much uric acid. And the cherries must balance that out.
Barbara stated that most of her ideas about health came from the food co-op that she was involved in, books on natural remedies, her doctor who used some herbs in his practice and personal experiences. After being disappointed with scientific medicine's ineffective treatment of her osteo-arthritis, Mary (informant four), felt that she learned to handle this ailment mainly on her own (see Table 1, p. 118) namely because of her will to live and not give in to her doctor's grim prognosis of her having to be an invalid for the rest of her life and dependent upon pain killers. She made the following statement:

Well, my main problem was osteo-arthritis, and by trial and error, I just kind of learned. And the main thing—it started to help me, was cutting sugar out of my diet. I'd really get the sugar blues. You know, the—refined sugar. O.K.? And then I learned that—ah—movements were benefitted by cod liver oil. And I hated cod liver oil.... So I learned how to emulsify it in the refrigerator so I could stand it.... So I had my cod liver oil cocktail every morning, and I had an hour of exercise—fifteen minutes right lateral; fifteen minutes prone; fifteen minutes left lateral; fifteen minutes supine. And all during the day I've got exercises....

All respondents wanted to get their ailments under control by stopping the discomfort they caused. They did not want to be dysfunctional. Some relied on scientific medicine to relieve them of the symptoms, while others
<table>
<thead>
<tr>
<th>Informant</th>
<th>Alternative Health Practice</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>Anne</td>
<td>Lots of fluids including good water, fruits, vitamins and herbs</td>
<td>For fevers</td>
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<tr>
<td></td>
<td>Went to osteopath that specializes in cranial manipulation</td>
<td>To help recover from illness such as mastitis</td>
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<td></td>
<td>Proper diet, fresh air</td>
<td>Son had trouble breathing</td>
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<td></td>
<td>Garlic, golden seal and cayenne</td>
<td>To stay well</td>
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<td></td>
<td>Home birth</td>
<td>For friend's ulcerated sore</td>
</tr>
<tr>
<td></td>
<td>Wheat grass, Plantain poultice, whiskey and honey, Iridology</td>
<td>To have baby in most comfortable environment</td>
</tr>
<tr>
<td>Nancy</td>
<td>Slant board, Nutrition: whole foods—tossed salads, nuts, fruits</td>
<td>For good health</td>
</tr>
<tr>
<td></td>
<td>Massages and touches</td>
<td>For bee sting</td>
</tr>
<tr>
<td></td>
<td>Positive attitude, touching, water, and fresh air</td>
<td>For arthritis</td>
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<tr>
<td></td>
<td>Friends</td>
<td>To stay healthy</td>
</tr>
<tr>
<td></td>
<td>Plenty of rest—8 hours per night</td>
<td>For emotional support</td>
</tr>
<tr>
<td>Florence</td>
<td>Friends</td>
<td>To stay healthy</td>
</tr>
<tr>
<td></td>
<td>Positive attitude, touching, water, and fresh air</td>
<td>For stimulation, to stay healthy, for clients with various problems</td>
</tr>
<tr>
<td></td>
<td>Proper diet, fresh air</td>
<td>For arthritis</td>
</tr>
<tr>
<td>Mary</td>
<td>Exercise—Shiatsu, hatha yoga, polisar therapy, reflexology, and massage therapy</td>
<td>For arthritis</td>
</tr>
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<td></td>
<td>Cod liver oil every morning with the exercise</td>
<td>For eyes</td>
</tr>
<tr>
<td></td>
<td>A lot of Vitamin C and fruits</td>
<td>For dizziness and feeling badly</td>
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<tr>
<td></td>
<td>Dr. G, local manual therapist</td>
<td></td>
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<tr>
<td></td>
<td>Sunflower seeds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fast walking, changing pace</td>
<td></td>
</tr>
<tr>
<td>Rev. T. David</td>
<td>Prayer and faith in God</td>
<td>For all healings—spiritual and physical (too numerous to mention here) For a cold For an open wound To stay well.</td>
</tr>
<tr>
<td>Faith healing</td>
<td>A glass of wine</td>
<td>For arthritis</td>
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<tr>
<td>minister</td>
<td>Salt</td>
<td>For arthritis</td>
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<tr>
<td></td>
<td>Moderation in food, maintain moderate body temperature</td>
<td>For arthritis</td>
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<tr>
<td></td>
<td>(e.g., stay warm when it's cool and cool when it's hot)</td>
<td>For arthritis</td>
</tr>
<tr>
<td>Pam</td>
<td>Aloe vera, Vitamins, positive thinking, swim and dance, nutrition—grows own vegetables</td>
<td>For burns</td>
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<tr>
<td></td>
<td>Lots of water</td>
<td>For kidney infection</td>
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<tr>
<td></td>
<td>Dreams</td>
<td>Unconscious helps her get well</td>
</tr>
<tr>
<td></td>
<td>Soda or salt water</td>
<td>For sore throat</td>
</tr>
<tr>
<td></td>
<td>Relaxation exercises</td>
<td>For stress</td>
</tr>
<tr>
<td></td>
<td>Faith healing and intuition</td>
<td>For certain people to get better or well</td>
</tr>
<tr>
<td></td>
<td>Support of friends</td>
<td>To stay healthy or to make you feel better.</td>
</tr>
<tr>
<td>Jean</td>
<td>Positive attitude, support of friends</td>
<td>Makes her feel better</td>
</tr>
<tr>
<td>College librarian</td>
<td>Eat a lot of meat, vegetables (particularly tossed salads) and fruit: no coffee: lots of</td>
<td>To stay healthy</td>
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<tr>
<td></td>
<td>liquids (mainly water), herb teas, and proper amount of rest (7-7 ½ hours)</td>
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<tr>
<td>Informant</td>
<td>Alternative Health Practice</td>
<td>Purpose</td>
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<tr>
<td>Dr. G</td>
<td>Diathermy, muscle stimulation and contraction</td>
<td>For patients with lower back and cervical problems, headaches, and lumbar-sacral conditions; also for preventive measures.</td>
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<tr>
<td></td>
<td>Fruit juices</td>
<td>For colds</td>
</tr>
<tr>
<td></td>
<td>Food supplements</td>
<td>To recover from any illness.</td>
</tr>
<tr>
<td></td>
<td>Moderation in diet, exercise and right mental attitude</td>
<td>To feel good</td>
</tr>
<tr>
<td></td>
<td>Dr. Christopher's herb formulas</td>
<td>For various conditions.</td>
</tr>
<tr>
<td></td>
<td>Took a serum that a firm in California made from his urine for 3 months</td>
<td>As a cancer prevent-ive</td>
</tr>
<tr>
<td></td>
<td>Partner, also a manual therapist, gives him a treatment regularly (once every two weeks)</td>
<td>To loosen up.</td>
</tr>
<tr>
<td>Regina</td>
<td>Edgar Cayce castor oil pack, poultices, and folk remedies, herb teas, and vitamin therapy</td>
<td>For many things such as gallstones, hypoglycemia.</td>
</tr>
<tr>
<td></td>
<td>Meditation</td>
<td>Helps free her clients from guilt they may be having about religion, relationships, etc.; helps them get in touch with themselves.</td>
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<tr>
<td></td>
<td>Psychic therapy, exercises: automatic writing; clairvoyance</td>
<td>To loosen up her muscles and joints.</td>
</tr>
<tr>
<td></td>
<td>Dr. G, local manual therapist</td>
<td>Diagnostic: to make her feel better (stimulates the glands).</td>
</tr>
<tr>
<td></td>
<td>Once a year to see an herbalist minister in a city inside the state (he uses iridology and massages)</td>
<td>Good for stomach; also used to mask flavor of unpleasing and tasting teas.</td>
</tr>
<tr>
<td>Barbara</td>
<td>Herbalism—peppermint (tea)</td>
<td>For insomnia</td>
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<tr>
<td></td>
<td>valerian (capsule &amp; powder)</td>
<td>For respiratory problems, allergy and asthma.</td>
</tr>
<tr>
<td></td>
<td>red clover (tea)</td>
<td>For tonsilitis</td>
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<tr>
<td></td>
<td>cayenne and ginger (makes herb gargle)</td>
<td>For athlete's feet, stress.</td>
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<td></td>
<td>Vitamins—B</td>
<td>Bladder or kidney problems</td>
</tr>
<tr>
<td></td>
<td>Cranberry juice</td>
<td>Bladder or kidney problems</td>
</tr>
<tr>
<td></td>
<td>Dolomite (tablets)</td>
<td>For arthritis or gout.</td>
</tr>
<tr>
<td></td>
<td>Cherries</td>
<td>Cleans the walls of the stomach.</td>
</tr>
<tr>
<td></td>
<td>Chaparral</td>
<td>For colds</td>
</tr>
<tr>
<td></td>
<td>Garlic and celery</td>
<td>To feel good</td>
</tr>
<tr>
<td></td>
<td>Exercise—walking</td>
<td>Good for all kinds of illnesses.</td>
</tr>
<tr>
<td></td>
<td>Foot rubs</td>
<td>For a more personal and natural environment.</td>
</tr>
<tr>
<td></td>
<td>Two homebirths</td>
<td></td>
</tr>
<tr>
<td>Lorie</td>
<td>Baking soda and water, or vinegar in bath water</td>
<td>For sunburn</td>
</tr>
<tr>
<td></td>
<td>Tries to maintain proper diet, avoids eating junk foods, exercise</td>
<td>To stay healthy</td>
</tr>
<tr>
<td></td>
<td>Friends and family</td>
<td>For mental help.</td>
</tr>
<tr>
<td>Dianne</td>
<td>Watches diet, vitamins in the winter, no caffeine, sugars, and salt; exercise</td>
<td>To stay healthy</td>
</tr>
<tr>
<td></td>
<td>Confides in friend who is also nurse</td>
<td>For emotional health problems</td>
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<tr>
<td></td>
<td>Osteopath</td>
<td>For back injury (at one time)</td>
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<tr>
<td>Informant</td>
<td>Alternative Health Practice</td>
<td>Purpose</td>
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<tr>
<td>(Dianne) continued</td>
<td><strong>Adolph's meat tenderizer made into a paste</strong></td>
<td>For bee stings at county fair.</td>
</tr>
<tr>
<td><strong>13. Margaret</strong></td>
<td><strong>Vitamins, exercise</strong></td>
<td>To stay healthy</td>
</tr>
<tr>
<td>Cares for aged mother in the home</td>
<td><strong>Positive thinking</strong></td>
<td>For nausea, stress</td>
</tr>
<tr>
<td></td>
<td><strong>Hot toddies</strong></td>
<td>For colds.</td>
</tr>
<tr>
<td><strong>14. Jim</strong></td>
<td><strong>Aloe vera; soda</strong></td>
<td>For burns</td>
</tr>
<tr>
<td>Digs roots as a hobby; grandmother was an herbalist</td>
<td><strong>Golden seal</strong></td>
<td>For asthma</td>
</tr>
<tr>
<td></td>
<td><strong>Blood root and burdock</strong></td>
<td>For the blood; gets it for friends</td>
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<tr>
<td></td>
<td><strong>Chiropractor</strong></td>
<td>For back injury when first injured on the job</td>
</tr>
<tr>
<td></td>
<td><strong>Herbs</strong></td>
<td>For a sprain</td>
</tr>
<tr>
<td></td>
<td>Home remedies—whiskey, rock candy, sulphur</td>
<td>For colds</td>
</tr>
<tr>
<td></td>
<td>A drink 2-3 times a week made of burdock, nerve plant, may apple, ginseng and whiskey</td>
<td>To make him feel better.</td>
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</tbody>
</table>
relied on alternative medicine to treat what they believed to be the cause of the disorder, or at least a contributing factor. For example, Barbara believed that cherries somehow balanced the surplus of uric acid in the body. This imbalance caused the arthritis. Mary believed that stress made her arthritis worse; therefore she tried not to worry and get upset over things and to relax as much as possible. She had gotten some negative results from hatha yoga when she first started doing it because she tried to overdo it, and she ended up in traction two or three times. She said that one should exercise caution in trying to do yoga. Although Pam believed in divine healing and natural healing methods, she did not contribute her relief from the discomfort her ailment caused her to these types of health resources. She stated that her family had a history of migraine headaches and that they tended not to talk about them very much and not to make a big issue out of them. Pam perceived this ailment to be some sort of genetic disorder or something that certain "family types" tended to produce. She felt that they were just a "personal pain you have to put up with." She elaborated in the following manner:

Well, once in a while they're really, really very severe and accompanied with vomiting and sometimes last a couple of days. But that's rare. That's why the minute I think I might have one I take medicine just as a preventive, and that
way I can almost always keep going. I rarely ever have to miss any time from work.... A few times, I've had, it's just been so terrible that 'I've gone and had a shot of something that really puts me out.' But that's only in extreme cases...it would never occur to (me) to go to the doctor at the time I had one going on. Because he said if I don't take the medicine before it gets started, then there really isn't much that they can do.

Pam believed that healing was a spiritual act. If one's spirit were whole, then God would use her as a medium for this healing energy, and one would have the power to heal herself and others too. Although she strongly believed this, she felt that she had not reached the point where it happened to her on a regular basis. She felt that surgery and synthetic drugs were unnecessary measures that people used to get well. God meant for us to be well. This line of thinking is certainly in keeping with the popular mythology discussed earlier in chapter two, i.e., the idea that we have lost that Edenic state and wellness becomes a goal (for many a spiritual quest) that we must work toward.

All respondents felt that they were either hardly ever or never sick. However, the data indicated that most of them had had short-term medical problems they had experienced personally and/or their family members or close friends had. Five (36 percent) had treated colds (see Table 1). Treatment ranged from drinking plenty of fruit juices, to using
whiskey remedies or herbal cures. Many of the self-help treatments seemed to be fairly straightforward, not time consuming, or tedious, and inexpensive. Some required some mixing such as the cayenne ginger gargle for tonsilitis, and the whiskey, rock candy, and sulphur cold remedy. Others required no preparation such as drinking lots of good water for fevers or drinking cranberry juice for kidney problems. There were some treatments, however, that were somewhat complex and required a certain amount of knowledge and preparation. For example, after having tests run at the local hospital, and being told that she had gallstones, Regina (informant nine) came home and spent the entire day reading up on the subject and decided to use Edgar Cayce's castor oil pack with some heat (a fairly complicated formula). Barbara (informant ten) who used red clover for respiratory problems told how she collected the blossoms to make tea from them.

The green part. Well, it's the little stalk that grows that one little bloom. That's the bloom of the clover. And some of them are white and some are red. And, when they're real healthy looking, full bloom, with no brown on them, that's when you pick them. Dry them and just pour hot water over them. Steam them. Like a tea.

Aside from revealing how people used various unconventional self-treatment procedures for certain kinds of medical problems, the data also indicated how prevalent the
notion of prevention was among the informants. Health was not something taken for granted but was the result of individual effort. All felt that there were certain procedures they believed in and followed that contributed to their health and well being. These procedures ranged from the common ones that the Public Health Service and the fitness movement have advocated such as proper diet, plenty of rest, and exercise to the more esoteric ones such as vitamins in the winter, wheat grass, and an herbal drink made from a certain formula (see Table 1). What was interesting was how they talked about the common preventive things most people know about. For Jean (informant seven), proper food and nutrition meant eating a lot of meat, vegetables (mainly tossed salads), and fruit, abstaining from coffee, drinking herbal teas, and eight glasses of water daily. Mary (informant four) singled out Vitamin C and fruits, and sunflower seeds for the eyes.

All of the informants indicated medical interests in other dimensions of the self besides the physiological. Their preventive programs included a socio-psychological and/or spiritual component. For example, Florence (informant three) strongly emphasized the importance of the emotional support their (her and her husband's) friends had given their family during their daughter's illness. Mary (informant four) expressed how changing her routine or doing something different had a positive psychological
effect. Pam (informant six) stated that she swam in a local pond during the summertime with a close friend as much as possible. They did the sidestroke so that they could talk to one another, and medical topics did come up in their conversation. Meditation was vital to Regina (informant nine). Being heavily influenced by scientology, Eastern mysticism and Christianity, she believed that the way we thought made us sick. If we corrected our behavior and our thoughts (which involved a long, arduous introspection process), we could heal. She felt that she could unlearn many of the negative things she was taught earlier in her life through study and meditation. "We will be happy only if we are in tune with ourselves." Much of the time spent with her clients often involved her trying to get them "to get in touch" with themselves.

Even though alternative medical practices were prevalent among the informants (some much more extensive than others), all had at some point seen a physician. While eleven (79 percent) of the informants had had at least one bad experience with the physician in terms of misdiagnosis and ineffective treatment, all indicated a certain awareness of what might be called the doctor's domain, i.e., a recognition that there were specific problems that they could not handle on their own and that required professional attention (see Table 2, p. 127).
The questions "When do you need the doctor the most" and "When should you go to the doctor" yielded the following responses: Most of the informants (93 percent) indicated that they had solicited the doctor's help for diagnostic purposes. They expressed this idea in various ways. For example, Anne (informant one) stated that she needed the doctor "when it gets beyond something that I can't diagnose. You know it's not a simple cold; it's not just a fever, or virus, or flu, or chicken pox or something like that, but something that needs to be diagnosed if possibly treated with antibiotics." Mary (informant four) talked about how she called the emergency squad when one of her elderly patients fell with her walker and hit her head. She wanted the doctor to check her over to see if any damage was done. She stated that that is what they (Public Health nurses in home health care) are trained to do.

What is interesting is what they do once the diagnosis is made. Some seek scientific medical treatment. For instance, Jean got a second opinion from a doctor/surgeon before she proceeded with her mastectomy. Anne got two medical opinions about her mastitis. One told her she would have to have surgery; the other told her she had time; in other words, it was not an emergency situation that needed immediate attention. She went home and used herbs to alleviate the problem. When she went back to her doctor,
## TABLE 2

<table>
<thead>
<tr>
<th>Informant</th>
<th>Things to go to the Doctor For</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anne</td>
<td>Husband had cancer, had to have operation; Mastitis, an infection in the breast from a clogged duct; Unfamiliar symptoms the kids have.</td>
</tr>
<tr>
<td>2. Nancy</td>
<td>Broken finger; Diagnosis of unfamiliar pain.</td>
</tr>
<tr>
<td>3. Florence</td>
<td>Broken bones; High temperature (fever); Annual checkup</td>
</tr>
<tr>
<td>4. Mary</td>
<td>When she cannot move; Broken bones, fracture; Loss of sight; Stitches.</td>
</tr>
<tr>
<td>5. Rev. T. David</td>
<td>Emergency—wife bit by a spider; Diagnosis of unfamiliar symptoms, e.g., when he injured his side in a car wreck; Broken bones; Child fell from swing and hurt her head.</td>
</tr>
<tr>
<td>6. Pam</td>
<td>Stitches for finger; Daughter fell off a swing onto her back; Pap smear once a year; Checkup (blood pressure and blood tests).</td>
</tr>
<tr>
<td>7. Jean</td>
<td>Broken bones; Annual Pap smear; When the problem won't clear up on its own, e.g., when your cold gets into the chest and you develop a fever; Children with sore throats; For a second opinion when considering a major operation.</td>
</tr>
<tr>
<td>8. Dr. G</td>
<td>Flu; Any problems he cannot resolve.</td>
</tr>
<tr>
<td>9. Regina</td>
<td>Checkups; Husband had an attack at home suddenly; Had a hysterectomy; Indigestion (primarily to please her husband who wanted her to go).</td>
</tr>
<tr>
<td>Informant</td>
<td>Things to Go to the Doctor For</td>
</tr>
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<tr>
<td>10. Barbara</td>
<td>Kids had broken bones; Advice about health; Emergency surgery like appendicitis or kidney stones; An unfamiliar pain that lingers.</td>
</tr>
<tr>
<td>11. Lorie</td>
<td>Stitches; Checkup; Advice about health.</td>
</tr>
<tr>
<td>12. Dianne</td>
<td>When elderly patients' lungs fill up with fluid; When one of her elderly patients fell with a walker; Injuries (broken nose) sustained in car accident; Broken bones.</td>
</tr>
<tr>
<td>13. Margaret</td>
<td>When aged mother has unfamiliar symptoms such as breathing problems, chest pains, or dehydration; Chest x-rays because she's a smoker; Removal of a sebaceous cyst; Any unfamiliar symptoms.</td>
</tr>
<tr>
<td>14. Jim</td>
<td>Broken bones; Flu; Heart malfunction; Annual checkup; Second opinion when wife had blockage in her bowels; When hurting all over.</td>
</tr>
</tbody>
</table>
the cyst was gone. Mary, after being told by the doctor that she was going to be an invalid for the rest of her life because of her osteo-arthritic condition, underwent a rigorous conversion process concerning her medical philosophy and turned to alternative healing therapies such as hatha yoga, reflexology, and Shiatsu.

