HEALTH CARE DECISION-MAKING AS A CONTEXTUAL PROCESS

Anthropological Approaches to the Study of Choice in Medically Pluralistic Societies

by

Bradley Philip Stoner

A Thesis submitted to the Faculty of Graduate Studies
and Research in partial fulfillment of the requirements for
the degree of Master of Arts

Department of Anthropology,
McGill University,
Montréal

August, 1984

ABSTRACT

Medically pluralistic societies offer a variety of treatment options to health seekers; decision-making leads to the selection of one or several alternative therapies. Health seeking is a processual phenomenon, for it involves the acknowledgement of symptoms of disorder in social and cultural contexts, and the subsequent choice of treatment in response to this perception. Health problems are recognized in an environment of contact, communication, and interaction with other persons in a social network. These "significant others" affect choice of health care by offering advice and recommendations concerning the most appropriate course of action. Formal models and quantitative analyses, which seek to clarify important factors or determinants of choice, distance us from a true understanding of the meaning of health care decisions by decontextualizing the decision-making process. While potentially valuable for the discovery of generalities and patterns of use, quantitative studies describe, rather than explain decision-making; this approach may complement but not replace in-depth analyses of decision-making at the individual level.

RESUMÉ

Les sociétés pluralistes dans le domaine médical offrent aux personnes en quête de soins sanitaires une variété de possibilités dans le choix des traîtements; le processus de décision conduit à la selection d'une ou de plusieurs options thérapeutiques. La recherche de la santé est un processus, car elle implique la reconnaissance des symptômes à l'intérieur de contextes socio-culturels, et le choix subséquent d'un traîtement en réponse à cette prise de conscience. Les problèmes de santé sont perçus dans un milieu d'interaction avec d'autres personnes à l'intérieur d'un réseau de contact et de communication sociaux. Ces autres personnes affectent le choix des thérapies en prodiguant des conseils et des recommandations quant au processus le plus adéquat. Les analyses statistiques et quantitatives, qui visent à mettre en lumière les facteurs importants et les éléments determinants du choix, ne nous permettent pas de nous élever à une véritable compréhension de la signification des décisions en matière de santé parce qu'ils placent hors contexte le processus de la décision. Bien qu'elles soient potentiellement valables dans la découverte des règles générales et des modèles d'utilisation, les études quantitatives décrivent, plutôt qu'elles n'expliquent le processus de décision; cette approche peut complémenter mais non remplacer des analyses en profondeur du processus de décision au niveau individuel.

ACKNOWLEDGEMENTS

Several persons have provided immeasurable assistance in helping me see this project to completion. First and foremost I wish to thank my thesis adviser, Prof. Margaret Lock, who introduced me to the field of health care decision-making, and the members of my committee, Profs. John Galaty and Michael Bisson, for providing insightful comments and thoughtful suggestions at every stage of the thesis development. I am grateful to have had the opportunity to work closely with these dedicated individuals.

At Indiana University, Dr. Bernice Pescosolido provided helpful comments and enlightening discussions on an initial draft of this thesis, Dr. Debra Schumann offered suggestions on a preliminary version of Chapter II, and Patrick Laude kindly offered assistance in translation of the abstract; I greatly appreciate their help.

I also wish to thank Dr. Nancy Waxler for furnishing unpublished data on decision-making in Sri Lanka, and Dr. Allan Young for stimulating conversation and suggestions for future research in this area.

Support for my study in Montréal in 1981-82 was generously provided by a William Lyon Mackenzie King Scholarship.

I would like to express my sincere gratitude to my parents Morris and Joan, sister Madelyn and brother Robert, for their full support of my studies at McGill, and for their faith in my efforts to complete the thesis.

Finally I wish to thank the one to whom I owe the most, my fiancée and confidante, Leslie Wright, who continued to stand by me during the long days and nights of writing and revising with confidence in my ability to persevere, and whose intellectual and moral support I greatly cherish.

TABLE OF CONTENTS

Introduction

In recent years, anthropologists have become increasingly concerned with decision-making processes and choice of health care alternatives in medically pluralistic societies. This interest is reflected in a rapid expanding body of literature on health care choice in cross-cultural perspective. From early studies of the differential use of health care resources in developing societies (Erasmus 1952; Gould 1957; Foster 1958), to analyses of "hierarchies of resort" to various treatment methods (Schwartz 1969), to investigations of decision-making in terms of individual cognition and reasoned, patterned behavior (J. Young 1981), anthropological approaches to the problem of medical choice have stressed the need to examine and interpret the decision-making process in light of the social and cultural environment in which illness is experienced, and in which any choice of health care alternative is made.