Fifty percent had sought a doctor's help for broken bones (see Table 2); 29 percent for surgery, 21 percent for wounds that required stitches. Clearly there were some specific kinds of problems the doctor was expected to handle. Also, there were certain kinds of problems the natives perceived the doctor to be unable to treat effectively such as arthritis, asthma, and other stress-related disorders. Nancy who was very against drug therapy felt that being in a bad environment and not believing you are going to make it led to stress, sickness, and unhappiness. She handled stress with good nutrition, positive thinking, and fresh air. "Just massaging people and touching them will help them alleviate a lot of stress." Nancy advocated a self-help stress management program for what she considered as a major cause of ill health.

Note in Table 1 how much of the alternative medical practices are concerned with prevention and maintenance. The informants often stated the goal of a particular self-help practice was to make them "feel good," to "stay healthy," "to loosen up," etc. No one associated going to
the doctor (scientific physician) with something that made them feel better, good or healthy. In fact, almost all seemed to associate "going to the doctor" with ill health. Regina and Mary felt that Dr. G, the manual therapist, was a doctor that always made them feel better and gave them a psychological boost. In spite of the somewhat elaborate descriptions of bouts with medical problems, all felt that they were well and in good health because they rarely saw a doctor, or rarely had to miss work or what they considered their normal daily routine because of illness. Thus a preventive alternative medical practice was something that one believed he must do on a regular basis to feel good, while going to the doctor was something one did only when necessary, e.g., after his self-help techniques had failed, for a diagnosis of unfamiliar symptoms, for a prognosis—a checkup, or for major problems that required scientific medical procedures such as surgery and drug therapy.

Most of the informants (93 percent) expressed some degree of skepticism towards scientific medicine; yet, all indicated that they utilized this medical system when they deemed it necessary. Dianne, the Public Health Nurse, stated, "I don't trust doctors completely because I know they're not perfect." Jim, the seventy-six year old man who practices some form of herbalism, stated that he goes to the doctor for advice about his health and well being. However, he said:
But sometimes, I have to search around. I go to one and get his opinion, and go to another to get his 'cause sometimes that doctor a miss something the other doctor will catch.... Sometimes they cross one another and it's 'bout the same. Once in awhile you get them and they're real far apart.

Several informants expressed some element of skepticism towards certain forms of alternative medical practices. For example, Jean stated that she was inclined not to believe in faith healing or to believe that there was a direct cause-effect relationship between one's getting over an illness and divine intervention even though she did pray and believe in God. Lorie, the pharmacist, stated that she believed in unconventional healing forms. She had known some people who had gotten some positive results from using psychic therapy (hypnosis) to help them stop smoking. She believed in divine healing. However, she expressed some concern about herbalism as a form of medical treatment because she felt that our knowledge about the natural pharmacology was too limited at this point to know the possible dangers of this form of drug therapy. Dr. G, the manual therapist, felt that all herbs, because they were "natural," were good for the body. Thus, the data indicated that there were various levels of belief concerning alternative medical practices. What is believed to work for one may be perceived as totally unacceptable by another.
Essentially, the self-help philosophy that is fundamental to the notion of alternative medical systems is a celebration of individualism. It indicates that good health is attainable only if one takes the responsibility for it. This responsibility involves engaging in a set of procedures that can directly affect one's health, e.g., exercise, positive thinking, nutrition, plenty of rest, etc. Not only might some of these procedures be implemented during a medical crisis but also on a somewhat regular basis for health maintenance and preventive purposes. Thus self-help and alternative medical strategies consisting of several dimensions of health care including the physical, psychological, social, and spiritual are vital resources to aid in the individual health management process.

The data indicated that all the respondents exhibited some health management ability. All were concerned about maintaining their health and were involved in some type of self-help medical practice. While there were no guarantees that medical crises would not occur, most had invested trust in procedures they felt would help them to stay healthy.

Those who maintained a great degree of suspicion towards the scientific medical system or disapproved of its biomedical framework in general utilized alternative medical strategies to a greater extent than those who felt more at ease with the scientific medical system. Respondents who were heavily committed to alternative medical strategies
came to adopt these practices as their commitment to the self-help philosophy intensified. Their ideas have been influenced by a number of forces including the fitness craze, the health food industry, the holistic health movement of Western society, and health-related reading materials. Individual experiences with sickness episodes that they or their significant others have had have also helped to shape their health consciousness.

While there was a tendency to resist using the scientific medical system as a resource in the health management process, all respondents turned to this system when they felt a medical problem was too difficult for them to handle with their self-help strategies or when they wanted a diagnosis of a condition often to treat it themselves once the condition had been identified. Thus, respondents sometimes used the scientific medical system simultaneously with unconventional medical practices. These alternative medical strategies played a significant role in the health management process. Seldom were their problems that respondents felt could be handled more appropriately by utilizing the scientific medical system.
NOTES

1 It should be noted that victory over communicable diseases such as yellow fever, cholera, diptheria and whooping cough during the nineteenth century is largely the result of the emergence of a comprehensive public health program that included improving the housing and sanitation conditions, the milk supply, and the distribution of water. These diseases were declining before vaccines became available for them. For a more in-depth discussion of the development of organized public health in this country, see John Duffy, *The Healers*, pp. 189-205.

2 The AMA has served as the mouthpiece for American physicians for over 100 years. Over the last decade or so, its membership has dwindled consistently. After World War II, most physicians, except blacks who were barred from the local chapters, belonged to the Association; only one-third were members by the early 1970s. Physicians have developed divergent interests with the increase in specialization. Thus, the AMA of today is unrepresentative of many physicians in the medical profession. Alternative national medical organizations such as the Medical Committee for Human Rights are a clear indication of dissidents among the ranks. See Twaddle and Hessler, *A Sociology of Health*, 179-181.

3 See Horacio Fabrega, Jr. and Daniel B. Silver, *Illness and Shamanistic Curing in Zinacantan* (Stanford: Stanford University Press, 1973). Fabrega and Silver provide an ethnomedical analysis of the medical practices within the township of Zinacantan, which consists of 7600 Mexican Indians located in the state of Chiapas in southwest Mexico. Although this community is medically pluralistic (also includes a scientific medical system), the h'iloletik is the most sought-after practitioner for treatment of serious and persistent symptoms. His activities range from diagnosis through divination and pulsing, administering of remedies, to conducting various private (e.g., curing) and public ceremonies (e.g., rain-making).

4 One of the problems with the holistic health model is its use of what appears to be some sort of metaphysical language. For example, one of the notions of health and
wellness is "to live life to its fullest." This ideal appears to be indefinable in concrete terms. The unclear notion of balance/imbalance is another example of this mystical language. Some doctors question whether this health model can free us from disease even though it might sharpen our skills for coping with health problems and make each day more meaningful for us. See Hoyt Gardner, "Wellness Has to be Sold as Therapy, Not a Preventive" in The Center Magazine, Vol. XVI, No. 1 (January/February, 1983), pp. 38-40 for a discussion concerning questions about this model.


Alexander, frequently called the father of psychosomatic medicine, was one of the first to examine the dynamics between emotions and organic disorders. In 1932, he and his associates at the Chicago Institute for Psychoanalysis discovered that patterns of emotional behavior accompanied certain disorders; e.g., asthma victims seemed to fear the loss of their mothers.

7 For a more detailed background discussion on the effect of the holistic approach in preventing and handling stress disorders, see Kenneth R. Pelletier, Mind as Healer, Mind as Slayer (New York: Dell Publishing Co., Inc., 1977).


9 It should be noted that an open-ended questionnaire is merely an ideal set of questions the researcher constructs to solve a set of problems in a non-natural context. All of the questions might not need to be asked, depending upon how much information the informant gives out during the interview. For example, an informant responding to question 19 might very well answer question 33 without the researcher having to ask it. Also, the ideal set of questions listed in Appendix A were not necessarily asked in the order in which they appear.
An individual's approach to health care involves a set of practices that will accommodate her needs. One may rely heavily on formalized medical care in handling health problems, another may reject it as a viable health resource. One's rejection of formalized medical care may be attributed to a number of factors such as inadequate financial resources, or strong mistrust of formalized medical procedures, or strong belief in self-treatment techniques. Variation in health procedures is not idiosyncratic and may be governed by variables including one's financial status, occupation, beliefs, age, and/or medical history.

The decision making process about health care may be influenced heavily by what one perceives as her medical history—whether one has had serious health problems in the past that required hospitalization and/or treatment by some type of practitioner, or suffered with an incurable ailment periodically for a long time such as asthma, or has been "well" all of her life. For example, a person suffering with hypertension might want to see a doctor if she has been experiencing chest pains for a couple of days; whereas
a person who has never been sick may not be alarmed by these symptoms and may assume that the pains are from fatigue and will disappear once she gets an adequate amount of rest. David Mechanic in focusing on the etiology of illness behavior identifies ten variables that affect individual responses to illness (Wolinsky, 1980:124). Mechanic's second variable which may be applied to the above example is concerned with the individual's (and significant other's) perception of symptoms and assessment as to whether there are present and future possibilities of danger.

Whatever one's procedures in dealing with a health crisis, the problem-solving level will often involve her social network. How might one's social network help in resolving a health crisis? For example, how does an individual diagnosed as needing a mastectomy go about getting a second opinion to confirm or invalidate the diagnosis? How does she find out about and make an appointment with a local psychic whose services are not formally advertised; or a manual therapist handling lower back and cervical problems who does not formally advertise?

Problems such as the above may be resolved through one's personal network. Before attempting to address the notion of how a social network is a vital component of the local health system, I will briefly examine some concepts relative to social networks.
A major problem in network analysis is that of conceptualization. Generally, a network is often viewed as the social relations by which one is surrounded (Boissevain, 1974:24). However, there is much less agreement in terms of what the researcher observes when he is exploring the dynamics of human interaction among social relations and what the network represents in some abstract form. Is a network defined by a specific group in that a set of persons (e.g., factory workers, local ethnic groups, and residents in a senior citizens' complex) have shared characteristics, a particular type of relation or link—how they are interdependent, the things that hold them together? If so, then the researcher must examine the structure of the links in the set. For example, Finifter, in looking at political alliances among work groups in large automobile plants in the Detroit area found that levels of friendship integration on the job were higher among workers with a Republican affiliation in an overwhelmingly Democratic environment than levels of those with a Democratic affiliation. The work group apparently served as a reintegration mechanism for those political deviants fairly alienated in nonwork social environments. In examining the network as something belonging to a group, the researcher usually is concerned with how groups influence individual members' behavior, or in Finifter's case, how people join groups to protect their self interests. Since one belongs to many groups and every
group has a network, one would be a part of many networks. Perhaps an insurmountable task would be to see how the group networks to which one belongs overlap.

Boissevain looks at networks with respect to a specific actor (ego) and is concerned with those individuals who are linked to ego in very specific ways—e.g., co-worker, neighbor, friend. He states:

This social network may, at one level of abstraction, be looked upon as a scattering of points connected by lines. The points of course, are persons, and the lines are social relations. Each person can thus be viewed as a star from which lines radiate to points, some of which are connected to each other. These form his first order or primary network zone. But these persons are also in contact with others whom our central person does not know, but with whom he could come into contact via members of his first order zone. These are the often important friends-of-friends (1974:24).

According to Boissevain, every individual has a personal network through which transactions are made. Through the concept of the second order zone, the friends of friends, ego has the potential to get in touch with far more people than she knows in her first order zone. When ego's second order of zones is included in the analysis, the researcher is faced with an insuperable task in trying to figure out the degree of interaction among the actors, as well as the nature of exchange in relation to a few variables.\(^3\)
In addition to defining networks from a group standpoint or ego standpoint, the network content (types of exchanges and interactions among actors) also must be specified. Mitchell states that a network is a specific set of linkages or interdependencies (relations) among social actors, a specific set of persons—individuals, groups, or roles (Fischer, 1977:33). Mitchell's definition is concerned with how the social actors in an environment are dependent upon each other, the type of exchanges that take place between them, the expectations they have of each other, and the criteria they use to make an assessment of their relations. After all, social relations are built around the actors' reciprocation of goods and services, whether material or intangible items such as understanding, support, or advice. However, networks are more than just support mechanisms (Fischer, 1977:43). They can impose demands upon an individual in terms of requiring her assistance, and they can influence one's beliefs and actions. People choose to create or maintain the connection or social relation in their networks based upon often concrete criteria, the rewards and costs (Jackson, 1977:44). For example, is she ever a good listener, or does she always just want to use me as a sounding board? Has this prayer group really helped me and made my problems a little more manageable, or is it just a self-righteous group whose members obtain self-gratification only after condemning
others? This continuous assessment of rewards and costs in maintaining social relations indicates that individuals will rationally develop functionally specific relations within their network. The network approach assumes that individuals are actors who make choices and manipulate their environment.

Along with the conceptual problem is that of determining the key dimensions of the network. Claude S. Fischer talks about the unmanageable list of key dimensions of social networks that evolved in relation to specific theoretical problems (1977:36). For example, in a re-analysis of the Detroit Survey concerning the friendships of 985 white males between the ages of 21 and 64 living in the Detroit Metropolitan area, Robert Max Jackson, et al., focus on attributes of links—i.e., intimacy, frequency, and duration of the relationship, rewards and costs, and the context in which the relationship evolved as well as attributes of networks including density, homogeneity (similarity of age and class of men in the network); dispersion (the number of social contexts that generate friendships); and dominant source (the single context that provided most of the informant's friendships).

The basic assumption of these analysts is that an individual's choices are influenced more by the network's content properties than its formal properties. For example, individuals decide whether to maintain a friendship with someone based on the rewards and costs of the
relationship and not because of abstract qualities such as multiplexity and density. In fact, the analysts state that a higher multiplexity results when individuals decide to maintain several kinds of links with each other. For example, one's co-worker is his "close" friend and his recreational partner. The multiplexitous role relationship is dependent upon the context in which the bond was formed (e.g., co-worker would be easier to see than a friend living out of town), how long the bond has existed, and why people want to maintain it. Multiplexity is a result of the decision making process. Thus, the formal qualities of the network have little effect on social bonds once one accounts for the substantive sources of the formal qualities (1977:45).

While these analysts focus on nine key dimensions of social networks, Elizabeth Bott, one of the first to employ a network analysis in studying a cultural scene, basically focuses on two structural dimensions: density and clustering. Her classic study is concerned with how extramarital factors, namely the social networks of twenty married couples in London, affect the relationship between the spouses. Bott attempts to account for the variation in performance of conjugal roles (role meaning expected behavior of one occupying a particular social position) by pointing out a direct causal link between the degree of "segregation in role relationships of husband and wife" and
the connectedness (same person frequently filling two or more roles simultaneously) of the family's social network (1971:60). Her findings are as follows: those couples with a clear differentiation of tasks and a considerable number of separate interests and activities (segregated conjugal role-relationships) had a close-knit network (people in network knew each other); and those couples with a minimal differentiation of tasks who carried out many activities together and planned family affairs together had a loose-knit network (few in the network—relatives, neighbors, and friends knew each other). While Bott's analysis continues to incite controversy, she was one of the first to move away from a conventional structuralist/functionalist approach to account for human behavior patterns by concentrating on the interpersonal relationships of her informants and the content and structure of those relations.

Researchers continue to use network dimension concepts in an ad hoc fashion with respect to their own theoretical problems; their findings are greatly influenced by the network dimensions they focus upon. The general properties of networks are yet to be expressed in more useful terms with substantive applicability (Fischer, 1977:36). The problem of meaning in network analysis involves the researcher's ability to distinguish the links in the network and their relationship between structural (e.g., density) and relational (duration of relationship) content. The
researcher must be able to abstract elements of human interaction (latent behavior in particular) into logical theoretical propositions without sacrificing the actors' intended meaning(s) in a social situation.

This study does not formulate any new network dimension concepts. It is not concerned with the structural aspects of the network, but is more concerned with the interactional aspects between the actors in the network and how networks function for them in a local health system. It is interested in the actors' perceptions of their social relations in their network (e.g., "She's my friend who happens to be a nurse") in terms of what those relations provide for and require of the actors. This study primarily delimits the personal networks to the local area, Johnson City. However, material concerning outside resources is included that is pertinent to an informant's health procedures. Obviously one's network extends beyond the geographical boundaries of place (e.g., one secondary informant talked about how she got folk remedies from her sister in Colorado over the telephone). Also, this study delimits the network in terms of content; the researcher is concerned only with the exchange of health-related items.

The application of the term "network" is twofold. In a general sense, the term refers to a segment in the network, a partial network—the exchange of health-related items among actors. Obviously, within a total network, the
exchange of goods and services is unlimited and would not be restricted to health-related items. One might get a job, find out the best realtor to rent an apartment from, or learn about which hairdresser to go to through the network. The term is used also from an ego-defined standpoint. The fourteen primary informants involved in this study all have their own personal network. Some are in touch with each other directly in different capacities. Others do not know each other and have never come in contact with each other; nevertheless, the potential to make contact is there.

Description of Sample

My research methodology involved networking in order for me to locate the appropriate informants. When I described my research problems in laymen's terms (see Appendix C), the informants often would suggest that I talk to their friends, associates, or someone they did not know directly but had heard about—individuals they felt would give me the information I needed. The network component of the questionnaire attempted to elicit responses that would indicate the capacity in which the informants might serve as health resources in the local health system, what people are health resources to the informants and on what level—whether co-worker, close friend, nurse, etc., the nature of the exchange and in what context it is likely to occur (see Appendix A, questions 3, 9, 26, 40).
One type of exchange in the network appears to be that of referral. Several practitioners in the system, namely the manual therapist, the massage therapist (Shiatsu consultant), the owner of the herb farm, and the psychic never formally advertise their services (i.e., via newspaper ad, yellow pages, brochures sent through the mail). Satisfied clients inform family members and friends of the successful results they are having or have had with a certain practitioner. For example, in describing the type of people that come to him, Dr. G, the manual therapist stated:

I'd say around ninety percent and maybe even a greater percentage than that are people that are referred to us. They're either somebody in their family that's been in or they know of somebody that comes in, and we get a lot better success with people like that cause they know somebody that's gotten help.

Unconventional practitioners are at a disadvantage in the sense that the general public is likely to have a certain degree of skepticism about what they do or claim to do, particularly if a fee is involved with his services. The practitioners themselves may be unable to define specifically what they do for their clients. Regina, the psychic therapist, stated: "I never feel that I'm doing anything. And I'm very insecure. I am...." Regina, a client and friend of Dr. G, the manual therapist, compared the positive results she got from him as his client with those her clients had
received from her:

He gives you a lot of attention for fifteen dollars. And whatever I have, now it doesn't make any sense when I get home. Then I feel so good and I think now what did he really do? Even I am analyzing it. And it's the same with what people get from me.

Unconventional practitioners rely heavily on a good success rate to promote their practice and to maintain a regular clientele. Any misunderstandings between them and a client could have serious repercussions in terms of damaging their credibility, which could lead to unnecessary lawsuits and even their being prohibited to practice in the community. Several townspeople told me about a palm reader who had trouble with local law officials because of complaints against her for maintaining a fraudulent practice. They stated that she eventually left town. The faith healer, a nationally known figure, is at odds with the community. Usually if community members brought his name up during a conversation with me or during an interview, they invariably referred to him as a "fraud," a "crook," or spoke of an instance or instances in which they felt that he had taken advantage of people.