Most, if not all societies are <u>medically pluralistic</u> (Leslie 1980) and thereby offer a series of alternative therapies or modes of treatment to which persons may turn in times of illness in an effort to achieve the restoration of health, a healing of the illness. The multiplicity of medical options, representing a variety of philosophical and historical bases of treatment methods or medical "systems" (Press 1980; see Chapter I below), provides a number of distinct and separate choices of health care at the level of the individual, and decision-making studies seek to discover the logic of such choices within pluralistic settings. In a pluralistic context, allopathic or biomedical alternatives are often optional, rather than normative. Persons can and do turn to a wide variety of health care alternatives, including "traditional" or "folk" therapies, or self-treatment of illness at home. In this thesis I argue that the onset and perception of an illness leads to a process of decision-making with regard to these many possible courses of action. Decision-making is indeed a cross-cultural phenomenon, and from an anthropological perspective it is important to consider how it is manifest in a wide variety of cultural settings. How does an individual in Sri Lanka, for example, decide whether to seek help from a biomedical practitioner or an Ayurvedic physician (Waxler 1976; 1984)? What factors influence the choice of espiritista or psychiatrist among Puerto Ricans living in New York City (Garrison 1977)? Indeed, what is the "pattern of resort" exhibited in South Kanara, India, for the treatment of disorders by biomedical or traditional healers (Nichter 1978)?

These questions are of major importance to the anthropologist seeking to understand the nature of health and illness within a community, how health problems are perceived and acted upon, and what they represent not only to persons who suffer them, but also to other members of society who are affected by the illness of a friend, family member, or relative. In terms of its impact upon daily patterns of behavior and fulfillment of obligations to family and community, illness is a disruptive experience. By threatening the very life of the individual, illness seriously compromises the integrity of social networks of interpersonal communication and interaction; for this reason, the need to bring about an alleviation of the disorder is strongly felt by other persons in such networks with whom the ill individual is involved.

Decisions are made at many different levels and at different times throughout the course of an illness in efforts to restore a normal level of functioning, both biophysical and social. Symptoms must be expressed and understood (am I ill?), accepted by others (is he/she ill?) and acted upon in accordance with these interpretations (what should be done, what decisions should be made?). In this sense, medical decision-making involves not only the choice between traditional healer or biomedical physician but includes all aspects of illness behavior (Mechanic 1962, 1978), from the decision that one is "not well," to the decision to solicit the opinions of others, and only then to the decision to seek formal help from one or another health care resource.

Such an emphasis upon the processual nature of choice takes into consideration the temporal element of the illness experience, that a person's health status is continually being redefined and reinterpreted from day to day, and that new decisions are formulated in response to the progression of the illness itself. Furthermore, the study of decision-making from this perspective emphasizes the very social context of the illness experience and the social nature of being "sick" (Frankenberg 1980; A. Young 1982). The choice of health care involves consultation and negotiation between the affected individual and other persons within the social network and thus cannot be understood outside of this frame of reference.

An anthropological approach to the study of decision-making in medically pluralistic societies is valuable not only from an academic standpoint, however, but from a practical one as well. The understanding of the contextual nature of the decision-making process and the social formation of illness and healing can contribute to the development of a health planning policy at a national level which acknowledges the efficacy of a variety of healing methods and does not seek to eliminate the use of treatment alternatives which lie outside the biomedical model. Following Nichter (1978, 1980), I propose that the continued investigation of illness behavior and medical choice from an anthropological perspective is necessary in order to demonstrate the limitations of biomedicine as a healing method and to promote the enlightenment of public health officials and government policy planners who fail to appreciate the value of plural medicine.

Thus, in my investigation of health care decision-making I hope to demonstrate the following points:

1) The concept of medical pluralism is best considered in terms of a variety of health care alternatives, rather than a multiplicity of medical "systems."

2) Decision-making is a social process, involving many other persons within a social network who interact with the individual seeking health care and who offer advice, suggestions, and recommendations concerning health care decisions. Health seeking is rarely an action taken by the individual alone.

3) Decision-making in pluralistic societies is environmentally contextual -- different episodes of illness are associated with different social, psychological, and economic circumstances, and these highly variable factors affect the course of action taken by the health seeker.

4) Anthropological studies of medical pluralism provide insights into the important sociocultural context of both the illness experience and the healing process. Quantitative analyses of health care decisions, while widely popular in sociomedical research, often serve to decontextualize the highly contextual process of decision-making by considering choice of treatment as a static event, rather than a dynamic and interconnected series of events. The identification of key factors or determinants of choice through quantitative methods may be useful to describe existing patterns of use in a community, but such research alone may not adequately

explain the meaning of health care decisions to the persons who make them. In this regard, quantitative studies are complementary to, but not a replacement for intensive case studies of help-seeking in particular microenvironmental contexts.

5) Research concerning the socially contextual aspects of decision-making in particular areas of the world can be of value to health planners and government officials seeking to promote effective delivery of health care, and anthropologists researching these issues can make important contributions toward the improvement of such delivery. Anthropological investigations support the assertion that biomedicine may never fully replace or displace "alternative" treatments, since many different treatment methods can aid in the healing process.