An actor's social relations in the network consist of actors who will help him by providing needed information, as well as telling him things in which he would be interested. One might consider seeing an unconventional practitioner if
he had health problems such as arthritis or asthma he felt the formally trained physician was unable to treat successfully. Out of desperation, one might look for alternative approaches in handling the problem. Someone in the network who learned of his need for assistance might encourage him to see an unconventional practitioner in which he had invested trust. Mary stated how she learned about the manual therapist from a friend after she became disenchanted with the medical doctors and their unsuccessful treatment of her osteo-arthritis:

...And so I went to all the doctors and I did everything the doctors said.... And I was getting worse and worse. And he give me a catalog that had an invalid chair, and I put the accent on 'valid'. in-valid! That hurt my ego.... So I just politely told the doctor good-bye. ...So it was during that interval that a friend told me that there was a Dr. ___ (Dr. G) here. She'd gone to this man. He had not gone to medical school, you know; he was just one of these ninety-day wonders. And I went into his room and I—I really embarrassed the poor guy. I says, 'the only reason why I came here is 'cause Karen (fictitious name of friend) told me to.' 'Well,' I said, 'I—I don't have any confidence in you. I just think you've got a lot of gadgets around here. But I'm desperate. I mean this is the last thing'.... And in five little treatments, he had my shoulder going again.

The element of support is an important exchange in social networks. Friends support each other when needed, either by being a sounding board, giving advice, or with
more tangible items such as providing financial support, or running errands. The fact that Mary's friend, Karen, had gotten positive results after being treated by the manual therapist entitled her to tell this experience to Mary, particularly since Mary was so desperate to find a solution to her health problem and seemingly was unaware of other approaches to the treatment of arthritis. She was unwilling to give up on treatment of her ailment altogether. Mary's initial skepticism as to whether Dr. G's treatments would be a viable solution to her problem is not an uncommon reaction towards marginal practitioners, particularly since she has a science background (She boasts of being a member of the American Society of Clinical Pathologists for 25 years.). Mary perceived her problem in serious terms since the physicians had told her that arthritis would make her physically incapacitated for the rest of her life. Hufford states that a very rational act of humans is that when one's first line of defense fails, one looks for a second line of defense (1984:36). Therefore, resorting to an unconventional practitioner is a rational form of behavior for Mary.

Note the importance of referrals in the health management process. In Mary's case, confidence in her friend's recommendation is one of the factors that motivates her to turn to a practitioner in which initially she has no trust. This action is a good example of how one's significant others are involved in her health management. Dr. G
attributed his success rate (i.e. client satisfaction) to the fact that most of his clients are referrals. Mary's statement of skepticism, however, seems somewhat contradictory to this notion. Initially, a referral may harbor complete skepticism towards a practitioner. To alleviate the client's doubts and suspicions, the practitioner must provide some type of treatment or therapy that is meaningful to the client (meaningful in the sense that the symptoms are eliminated, or controlled, or dealt with to the client's satisfaction).

Often referrals are handled by actors performing two or more roles simultaneously such as nurse and friend. For example, when Florence, an R.N., first moved to Johnson City, she called up her nurse friend who was already living in the community to ask her about the local doctors. Florence felt that her friend was knowledgeable about the formal health system since she had lived and worked in the community.

Actors have some notion of the goods and services those performing certain roles should offer. Health food store owners/workers and food co-op volunteers are in a position in which clients will ask various kinds of health-related questions expecting some kind of credible response in return. A client's coming into the store usually indicates some type of need on his part whether he articulates this need to the workers in the store or not. An example of how the health food store people referred a client to an unconventional
practitioner was stated by the psychic therapist. She began by talking about a practitioner located in another city and how she utilized his services. The following example of a referral is in response to the researcher's question, "How did you learn about him (a particular healer)?"

Well, I have a very close friend who really could read palms very deeply and spiritually, but she moved to Florida. And she went to visit her husband who was working on a job in ___ (cites the name of a city near Johnson City). She went to the health food store to get a couple of things that she needed. And she made a remark about some aches and pains. And the health food people said 'you know,' they call, he can be called 'Doctor.' But they said, 'This man is just a few miles out of here and you ought to meet him. And he could take care of this pain. And so she went down. And she called me; she says, 'You've got to come.' So that's how I found out and I must have sent a dozen people there since. People come there from out of state. And he's very selfless.

The above narrative indicates how referrals are distinct aspects within continua of human interaction in the network that may include a number of people. Referrals are not restricted to time and place. Referrals seem to materialize very spontaneously. They may occur over the telephone, in a letter, at an ice cream parlor—whenever and wherever the need arises. Only a limited number of social relations in one's network will actually be involved in referring him directly to an unconventional practitioner.
First of all, some in the network would not see an unconventional practitioner under any circumstances. Secondly, some have no need to see an unconventional practitioner because they have never had a problem that required anything outside of a self-treatment technique; however, they may know someone who has seen one and may refer the one in need directly to the person who has been a client of the alternative practitioner. Boissevain states that those individuals in the first order zone can act as a relay to place ego in touch with those he does not know in other zones in the network (1974:25). One's potential to obtain information is unlimited because of the links in the network which are "potential communication channels."

A major function of networks is to disseminate information. However, the types of information transmitted from one actor to another depend upon the content of their relation and how the information is being used by those who pass it on and those who receive it. If one is seriously ill in the community, actors in the sick person's network will pass this information on to others in the network. Hufford states that when knowledge of a serious diagnosis spreads in the community, the sick person is suddenly besieged with an unlimited amount of information and advice from people attempting to offer some possible solution. For example, a secondary informant whom I will refer to as Martha, had a son with asthma. As a child, his condition was very
serious, and he was frequently in and out of the hospital. As a result, his name was often in the local newspaper for having been admitted or discharged from the hospital. Or news of his condition would come up at church or various organizations to which Martha belonged. People would call her over the telephone or just come up to her inquiring about his condition and giving her remedies they thought would help him. For instance, one friend of hers recommended a mint oil from Tennessee. People there had used it for asthma and found it successful. Others told her that he would grow out of the asthma if she would put a nail in the tree in her yard. Once her son grew past the nail, he would grow out of the asthma. She tried this remedy when he was seven years old. Today as a young man, he yet has periods where he suffers with his breathing and has to be admitted to the hospital. For the most part though, the asthma is under control through medication.

An actor's social relations in her network would include members of the community, as well as those outside its geographical boundaries. When one is seriously ill, telephone calls and visits from individuals in the network living in the local area and outside of the immediate area would certainly take place. People who do not know the sick person are willing to donate their money and their services to the individual once they hear about her misfortune. Somehow fund-raising efforts seem to generate altruistic
forms of behavior and some common bond of giving is expressed. For example, Anne (food co-op member and former health food store owner) and her family had no health insurance. Her husband had cancer that required surgery. She had the following response to the researcher's question: "How does your insurance help you through your sickness?"

We don't have insurance. I told you my husband had cancer last year. So that was a pretty big, but we got through it with a group of our close friends that had a big benefit for him with bands and sold tickets; a place in Norton (nearby city) made wholewheat pizza and they sold it by the piece and they sold beer and raised several thousand dollars. You know if it wouldn't have been for that, I don't know where we'd be.

Note how Anne emphasized their overcoming the health crisis in relation to friendship. In fact, Anne felt that without the insurance to cover the costs of treating her husband's cancer, friends were able to express their love for him in very generous ways. She believed that reliance on friendship in a health crisis was an alternative to health insurance. Anne felt that the structure of the insurance system was inadequate. She commented on how she felt health care facilities overcharged insured clients for their services. The high cost often was disproportionate to the quality and degree of services one receives from health care centers. Anne recognized the value of having close friends who are
doctors. Her husband's operation which required the removal of a testicle was done free of charge by a surgeon who was a friend of the family.

A health crisis may bring those who have very limited connections to ego closer to ego. The exchanges between ego and others may consist of short-term interactions such as a visit to the hospital or a telephone call. The important thing is that individuals in the network will show some type of support to ego during his health crisis. When Jean R, (university librarian and wife of professor who died of cancer in 1964) had her mastectomy, women connected with the university, mainly faculty wives, came forward to let her know they had gone through the same operation and survived it. Some had had the operation as far back as fifteen and twenty years ago. Jean stated that these women wanted her to know that her life would regain its normalcy. She recalled what happened when one woman in particular came to visit her at the hospital.

The wife of the president of the university had had one two years before. And I don't know whether she knew it (Jean's scheduled operation) beforehand. It happened so suddenly. I don't think she knew it beforehand. But boy, the day after, she was right in the hospital. And she brought her form and threw it on the bed and says 'Here's what you'll be wearing later.' ...You know, she's very positive about hers too. So, I'd never seen the form that she wore. I didn't know what was coming up. I didn't even know how you
looked afterwards or anything else. And she was talking about the fact that she was fairly small-busted and I'm just kind of medium. In fact, she had been at the point where she didn't even bother wearing it when she went swimming in her own pool. You know, so she was far enough away from me that she could let me see that in the future, this operation wasn't going to be hurting and that you would get back to a normal kind of life.

The recovery period is one of the most difficult aspects of a major operation. The uncertainties of not knowing what will happen next or whether one can resume a "normal" life (i.e., work, recreational activities, and in Jean's case, style of dress attire) can be overwhelming. In recapitulating the mastectomy experience, Jean indicated that the period from diagnosis to actual surgery was very brief, and that there was no time to prepare psychologically for the radical change in her physical appearance.

The discussion of a mastectomy based upon firsthand experience appears to be a topic that is reserved for very restricted contexts. The fact that Jean had interacted with these women in the past—after all, since they were all connected with the local university, their paths were likely to cross at times—but was unaware that they had had mastectomies indicated the privacy element of this experience. Jean stated that she had been in social groups with these women before, but the subject of their mastectomies never
came up in the conversation. Jean's operation made her entitled to hear these experiences. Apprehensions about what kind of clothing to wear and whether the cancer would recur were events of this experience. Therefore, one who attempted to relate this experience to another who just had the operation would more than likely touch upon either or perhaps both of these items. Jean indicated that some of the women in their discussion of this topic with her focused upon the physical appearance aspects (e.g., what the form was like, and what styles of clothes to wear or avoid) while others focused on the fears and worries they had of the cancer's recurrence during the first few years after surgery. When I asked whether she would voluntarily let a stranger about to undergo a mastectomy know that she had experienced this trauma, she stated that she would if she thought the stranger would benefit from the information.

Having had a mastectomy, Jean was concerned with informing others, mainly friends and family, about how to detect a growth in the breast, particularly since she inadvertently noticed hers without even looking for it. She volunteered this information when she felt it appropriate or pertinent to the situation.

...Mine I discovered myself. But it was not a lump. It was an indentation. A dimpling effect...which the doctor had mentioned in just a general conversation several years ago. That a lot of women didn't realize the
dimpling effect. There was something underneath drawing the skin in. I never felt any lump. The lump was down deep, but the skin was being drawn in. So as I say, when I say I volunteer. I have told my friends how I discovered it because it was just by chance the doctor had mentioned this to me. Otherwise it would have gone on for a lot longer. I've told my daughter about it, my daughters-in-law. You know, watch for this also, in addition to feeling the lumps.

Getting cancer of the breasts is something that is unexpected. Women leave themselves unprotected when they fail to monitor their breasts. Jean expressed concern for this vulnerability in women. Having the mastectomy raised some level of consciousness for her in terms of needing to inform/warn those close to her about the inherent dangers of not monitoring the breasts regularly. The telling of a personal experience frequently places the narrator in a favorable light. The fact that Jean survived the cancer and told others about her experience was an indication of her meritorious qualities. Her story also exemplified the notion of human vulnerability, that anyone may have to confront a serious illness.

The network data seemed to indicate that the transmission of medical information among individuals is concerned with rights (entitlements) of exchanges and the actors' perceptions of reality with respect to expectations and obligations among social relations. When one experiences
a health crisis, one acquires a certain level of medical knowledge and is placed in the role of "lay specialist," a role which requires certain kinds of obligations to and generates certain kinds of expectations from those in the network. Those persons going through a health crisis will seek the advice of one who has experienced a similar health crisis; or one who has gone through a health crisis will want to share this experience with others who are going through a similar crisis to inform, support, or encourage them. In the case where the linkage in the network is that of friendship and/or familial ties, informing may mean giving one new information or evaluative comments about the practitioner's treatment procedures in a health crisis or merely giving an update report of one's health condition to significant others.

Decision making is a vital part of health care. People are constantly having to evaluate situations to determine what measures should or should not be taken to overcome a health crisis or to prevent one from occurring. People rely on various social relations (often their "close friends") in the network to give them a second opinion, to get advice, approval or disapproval, in assessing their situations. Jean's father, now deceased, had prostate trouble at one time in his life. She talked about how she took a somewhat active role in evaluating the treatment procedures of a physician who was treating a friend of hers
with a problem similar to that of her father's.

This one friend was having inflammation of the prostate. And he knew that my father had had problems along this line and several other men that I knew about. And he was not sure that his doctor was handling it right. So he was just talking about how his doctor was handling it and then I put my two cents' worth in. 'I think you ought to see another doctor'.... I thought his doctor was not, I thought it had gone on, the pain had gone on too long not to change medicines or try something else. And this was based on basically a problem that my father had. I was also a little concerned that I felt the doctor had not done enough testing to see whether it was cancerous you know. And my feeling is you try to find this out as soon as possible.

Jean's assessment of the practitioner's ineffective treatment procedures involved comparability, one of the dimensions of what Garfinkel calls the "perceivedly normal environment" (1967:93-94), or how actors in the social world perceive objects, events, situations as a reality. Jean had had no formal medical training in the treatment of prostate problems. Yet her friend's medical problem had a certain level of reality to her since it was a problem comparable to that of her father's, with visible symptoms that should disappear provided the proper treatment was administered. Comparability involves actors noting points of similarities and differences between present and past events in order to estimate future probabilities of the situation. The
prostate trouble Jean's father had and her husband's fatal bout with melanoma are two major traumatic experiences in which she obtained medical knowledge in terms of how to evaluate treatment procedures and the importance of getting a second professional opinion. In this instance, Jean's friend shared his medical problem with her so that she might help him make an assessment of the health crisis, particularly since her father had had the same kind of trouble.

Thus far, in talking about actors' involvement in the decision making process during a health crisis, we have primarily focused on how they might help to evaluate a practitioner's treatment procedures of a serious (high risk) medical problem. How might they be involved in evaluating what might be considered "less serious" health-related problems such as a minor fall and a natural healing advocate surviving the trauma of her son's first visit to the dentist?

Nancy, the herb farm owner, is a strong advocate of good nutrition, positive thinking, and self-treatment techniques. She explained her reaction to an accident she had:

I fell down the steps, and my little finger was just like (shows researcher how it was bent out of place). It's a shock to your system to see something like this. So I went out in the garden and got some chamomile tea. And my neighbor happened to come along, and she said, 'Now look. You have a dent in your leg.' 'Cause it hurt, she took me in—she being a nurse, she
took me in. I wouldn't have gone probably. She took me in. So they x-rayed it and said, 'Yes, you broke your little finger.' But they couldn't do anything for me.

When accidents occur, one must assess the seriousness of the injury and how threatening it may be. Will the pain go away? Is this something that will heal on its own? Should I call the emergency squad or just lie still for a couple of hours? These are some questions that may emerge during the assessment process. Nancy felt that she went to the hospital after the accident because her neighbor was a nurse and recommended she be examined at the local hospital. She might have gone if her husband or one of her children had been there at the time and insisted that she go. Note how Nancy accounted for her going to the hospital even though she felt she could have treated the injury herself. She believed that most medical problems could be handled in the home. A cut or a hurt perceived as "not serious" would heal in the proper time. She felt that the hospital did nothing to help her, primarily because they told her what she already knew—that she had broken her little finger.

Another example indicating how actors were influenced by others in the network in terms of resolving a health crisis involved Anne (a strong advocate of natural healing and very anti-drugs) taking her child to a children's dentist her friend recommended to have a cavity filled.
They sent home this little bottle of medicine that was to make him a little drowsy for the pain. Then they did something else. But I was supposed to give him this, and he's never had medicine before. He's completely against it. I'm real leery of medical people you know. And I don't know why I went ahead with this. But I tried to give him medicine and he wouldn't take it and he spit it all out. And he got a little bit down him. By the time he got there (dentist's office), I told them that. They won't let the mother come back with the child. And I can't believe I submitted to all of this cause usually I'm just the opposite. But it was my first experience with the dentist with the kids.... They made him take more medicine. And they gave him gas or a shot, I can't recall right now. ...So by the time he came out, he couldn't even walk.... He was so drugged....

Taking her son to the dentist for the first time was a traumatic experience for Anne, primarily because her beliefs and health practices were at odds with those of formalized medicine. She attempted to explain to the practitioner how her son was reacting to the medicine; yet, he was given more once he got to the dentist's office and was separated from her. Anne attempted to reach some type of mutual understanding with the practitioner by explaining to him that her son who had never taken drugs before would not take his medicine. Her acts of negotiation were ignored by the practitioner. Hufford states that a patient in the decision making process is concerned with the flexibility
of a healer—that is if he is open or closed to working with the patient's alternatives if they are different from the healer's (1984:43). Anne was unable to explain why she went along with the practitioner's treatment procedures in spite of her opposition towards them. Her friend was involved in the health crisis on the referral level. Anne took her son to a dentist her friend recommended. She then told her friend about the negative consequences of that experience. Anne felt that her friend was very perceptive and very articulate in terms of expressing her feelings about something. Her friend attempted to reassure her that the dentist was adhering to normal procedures. She also stated that Anne felt guilty over subjecting her child to that traumatic experience. Anne's friend acted as evaluator, commentator, and support person in the medical crisis. Anne stated that talking to her friend helped her to release some of the guilt she was feeling from the experience.

The mutual expectations and obligations held by actors engaged in an exchange were relative to their notions of their respective social roles. Actors engaged in transactions for various reasons, including necessity, obligation, and/or desire. They performed certain activities based upon their perception of the relations in the link in terms of how they were interdependent. For example, one had the right to ask a certain kind of favor from a friend, co-worker, or librarian, depending upon the circumstances.
Actors engaged in a transaction used normative criteria to evaluate the performance of those involved.

Florence (the nurse with the anorexic daughter) worked part-time for a surgeon. Patients called the doctor's office and often asked her for advice before they made an appointment to see the doctor. She stated that she could not tell people what to do or how to lead their lives. Frequently, she found herself suggesting alternatives to people who included her in their decision making process. Those who saw her outside of her work environment and knew that she was an R.N. would ask her for advice if they felt comfortable enough around her and perceived her as a friend who was a nurse. Florence stated that as a rule, patients' calls were restricted to the doctor's office though. Patients never called her at her house; however, neighbors and friends would call her house to get her advice about a health-related problem they were having. For example, she had a friend with a diabetic daughter who called her up to discuss her daughter's medical condition with her. If the daughter had a medical problem (e.g., an infected toe), Florence might ask, "How long has it been that way? Is she running a temperature? Have you seen your doctor about this?" In formulating how people respond to illness, Mechanic suggests that the frequent occurrence or recurrence of visible symptoms and their persistence is a variable that will affect one's response to the illness (in Wolinsky, 1980:
Evaluation of the symptoms may involve only the person experiencing them or may involve friends, family, and any significant others. When friends wanted to include Florence in on the evaluation of their symptoms, she felt she usually gave a stock response: "You know, you can watch it for a day or so; but if you are uncomfortable with what you see, you really need to see a doctor." A significant question here is whether friends were actually seeking advice from Florence particularly since she (Florence) often responded with a stock statement. Perhaps it is the predictability of Florence's response that comforts them and offers them some reassurance they are handling the medical crisis efficiently.

In terms of providers of health-related information, those involved in formalized health care seemed to perform very clearly defined roles. The pharmacist and nurse were seen as medical authority figures, capable of providing a certain type of information, someone to consult for a diagnosis. The pharmacist frequently was asked, "What should I do about health problem X" from clients at the pharmacy and from friends and family members. The nurse was approached by patients at the doctor's office wanting to know what to do about their health crisis and while shopping by friends with a medical problem.