6) Anthropologists must carefully consider the <u>ethics</u> of studying health care decision-making, in light of the possibility that information derived from such studies may be used inappropriately by health planners to promote biomedicine at the expense of alternative or traditional practices.

It is toward the documentation and support of these ideas that the thesis which follows is directed.

Chapter I. Medical Pluralism: Toward an Understanding of Medical Systems

In this chapter I will examine the concept of medical pluralism and its relationship to the study of health care decision-making cross-culturally. Anthropological investigations of pluralistic medical practices have shown that the existence of many different health care alternatives within societies is the rule and not the exception (Leslie 1976, 1980). These alternatives are generally held to represent various "systems" of medical practice and ideology, each deriving from a separate historical and philosophical basis and each providing a different mode of treatment for the individuals who resort to them. Indeed, the "comparative study of medical systems" (Kleinman 1978; Janzen 1978a) is a major research interest within medical anthropology, and for the issue of decision-making it is important to consider the pluralisitic medical context in which any process of choice takes place.

The question of "what is" or what constitutes a medical system (Press 1980) is extremely problematic, for in defining and conceptualizing different systems of belief and action the presupposition is made that such distinctions are necessarily relevant to the persons who choose from among various medical options within a society. Nevertheless, it is useful to examine how previous authors have viewed the problem of decision-making in terms of the medical "systems" which exist within pluralistic societies. I hope to demonstrate ~~that~~ the definition of such systems is perhaps less important than the clear and focused study of the medical alternatives to which people turn in times of illness. The aim of the fieldworker is to uncover why and how the decision to utilize one option over another is made, rather than to develop a taxonomic classification of alternatives or to delineate which practices correspond to which system of medical theory and ideology.

"Traditional" vs. "Modern" Systems

A popular distinction is made in the literature between what can be termed "traditional" medical practices and beliefs on the one hand, and "modern" biomedicine (variously labelled Western, cosmopolitan, allopathic or scientific medicine; see Hahn and Kleinman 1983) on the other. Fabrega and Manning (1979:41) define a "medical care system" as

> "the constellation of beliefs, knowledge, practices, personnel, and facilities and resources that together structure and pattern the way members of a sociocultural group obtain care and treatment of illness."

These authors suggest that essentially two polar medical care systems can be identified across the world, "folk" and "Western biomedical." Folk systems can be thought of as local, indigenous, or traditional health care practices which have evolved within particular cultural settings and which, until recently, provided the sole source of health care for most of the world's population. Western biomedical practices are held to be based upon the principles of modern science, in which the concepts of health and illness are viewed in terms of the organic, biological constitution of the human body. This view is further supported by Good et al. (1979:141), who hold that:

> "basically, there are two systems of health care in the developing world: one is traditional and prescientific; the other modern, scientific, and Western in derivation. The two exist side by side, yet remain functionally unrelated in any intentional sense."

Such a dichotomous view of health care systems has a long history of acceptance by workers in the field of international health and, more recently, medical anthropology. Gould's (1957) recognition of a dualism of treatment options in India, along with Foster's (1958) observance of a similar pattern in Latin America, gave early support to the concept that traditional and modern medical practices constitute separate and alternative systems of health care. More recently, work by Dunn (1976), has suggested that "traditional Asian medicine and cosmopolitan medicine" are distinct, essentially independent systems of health care which co-exist within and provide essential services to the citizens of modern Asian nations. In light of this research, Elling (1981) addresses the general issue of "relations between traditional and modern medical systems" in different cultural settings across the world, and Worsley (1982) similarly discusses "Western" and "non-Western" medical systems and their interaction cross-culturally.

Yet social scientists who discuss decision-making as a choice between Western and non-Western therapies present a falsely restricted view of the complexity of the environment and the multiplicity of therapies within a society. Press (1969), for example, examines the use of modern physicians and folk curers (<u>curanderos</u>) in urban Bogota, Colombia, and focuses upon the "dual use" of modern and traditional medical systems. While the concept of simultaneous utilization of two health resources was an important contribution, Press' analysis neglects to consider the many potential sources of health care other than these two types of healers. Traditional and modern health care beliefs and practices are held to be self-contained, mutually exclusive bases of healing and therapy, i.e., systems of health care and medical treatment. Traditional ideas and practices are contrasted with biomedical or scientific therapies, and these separate medical systems are viewed as generators of treatment alternatives and choices in pluralistic societies. The implication of such a stance is that "medical decision-making" pertains primarily to a choice between modern and traditional, indigenous, or folk medical systems. However, as investigators continue to carry out in-depth studies and report upon the variety and range of medical practices and health care alternatives cross-culturally, this conclusion becomes increasingly untenable. The traditional/modern distinction tends to imply that therapy options within each system are similar, and this simplification obscures the true nature of decision-making in a society. The choice is not one or the other, but rather one alternative from a variety of many. It is clear, for example, that many different forms of traditional medicine may exist within a single community (Unschuld 1976).

Leslie (1976:1) notes not only a plurality of traditional treatments but also a plurality of traditional medical systems from which they derive, for Chinese, Ayurvedic and Yunani medicine co-exist with "cosmopolitan" medicine across the Asian continent, "most notably in China and India, but also in Japan, Sri Lanka, and other countries." These regional medical systems have maintained their essential identities as separate traditions, yet they have thrived side by side in pluralistic societies for ages. For Leslie, then, pluralism as a multiplicity of regional healing systems and traditions argues against the usefulness of a traditional/modern dichotomy. Each of the three regional systems is "traditional" relative to biomedicine, but clearly each is very different from the others in historical and philosophical bases.

Similarly, Heggenhougen (1980a, 1980b) describes the pattern of medical pluralism in Malaysia and observes that the "traditional" practices include Ayurvedic, Chinese, and local Malay therapeutic techniques. These medical options continue to thrive in spite of a government-sponsored biomedical health care system. Again, the traditional label fails to describe the great variety of practices in Malaysia which are not modern, scientific, or biomedical.

Lasker (1981), working in the Ivory Coast, documents the wide range of health care practices which are not a part of the biomedical treatment system. Such practices include the use of herbal medicines, and the healing efforts of diviners, cult prophets, and Moslem <u>marabouts</u>. Decisions to utilize any of these resources could be termed choices of traditional health care alternatives, though clearly they differ among themselves to a great degree. In addition to these alternatives, the biomedical health care system itself provides a number of distinct choices to the residents of the Ivory Coast, including self-help therapies, pharmaceuticals, and the seeking of advice from a nurse or physician.

Similar findings are reported by Cosminsky and Scrimshaw (1980:267) in a discussion of the great variety of traditional medical resources available to workers on a plantation in Guatemala. Decisions regarding the form of treatment are made with reference to a generally traditional "complex of home remedies, folk curers, herbalists, midwives, spiritists, shamans," as well as a number of distinctly biomedical alternatives such as public and private clinics, hospitals, pharmacists and physicians. Clearly, this evidence supports the assertion that the use of the term "traditional" is inadequate for a thorough understanding of the range of health care alternatives in pluralistic societies.

Another problem with the distinction between traditional and modern is its implication of rigidity and conservatism of traditional healers. According to Leslie (1976:6-7),

> "the dichotomy opposes the changing and creative nature of modernity to an assumed stagnant and unchanging traditionalism,"

even though the medical institutions labelled "traditional" have undergone considerable change in the last century. Far from being wholly conservative, practitioners of traditional or folk medicine have shown increasing interest in the acquisition of new skills and the use of certain "modern" treatments or technologies in their own work. As well, scientifically trained biomedical healers may make use of "traditional" or unscientific practices without paradox.

The kanpo clinic in modern urban Japan is a case in point. The practice of medicine in these clinics is characterized by an integration of biomedical and traditional East Asian medical approaches to the diagnosis and treatment of health problems. Kanpo doctors are licensed M.D.'s who utilize:

> "basically cosmopolitan notions of specific, cellular level disease causation, cosmopolitan and East Asian diagnostic techniques, and a totally East Asian system of therapy" (Lock 1980a:142).

The Taoist approach to nature is the foundation for therapeutic action, and the goal of the practitioner is to restore balance to the body by effecting biophysiological changes in the individual. These changes can come about by means of diet modification, through herbal therapy, or resort to acupuncture or moxibustion. However, while:

> "dietary advice is based on the classical theories of balancing yin and yang foods...the doctors do not present their ideas in the classical terminology. They talk in terms of vitamins, carbohydrates, proteins, and so on, and they believe that a diet balanced in the classical way will also provide a scientifically nutritious meal" (Lock 1980a:133).

The distinction between what is traditional and what is modern is blurred in this case. The fact that biomedically trained doctors are also traditional healers, who use a mixture of traditional and biomedical language and thought in the practice of kanpo, makes it difficult to distinguish completely between the two medical systems. Although biomedicine and East Asian medicine may be "compartmentalized" and practiced independently or separately by some dual practitioners (Lock 1980a:201), the kanpo clinic appears in many respects to be a resolution between the two approaches; the best of both systems, as it were, are uniquely combined in a single syncretic health care alternative. This conclusion is further borne out by the observation that much of the symbolic content of the biomedical treatment system has been exported directly to the kanpo clinic: Lock reports that one young doctor performing preliminary examinations of patients "wore the familiar white coat of his profession and had a stethescope protruding conspicuously from his pocket" (1980a:113). The kanpo clinic is thus a modern health care resource which exhibits elements of both traditional and biomedical systems of illness diagnosis and treatment.

Further evidence that health care alternatives do not always neatly fall into traditional and modern categories derives from the study of healers who combine elements of several traditions in their curing beliefs and practices, or who have incorporated biomedical methods to a greater or lesser degree into their own work. Cosminsky and Scrimshaw (1980) report that in the pluralistic medical setting of a Guatemalan plantation, certain individuals may perform multiple health care functions for the members of the community. One such individual is Maria, a "traditional or empirical midwife" who practices a syncretic form of midwifery which exhibits elements of both traditional and biomedical approaches to birth. Her case will be examined in some depth below.