The health professional who was a friend to ego was seen as someone to cut through the bureaucratic red tape of the formal health care system to make the hospital
facilities accommodate the needs of patient X. For example, when Jean was first diagnosed as having cancer of the breast and needing to have a mastectomy, her nurse friend arranged for her to get a second opinion from doctors she knew at an out-of-town hospital. Her nurse friend also arranged for her to get a private room at the local hospital. Her children came to see her from out of town and stayed with her until ten or eleven o'clock at night since she was in a private room. Jean's friend knew that all the rooms at the hospital were the same price at the time.

The type of medical information and who it was transmitted to was dependent upon a number of factors including one's concept of another (i.e., whether one was in need of medical information, could be of some support, could be trusted) and one's medical orientation in terms of whether one's belief system was similar or accommodating to alternative belief systems. Health professionals of this study saw themselves as transmitters of medical information. To them, the transmission of medical information was assymetrical. They sought out other health professionals but not lay people for medical advice. The pharmacist stated that no one she ran around with was medically inclined; therefore, she always went to her family physician and gynecologist for advice and never her family and friends. Lay people frequently went to them for diagnostic; evaluative, and sometimes treatment purposes. It is questionable whether
various actors in the network perceived themselves as transmitters of medical information to health professionals. One secondary informant who worked with senior citizens and the needy said that she learned from an elderly woman about Vitamin E clearing up shingles in several days when put directly on the blisters. She stated that the woman's physician was very surprised when the shingles cleared up so quickly. She further stated that the elderly patient had tried to convince the physician in the past about Vitamin E's effectiveness in clearing up shingles but was unsuccessful. Now he was sold on it since his patient's shingles cleared up so quickly.

While two of the health professionals of this study saw the transmission of medical information (advice) asymmetrically from their standpoint, the data indicated something different for the public health nurse. Although she had been scientifically trained, she often had to utilize unconventional methods while working in environments lacking the equipment of the local hospital. Dianne seemed more susceptible to the idea of obtaining health-related information from lay sources than did the pharmacist and Florence, the other nurse informant. For example, Dianne stated that Adolph's Meat Tenderizer made into paste was the best for bee stings. When I asked where she obtained this information, she stated, "Somebody told us." She went on to state that presently this was the only product that
was used for bee stings at the fair. She felt that it broke down protein that was injected into the skin from the sting.

A second instance in which the public health nurse received medical knowledge from lay people came from her discussion of her personal health regimen. She stated that she did not take any teas for preventive reasons, but she knew a friend who drank sassafras tea to thin her blood. She went on to state how her friend cut her finger, and how it did not stop bleeding. She felt that maybe the tea did thin the blood, but she was uncertain.

A third example of Dianne's interest in medical knowledge coming from nonmedicals was indicated in her response to my telling her how I had recently learned from someone in the community that Vitamin E capsules cleared up shingles in a couple of days. She was delighted to hear about the information and wrote it down.

Perhaps Dianne's receptiveness towards these alternative remedies was due in part to her orientation towards natural healing, as well as her experience in working with the home health care program for nine years which required the use of various make-shift treatment techniques. Part of her job involved listening to the patient talk about what he felt was going on in his life so that she could make a physical assessment. At times the client would tell her about some alternative treatment techniques he was using.
Dianne felt, however, that she did not know about many cures or alternative treatment procedures her clients were involved in because they usually kept that kind of information from her. She did state that it was not uncommon for her to find out about her clients secretly going to some kind of out-of-town alternative health clinic or to a faith healing minister. She felt that her role as health official in some sense inhibited them from openly sharing this information with her. Dianne was an important evaluator of her clients' needs and functioned as a catalyst between her clients, their families, their doctor and the hospital. Her assessment of her clients' needs could be crucial to saving their lives. They recognized her importance and did not want to violate her authority by not following her orders in turning to alternative therapies and procedures that were in conflict with her medical practices.

For the purposes of this study, medical knowledge was something gained from study, investigation of facts and ideas, observation and experience. It was not static but something that was continuously transmitted through the network. The notion of selectivity and who transmitted certain types of medical knowledge to whom was complex. The evaluator or consultant role in the decision making process required a certain type of medical knowledge. Mothers who had raised their children had undoubtedly evaluated the symptoms when their children became ill and
had to determine the proper steps to take in resolving the health crisis. Yet some daughters might not include their mother in the decision making process of a medical crisis. Why would one mother be consulted about her daughter's health-related problems and another would not?

Jean stated that her daughter who was married and lived in the vicinity of health care centers in another state always consulted her about family health-related problems. Jean said that their (her daughter's) family insurance covered just about everything and the visit to the doctor was only about three dollars. Yet her daughter would call her up periodically and ask her whether Jean thought she should see a doctor about a medical problem she described to her. While Jean's daughter involved her mother in the decision making process, Margaret, a science teacher who lived with and cared for her disabled mother, never went to her mother for medical advice. She stated:

I would never discuss any symptoms I have with my mother. I don't think I've done this for a good course of my life because she would she doesn't handle those things well. She would be a detriment to me rather than a help. I don't tell her any symptoms I have.

Involving someone in the decision making process was based upon expectations, rewards and costs. If in the past one had been unable to give practical advice about how to handle
medical problems, then one was less likely to be consulted about present medical problems. Not only was this probability relative to the lay person but also to the professional medical consultant. A physician who misdiagnosed a client's disease was less likely to be consulted on the client's future medical problems as in the case of the physician who misdiagnosed Jean's husband's cancer. Several informants spoke about the importance of getting a second professional opinion in the diagnosis of a serious medical problem or when a practitioner's treatment procedures seemed unsuccessful.

Much of the medical knowledge we have explored was heavily tied to common sense formulations related to the norms and beliefs of the actors. Even though most of the informants stated that they were well or that they were never sick or hardly ever sick, a medical crisis was a common occurrence. Each had some means of combating this crisis, particularly that involved friends and family. The knowledge one needed to overcome a health crisis was out there in the everyday world. One needed only to utilize her personal network to locate it.

Some knowledge had an esoteric quality and had a more restricted domain. For example, one respondent felt her practitioner disapproved of some of her alternative health methods. Anne (the former health store owner and advocate of natural medicine) felt that she could talk only within
limits to her physician friend about her self-treatment
techniques even though they were both members of the food
coop and he had attended her home birth.

Well, the one thing when I had my
cyst, you know, one of them thought
I was going to have to have surgery
and have it removed probably. And
I said, 'How life threatening is it?'
So I went to another guy for a second
opinion and he said that I had time.
And I just went home and did that
myself with herbs and I never really
talked to him about it. But when I
went back it was gone. He said,
'Fine'.

Anne went on to talk about how her doctor friend would not
have seen a direct correlation between the herbal remedy
that she used and the disappearance of the cyst. Therefore,
her knowledge of his disbelief in her medical procedures
caused her not to share this information with him. She
would be more inclined to share it with a friend with a
similar belief system. His role as medical doctor inhibited
her from sharing certain types of health-related information
with him. Obviously Anne had attempted to share some of her
healing techniques with her doctor friend in the past. She
stated: "I think they think some of the things we do are
silly." The practitioner's failure to understand her belief
system caused some irreconcilable differences between client
and practitioner.
What can networks tell us about human interaction that is medically related? First of all, there is a wealth of medical knowledge out there in the everyday world. This information is accessible through one's network. Through relations in the network, one can obtain the proper information, assessment, and support needed to overcome a health crisis or to prevent one from occurring. The information may be transmitted in various forms such as advice, personal narrative, and folk remedy.

In this study, the term medical knowledge has a more general applicability than most medical professionals would recognize. The term refers to any kind of information that is health-related such as learning about the cost of a private room in the hospital, learning how to evaluate a practitioner's treatment procedures, and learning about using cherries to treat arthritis. Medical knowledge is transmitted selectively through the network channels. Who gets told what has a lot to do with the actor's perception of her social relation, the nature of the connection and how they are interdependent, and the normative criteria the actor uses to evaluate the relation based upon the rewards and costs of the relationship. For example, a close friend "X" is someone to consult before one decides to have an operation because X's father has had a similar operation. One of the properties of the factual environment is comparability. One can derive at an estimation of a future event by comparing
what is perceived as a similar present event to a similar past one. Some in the network will not consult X about a particular medical problem because they are unaware that her father had a similar crisis. Since she is not a medical professional, they would assume that she knows nothing about the medical problem and is not the one to consult. However, through the network, they can learn about her medical experience and get in touch with her, the friend-of-a-friend connection.

In terms of alternative health procedures, one's medical orientation and beliefs have a lot to do with the sharing of medical information. One would be unwilling to talk about natural medicine or herbalism around a friend who was totally opposed to this medical approach. Dolomite for kidney stones, or cherries for arthritis would be information one would pass on to one with a similar belief system.

The network consists of a specific set of interconnections or linkages among specific actors where types of exchanges materialize through human interaction. Actors in the network manipulate their environment by making choices about their relations in terms of assessing the rewards and costs of the relation and how they might resolve a medical crisis or prevent one from occurring. Medical crises are common occurrences that are often resolved through one's network.
Mechanic's model of help seeking is an expansion of Parsons' concept of the institutionalized sick role (1951) where the individual is not responsible for being incapable of performing his social tasks but is obligated to seek medical help. Mechanic attempts to account for the variation in illness behavior, something Parsons does not do. A basic notion of Mechanic's theory is the individual and his significant others response to symptoms based upon socio-cultural factors and their medical orientations.


Boissevain sees the size of the network as the most important structural criteria because the other criterion are calculated proportionately to the total possible links. It is virtually impossible to get all of the links in the network including the possible links, particularly if ego has 1750 persons in his first order zone such as his Maltese informant, Pietru Cardona. In terms of content specifications, the problem of considering the total size in a network—the links in the first order zone and any possible links such as the second order zone and latent links (those links not in use at the time of the researcher's observation) is that the relations and interdependencies change among actors.


Kapferer argues that Bott overly concentrates on connectedness and density and in the process, other important structural aspects such as span, zone, degree of cross linkage are obscured. For Kapferer, the focal point of each social network is the individual spouse and not the family.
unit of husband and wife as it was for Bott.

5 Barnes (1969) used the term to mean the shared social context of actors in a bounded sense such as members of a religious cult, workers at a factory; in other words, he was referring to relationships that derive from the actor’s membership in a group. He uses the term "personal networks" to indicate those relationships that derive from a person’s status such as friend, associate, neighbor, etc. My use of the term indicates a principle of specification—what aspect of the total network the researcher is observing.

6 This statement is not intended to imply that desperation is the only reason people get involved in alternative health treatments. Those against the scientific medical approach of treating diseases and other medical problems often feel more comfortable personally taking the responsibility for their health, including the use of self-treatment techniques. They will use a physician only for very serious problems such as a fall that results in a broken bone or a concussion, or for diagnostic purposes, only to begin self-treatment procedures. Some will use unconventional practitioners such as a manual therapist or a Shiatsu consultant to stretch the spine, or to stay loosened up to prevent health problems from occurring (see Chapter III, Table 1).


9 Audre Lorde in The Cancer Journals (San Francisco, California: Spinsters Ink, 1980) presents a moving examination of her encounter with breast cancer and her attempt to survive it. She warns of the dangers of seeing this disease as a cosmetic problem rather than looking at it in survival (e.g., what can be done to prevent its recurrence) terms. Like Jean, she too noticed that survivors could focus on the physical (appearance) aspect of the experience or the
psychological/emotional (Will my life be shortened? What can I do to prevent its recurrence? Will my friends accept me?).
Ethnosemanticists have assumed that natives of a cultural system use language meaningfully in that they have predictable sets of terms to clearly differentiate events and situations of their world. In assuming this systematic relationship of meaning between words, ethnosemanticists have attempted to describe it in scholarly terms. Frake, for example, in his partial analysis of the diagnosis of disease among the Subanun, islanders of Mindanao in the Philippines, assigns certain skin disease terms to various taxanomic categories and subcategories. Frake claims that these categories and divisions conceptualize particular illnesses and the stages of their development. He recognizes variation in diagnosis or labelling of specific skin diseases among the natives (i.e., different people and/or the same people on different occasions may provide a variety of different disease names as they identify a given set of symptoms of a particular illness case). Frake attributes this variation to a hierarchy of levels in Subanun disease nomenclature. Thus, a skin disease might be labelled "nuka" ("skin disease") which denotes a general category of ailments
or a much more specific term, "pagid" ("inflamed quasi bite"), also an inclusive term of "nuka" (1961). Similar studies are Burling's analyses of Palaung (the language of a small tribe in the northern Shan states in Burman) pronouns, as well as kinship terminology of various cultures (1970), and Spradley's examination of Seattle's skid row culture (1979). Is folk language actually ordered in clear and explicit patterns as these studies seem to indicate? People at some point do acquire a cultural vocabulary by learning what they perceive to be the appropriate terms for describing a particular event and/or classifying the phenomena of their world. A serious question to consider is whether this cognition process is amenable to scholarly description.

My intention in this discussion is not to examine how people inside a health system assess symptoms and utilize disease terminology. For the most part, my informants made very few references to a specific disease. In Western society, disease is something that might possibly be realized in concrete terms. There are a host of scientific terms for labelling sets of symptoms for particular diseases. Unlike the Subanun in Frake's study who supposedly know how to identify any skin disease found in that culture, Westerners, for lack of scientific knowledge, often seek professional assistance for the diagnosis of what they perceive as serious and/or unfamiliar disease symptoms.
Getting people to talk about their health experiences can reveal certain types of health behaviors from their perspective. How they conceptualize the world in medical terms is problematic and somewhat unpredictable. The categorizations of their experiences at times seem miscalculated and contradictory. Ethnosemantics can provide some understanding of this complexity. What are some of the ways in which natives conceptualize their health-related experiences in a local health system? How might they perceive their world in medical terms? What are some problems that seem to emerge with their interpretations?

Aside from ever experiencing any type of disease, several (Nancy, Florence, and Lorie N.) had difficulty remembering specific instances in which they had been sick. What is crucial to this study is how respondents talk about being well. They appear to be imprecise in their application of terms which have an unlimited range of possible meanings. While there seems to be opposing terms in this language system, the parameters of these terms are at times indistinguishable. For example, what does being sick mean as opposed to being well? How can one who recently had a mastectomy and is currently undergoing chemotherapy treatments be considered well? Where does sickness begin and end in relation to wellness and vice versa?

Note the following sets of terms representing perceptual continua, ways in which natives possibly conceptualize
their experiences: medical→nonmedical, sick→well, healing→cure, interventionist→natural, self-treatable→professionally treatable, and compatibility→noncompatibility. Respondents do not have a monolithic view as to what these categories mean. At times, some of their perceptions appear contradictory to their own as well as those of others. This variation in meaning cannot be neatly accounted for as that of the supposed Subanun diagnoses of skin diseases in Frake's study. This list of terms is by no means exhaustive. Perhaps it would have been strikingly dissimilar had my research problem focused on disease or people who perceived themselves as ill, completely disabled, or terminally ill, etc. Or perhaps their worldviews would have included these terms but perceived them in distinctively different ways. In other words, I am uncertain as to how these terms might be applied in a completely different set of circumstances. Given what studies have shown about health behavior (Schulman and Smith, 1963; Zola, 1966), socio-cultural traditions do affect one's attitudes, beliefs, and practices concerning health and illness. Natives' use of language to communicate knowledge of their world and to give account of their experiences is indicative of their culture-specific health behavior.
Conceptualizations of Health

1. Medical—Nonmedical. While all respondents on some level were involved in certain forms of alternative health practices (see Table 1), some would not see certain practices as being medical. For example, Lorie, the pharmacist, said that she was uncertain of herbal medicine's validity and whether people who used it really knew what they were doing. On the other hand, five respondents (Anne, Dr. G, Regina, Barbara, and Jim) indicated that the use of herbs for medicinal purposes was a vital part of their health strategies. Since all fourteen informants consider themselves healthy, it is important to note how they differentiate between the medical and nonmedical items in their world and what criteria are used to make this distinction. Is medical something only associated with the kind of help health professionals provide, or can it also include anything that lay persons do to make themselves feel better and/or good such as walking, dieting, meditating, or having medical insurance? Is comforting a friend who is experiencing guilt feelings about her anorexic daughter (e.g., did I do something to cause this?) inherently medical? Is telling someone what doctor to go to or what medical insurance policy to subscribe to medical advice? Is getting the proper amount of rest every night and eating the proper foods in moderation a medical practice or merely the use of common sense? Is anything that is health-related considered medical?
According to the data, the notion of what is medical and what is not may be determined by different criteria. Perhaps the most meaningful differentiation was revealed from the responses to the question, "Who do you go to for advice about your health and well-being?" The conventional health professionals in this study (Florence, an RN; Lorie, a pharmacist; and Dianne, a public health nurse) gave very similar responses to the question. All felt that their friends did not help them with anything medical. For example, Florence made the following statement:

If it's a medical thing I go to our family doctor... If it's something I feel he can take care of.... If it's something if after a couple of days or however long it takes to feel better then I wait it out.... As far as going to friends for advice about medical things, I don't think I usually go to them, they come to me.

Lorie, on several occasions made explicit distinctions between what she perceived to be medical and nonmedical. The above question elicited the following response from her: "I got a family physician and a gynecologist. I would go to my family physician first, for anything. And to the gynecologist for a check-up." I then asked her if she had friends she could discuss her health problems with and she stated:

Usually if it's a friend, we tend to complain. But I wouldn't just call
her up to complain that I'm not feeling well.... There's no one that I run around with that's really medically inclined that they could give me their advice. But I could give advice.

The term "medically inclined" as used here refers to anyone trained in a conventional health-related field such as nursing, pharmacy, pathology, etc. Dianne made a meaningful distinction between physical health and emotional health resources. In response to the above question "Who do you go to for advice about your health and well being?" she commented: "I have a close friend, she's a nurse too.... Well, emotional health problems to her probably. The physical health, I tend to go to my doctor. I know him socially."

This dualistic view of health seems to have been expressed also by Florence and Lorie when they stated how friends and family helped them by providing them with mental support and counselling, while their doctor helped them with physical problems they were unable to handle. However, Dianne made it clear that her friend was a nurse which might be why she perceived her as a resource to turn to for help with her emotional health problems. Florence and Lorie may not see the mental support of friends as medical help. Dianne also made the comment that her friends and minister did not help her with health things in her response to the question "Describe something others always help you with."
All felt that people who knew they were health professionals came to them for a medical opinion in both a work and nonwork environment. It appears that "medical" was something they associated with formal training. Lorie stated that she learned how to treat childhood diseases from what she has seen doctors and pharmacists recommend. I asked her whether she had learned anything about childhood diseases from the mothers who come into the pharmacy. She stated:

Yeah, there's a lot of different mothers that come in here and tell me about stuff they use and it's effective. And I will tend to use that knowledge now when someone else comes in. And I'll say well someone else uses this.

Lorie saw the customers' endorsement of a product as valuable information to share with other customers. After all, they do want to know whether something works or not. However, she did not see what the mothers told her as medical advice. In fact, she stated that no one ever recommended a product to her. While this statement seems to contradict her previous one concerning mothers coming in talking about product effectiveness in relation to a certain medical problem, it should be noted that Lorie more than likely recommended the product to them in the first place. Some then in turn would eventually tell her whether it was effective or not. Customers' discussion of a product to a
pharmacist would not be the same as that of a pharmacist to another. While customers would more than likely talk about how a product made them feel and whether they felt it relieved them of their symptoms, a pharmacist might ask another pharmacist whether she has heard about a drug. A pharmacist might want to verify the accuracy of a prescription with another pharmacist if she is unable to contact the physician who wrote it. For example, a customer came in a certain drugstore with a prescription for mycostatin (normally used as a troche lozenge) to be used as a vaginal tablet. The pharmacist, thinking the doctor had made a mistake, asked another pharmacist whether he had heard of this particular usage of the drug before. The other pharmacist said that he had. Lorie's information to customers involved her giving them a diagnosis after the customer discussed the symptoms with her, some explanations about various medications including dosages and content in relation to a problem, a recommended treatment, and possibly a prognosis—if symptoms linger more than several days, then see a doctor. The other two health professionals offered similar examples of how they disseminated medical knowledge.