Maria is the most active and visible health care provider on the plantation, and her roles extend well beyond her title of comadrona, or midwife. As a knowledgeable and proficient practitioner, she is highly regarded by members of the community and is called to attend nearly all births which occur in her jurisdiction. After several years of strictly "traditional" practice, Maria completed a training course sponsored by the Guatemalan Ministry of Health on biomedical approaches to the practice of midwifery and became officially licensed by the government in 1960. Since then she has attempted to integrate traditional methods learned during her original apprenticeship with biomedical or modern methods presented in the government course and follow-up review classes. Her technique technique is not so much traditional <u>or</u> modern as it is the union of both approaches; for a typical delivery, Maria "cauterizes the umbilical cord with a candle flame, a traditional practice," yet afterwards she immediately "applies alcohol, merthiolate, and talcum powder, as she was taught in the course" (Cosminsky and Scrimshaw 1980:270). Clearly the individuals who choose Maria as midwife do not receive wholly "modern" or "traditional" care, but rather a unique combination of these techniques embodied in a single individual.

Furthermore, Maria is often called upon in her capacity as <u>curandera</u> to treat infants and children who have fallen prey to the "evil eye" and women who suffer from such ailments as fallen uterus and delayed menstruation. She has also served as a spiritist on occasion, though this function is physically very draining and is rarely demanded of her. Perhaps most interesting, however, is the revelation that Maria has recently become a <u>zajorin</u> or shaman in the tradition of the Mayan Indians, even though she identifies herself as a non-Indian Ladino. She was recruited for the role by a shaman who cured her of a serious ailment and who subsequently took her on as an apprentice for nine months. During this time Maria learned the process of divination using seeds which are laid out and interpreted according to the Mayan calendar, as well as the method of performance of

Mayan rituals involving offerings of copal, incense, candles, chocolate, rum, and chicken sacrifices (Cosminsky and Scrimshaw 1980:270-1).

Maria is not the only health care resource available to members of the plantation; far from this, she is but one of several different alternatives which persons can utilize when health care is required. Her case is illustrative of the nature of medical pluralism, however, in that Maria is not allied with one or another "system" of medical practice. Rather, she makes use of a variety of methods from many different sources, and in her capacities as midwife, curandera, spiritist, and shaman she provides essential services to the members of her community. When people choose Maria to deliver their children, it is not a choice between traditional or modern, Indian or Ladino, but a choice of one particular individual over any other. Pluralism in this sense represents the existence of a multitude of alternatives, and decision-making develops in response to the availabilty of actual health care options, rather than systems. Certain practitioners may be allied more closely with biomedical or traditional models of health care, but this sort of dualism falsely divides the world of healers into two separate camps. As the case of Maria demonstrates, in practice there may be much overlap between these approaches.

These data seriously call into question the usefulness of a traditional/modern distinction for the study of medical choice, and for the definition of pluralism in general. In fact, the decision between traditional or modern health resource, supposed by many investigators to be of major importance (i.e. Press 1969 above), may not be consciously made by the members of a community who choose between treatments and not "systems." Self-help therapies (Dean 1981), which may include elements of both traditional and modern origin, and their use prior to or concurrent with other health care options, further confound the issue of decision-making with regard to traditional or modern medical systems. In many cases, it may be difficult if not impossible to ascribe a therapies neatly to one or another medical system.

At this point, the question may appropriately be asked: to what extent is the very concept of a medical system, and the subsequent comparative analysis of such systems, a product of a decontextualizing social science, an assumption of the ways in whch societies are organized and of the ways in which this organization is to be investigated? In many respects, this sensitive issue is a subset of a larger problem concerning the cultural constraints and preconceptions of the fieldworker, and the relevance of the assumptions and methods of Western social science for the study and understanding of phenomena in cross-cultural perspective. I would now like to turn to a discussion of how medical systems are defined and described by anthropologists and other social scientists, and the implications of these findings for the study of medical choice in field situations.

The nature of "medical systems"

A general criticism of the basic enterprise of defining and analyzing separate "medical systems" of societies is presented by Comaroff (1983), whose insightful analysis illustrates the tight bond between medical anthropological theory and the culture in which it is propounded. While historically sensitive to allegations of ethnocentrism, anthropologists, argues Comaroff, have nevertheless fallen prey to the temptation to carry out social science research in a manner which derives from and is consistent with their own experiences as members of Western culture. In their efforts to seek the "natives' point of view" and elucidate the relevant categories and concepts by which people structure their world and give meaning to life experiences, researchers often neglect the fact that to search for "categories" or structural components of society in the first place assumes a priori not only the existence of such components, but also that Western social science methods are appropriate for exploring the interrelationships among them. In this sense, social science is a culture-bound enterprise. The expectation that various domains of belief or action, such as the religious system, political system, or medical system are present within a society under investigation and can be apprehended by the fieldworker, is an assumption left untested but which nonetheless forms the basis of cross-cultural research and analysis.