Listed in Table 3 are the responses of the remaining eleven informants to the question, "Who do you go to for advice about your health and well-being?" In terms of strictly associating "medical" with formal training, Jean's notion of medical was similar to Florence's, Lorie's, and
<table>
<thead>
<tr>
<th>Informant</th>
<th>Medical Resource for Health and Well-Being</th>
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<tr>
<td>1. Anne</td>
<td>Friends, including two physicians, interested in the holistic approach.</td>
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<tr>
<td>2. Nancy</td>
<td>Doctors who can give her information about natural health (she goes to a nearby town to see them because she does not feel that any &quot;natural&quot; doctors are in her local community.</td>
</tr>
<tr>
<td>4. Mary</td>
<td>Home library that has materials on Shiatsu and polarc therapy among other things. Sees a doctor (Dr. G, the manual therapist) if professional help is needed (she considers him a professional).</td>
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<tr>
<td>5. Rev. T.</td>
<td>God by exercising faith; the church; goes to the doctor for inside pain (i.e., pain that he cannot account for and lingers such as that he sustained in a car wreck).</td>
</tr>
<tr>
<td>David</td>
<td></td>
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<tr>
<td>6. Pam</td>
<td>Female physician she's gone to for 12 years; friends for support.</td>
</tr>
<tr>
<td>7. Jean</td>
<td>Family physician and two nurse friends.</td>
</tr>
<tr>
<td>8. Dr. G</td>
<td>Dr. X (an obstetrician who is one of Anne's physicians and her friend) for any problems that he cannot handle because he knows his father was a good doctor; never goes to the doctor just for advice (means that he goes to see a physician only if he is very ill, and he expects some type of treatment then).</td>
</tr>
<tr>
<td>9. Regina</td>
<td>ARE (The Association for Research and Enlightenment founded in 1932 to preserve Edgar Cayce's materials and teachings) in Virginia Beach; Cayce's readings; friends and teachers in metaphysics; asks ARE about cures such as those for warts so that she can share this information with people who come to her.</td>
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Informant | Medical Resource for Health and Well-Being
---|---
10. Barbara | Physicians (one is the same physician that Anne and Dr. G uses) and friends who believe in "natural" medicine like she does for diagnosis.
13. Margaret | GP for anything serious; most of the time to herself. (This reflective process involves her thinking of her body as her best friend when she gets sick and that it works for her not against her. Wonders if the problem is serious and if so, how she will handle it, etc.).
14. Jim | Family physician. Also has seen a chiropractor for his back injury.
Dianne's. In fact, Florence was a nurse friend that Jean relied on more frequently for medical information than she did her physician. While nine of the eleven remaining informants listed a physician as a medical resource for advice about their health and well-being, all specified a particular set of circumstances under which they utilized his services. For example, Jim stated that he had to be about dead before he went to his physician. Anne stated that her physicians who are also her friends believed in holistic medicine as she did. However, she did not tell them about certain health procedures she got involved in (e.g., using herbs to cure the mastitis) when she knew that they would disapprove of her methods. She also said that she tended to take her children to the doctor quicker than going in for herself. Nancy said that she preferred to go to doctors who could tell her about nutrition and who had a natural health philosophy. Mary and Regina were the only two respondents who did not list a physician as a medical resource possibly because of several factors. Both were vehemently opposed to synthetic drugs which were something they associated with a formal physician. Also, Mary felt that a physician could do nothing for her arthritis which is why she went to Dr. G when it got severe. Regina adhered to the science of the mind philosophy and believed that our thinking made us sick. "If we correct our behavior and our thoughts, we can heal. We stop healing with our own
Thinking. Both Mary and Regina felt that they had a vast library of materials on unconventional methods of healing and that they consulted these materials when a medical problem arose.

The question addressing the issue of medical changes in the city (#38—see Appendix A) was designed to get informants to discuss what they perceived to be medically important to the city at large. For example, in response to the question, "What medical changes should be made in this city?" someone might say that she felt there should be a holistic medical center or more home births for various reasons such as people need to take more responsibility for their own health, or they should have the right to choose the kinds of health practices they desire, etc. Embedded in this statement is what Spradley refers to as a universal semantic relationship called strict inclusion, i.e., x is a kind of y (111), or in more specific terms, home births are a kind of medical practice. As stated earlier, it was important to note how natives inside this cultural system made distinctions between medical and nonmedical.

In terms of responses, medical changes in the city that were perceived to have been made or needed to have been made were usually associated with conventional health resources such as the hospital, physicians, and the county health department. For example, Nancy (informant two) who was very interested in "natural" medicine (nutrition) said the local
hospital needed more responsible emergency staff. She indicated that she had had several negative experiences with them and felt that they were ineffective in their handling of emergency cases. Dr. G who rarely had any need for a physician stated that there were new doctors (meaning physicians) coming into town all of the time. Seven informants mentioned various ways the hospital had expanded in terms of physical space and/or new programs such as the out-patient clinic and the birthing room. Margaret (informant fourteen) felt that city medical services had degenerated because there were no house calls being made by physicians. This statement at first seemed to contradict Anne's and Barbara's experiences since they both had had home births tended by a physician. Also Barbara talked about how she was ill in bed for two days with a virus and was unable to breastfeed her baby. So her doctor came by and gave her some suppositories which made her feel noticeably better. Margaret, however, felt that GPs were not interested in geriatric cases. She expressed her frustrations of having to phone in her mother's symptoms to her physician. She said that she would be willing to pay fifty or sixty dollars a week to have one come into the home and examine her mother. She also stated that her mother had not seen a physician in two years (at the time of the interview). Margaret felt that the medical care at the local hospital had deteriorated, and more GP care was needed not only in
Johnson City but all over the nation. Margaret clearly expressed her disenchantment with the local hospital because of the lack of quality care her invalid mother received when she was a patient there.

The last time I had my mother in ___ (the local hospital) with impacted bowels. After ten days of which I as a professional (a science teacher) for a while, thought it would be wrong of me to pursue it and when I did, they dismissed her with impacted bowels. The public health nurses of this town had to digitally unimpact her. At which point they said to me, 'This is the worst thing I've ever seen.' I said, 'Five nights and days of trying to treat her with enemas when in the local hospital they came into an eighty-four year old woman and said, 'Oh, what kind of enema would you like?' And each time she replied, never having one, 'What kind are they?' I cannot forgive the fact that if you're a geriatric patient, they think one, you're senile, or two, you're irregular. And if you hire private nurses and bring them in from ___ (nearby city), then the other nurses pout in the hallway because they feel it's something against them....

Margaret in some sense qualified her negative evaluation of the hospital's services by commenting that many of her middle-aged friends had gotten excellent care there. Yet she felt that an incapacitated elderly patient was not treated in the same positive way; consequently, she was horrified at the aging process and the possibility of becoming dependent upon someone.
Aside from the conventional medical forms, several informants mentioned other kinds as well. Mary felt the city needed a health spa while Regina thought that doctors should incorporate holistic medicine in their practice "because you have to balance with the body your mind and your emotions. And I think there's where they would really be healing." She said that any doctor who did emphasize this notion of balance in his practice would have all of the patients in town. Pam also felt that local physicians needed to become more conscientious about treating the whole person. Unlike Regina who felt that there were no holistic physicians in the local community, Pam thought there was one. She felt that because there was one holistic medical doctor in the city, a medical change had been made. Other medical changes in the city according to Pam were an exercise center, exercise fitness trail at a local park where one could go swimming, and jazzercise and aerobics classes.

In relating her involvement in the fluoridation issue, Anne expressed some uncertainty as to whether it fell under the rubric of medical.

One thing that we're working on right now—I don't know if this falls into that category or not. The city council president has just brought up the fluoridation issue to fluoridate our water. And I'm real against that. We have an information board in the store to try to disperse facts on fluoride to the people.... There's a group of citizens that asked us if we
would become a clearing house for information, to pass out information on fluoride—facts. So I guess I consider that a medical change with them trying to do that.

Anne stated that fluoride is a drug and that people should be given a choice as to whether they want to use it or not. Anne considered herself an active consumer and one who would question any procedure she felt was harmful to the health of her family.

I think there's two different sides of the story. People that really like fluoride and think that it does a lot for your teeth. And then there's the other side that fluoride causes your teeth to turn black and mottle and fall out. Among other things, we have customers that come in whose children have been poisoned by fluoride treatments at school, or fluoride in the water, or who are allergic to it. And I just think it's another place where they are trying to take away our choice....

That Anne perceived the fluoridation of water as a health hazard with serious medical consequences, i.e., the destruction of children's teeth and the triggering of allergic reactions, was indicative of her anti-drug philosophy of health. She believed that drugs used unnecessarily for supposedly medical purposes tended to make people worse or at least certainly interfered with the natural healing mechanisms of the human body. But more importantly, at least in this instance, she resented someone else's medical
philosophy infringing upon hers. Anne's fundamental belief in the importance of medical alternatives and one's right to choose was the driving force that led her to action, i.e., to express her views to others. Consequently, others might be prompted to participate in a decision which to some, Anne included, had medical implications that might affect the entire community.

Clearly the notion of medical had a wider range of applications for those who embraced unconventional medical systems and a much more restricted use for those who were a part of the scientific medical system. That is not to say that all conventional practitioners saw all unconventional medical practices as nonmedical or inefficacious. Dianne, the Public Health Nurse, seemed to be more tolerant of unconventional medical practices than the other two health professionals possibly because she has had to use them in her involvement with patients in the home health care program. For example, when I told her what I learned about the treatment of shingles from a social worker who worked with the elderly (i.e., the use of Vitamin E capsules clears them up in several days), she was delighted to obtain this information and expressed interest in trying this technique on some of her home-health care patients.

The use of the term medical was problematic in the sense that it could have both positive and negative connotations and could be used in a very limited or comprehensive
sense. Those who had a greater propensity to utilize the scientific medical system in their health management process (Lorie, Florence, Jean) rather than alternative strategies realized the term in a positive sense. For example, Lorie stated, "I would go to my family physician first, for anything." In terms of medical changes that needed to have been made in the city, she felt that people needed to be more aware of community health programs and take advantage of them. Such programs were often connected with the local hospital. Thus medical was something almost always associated with scientific medicine and considered a very useful resource to aid in one's health management. Those who had invested trust in "natural" medicines, self-treatment procedures, and maintained a greater degree of skepticism towards physicians and the scientific medical system used the term more comprehensively. It referred to unconventional health practices as well as practitioners and lay persons that were perceived to aid in the treatment of specific health problems, both curative and preventive. For example, Regina felt that the local physicians needed to incorporate the ideologies of holistic medicine in their practice in order to successfully heal. Regina and Mary considered Dr. G a professional who always made them feel better. On the other hand, physicians were practitioners to avoid when possible and to distrust. Jim stated that he had to be about dead before he sought one for help. Mary stated that
she would not "spit across most of the doctors in this town."

Medical was something they disapproved of but used when they deemed it necessary.

2. Sick—Well. These terms were used to appraise health in both a general and specific sense. At times, it seemed as though they were used in contradictory ways. For example, one who rarely suffered with a cold or headache but who was recovering from a mastectomy and was undergoing chemotherapy considered herself well, while others perceived her as sick. One who suffered with a migraine headache periodically (at least once every month) after experiencing a stressful situation considered herself well, while her husband labelled her as "sickly" or "frail." What criteria was used to make these very subtle but important distinctions when assessing one's state of health? Were self ascribed health assessments determined in the same way as other ascribed? In other words, would Jean's notion of herself as "well" be the same as Florence's (her best friend) notion of Jean's state of health?

The data yielded the following descriptions concerning the concept of sick: someone who caught colds easily and/or frequently suffered with a headache; who indicated drug' ("pill") dependency; who suffered with a specific disease or disorder such as anorexia nervosa; who often was dysfunctional in that she had to miss work or was unable to
perform expected tasks; who was in and out of the hospital; who was incapacitated, immobile, or in pain and struggled with normal body functions such as breathing, sleeping, and/or elimination of waste materials; who frequently collected on her health insurance; who had to undergo major surgery such as a hysterectomy or a mastectomy; who suffered from a terminal illness such as melanoma or leukemia; who felt lousy, i.e., nothing hurting in particular but unable to perform up to full capacity; who suffered with an ailment such as a backache periodically to the point of restricting her normal activity; who suffered with guilt to the point of feeling "low" and despondent; and who suffered from sin (i.e., one who had not accepted Christ as her saviour was living in darkness). While this list of criteria is not an exhaustive one, it does indicate a general pattern as to how the notion of sick was applied. The term could be used in reference to the physical, psychological, and spiritual state of an individual; how one looked, felt, and acted; the longevity of an illness; the seriousness of an illness (i.e., how life threatening it was, whether it caused pain and discomfort); the frequency of occurrence of an illness; one's optimum ability to perform certain tasks; and how often or to what extent one had to rely on institutionalized health resources including health insurance, over-the-counter drugs, treatment of a physician/surgeon, and hospitalization. These were not mutually exclusive
categoric descriptions. It was likely that several or more of these categories might apply simultaneously to one who was sick.

All of the informants in this study emphasized that they were well. For example, in response to the problem "Describe an illness you had some time ago" (see Appendix A), they would invariably preface their answer with a statement such as, "Well, I'm never sick," or "I'm not a good one to ask because I'm hardly ever sick." Yet I found that they could talk about being sick and they had had experiences with certain kinds of illnesses. Sickness represented an undesirable condition for them to be in. All were able to state what they disliked about being sick such as the isolation, dependency, and feeling bad to the point of not being able to do anything. Pam stated that she disliked not getting any sympathy from her husband when she was sick; therefore, she was reluctant to tell him when she was not feeling well. She felt he believed that talking about one's sickness exaggerated it and made one feel worse. Pam did give an example of her husband comforting her once when they were out of town and she came down with one of her migraine headaches. All stated that their family helped them to get well in some kind of way by comforting them, and/or temporarily taking over their family duties. Being sick was seen as disruptive and a temporary state that one attempted to recover from. Some felt that sickness episodes were unusual
for them and were embarrassed somewhat for having to be
treated by a physician. For example, Barbara recalled a
time when she was ill at home with a virus:

Yeah, we called the doctor. Because
I was nursing, I couldn't lay there
forever. I wouldn't have any milk
and the baby was starving. And it
was viral. And it was the first
time I ever used suppositories and I
thought, 'Oh no!' And the first one
helped so much. I thought, 'I don't
mind at all.' I was kind of getting
well. Anything was better than what
I had.

Many informants felt that there were a lot of sick
people in the community and some indicated they had direct
contact with them. For example, Rev. David felt that the
people who came to him the most for help (prayer, counsel-
ing, etc.) were sick, some having major medical problems
such as cancer and heart disease and some having minor ones.
Florence, by working part-time for a surgeon, felt that she
saw a lot of what she would label as sick people (including
those undergoing chemotherapy) come into the office. She
also knew of families in the community with terminally ill
members. When I told her that all I had talked to thought
themselves well, she stated, "That's good. There are an
awful lot of sick ones walking around, believe me."

Being well was considered an asset by all of the inform-
ants and something inextricably connected with their concept
of self. It was questionable as to how much one's
significant others contributed to this self concept of well-
ness, particularly when they might perceive one as ill. Such was the case of Jean who had the mastectomy and was taking chemotherapy. She said that people at work might perceive her as ill, particularly when she had to miss two days off the job every month because of the discomfort she felt after taking the chemotherapy. Florence, her nurse friend, referred to her as being ill. Jim who lived in the midst of death and sickness in a senior citizens' building where people frequently discussed ailments they suffered with felt that he was well most of the time. It was certainly questionable as to whether being well in such an environment was even given that much consideration when sickness and death appeared to be a way of life and many were dependent upon others for so many things such as preparation of meals, getting to the store or the doctor. Jim stated that he felt best when he and his friend took a drive in the country hunting for herb roots. Being well to him meant being able to breathe freely since he suffered with asthma periodically and being able to get in his car and hunt for roots. He stated that when he had an asthmatic attack, he did not leave the building. Or when he was suffering with severe back pains, sometimes he was unable to get out of bed.

Being well as used by my informants was a relative term with many different shades of meaning. They did not have specific terms for being well as they did for being sick.
Being well was a concept whose meaning negated sickness. They gave descriptive comments such as "I'm never sick"; "I feel good most of the time"; or "I never get colds or headaches." It was something equated with physical activity, i.e., being able to perform normal tasks with minimal or no discomfort. It was something that could be used in reference to a very short, as well as an extended period of illness. Thus, one could conceivably say, "I am not well today, but most of the time I am." Being well also meant both not going to see a physician often and not being in bed on a frequent basis because of ill health. Being well was inextricably connected to one's self concept. One could point to specific things she did to stay well. It was invariably associated with individualism, taking control of one's life through preventive and curative procedures.

3. Healing—Cure. The question "Describe a healing experience from beginning to end that you will never forget" (see Appendix A, #21) assumes that informants have at one time or another been ill and have had recognizable moments in which they felt they were restored to health. It is important to note their ways of talking about how they got over an illness and what seems to be memorable about the experience.

The term "healing" was most often associated with a dramatic phenomenon such as a miraculous recovery or
something that happened totally unexpected and was perceived as having some relevance to their getting well. The term also had a transcendent and/or spiritual meaning. Six respondents (Jean, Margaret, Nancy, Florence, Lorie, and Jim) felt that they personally had never had any healing experience. Jean said that she had read about people getting healed in an unconventional way, which she immediately associated with faith healing. She did not hold that there was a direct link to one's praying and one's getting healed. "I definitely don't believe that if I pray to get well, then I'll just sort of get well.... I think the doctor has to be there too." Margaret stated that there was no great healing experience. "It's a promise in faith and a promise that hey, you're gonna be alright." Nancy immediately associated getting healed with faith healing. She had read about this type of healing and felt that it was a form of hypnosis. "Someone touches you...and the waves are so strong that you have convinced yourself that you are all right." She felt that she was a humanist and firmly believed in the common bond of humanity as a source of strength. "You have to know you're gonna be all right. If you don't know you're gonna be all right, you're gonna fall apart." For Nancy, the process of recovery did not involve a deity or any supernatural agent; however, it did include a spiritual dimension. The other three believed in faith healing even though they had not experienced it themselves.
Florence recalled reading a former Miss America's divine healing story in an issue of Guidepost and thought it was great. In addition to hearing acquaintances talk about faith healing, Lorie also knew of people who had been hypnotized to break their smoking habit, and they stopped smoking for awhile. Jim felt that he had not been sick enough to experience a healing. This statement implied some sort of fantastic near-death association on his part. There were days when he was unable to get out of bed because of his asthma and/or aching back. Yet he felt he had not been sick enough to be healed. He related three different examples of healing that he had either seen or had heard about. One occurred when he was a small boy growing up in the hills of Tennessee. His grandmother and another woman successfully treated a boy suffering from intestinal problems with a black cat. He claimed that the hospital had pronounced the boy's case as hopeless. Another example involved his going to a church several times and witnessing invalids in a wheelchair being able to walk after a minister prayed for them. A third example concerned his wife who died of cancer.

She was against going to the doctor. Even when she suffered with cancer. She died the fifth of December, 1983 .... My wife didn't take a thing for the cancer. She would get up every morning and get breakfast up until the time she died. She never complained about hurting or anything.
Jim's notion of one with a terminal cancer was that the victim was normally in a lot of pain and heavily sedated. Even though his wife did not survive the cancer, he felt that it was a miracle that she felt comfortable enough to do some tasks around the house without being dependent upon drugs while she was alive. The fact that his wife did not verbally indicate any discomfort she may have felt from the cancer does not necessarily mean that she did not experience any. Cassell in his article entitled "Suffering and Medicine" states that when some terminally ill patients know the source of their pain, they may experience some relief and develop a high tolerance level for pain (1982:641).5

Several informants felt that they were responsible for helping clients get well but resisted the notion that they healed anyone for the following reasons: (1) While Mary felt that she had had nothing but positive results with the massage therapy she gave her clients, she never claimed that she healed them for legal reasons. She did not want to be accused of practicing medicine without a license. She preferred to say that her clients got good results from her and they expressed this satisfaction to her. (2) Those (Rev. David and Pam) operating from a faith healing framework saw God as the power that healed and they were channels or mediums for this divine energy. While much of Rev. David's responses involved faith healing
experiences he personally had had or witnessed from the minister whom he thought of as his mentor, he considered himself a humble servant that God worked through. To think of himself as anything more was somehow a sin. He stated:

Well, I don't really know how to treat anything you know, as far as any particular illness. You know—God's the healer...and sometimes people get it confused and they think that the preachers can heal 'em. And I had a guy tell me 'I healed his arm.' And I said, 'Uh-uh!' I didn't heal it; God did. I prayed for it, but God healed it.