Such a "Western essentialist view of the world" (Comaroff 1983:4) is replicated time and again in studies which approach the concepts of health and illness with respect to the "medical system" of a society; implicit in this attitude is the concept that medical beliefs and health care decisions can be analyzed separately and without necessary reference to other such systems as "legal" or "religious." The medical sphere of life is broken off from the rest of experience and is decontextualized for the purposes of inquiry and explanation, yet at the same time it is not clear that illness is ever a discrete category which can be isolated and treated outside of its social, cultural, and political contexts. Medical decisions are life decisions and bear upon all aspects of human existence. Thus, to focus solely upon perceived medical systems and not upon other areas of the lives of people which directly affect health care decisions, ignores the essential nature of the human experience and one of integration at many levels, of the interconnectedness of belief and action. Perhaps medical systems per se are discovered because they are presupposed to exist, and because the assumptions of the research design allow for their discovery and analysis.

Efforts to describe and define medical systems as conceptual categories and to develop typologies of systems (Press 1980) should therefore be undertaken with the realization that the resulting analysis is largely a product of the viewpoint of the investigator. The condeived systems are not objects-in-themselves but rather social constructs which should not be reified. Once it is accepted that medical, i.e. health care, decisions are made "within a 'metamedical' framework of thought" encompassing many other non-medical modes of experience and interaction (Worsley 1982:315), then it will be possible to view medical pluralism in the context of the total life patterns of individuals within any society and the interconnected nature of many spheres of existence (social, biological, cultural, political, medical), rather than the independence or separate functioning of these spheres. In this light, the process of healing is at once a medical and a non-medical operation, and medical anthropologists probing these issues must necessarily consider health care decisions in this greater contextual frame of reference. A "religious system" is often hard to separate from a "medical" one, for example, and perhaps even the attempt to make such a distinction promotes a decontextualization of the study of societies which anthropologists should strive to leave behind:

> "While...earlier generations of ethnographers regarded healing as part of 'religion,' we must be careful, in now claiming this as an exclusively 'medical' domain, not merely to be replacing one outworn functionalist label with another. For advance in our comparative understanding of such phenomena can only proceed by way of their indigenous meaning, which frequently entails no dichotomy between 'religion' and 'healing'" (Comaroff 1983:6-7).

In a similar vein, Fabrega and Silver (1973) argue that the medical system per se in Zinacanteco society is merely a conceptualization of the investigator, perhaps inseparable from the social system as a whole. Zinacantecos:

> "do not have what we could term a medical care system that is a clearly delimitable and independently functioning unit within their culture [since] the beliefs, practices, personnel, and facilities available for dealing with occurrences of illness are

> not easily separated from those that serve other institutional functions in the society...religious, social, and ethico-moral" (Fabrega and Silver 1973:88).

The study of health care must therefore proceed with reference not only to health care or medical systems, but also to these other integral features of the total social system of a society. The recognition that medical systems are analytical constructs allows for the development of a new definition of medical pluralism, one which is of practical significance to the fieldworker investigating actual decision-making within a society. Pluralism can now be examined as a multiplicity of healing techniques, rather than of medical systems, and the study of choice in pluralistic societies can proceed with reference to these various therapeutic alternatives. The "pigeon-holing" of healing methods as traditional or modern becomes less important than the development of an understanding of the contextual, metamedical nature of the illness experience, the healing process, and the decision to utilize one health care resource over another. Health care decisions cannot be examined in isolation, but rather must be explored with reference to the precise social, cultural, and political environments in which illness takes place and in which decision-making occurs. This context may include a variety of potential resources, some of which are modern, some traditional, and some containing elements of more than one origin.

It is important to note that these contextual variables are not static or permanent but are constantly changing, and this flux itself affects the health care decision-making of persons within a society. This changing totality of alternatives, then, is <u>the</u> medical system of a population, and such a system can be said to be pluralistic if many different therapeutic options are available for persons to choose in times of health crises. Operationally, the investigator of decision-making is wise to focus upon the actual alternatives to which people resort, rather than upon abstractions of choice between traditional and modern therapies. In this manner, the social nature of the illness experience, and of decision-making, is appreciated in terms of true-to-life decisions.

Kleinman (1980:49-70) describes health care systems as a complex of professional, popular, and folk sectors, and this may in fact be a better characterization of pluralism in a society than a traditional/modern dichotomy. This model has recently received support from other fieldworkers, attesting to its potential value in medical anthropological analyses (Coreil 1983). However, the content of each of these sectors is highly dependent upon cultural context, such that the actual health care alternatives within each sector are likely to vary greatly from one society to another. At the individual level, health care options, rather than sectors or systems, are the immediate material of decision-making, and again as with any division scheme, some alternatives probably exhibit elements of more than one sector. With regard to the study of decision-making cross-culturally, the precise ascription of alternatives to Kleinman's tripartite model may be less valuable than a careful analysis of the range of options and subsequent choice in light of this variability.