Note the distinction Rev. David made between "treating an illness" which to him involved some specialized medical skills and "praying for someone to be healed." The latter required an agent to make contact with a supernatural power which in itself involved specialized procedures (e.g., having enough faith and knowing how to pray sincerely).

When the term "healing" had spiritual ramifications, it possibly was or was not perceived as something dramatic or spectacular that happened. While the evidence might be somewhat intangible, the healing was still very important to those involved. Healing that got beyond the physical realm could consist of someone letting the suffering person know he cared which in turn made both parties involved feel better. Mary stated: "And sometimes just being there. That's why when a person's being consoled by a friend who
puts his hand on your shoulder, that is a form of healing. He's administering some sort of healing and energy and something." Regina expressed her concern about doctors being medical but not humanitarian. She felt that both factors had to be taken into consideration simultaneously to effect a healing process. She stated:

And I would like doctors to be humanitarian as well as medical, to work the two together. And there are some. And Dr. Simington in Texas started that movement, and I did a workshop with him recently in ___ (nearby city). And he is the one who is doing so much good with cancer because he starts out with the patient and says, 'What's eating you up'. Because cancer is something that's eating you up, like 90 percent of the times.

Regina made a distinction between medical and spiritual. She felt that physicians were concerned with alleviating the physical symptoms and not concerned with the emotional dimensions of the person that might be causing him to suffer more than the actual disease itself. The notion that the patient's psychological and spiritual selves must be dealt with in the healing process is reflective of the holistic health model. Regina believed very strongly in this model of health care. Like other holistic health proponents, she felt that being made whole involved more than being cured of a disease.
For some, the term healing did have spiritual connotations; for others it did not. Healing could be the result of one utilizing good therapy that had little to do with divine energy. In describing the particulars of a healing experience, Dr. G recalled a man that he treated for arthritis:

Well, I had a man that came to me several years ago who worked for Standard Oil. And he'd been diagnosed as having arthritis. Of course those fellows work on cement all day long. And we let him take some time off from work, and put him on some pretty heavy dosages of supplements. And I think I treated him a couple of times a week for about six weeks. Uh, he went back to work and retired and he'd given up really and truly. He was hurting so that he couldn't even bear to think about going to work.

Dr. G went on to state that he had had a lot of cases in which people were healed. However, he felt that the above example was one of the most outstanding cases he had dealt with, particularly since the client made a complete turn around from the grim prognosis he had received from physicians. While Dr. G did not directly attribute his successes in treating his clients to a divine source, he did express belief in divine healing and that there was a higher power out there controlling our lives and the universe to some degree.
When Dianne talked about a healing experience she had had, she focused more on the remarkable help she received from others rather than the actual physical recovery. The emotional trauma from the accident was alleviated at a much more rapid pace than that of the physical injuries she sustained. Dianne relayed the following story:

Well, I was in an automobile accident and fractured my nose. And cut my face above the eye and it was icy. And I had slipped off the road and hit a tree and proceeded to go on into a field. And it was bitter cold. The wind was blowing. I was on 25 (fictitious name of the actual highway). And I got out of the car and I was bleeding so badly. And started up toward the road. And as I approached the road I thought, 'Gee'. It was so slippery there. I slid off. 'What if somebody stopped to help me and slid into me?' And so I didn't know whether to, what to do. So I started back to the car which was probably fifty feet off the road, and got in out of the wind and cold. And then this car pulled over to the side of the road. Just about the time I reached my car, a man said, 'Don't worry, babe. I'm coming.' I think. This man shouted at me. And he came out into the field where the car was. And he said, 'I saw you go off the road. I hope you missed that tree, but I see you didn't.' And turned out he was a medic. But he was with his wife and two sons. And he had, he took a clean handkerchief and made a pad to put over this cut on my eye. And he had a CB in his car. And he called the emergency squad. And they came and took me to the hospital. I have a friend who is a surgeon, and as I was brought in the stretcher in the emergency room, they had put handkerchiefs around my eyes and I couldn't see. He came walking into the emergency room. He said, 'I'll sew her up' to the emergency room doctor which I
was grateful for.... His wife is one of my closest friends—that he is excellent... and would do a good job.... My nose was set in a day or so. After that the actual healing process was not as dramatic as the fact that right at that time things happened that were so good. I was very fortunate.... The priest in our church... took me out to find a new car...with my son along too.

Dianne used the term healing in a very restricted sense, i.e., the physical recovery from the injuries she sustained in the accident. Yet she indicated certain factors which in the conventional sense would be considered nonmedical (e.g., the fact that a medic discovered she had had an accident, her surgeon's wife was her best friend, and her priest helped her to get a new car) actually aided her in the recovery process. This example is one that again raises the question about the distinction between medical and nonmedical and whether medical is something that includes anything directly or indirectly related to maintenance of health in both the curative and preventive sense.

While the term healing usually had a dramatic and/or miraculous connotation to it, the notion of cure often seemed to indicate the more commonplace, mundane elements of recovery. A cure was perceived as something one's parents or grandparents either used or did not use. It was sometimes referred to as a home remedy. Florence stated, "My parents probably relied more on professional advice,
but still they used the home remedies." Dr. G stated that his parents were healthy and did not use remedies frequently. He felt that remedies were something to use when sick. Both Pam and Jean associated this term with something negative. "They (parents) didn't go in for home remedies." Pam felt that her grandparents and parents were very healthy and did not need them. They lived into their 80s. She stated:

I can't remember them having all that stuff around the house. They probably had some little patent medicines. I remember we used to have to take castor oil with orange juice. I'm sure they had aspirin.

In terms of treatment, a cure could be used to relieve one from something as commonplace as a cold or something as deadly as a cancer. Jim stated, "I ain't had nothing but some bad colds.... I just fix up those remedies...whiskey, rock candy, a little bit of sulphur can make you the best cough medicine you can get." Rev. David felt that a cure came from God. He thought that his spiritual mentor had a cure for cancer but was somewhat unsure what it involved. "Eat some part of an avocado seed." For some the notion of cure had a metaphysical element to it, that of belief. It was something that could be used on a daily basis to prevent a medical crisis from occurring or to eliminate one altogether. Barbara felt that it was something you
learned from friends and/or shared with friends who had similar medical interests. "I know they (friends) believe in preventive medicine...and maybe natural cures...they are not into chemical."

The term "cure" was used to refer to what physicians do when they make you better. Thus, it denoted the successful treatment of a disease and/or the elimination of symptoms associated with an ailment rather than an injury. Being cured of a disease did not necessarily make one whole in the spiritual sense. Florence indicated that she expected a cure from her doctor when going in to see him. She stated: "If he feels that medicine is necessary, he'll prescribe it or tell me what to do to relieve the symptoms."

The term "cure" referred to some kind of conventional or unconventional agent or medical practice that restored health such as a cure for cancer or a cure for the common cold. Barbara stressed an interest in learning more about natural cures for preventive purposes from friends and books. To her, a natural cure meant anything nonchemical. When used in a strict scientific medical sense as Florence used it, the term usually did not imply anything spiritual.

This area of terms raised some significant questions about the curative and preventive dimensions of health and how they might be meaningful inside a local health system. Knowledge that was a commodity to one might be completely worthless to another. For example, while Barbara sought
new cures or advice from friends for handling certain medical problems her children might have, Jean felt that cures were something of the past and based on superstition and irrationality. What happened when one recovered from a medical problem? Was the recovery an observable phenomenon or did it include metaphysical elements as well? Many stated that the support of friends and family made them feel better during a medical crisis. What happened when one was healed of a medical problem versus being cured? For some, healing had spiritual ramifications involving a divine energy source; to others, it was the result of good therapy as in Dr. G's successful treatment of his client with arthritis. To cure someone could mean to relieve them of a cold through the use of "natural" remedies or to get relief from an ailment through treatment techniques administered by a physician or lay specialist skilled in some form of alternative medicine. Based upon this data, there were two types of healing: Recovery involving the dramatic (in terms of the seriousness of the disease such as cancer, myocardial infarction, how and when the event took place, e.g., gradual, suddenly) and spiritual or the dramatic and nonspiritual. The two forms of cures involved the use of conventional or unconventional agents or medical practices.
4. **Natural—Interventionist.** Those who felt a strong sense of commitment towards a self-help health ideology had a tendency to perceive their health practices as "natural," while much of what physicians did was seen in often stereotypically negative terms. For example, Jim stated that doctors gave you dope, something to work against the body. Nancy felt the doctors were the biggest drug pushers that there were, meaning that they did not concentrate on the causes of a medical problem but rather on suppressing the symptoms with a drug. A natural medical practice was something that worked with one's body and not against it while a medical treatment from a physician, particularly a non-holistic one, or other scientific medical practitioners such as a dentist was more likely to be ineffective and might even cause harm in a physical and/or psychological sense. Anne recalled the traumatic experience of taking her son to the dentist for the first time after a close friend of hers recommended him to her:

He (her son) had to have one cavity filled. They (the dentist's office) sent home this little bottle of medicine that was to make him a little drowsy for the pain. Then they did something else. But I was supposed to give him this, and he's never had medicine before. He's completely against it. I'm real leery of medical people you know...But I tried to give him medicine and he wouldn't take it and he spit it all out. And he got a little bit down him. By the time he
got there, I told them that. They won't let the mother come back with the child. And I can't believe I submitted to all of this cause usually I'm just the opposite. But it was my first experience with the dentist with the kids. And I told them that he'd just taken a little so they took him in there and they made him take more medicine. And they gave him gas or a shot; I can't recall right now. No, I think they gave him the medicine and then they gave him a shot to numb the pain. So by the time he came out, he couldn't even walk. It was sickening. He was so drugged and that was the normal procedure, and I submitted to it and let them do this to my child for a little filling.

Anne felt the dentist's procedures were harmful to her child. She went on to talk about guilt feelings she experienced for making her child submit to this form of treatment which involved practices that violated her medical beliefs (e.g., taking drugs made from synthetic materials unnecessarily—at least she perceived it as such; separating the mother from the child while implementing treatment). She saw the doctor-patient relationship in asymmetrical terms in that the practitioner had complete authority in implementing treatment and ensuring patient compliance. The patient's beliefs and feelings were given little or no consideration.

A natural medical practice might be realized on a frequent basis, or it might not, depending upon the circumstances. For example, Barbara might eat cherries for an arthritic ailment primarily when she had an attack while
Mary engaged in yoga exercises and polarc therapy daily for muscle stimulation and the loosening of joints. Whatever the case, a natural medical practice was beneficial to the body when not implemented excessively. If one engaged in natural medical practices frequently, such practices were perceived as beneficial to the participant and not harmful. On the other hand, if one took medication on a regular basis, he might experience some negative side effects from it and be perceived by others as drug dependent. A natural medical practice, particularly if it were preventive, involved much larger goals than an interventionist one. For instance, vitamin therapy could be used to prevent colds and headaches, as well as to make one feel energetic, mentally alert, and healthy. On the other hand, aspirin for backache could lessen the pain but might also be inflammatory to the stomach. Proponents of natural medicine often felt that different natural medical practices could be utilized simultaneously and would not counteract each other, while different medications taken simultaneously might counteract and even have adverse effects on the body.

Jim expressed the importance of using herbs and natural treatment procedures before seeing a physician. He felt that he was unlike most people in the building in which he lived because he often relied on natural medicine for curative and preventive purposes while he felt they were too dependent upon the scientific practitioner's medicine.
People today, it ain't like it was back years ago. They depend upon doctor's medicine. And it's nothing but dope. You take people right in here take ten or eleven pills at a time.... They got them in bottles. They just lay them out and go to swallowing them. How in the world is ten different pills gonna, they're gonna counteract one another. And if there's any of them (the medication) that got that dope in them, pretty near all of them have, that's gonna counteract against your body and against one another. That's the reason that I don't take too much doctor's stuff.

Dr. G expressed some similar concerns about his mistrust of physicians and their medications.

I'm afraid of some of the things that they give me. I'm scared to death of some of these drugs. I just see people everyday that've taken drugs and they're worse off with what they've got now than what they went for. Literally, they're just basket cases. And it's really very, very frightening.

One could learn about natural health practices from one's friend, while many interventionist procedures were often too technical to comprehend. Proponents of natural medicine felt that those who utilized interventionist techniques (i.e., primarily physicians in the treatment of patients and patients who failed to take responsibility for their own health) unnecessarily upset their natural bodily processes. For example, Anne and Dr. G felt that a cold was a natural process in that waste materials were eliminated from the body. Fasting rather than taking antihistimines
would aid this process more effectively. It was felt that one should resort to interventionist procedures only after the use of natural medical forms appeared ineffective.

The data indicated that for the most part, the notion of natural was primarily used in association with the physical dimension of health practices. Even those who were heavily involved in the spiritual aspects of health (Nancy, Pam, Rev. David, and Regina) seemed to use the term "natural" to refer to the physical. At times, the distinction between the natural and the spiritual was somewhat unclear, particularly since many of the respondents engaged in medical practices containing both elements. For example, while Dr. G administered certain types of treatments such as naturopathy, mechino therapy and vitamin therapy to his clients, he also helped some of them feel better with what was perceived as his altruistic personality. Regina, one of his clients, said that he was very spiritual but was quiet with it. She stated that she always felt better after seeing him even though she did not know what he did to make her feel better.

The term "natural" as used by the respondents had widespread application, and respondents differed as to what was or was not perceived as natural. Listed in Table 4 are examples of variation in usage of the term. In some instances, the term itself was not used; however, the context of the statement indicated that the concept of
<table>
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<th>Informant</th>
<th>Usage of Term</th>
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<td>1. Anne</td>
<td>I think, a fever is your body's way of healing itself.... As far as the fever itself, you know, I'll just do things to help that what I consider a normal body process. Drinking lots of fluids, trying to keep the channels of elimination open as much as possible to help the body cleanse itself. I stop eating you know (goes on fast).</td>
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<td>2. Nancy</td>
<td>There's a relief that comes when you relax.... A lot of people don't know that it's a natural thing for our bodies to do that.... Almonds are a whole food.... Someone will say 'I'm allergic to almonds.' Well then, stop eating for maybe a couple of days, and then start again on whole foods and they'll be all right.... If something's wrong in your body's system, you need to change what you're eating.</td>
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<td>4. Mary</td>
<td>Salt, it's natural by evaporation.... I like to use my salt when I'm cooking .... But I'm not scared of a little sodium. It holds water in the system. ... And I got to have a nice apple cider vinegar.... It gets the sodium out of your tissue.</td>
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| 5. Rev. T. David | Products (non-natural) with monosodium glutamate, sodium nitrate, sugar and salt. Sugar and salt is in just about every prepared food.... We had (when church owned a health food store) all kinds of natural juices and organically grown things: organically-grown raisins, granola, and stuff like that.... There's a well with pure water in the back of the church. The guy (drilling engineer)
hit pure water at a hundred feet, and it's still running pure. Never ran dry.

6. Pam
I don't get that junk food, and I don't get mixes.... I buy the plain, basic ingredients...whole grain cereals, and brown rice and those things.

7. Jean
I'm in favor of natural childbirth in the hospital.

8. Dr. G
Herbs are very, very helpful.... I think every herb, according to the Bible, every herb was put here for a purpose.
"natural" was realized by the respondent.

The use of the concept natural versus interventionist occurred at a greater frequency rate among some respondents than others. Those who were heavily involved in the use of unconventional alternative health practices for curative and preventive purposes (Anne, Nancy, Mary, Rev. David, Pam, Dr. G, Regina, Barbara, and Jim—see Table 4), showed a greater realization of the concept than those who were less inclined to use unconventional medical forms (Florence, Jean, Lorie, and Margaret).

5. Self Treated—Professionally Treated. While there is a group of medical practitioners clearly designated as "professionals" in our society, there are others whose status is somewhat dubious. These "unorthodox" or "alternative" practitioners may be perceived as "professionals" by various persons in that society. The data of this study exemplified this notion. For instance, two of my informants, Regina and Mary, thought of Dr. G as a professional. They indicated that they had always gotten good results from him, and they held him in high esteem. "He's a perfectionist and he runs everything meticulously; and he never talks about himself.... You never get out of there owing him anything.... So that's very good because it's a good reverse exchange." A biochemist (a secondary informant) in the community referred to Dr. G as his
family doctor, and like Regina and Mary, he expressed satisfaction in reference to Dr. G's services and treatment practices.

In this community, the term "professional" was an evaluative one with a host of positive connotations such as "conscientious," "trustworthy," "responsible," "pleasant," and "possessing some kind of specialized knowledge." One possessing this status indicated it through symbolic structures such as modes of dress, tools used along with other methodological procedures, and language used. The physical space that a "professional" occupied was replete with visual symbols that expressed something about her.

For example, Dr. G's office (two rooms with a private entrance located around the back of his home on the north side in the basement) had the trappings of a scientific medical office. In the front of his home, there was a sign that indicated to clients the location of the office. One went down a unit of steps to the outside office door that had a sign on it stating whether the office was open or closed. The waiting room was complete with soft music, cushiony chairs, carpet, and magazines to read. The inner room had a big desk that Dr. G used to perform various tasks such as writing up reports on his clients and talking to them. There was a chair beside the desk for the client to sit in. This room also contained filing cabinets with records of various clients and their medical histories,
insurance claims, and other materials related to his practice; diagnostic and treatment equipment, and medical literature on diet and supplements that he distributed to his clients when appropriate. Located on the wall were various certificates and degrees that indicated his medical training. Dr. G and his assistant (a male manual therapist) conducted seminars occasionally. He spoke briefly about a seminar they had had several months prior to the interview:

We do a lot of work for the state compensation.... Any job-related injuries, usually if it's in any plant that carries state compensation, they're covered for that. We have done a lot of work for them many years.... In a seminar we had a few months ago, they had a man that came up and spoke from state compensation. He said that our type of treatment gets people well faster with less expense. So they're gung ho on giving us all the work they can.

Most of Dr. G's clients have had their medical problem for some time. Occasionally he got some clients with acute conditions and/or recent injuries. In determining what course of treatment to follow with each case, Dr. G engaged in very formalized procedures during the diagnostic exam. He expressed some concern over doctors today relying too heavily on hi-tech equipment such as the x-ray to make a diagnosis. Dr. G went on to state that the x-ray as a diagnostic tool had its place in the practice of medicine.
For instance, a car accident victim who has sustained a fracture might suffer more damage by submitting to manipulation rather than an x-ray. In this case, as a medical document, an x-ray would be helpful to collect one's medical insurance. When serious injuries were sustained, Dr. G insisted that those clients have an x-ray "for their own benefit."

All of the alternative practitioners (those persons—Dr. G, Nancy, Regina, and Mary—received some amount of monetary compensation for the medical assistance they offered their clients) work out of their homes. In discussing the notion of the home being a symbolic environment of and for the self, Csikszentmihalyi and Rochberg-Halton state:

The importance of the home derives from the fact that it provides a space for action and interaction in which one can develop, maintain and change one's identity. In its privacy, one can cultivate one's goals without fear of ostracism or ridicule. The home is a shelter for those persons and objects that define the self; thus it becomes, for most people, an indispensable symbolic environment (1981:144).