Pluralism, then, is the environmental context of the decision-making process. But how do individuals eventually make the decision to use one particular health care resource rather than, or in addition to all others which are available in society? I wish now to turn to a consideration of the nature of the decision-making environment and the ways in which this environment shapes and forms the help-seeking process. In one sense, the microenvironment of decision-making can be seen as crucial to the determination of which resource is utilized, for family, friends, and neighbors exert strong influences upon the ill individual and participate to a great degree in making these decisions. But at another level, the macroenvironment of illness and decision-making, the historical, political, geographic, and economic context of individuals and their social systems, can be seen to define and limit the types of choices available to the individual, such that the final decision-making process is as much a function of societal and global influences as it is a result of interpersonal interaction. These issues are taken up and discussed more fully below in a consideration of the environment of illness and the process of decision-making.

Chapter II. The Environmental Context of Health Care Decisions

The purpose of this chapter is to describe more fully the environment of decision-making and the process by which health care decisions are made in response to sickness. In many respects, the immediate and local surroundings of family, friends, and "significant others" (Frankenberg 1968; Igun 1979) can be seen to exert a great influence upon the sick person's ultimate choice of therapeutic alternative (cf. Mead (1964) concerning the importance of others in self-definition for historical and philosophical roots of this viewpoint). The microenvironment of the illness experience is thus an important focus of decision-making research. Equally important to an understanding of decision-making, however, is a macro-analysis of politics and pluralism within the society under investigation. While actual health decisions are made at the microenvironmental level, these choices are guided and shaped by societal, i.e. macroenvironmental factors, such as the professionalization of health practitioners, regulation of health care delivery by the state, or international health policy. Consequently, a more thorough appreciation of decision-making requires an analysis of "the linkages between the health system and the broader political, economic, and social systems of the society" (Waitzkin 1983:5), for what an individual chooses to do about an illness cannot be removed from the pluralistic environment in which health-seeking takes place.

As well, I hope to demonstrate that decision-making is not a single event but rather a process, which develops in response to the precise micro- and macroenvironmental features of the illness experience. The process of health-seeking (Chrisman 1977), or when referring to health issues, help-seeking" (Calnan 1983), involves the continual evaluation, reevaluation, and reconfirmation of the status sick throughout the course of an illness. Sickness is a socially recognized state of suffering, and in this regard it requires the acknowledgement of many persons in a network of social interaction, beyond just the individual experiencing the illness. I argue below that the concept of sickness as a career of help-seeking (Twaddle 1979, 1981; McKinlay 1981) emphasizes the dynamic nature of health care decision-making, as well as the temporal aspects of illness perception and subsequent therapy decisions.

The microenvironment of decision-making: the sociocultural constitution of sickness and health

Persons seek health care when they perceive a health problem which may be alleviated or ameliorated by intervention. In this sense, the decision-making process is intimately connected with the recognition of symptoms and the desire to have a normal state of health restored. Recent work in medical anthropology has stressed that the terms sickness and health are culturally relative in their definition. While the sociological literature on illness perception and its variability dates to thirty years ago (Koos 1954), it is really only within the past decade that anthropologists have systematically begun to explore this issue.

In focusing upon the microenvironment of interpersonal interaction and communication, I hope to demonstrate the highly contextual nature of the state of well-being and its undesirable permutation, the state of sickness. By calling these antagonistic statuses contextual in their formation and experience, I mean to imply that the immediate and local environment in which persons live and interact with other persons greatly affects the peception and assessment of health problems and the courses of action taken by affected individuals.

The context of experiencing and acknowledging sickness is a social one, demonstrable by the importance of "significant others" in the processes of diagnosis, therapy, and the adoption of a sick role (Frankenberg 1968, 1980; Parsons 1951). It is also true that the anthropological concept of culture bears greatly on the discussion of the context of sickness, for shared sets of beliefs and values often provide a behavioral standard or code which prescribes sanctioned or acceptable decision-making options. Yet the culture which affects what an individual believes and how sickness is interpreted, is expressed by means of social processes, that is, contact and interpersonal interaction among members of a social community. Culture reinforces conceptions of appropriateness of belief and behavior, but in a manner by which humans in a social group are utilized as mediators of cultural values. Thus I will concentrate upon the effect of sociocultural context on the formation of sickness, and health, as these states are experienced by individuals within units of social interaction. Crucial to this discussion is a consideration of the differences between disease, illness, and sickness, as developed in the anthropological literature (Frankenberg 1980; A. Young 1982).