Indeed, the home of those practitioners (Dr. G, Nancy, Regina, and Mary) whose medical philosophies are an integral part of their self concept served as the ideal physical space in which their beliefs were reinforced through the objects they possessed and those beliefs were openly
communicated to those who came seeking their assistance. For example, Nancy's moving away from the city and building a chalet in a rural, secluded, and serene setting was tied in with the development of her health consciousness and ultimately her present state of wellness that she had not experienced in the past. She credited her husband for making the chalet dream become a reality. Her responses to the questions "Describe an instance in which your family helped you to get well" and "How has your health changed within the last ten years" were tied in with her getting the chalet and doing the things she always wanted to do such as growing many plants, herbs, and fruit trees, having a place with a duck pond and a picnic area where people could come and relax, and having access to wide-open space and fresh air. She stated:

When I first came here, my legs were giving me trouble. In fact, I—that first winter, I wore men's elastic socks. Of course, on me, they were like knee socks. But—my legs hurt so bad. Now my activities, my activity and getting the oxygen inside me, I don't hurt. And I've been eating the good foods too. So for the last ten years, it's really been good to be out, to be here.

The notion of hospitality was expressed very strongly by the female practitioners Nancy, Regina, and Mary. It is uncertain as to how much my being female had to do with their generosity towards me and whether they would have
openly communicated this hospitable attitude towards a male researcher in the same way. For example, Nancy provided me with several bags of herbs to make teas from, free of charge upon my leaving. She also put some ice on a bee sting I received while interviewing her outside on a picnic table. Regina served me some cinnamon tea during the interview session. Mary offered to fix me something to eat and to put me up for the night since her interview ran late into the evening and I had to drive a fairly good distance to get back home.

Nancy ran a business located a few feet away from the back of where she sold dried flower arrangements, plants, wood pieces, herbs, and various other things. Many people came mainly to stroll around in the herb garden, take a walk over to the duck pond, or have a picnic. Nancy was home most of the time and one did not have to make an appointment to browse around on the grounds. She felt that the place had an energy of its own, providing the serenity and comfort people needed to handle stress. Therefore, she did not have to be there for the people to reap the benefits. People walked around the grounds when she was not home. She felt that people should "make themselves at home" whether she was present or not. She believed her biggest clientele was widows who often said that they wanted something like the chalet. The men who came there were often in stressful situations, feeling as though they were trapped
and might not survive; they often sat in the garden and
experienced some sort of rejuvenation. She felt that the
biggest problem her clientele had was that of stress.
Nancy thought that she helped them in very subtle ways, but
the dynamic that happened between the place and the indi­
vidual was how relief for them came about. She stated:

If I help someone release something,
anything, I try.... And I don't do it
by talking. I try to do it subtly.
They get more from here than just
purchasing something. There's more
to country than just the word 'country.'
Something to hold on to. Something to
value.... Those who do come out. It's
interesting. They come and they're
just exhilarated. And the men who come
sit down in the garden.

What Nancy did with her clientele seemed to be incidental.
People came often to make a purchase or just to window shop,
and in the process, some form of "healing" took place.

While the home is generally thought to be a very
private space for those who live therein, for the practi­
tioners of this study, the home was a treatment center, a
haven, reserved for a limited public who came to them for
assistance. Each home was personalized in that it contained
its own set of symbols that were relative to the practition­
er's beliefs about health.

Those who practiced unconventional medical procedures
often did not reveal this information to others to save face
and/or to protect their credibility. Knowledge of these
unconventional forms was vital to the participants' self concept and was a way of maintaining control over their lives from a holistic health standpoint that invariably became political. Since what these participants did often had little or no medical legitimacy in the scientific medical community which is the most powerful and protected under the law, they often had to "practice" underground, using the home as a place to heal and help those who sought their services.

The utilization of unconventional medical forms will continue to be a reality as long as those who practice them feel that the rewards outweigh the costs. Those who use these medical systems and derive a high level of satisfaction from them have invested their trust in them. These medical forms are often at odds with those of the scientific practitioners. However, those who are committed to the self-help alternative medical philosophy refuse to surrender their values by yielding to the scientific medical system.

6. Compatibility→Incompatibility. Parsons in his formulation of the practitioner-patient relationship model describes very predictable forms of behavior between the two units and sees the relationship as one analogous to that of the parent-child. Both cases involve the social control of a legitimate authority figure (parent or practitioner) over a dependent (child or patient); both are highly charged
emotional situations; therefore, the authority figure must protect his status distinction by maintaining a certain level of affective neutrality; and both have goals to help the dependent become a healthy, functioning member of society. This model contains the following misassumptions: (1) That people take on the institutionalized role of patient and do not remain individuals when encountering a physician; thus they all respond passively to this authority figure; (2) That all people expect the same thing from a physician and have a similar perception of what she should do; (3) That all physicians exhibit the same kind of behavior towards their patients (Wolinsky, 1980:99-121).

It is probably safe to assume that most people dislike being sick and many will utilize institutionalized medical resources if they feel the need to do so to regain their health. Although all of my informants perceived themselves as being well, they all had seen a physician at one time or another for assistance with various kinds of medical problems. Most of the informants (namely Anne, Nancy, Mary, Pam, Dr. G, Regina, Dianne, and Jim) expressed skepticism towards physicians in general, some to a higher degree than others. For example, Nancy stated, "Doctors are the biggest drug pushers." Pam said, "I've come to realize they don't know as much as I thought they would." Mary expressed vehement disillusionment with local physicians. "They give you pills, and they butcher you all up." Dianne felt that by
being an R.N., she had seen physicians make mistakes and that people in general were more trusting of them than she. This skepticism, to a large degree, was the result or experiences they had had in which the physician's treatment objectives were in conflict with the patient's expectations of the treatment.

While the remaining six informants (Florence, Rev. David, Jean, Barbara, Lorie, and Margaret) did not express an outright opposition to physicians in general as the preceding eight did, several expressed some level of concern as to whether physicians used the most appropriate treatment procedures in handling medical problems. For example, Barbara indicated a preference for utilizing self-help health procedures in the home over utilizing a physician's prescribed medicine. She stated:

The thing at our house now, to some people, you know, with a sore throat, you run to the doctor and see if it's strep. Or a 102 fever means it could be strep. And now, it's uh, 'let's do what we can so we don't have to go and get antibiotics'. Anything but antibiotics. Or, 'let's try not to go and have to get medicine. Let's see if we can't do it.' And we try to give our bodies time to do it on our own.

Rev. David said that he seldom saw a physician; yet, he had numerous examples about how God had healed him, family members, church members, his dog and different animals on his farm. These healing examples indicated that he had
encountered a number of medical problems, but he believed that they were resolvable through his having faith in God. He felt that physicians believed in this divine healing, but many of them would not admit it. "There's a lot of doctors believe. A lot of 'em believe in a higher power. They won't, you know, come straight out and say God heals, or Jesus heals".... Rev. David ideally would like to see all physicians openly admit to patients that ultimately God healed them, and that they (physicians) were only mediums for this divine healing energy. Margaret stated that she had the greatest admiration for physicians because they had to make so many important decisions; yet, she had become disillusioned with the scientific medical system in general in this country. She had experienced many frustrating situations while taking care of her invalid mother. She felt that GPs were not interested in geriatric cases and they did not make house calls. She had to discuss her mother's symptoms over the telephone with a physician at times. She stated:

My mother has not seen a doctor in two years.... They tried over the phone. You know the pressure that puts on the person phoning in the symptoms.... It's gotta change.... I would gladly pay by the minute for a doctor who walked in. I'm saying that any professional doctor can walk in and see a person and say to that person, 'Hey you go (to the hospital) now,' rather than me calling and giving the specifics. And it's got to come to this.
In looking at the criteria the respondents used to evaluate what physicians ought to do for patients (see Table 5), the alleviation of pain and discomfort seemed secondary to the communication of the physician's affective qualities to the patient. All respondents seemed more concerned as to whether they felt comfortable and at ease with the practitioner. They were interested in whether they could trust her and whether she would understand them. Pam concluded that it did not bother her if her physician did not know what was wrong with her as long as she (physician) admitted it. She stated:

This woman doctor I'm going to, um, I know that she's a dedicated Christian woman. And so, I believe that even though she's got a heavy case load that she really cares a lot about her patients. I feel that I could trust her. That doesn't mean she knows everything there is to know. As far as I'm concerned, it's okay with me if she says, 'I don't know what's wrong with you.' I would rather she tell me that than to lie. Than to say 'This is what it is' when she doesn't really know.... I know she's had good training. I mean, I wouldn't want a doctor I felt hadn't had good training too. But I feel like she does. In addition to that fact, I know that as a Christian person that she would be honest with me and would care about me.... I've gone to her at least twelve years.

The terminology respondents used to describe their ideal model of behavior for a physician was very similar to that used in the holistic medicine literature. Terms such as "trustworthy," "dedicated," "understanding," "caring,"
### Table 5: Criteria of Assessment for Medical Compatibility and Incompatibility

<table>
<thead>
<tr>
<th>Informant</th>
<th>Compatible Doctor</th>
<th>Incompatible Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anne</td>
<td>Does not give drugs unnecessarily; is caring; listens to patient; can diagnose properly.</td>
<td>Too inventionist. Administers drugs without knowing what he is doing; is impersonal; doesn't listen to patient.</td>
</tr>
<tr>
<td>2. Nancy</td>
<td>Tells you it's your diet that's causing you trouble.</td>
<td>Not natural (uninterested in nutrition); treats symptoms and not cause(s) of illness.</td>
</tr>
<tr>
<td>3. Florence</td>
<td>Is concerned and cares about you.</td>
<td>Doesn't get alarmed about symptoms quickly enough.</td>
</tr>
<tr>
<td>4. Mary</td>
<td>Doesn't fill you full of antibiotics and narcotics; tries to do it (administer treatment) in the home. Doesn't see your case as hopeless.</td>
<td>Writes up a prescription for pain killers.</td>
</tr>
<tr>
<td>5. Rev. David</td>
<td>Can diagnose problem; is knowledgeable; can treat a serious injury.</td>
<td>Is lacking in wisdom, knowledge, and understanding.</td>
</tr>
<tr>
<td>6. Pam</td>
<td>Is dedicated; cares a lot about patients, and admits when uncertain as to what is wrong with the patient; is interested in nutrition and the whole body; interested in keeping me healthy.</td>
<td>Administers ineffective treatment; does not allow patient's spouse in the room when treating her; is arrogant.</td>
</tr>
<tr>
<td>7. Jean</td>
<td>Explains things to patient.</td>
<td>Can't trust his medical knowledge because he doesn't keep up; uses medications excessively.</td>
</tr>
<tr>
<td>8. Dr. G</td>
<td>Grows up in an atmosphere of healing; is trustworthy.</td>
<td>Gives you medicine that makes you develop an adverse reaction; misprescribes drugs.</td>
</tr>
<tr>
<td>9. Peggy</td>
<td>Is a perfectionist; doesn't let you owe him anything; is spiritual and anti-medicine; is dedicated; is understanding; is a humanitarian.</td>
<td>Has a big ego; talks down to the patient; misprescribes drugs.</td>
</tr>
<tr>
<td>10. Barbara</td>
<td>Is kind and caring; practices natural medicine; asks questions that go beyond the last two days of my sickness; interested in diet and what I'm putting into my body.</td>
<td>Gives me something that is bad for the body. Can't discuss things with him.</td>
</tr>
<tr>
<td>11. Lorie</td>
<td>Can talk freely with him.</td>
<td>Can't trust diagnostic skills; does not do a thorough physical exam when needed.</td>
</tr>
<tr>
<td>13. Margaret</td>
<td>Knows how to make important decision; if GP, is interested in geriatric patients; is family doctor and a friend of the family.</td>
<td>Is unconcerned about patients.</td>
</tr>
</tbody>
</table>
and "knowledgeable" represented forms of behavior that would generate ideal therapeutic conditions causing the patient to experience optimum satisfaction. Based upon the data of this study, the ideal relationship between physician and patient was one of compatibility for several reasons: (1) it allowed for interpersonal openness between the two; (2) the physician was nonjudgmental towards the patient in terms of his medical beliefs; and the patient maintained a more active role in his health management; (3) he had reliable technical skills that did not conflict with or contradict other skills in which the patient had invested trust. This model emphasized practitioner and patient self-disclosure, i.e., patient A's communication of personal information to practitioner A and vice versa. This information might not be known or otherwise available to him. The affective qualities the physician communicated to the patient would undoubtedly influence the way the patient revealed information to him. According to some social penetration theorists, endogenous factors such as personality or dispositional qualities are significant motivational determinants of self disclosure in a social interaction situation (Altman, 1975:113). The importance of the practitioner's dispositional qualities in relation to patient self-disclosure was expressed in this data. For example, Regina felt that Dr. Simington of Texas who worked with cancer patients was a model physician. She felt that he combined his humanitarian
qualities with his medical skills. She stated that he began treatment by asking the patient "What's eating you up." This question is a very personal, pointed and graphic one with the use of the phrase "eating you up" as a metaphor for suffering. It encourages the patient to reveal his innermost thoughts. It also aids in putting the practitioner in the listener-type role, a situation which would facilitate patient self-disclosure. Dianne, the public health nurse, felt that many of her home health care patients revealed personal information to her such as various unconventional medical systems they might be using in conjunction with scientific medicine. Disclosure of such information could cause the patient to be reprimanded by some scientific medical practitioners. Dianne felt that she had to be a good listener. She stated that her patients were suffering (some with terminal diseases) emotionally and physically and had "gone through so much." Dianne said that she did not talk much about herself to her patients. She had tried it a couple of times but felt that this procedure did not go over well with them. She felt that they had many problems and needed someone to talk to. Research has shown that people are more willing to disclose information to a warm therapist who had moderate disclosure (Simonson, 1976).

A physician's behavior that fulfilled the patient's expectations might be viewed as rewards, while those
behaviors that produced a negative encounter between physician and patient might be termed costs. For example, those who utilized unconventional medical systems felt more comfortable with a physician who could at least tolerate those systems rather than one who was highly critical of them. Those who utilized alternative medical systems to a great degree would more than likely terminate their relationship (treatment) as quickly as possible with a physician or practitioner who exemplified behaviors totally incompatible with their belief system. For instance, Anne probably would not take her son back to the same dentist whom she felt administered inappropriate treatment to him, i.e., giving him medicine that made him drowsy, separating the mother from the child during treatment, etc. There may be different levels of compatibility between practitioner and patient. For example, Anne was very anti-medicine but felt very comfortable with several physician friends whom she perceived as being interested in the holistic approach to health. One of them did home birth deliveries and was instrumental in getting the birthing room at the hospital. Anne described the compatibility of their beliefs with hers in the following manner:

I'm most leery of anything interventionist. But my position is a little different too because I have two very good friends that are doctors and I know they're not going to do anything. They know how I feel, and they feel
similarly that they don't want to give my kids drugs unless it's absolutely necessary. And so they've (her kids) never had drugs except for him having that antibiotic once during the dentist surgery. So the medical profession itself, I don't have a lot of trust in it.

One of the rewards in disclosing personal information is to gain approval from the recipient. The cost of revealing oneself may be too much if the discloser is perceived in negative terms. Anne went on to talk about certain kinds of private information which were off limits to her physician friends. She stated, "I think they think some of the things we do are silly." One of them thought she would have to have surgery to remove the cyst from her breast. After learning from a second opinion that it was not as life threatening as her friend felt, Anne treated it with some herbs. She felt that her self-treatment was directly responsible for the disappearance of the cyst but did not express this belief to her physician friend for fear of being misunderstood or perceived in negative terms.

The data indicated that optimum patient satisfaction with a physician was contingent upon whether the attending physician was trustworthy, caring, and understanding. Such abstract qualities primarily involved the compatibility of medical belief systems of the patient and physician. Mis-trust and patient dissatisfaction resulted when these belief systems were at odds with each other. Those with a
greater propensity to use alternative medical procedures indicated a higher degree of incompatibility and discontentment towards the scientific medical practitioner than those who were minimally involved in using alternative medical strategies.

Conclusions

A fundamental activity of a local health system involves establishing criteria to evaluate medical strategies and alternatives, as well as the state of one's personal health and the health of others. This process is influenced by cultural attitudes and personal beliefs. It revolves around natives' reliance upon what ethnomethodologists would call the common stock of knowledge at hand. According to Garfinkel, natives' interpretation or management of such a world consists of their application of its properties (e.g., typicality, likelihood, comparability, etc.) to objects, events, and actions (Leiter, 1980:71-2). Consequently, frameworks emerge to determine the relevance of such objects, events, and actions.

One event that takes place in a local health system involves utilizing medical systems when a perceived need arises. Medical crises are a fact of life, and natives seek help from these resources to protect their health. What they expect to receive from medical systems often may not be realized particularly when they maintain a set of
beliefs that are in direct conflict with those of the medical resources they seek out. This notion poses some relevant questions. What are the natives' criteria for health assessment, and how are they applied to the health management process?

The data yielded two forms of evaluation occurring in a local health system: namely, personal and other health assessment, as well as the evaluation of medical strategies and approaches along with their practitioners. Both involved some level of role enactment defined by self and others. From the natives' perspective, both stood in relation to each other. More specifically, one's state of health was defined in reference to the frequency with which one utilized medical systems and practitioners, and the value of medical systems was determined by what they contributed or failed to contribute to one's health regimen.

In terms of personal health assessment, the data indicated that "wellness" much like "sickness" was a label referring to one's state of health based upon indicators such as symptoms or the absence of symptoms and one's ability or inability to manage his health. Wellness was connected to one's sense of identity possibly due to the infrequent illness episodes one had experienced during his lifetime or had recently undergone. Wellness was associated with independence and one's willingness to take active participation in her health management. This process was likely to involve
taking actions and making decisions that might be dis­approved by others at times. "Wellness" as a state might be possible to realize or maintain when one depended upon one's personal acumen and self or lay administered medical strategies rather than on the guidance of a scientific medical practitioner. Such strategies could include any­thing from exercising one's faith in a supernatural force, to getting involved in the fight to prevent the fluorida­tion of the local water system, to using herbs and "natural" treatment procedures for health maintenance and/or curative purposes.

The notion of self help and lay administered treatment procedures while connected to "wellness" and independence was also connected to the natives' categoric labelling of events and actions as medical and nonmedical. The sets of terms, including sick©well, healing©cure, intervention­ist©natural, and self treatable©professionally treat­able represented ways of looking at the notion of what is medical in relation to nonmedical, and ultimately what the domain of the scientific medical system is in relation to alternative medical systems, as well as the scientific specialist as opposed to the lay specialist. The notion of medical and nonmedical raised questions about place and setting in which treatment strategies could be administered, ways of obtaining medical knowledge, and ways of defining who is a medical specialist in relation to her services
rendered. For example, was a medical practice something administered over the telephone by a friend comforting one experiencing guilt feelings about her anorexic daughter? Was medical knowledge something one obtained through scientific, formal training or through other means such as divine inspiration, extensive reading of materials concerning alternative medical strategies, or apprenticeship, etc.? Was a medical specialist anyone who assisted another in some area of health management, including psychological, physical, spiritual, financial, etc.?

In terms of the evaluation of health systems, the data showed that those with a greater propensity to rely on alternative health systems for their health management maintained a more negative stance towards the scientific medical system than those who were less likely to rely on alternative medical strategies. That is not to say that those with a lesser inclination to use alternative medical systems were less healthy than those with a greater inclination. All felt that they were well.

The terms "compatability" and "incompatability" represented what natives perceived as relevant in relation to what a medical system should and should not do respectively. For example, according to the data, one of the goals of a medical system should be to generate trust and understanding between the practitioner and client. This criterion referred to the types of communicative processes
that materialized during the diagnostic and treatment phases of the practitioner and client encounter. Based upon the data, the practitioner might gain the client's trust and confidence by conforming to the following types of behavior: be a good listener in an effort to reveal some degree of toleration for the client's beliefs even though they may conflict with his; indicate a moderate level of self disclosure, i.e., to not be reluctant to admit his uncertainty about a case; and exhibit competency during the diagnostic and treatment stages. The latter type of behavior particularly raises some important questions about what a practitioner should do to aid a client in the health management process. Should he provide information about diet? Should he see nutrition as a vital aspect of the therapy he offers? What types of coping strategies should the practitioner provide (e.g., in Mary's situation, "doesn't see your case as hopeless")? Ultimately the terms "compatability" and "incompatability" represent the problem of conformity, i.e., to what degree a medical system should or should not comply with a client's wishes and expectations.
NOTES

1This philosophy is elaborated on in a section entitled "Science, Theology, Medicine" in Science and Health, Mary Baker Eddy (Boston: The First Church of Christ Scientist, 1971) 107-164. The Christian Science Organization founded by Mary Baker Eddy who after a long bout with an illness and the loss of her first husband and brother claims to have received a physical healing and a spiritual revelation when reading an account of Jesus' healing of the paralyzed man in the Gospel of Matthew. A fundamental belief of the organization is that one's mind is the origin of one's pain and suffering. Believers feel that the early Christian church healed originally, but systems of medicine have led us to put confidence in matter, drug therapy rather than in Deity, the Divine Mind. One's quest for good health involves an intense reading of the scriptures along with a soul-searching process that ultimately leads to a heightened spiritual level.

2This description was first used in Talcott Parsons' classic definition of health which was a pioneering attempt to redirect the sociology of health field away from the biomedical notion. See Wolinsky, 1980:72-75 for an elaboration of Parsons' model.


4This form of healing is similar to that of the curanderos in the Mexican-American culture where common items from the everyday world are employed including animals, species, flowers and herbs etc. during the material level of treatment. For a discussion, see Robert T. Trotter II and Juan Antonio Chavira, Curanderismo: Mexican American Folk Healing (Athens, Georgia: University of Georgia Press, 1981) 73-101.

5Cassell goes on to state the reasons why people in pain disclose their degree of suffering. Such information
is more likely to be revealed when the person feels out of control, the pain overwhelms him, the origin of the pain is unknown, the meaning of the pain is frightening (indicator of terminal disease), the pain itself is chronic.

Although Rev. David performed many tasks during the church services such as praying for the sick and counselling those who sought his advice, these services, while normally conducted at the church, did not necessarily have to be performed there. They could be conducted in his home and various other locations whenever the need for them arose. While I do consider him an alternative practitioner, I did not observe him practicing out of the home. His interview was not held in his home because he did not live in Johnson City. It was more convenient to schedule an appointment with him at the church.

Nancy was not directly reimbursed for her services rendered. Clients who came to the chalet often purchased something such as a dried flower arrangement. By their strolling around on the grounds, some form of therapy was often realized. However, Nancy was never compensated directly for providing the environment for this process to take place.

Another example where the home serves as the ideal physical space in which to reinforce medical beliefs would be that of homebirths. One study conducted by a State Health Department (the state in which this study was conducted) indicated an increase in home births during 1982. Many of the women expressed that a negative hospital birthing experience was a determining factor in their decision to have a home delivery.

It should be noted that some clients might develop trust towards a practitioner if she relieved his symptoms indicating some degree of competency and skill. Others such as Barbara and Pam would tend to distrust a practitioner who merely offered immediate and/or temporary relief from symptoms and did not attempt to get beyond them.

Frequency of utilizing the practitioner's services might have a lot to do with how relevant the establishment of trust between practitioner and client is. If a practitioner were to be seen on a regular basis, getting the client's confidence would be very important. However, if it were a specialist that one rarely needed to see, trust might be less significant.

Research has indicated that personal disclosure from a paraprofessional is acceptable and facilitates disclosure by the subject, but is unacceptable from a professional and inhibits disclosure by the subject. Demographic disclosure
CHAPTER VI

CONCLUSIONS

This study has documented various self help and alternative medical strategies that are meaningful in the lives of some who are committed to making choices related to their health. What is significant about these choices is that they involve trust. Any medical system that fails to yield the desired results or benefits may be viewed with dissatisfaction, suspicion, and/or contempt. People make commitments to a medical system based upon its pragmatic value and relevance to their health management process. These commitments more often than not involve the application of common sense reasoning, acquired knowledge through first hand experience, reading, membership into some self-help groups, etc. At this point, a further elaboration of the people in this research sample would be useful.

Part of their self-concept stems from their involvement in medically related activities. According to some scholars, one's sense of identity (used interchangeably with self-concept) is derived from a number of different sources; however, one's capacity for reflexivity is a precursor to his sense of identity (Scheier and Carver, 1980:231). One
with a high level of private self consciousness or reflexivity is very much aware of his bodily sensations, beliefs and feelings (Scheier and Carver, 248). In daily activities, he tends to be introspective and attentive to things that happen to him. A statement such as "I'm always trying to listen to my inner feelings" is indicative of his inner quest.

Many of my informants, particularly those with a high level of commitment to alternative medical procedures, perceived themselves as exhibiting the above kind of behavior. For example, Nancy described a past illness episode commenting on its relevance to her present medical framework. This example is one representing what might be called her pre-health consciousness stage.

When we first came here I was having problems, but I had a partial hysterectomy.... The doctor told me I was hemorrhaging. If I look back on it... I could have helped myself. I hadn't got that far in my thinking. About a week later he said I needed a hysterectomy.... My body was taking care of me because he went in.... He went in but somehow he couldn't get to the left ovary.... I kept thinking, 'why couldn't he go through?' He couldn't take that one out. Well, if you're left with one you're not to have a total loss. So my body was protecting me by keeping it. He was determined to take it. Because he thought anything that might get a cancer he would take out. He convinced me at that time. He wouldn't convince me now.... I insisted that I be well.
According to Scheier and Carver, one constructs her personal history by recognizing a specific set of life events that have happened to her over time. This notion of continuity is another factor that helps one to formulate her self identity. The selected sequence of events is unique and is recognized as happening to no one else. While each of us may experience some continuity of the self, the set of events one's life is centered around is different providing a partial framework from which she may view her uniqueness. Note how Nancy recognized a change in her medical beliefs over time, stating that the physician convinced her she needed to take radical measures to correct what he perceived as some sort of organ malfunction. "I could have helped myself. I hadn't got that far in my thinking." Her present belief that her body works for her good was something that she had to come to discover over the course of time.

All of my informants indicated some type of criteria by which they embraced the notion that they were well. For many, like Nancy, it was a noted change in their ways of thinking about their health. Reference was made to some type of illness episode they personally had experienced and/or a significant other had. Some felt that at the time the event occurred, they did not have a handle on things, meaning they lacked the control over their health that they presently perceive themselves as having. Only one (Lorie)
felt that she herself had not experienced any significant illness episode in her lifetime. She stated, "I'm not really sick that much. I haven't been sick where I've missed work.... I haven't had the flu or a cold or anything that required medication." Lorie did make reference to her twin sister who, unlike herself had experienced no major incidents of sickness, had undergone many medical crises.

Even back in junior high and high school I never had like mono or anything like that. I have a twin sister who had everything. She had mono and pneumonia.... Chicken pox was probably the worst thing I've ever had.... I never had stitches or anything.

Even though Lorie personally had no major episodes of sickness she had experienced to compare with her present state of health and how she felt about the topic, she, like the others, expressed a noted change in her health behavior. Her change was perhaps more recent than most. She stated:

Well, I recently gave up chocolates. I'm glad I did that because I didn't need the caffeine. Lately I've been having a lot more fruits and vegetables and things like that instead of eating junk food. I've been trying to cut things out like that....
This notion of wellness the respondents described seemed to be some sort of lifestyle to which they were committed that required a conscious effort on their part to maintain. Regina stated that she enjoyed being around people who felt the way she did about the mind being a healing agent. "The thing I like from others is their high thinking and their good vibes." Anne believed her present lifestyle that centered around her commitment to health maintenance was innate and something she first felt as a child when she went to the mountains. She lived in the Appalachian mountain region when she was seventeen. She learned a great deal about alternative medical systems in this environment and "got into a lot of different facets of healing." She discussed how she later went through a period where she used drugs and smoked cigarettes excessively. When she gave up those habits, her health and lifestyle changed completely. "I did a lot of fasting. I was real involved in my nutrition." Her present commitment to health was something that evolved gradually. It was some sort of force whose presence she realized as a child, but strayed away from for a period of time, and then later embraced.

I really think it was in me. From the time I was a little girl the first time I ever went to the mountains, I knew that was where I was going to go as soon as I could. And so I did. It all just sort of came with that whole thing (going to the mountains). I think it (the
health commitment) was a gradual process.

The notion of identity is complex and one that merits further exploration in this study. Its definition seems dependent upon sameness and distinctiveness (Dundes, 1983: 237; Jacobson-Widding, 1983: Intro; Vallacher, 1980:23), both of which may refer to an individual or her personal identity as well as a group or a collective identity. Personal identity seems to involve consciousness and continuity, that is, one's awareness of her existence through time and space, examples of which appear in the above four narratives of the respondents. For instance, Anne reflecting on the development of her health consciousness, saw her trip to the mountains when she was a girl as the initial factor that helped to shape her medical beliefs and her commitment to holistic healing principles.

One of the things this study seems to be about is sameness and distinctiveness, how people go about selecting and rejecting or discarding criteria in their relation to health care. Essentially health care involves the process of selectivity and repudiation in regards to medical systems, beliefs and values. While the group of this study is not homogeneous like an ethnic or religious group, there might be some sort of "sameness" and "distinctiveness" quality about it in relation to a collective identity. The "sameness" involves the shared criteria they use to select which
medical system to utilize for what problem (see Table 1, p. 118 and Table 2, p. 127), as well as which doctor to accept as providing satisfactory services and which doctor to reject altogether for providing inadequate care (see Table 5, p. 234). Selectivity is very important to this group of people in determining what it is they do in relation to health care. The "distinctiveness" of this group also involves the use of criteria and how they (namely those having a greater realization for alternative medical systems) make an effort not to be what they perceive the scientific medical practitioners to be, i.e., too interventionist, not "natural," and uninterested in diet therapy. These criteria are not constant but something that must be negotiated as they move back and forth between medical systems. In a sense, it is the continuous process of assimilating new ideas while rejecting or modifying old ideas, that help to validate their medical beliefs and values. The end result or product is their wellness that they claim which is an integral part of their self concept.

The respondents of this study might be thought of as those who place a high value on presenting themselves as well. This notion is certainly in line with some of the wellness symbols of this society such as the Pepsi Generation commercials. The sick and disabled are rarely if ever used to promote a product. Wellness is a cultural term.
that represents a way of thinking about one's health. For the respondents, being healthy and well means much more than being free of disease. It is the commitment to a lifestyle that involves making very specific choices.¹

As stated earlier in the study, what these people do might in some way be related to the growing world-wide self-help movement. With the self-help health model, the traditional distinction between caregiver and client is blurred. Help is provided by those who are in the system with similar needs. The helper derives satisfaction and achieves therapeutic results when he offers his service. Groups such as Alcoholics Anonymous, Overeaters Anonymous, Parents Anonymous, and SAGE (Senior Actualization and Growth Explorations) offer help for problems traditionally in the domain of professional therapists.²

This form of aid raises some questions about the notion of professionalization and how much of it is necessary for clients to derive an adequate level of satisfaction from treatment procedures. Professional health systems place a high value on specialization and assume that high-level skills are necessary to provide effective therapy. The positive results coming from many self-help health groups challenge this notion in a way similar to that of the self-help medical behavior this study explores. The nonprofessional as a therapeutic agent under the self-help model has unique skills unavailable to the professional that
she has acquired from having direct experience with a particular problem (Bliwise and Lieberman, 1984:229).

Certainly, there are inherent dangers in moving away from professionalization altogether. Some degree of control is necessary in health care. We cannot afford to return to the time when every person was her physician. There are some medical problems such as myocardial infarction, bacterial infections, and some respiratory disorders that must be attended to by a formally trained specialist. It is uncertain as to what problems the laity can or cannot handle. The lay helper remains a powerful resource that needs further exploration and to be given some legitimacy relative to the health services he can provide.

Scientific medicine's claim of dominance over health care management is sanctioned by powerful institutions. However, a cultural analysis of lay medical beliefs and behavior indicates that this claim is unfounded. Medical behavior is complex and encompasses much more than the treatment of disease. Self help strategies and alternative medical systems are meaningful resources utilized in the health management process and deserve further scholarly attention.
NOTES

1 A contrast to this notion of healthy would be that of the Spanish-speaking villagers of northern New Mexico and southern Colorado. Health indicators consist of (1) vitality; a high level of physical activity; (2) plump; a well-fleshed body; (3) free of pain; and (4) alert, friendly and a happy disposition. See Sam Schulman and Anne M. Smith, "The Concept of 'Health' Among Spanish-Speaking Villagers of New Mexico and Colorado," Journal of Health and Human Behavior, Vol. 4 (September, 1963) 226-234.

APPENDIX A

INTERVIEW QUESTIONNAIRE

1. Describe what you do when there's an accident around the house.

2. Describe what you dislike the most about being sick.

3. Who do you go to for advice about your health and well being? What do you ask them?

4. Describe an instance in which your family, friends, and/or minister helped you to get well.

5. When do you need the doctor the most? How often do you go to the doctor?

6. What do you trust most about the doctor? Least and why?

7. When you go to the doctor, what do you expect to get from him?

8. Describe an illness you had some time ago.

9. What are some illnesses you have learned how to treat? How did you learn how to treat them? Who do you share this knowledge with?

10. Is there anyone ill in your house? If so, describe the nature of their illness. What do you do for them?

11. What do you have around the house to help you recover from illnesses? What resources are available outside your house? What health resources do you use outside of the city and why?

12. What do you do to stay as well as possible?

13. What do others in your family know about health/illness?

14. What are some old health secrets you believe in?

15. What medical topics are you most interested in and why?
16. What types of health literature do you read and why?

17. Describe an ailment that you suffer with frequently.

18. Describe something you always go to the doctor for.

19. Describe something you always treat at home.

20. How does your insurance help you through your sickness?

21. Describe a healing experience from beginning to end that you will never forget.

22. Do you pray when you are sick? If so, what are some things you pray about?

23. Have you ever heard of anyone getting healed in an unconventional way? If so, how did you feel about it?

24. Do you believe in divine healing? If so, why? If not, why not?

25. Have you ever made any promises that you would fulfill if you were healed? Describe the nature of the promise. Did you fulfill the promise?

26. Describe something others (friends, minister, etc.) always help you with.

27. What is something you always help others with?

28. When you are a patient, what are some of the things that are difficult for you to cope with?

29. What health movements do you know about and are interested in?

30. Describe your responsibilities in terms of taking care of others.

31. Do you think of yourself as a person in need of care or a person who gives care?

32. Who should regulate the use of legal drugs and who should not?

33. What kind of health problems should be treated at home?

34. When should you go to the doctor?

35. Where should people have babies?
36. If you were hooked up to a life support system, what would you like people to do?

37. What health resources were available to your grandparents and parents? What kinds of remedies did they use around the house? Do you use them today?

38. What medical changes do you know about in this city? What type of medical changes should be made in this city?

39. How has your health changed in the last 10 to 20 years? How has this change affected your life?

40. Describe some health-related problems people come to you with. What do you tell them? Who comes to you the most with health-related problems?
APPENDIX B
INFORMANTS' PROFILE

1. **Anne M.** Health food store owner at the time the interview was conducted; currently no longer the owner. Food co-op member. Has had home birth. Believes strongly in natural cures. Studied under an herbalist while living in the mountains in Kentucky.

2. **Nancy D.** Herb farm with a Swiss flavor, a chalet. Home most of the time; people come and browse around, have picnics, and/or buy goods such as dried flower arrangements, wall hangings, and herbs. Believes firmly in good nutrition and being out in the fresh air as much as possible. Grows a number of different herbs; however, tends not to focus on their medicinal properties for herself.

3. **Florence T.** An R.N. Works part-time for a surgeon. Patients give out wart cures to her and surgeon at the office. Has daughter with anorexia nervosa. Interested in hospice and the terminally ill. Believes in getting an adequate amount of sleep (eight hours per night) to stay well. Takes vitamins. Controls her children's activities so they do not get overly tired.

4. **Mary Z.** Suffered with osteo-arthritis for some time. Eventually turned to Eastern meditation; has a guru. A massage therapist. Claims to have coined the term "auto-shiatsu" (Shiatsu is acupuncture without needles. Autoshiatsu means to massage oneself with the fingertips in areas in
which acupuncture is applied.). Integrates shiatsu, hatha yoga, massage therapy, polar therapy, and reflexology in her health program. A member of the American Society of Clinical Pathology.

5. Rev. T. David
Faith healing minister. Uses oral tradition preaching style. Ministry includes praying for sick and those in need. Believes strongly in the notion of prayer and the point of contact. Sends out prayer cloths and blessed water to those on mailing list. Worked under a faith healing minister of national acclaim. Currently runs the church while head minister is away. Is a musician.

6. Pam C.
She and husband make and sell wooden games. Belongs to folk dancing group. Once belonged to Edgar Cayce prayer group. Believes in faith healing. Knows of several instances in which others have been healed through her prayers. Strong interest in nutrition. Family history of migraine headaches.

7. Jean R.

8. Dr. G.
Manual therapist who mainly sees people with lower back and cervical problems, headaches, and lumbar-satic conditions. Handles a lot of industrial injuries. Has a degree in naturopathy and machino therapy. Interested in psychic phenomena.


11. Lorie N. Pharmacist. Has worked at a local discount pharmacy for four years. Health has always been good. Never had stitches. Takes medicine as last resort. Skeptical about herbal medicines.

12. Dianne T. Public health nurse. Involved in home health care program for nine years. Decision making process often involves listening to the patient in the home and taking a physical assessment. Sometimes has to resort to unconventional methods of health care such as making a bedside table or using a clean paper napkin. Can't use true sterile techniques in home because it lacks medically structured environment of hospital.

13. Margaret C. Science teacher who has been taking care of aged and disabled mother ever since 1974, just two months after her father died of cancer. From a small, wealthy, Irish Catholic family; only other living person in family is a cousin. Costs $25,000 annually to take care of disabled mother in home.
Seventy-five years old. Native American background. Lives in senior citizens' building. He and neighbor friend dig roots along various county roads. Learned about herbal medicine from his Indian grandmother. Uses golden seal for a lot of things. Believes reddock is best blood medicine. Wife died of cancer recently; she could make warts go away. Lived in hills of Tennessee. Wants to relocate there. Comes from a family of bloodstoppers.
APPENDIX C

THE OHIO STATE UNIVERSITY
PROTOCOL NO. 83B0094
A GENERAL DESCRIPTION OF A STUDY ON
HEALTH ATTITUDES AND PRACTICES IN A LOCAL HEALTH SYSTEM

This study examines the local health system in terms of what people do to combat a health crisis and/or to prevent one from occurring. Oftentimes a health crisis occurs in the home. The study will explore how family members, friends, and others in the community are involved in resolving this crisis. In other words, what health problems do you let your mother, uncle, sister, friend, or minister handle, and what problems do you let the doctor handle? If you were terminally ill, would you be more likely to rely on self-help and/or unconventional treatments, or would you rely on the doctor for treatment of your illness? Is a physician someone you see after self-treatment practices fail or someone you see while you are using self-treatment techniques? What do you perceive as health alternatives (past and present) in the community? Who are the local healers? When do you go to them and what do you expect from them? How do you go about selecting one healer over another?

In addition to examining self-treatment health techniques and who you go to for various problems, this study will explore your role in administering aid in a health crisis. Who comes to you for what kind of problems? What part do you play in helping someone through a health crisis and helping someone to prevent one from occurring?

This study is also concerned with how you categorize health problems. For example, is catching a common cold a typical health problem for you, or a rare one for you personally but something typical for your friends and family? Do you see allergies or tension headaches as something you have to put up with and something you can best treat yourself? Is a bee sting less serious than a back ailment?

The way you categorize health-related problems has a lot to do with how you have experienced illness. From your varied experiences, you have obtained some level of medical knowledge. This study wants to examine to whom and how this knowledge is passed on in the community. For example, if
a friend of yours hurt her toe, how would you talk about this problem to her? Would you tell her a story of a similar personal experience in order to show her how she might resolve the problem and to encourage her, or would you just give her straight advice on how to make the toe well again?

Participation in this study is strictly voluntary. All participants will remain anonymous and the actual name of the community will not be cited in the study. No data from personal files will be used.

Interviews will be scheduled at the participants' convenience. Taping of interviews will be done only with the participants' permission. The tapes will remain in the researcher's possession and will be logged according to topics. Photographs of participants might be taken but only with the participants' permission.

All participants will receive a copy of a description of the study and consent forms for participation.

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