The distinction between disease and illness, as presented by Eisenberg (1977), Kleinman et al. (1978) and other authors, is illustrative of conflicts of interpretation between (objective) biomedical diagnoses of pathology and (subjective) assessments of health status by members of a society. Clinicians, as biomedical scientists and healers, are trained to recognize and focus upon biophysical dysfunction or disease states, without attention to other extraneous variables. A consideration of how a person "feels" is important to the biomedical practitioner only inasmuch as it furnishes insight into the underlying pathophysiological mechanisms responsible for the condition. Thus, disease is the primary concern of the physician, and attempts are made to cure the biophysical problem.

Patients, and their family and friends, however, are generally non-medical personnel, and as such they may not share the same attitudes toward the health problem or adhere to the same conceptual framework as the physicians and nurses of the biomedical system. Patients tend to be concerned with their overall health and the continued well-being in a gross sense (Mechanic 1979, 1982). Thus when something occurs to disrupt a normal or daily pattern of function, illness, rather than disease, characterizes the experience of the individual. The malady, as a disruption of the routine fulfillment of social obligations, represents more than a particulate disease category to the patient; it is a subjectively experienced illness for the person whose life is so affected. By this analysis, clinicians concentrate upon diagnosing and curing disease, but the persons they are treating, the patients, are suffering from and experiencing illnesses in response to, or apart from, whatever disease states or pathophysiology their body is enduring.

The dichotomy between disease and illness allows for the possibility that these conditions may occur separately or apart from one another. Disease may be the underlying cause of an individual's loss of overall health, but certain diseases can be identified which do not promote a subjectively experienced state of illness. The diagnosis of disease is made by the clinician by means of objective and scientificially verifiable tests, and this can be accomplished even without prior knowledge of a health problem by the affected person. Hypertension, the classic example of a disease with "hidden symptoms," demonstrates the failure of correlation between pathology and illness experience, since persons suffering from elevated blood pressure often have no idea something is "wrong" with them until they are told so. Clearly, their normal patterns of behavior and social interaction are not markedly affected by the disease, and they recognize no problem to exist. Illness, then, may not be an immediate consequence of the disease state.

A case can be made by analogy for the occurrence of illness without a necessarily concomitant disease state serving as its underlying cause. If illness is a subjective assessment of functional impairment, then the development of "combative hysteria" among young men at fronts of war (Eisenberg 1977) may be seen as a form of illness which is not disease-based, that is, which derives from psychosocial rather than strictly biological factors. Such young men may be severely affected, even though a scientifically verifiable disease state cannot be conclusively demonstrated.

While the proposed schema does indeed provide insight into the nature of health perceptions, it has been recently amended to provide a social or sociocultural dimension to the health context. Frankenberg (1980), A. Young (1982) and Lock (n.d.) have demonstrated that illness as an experience at the individual level also extends to and affects the social group of the ill person. In this respect, sickness is characterized primarily by an inability to perform normal social roles (Pescosolido: pers. comm.). Parsons (1951) considers that the social acceptance of an illness as a <u>real</u> or legitimate (as opposed to feigned) problem is crucial to the subsequent acceptance of a sick role by the individual, and the granting of exemptions from normal role requirements and obligations. In other words, interpersonal interaction and communication of the illness verbally or non-verbally to those not experiencing it constitute the contextual basis for expression of the illness. People are not sick in a sociocultural vacuum, and social recognition, empathy, and offering of support contribute to the formation of the individual's illness experience. The process whereby health problems gain social awareness and acceptance is the "socialization of illness to sickness" (A. Young 1982), with sickness now applying only to a state of health disorder, subjectively perceived by an individual, and brought to the attention of "significant others," that is, important members of the ill individual's sphere of social interaction.

Now the question can be appropriately raised: What does it mean to be sick, and what characterizes the status or role change of someone who becomes sick? Parsons conceives of the "sick role" as a sanctioned set of behaviors and attitudes adopted or taken on by individuals when their claim to illness is given social recognition. In this manner, "social relations shape and distribute sickness" by providing a mechanism for the interpretation of certain sets of symptoms as indicators or serious illness, and also for the interpretation of other symptoms which may not be such indicators (A. Young 1982:269). The result is that only particular configurations or patterns of disorder provide acceptable justification for the "taking on" of a sick role.

In its original formulation, Parsons' conception of the sick role involves two distinct rights and two separate obligations for the individual who becomes sick. The rights include:

--the exemption from normal role responsibilities;

--the acceptance by others that the illness is not the fault of the sick individual, i.e., the right not to be blamed for becoming ill.

As well, the obligations incumbent upon the sick person are:

--to attempt to recover and to wish to become well;

--to seek out and cooperate with persons who are "technically competent" to help the individual recover (Parsons 1951:436-437; Ludwig and Gibson 1969:125; Segall 1976:167; Chrisman 1977:356).

Such a characterization of the sick role is perhaps too restricted to the behavior of persons in Western industrialized states to be of complete cross-cultural applicability. For the society in which Parsons undertook his analysis, the biomedical model of disease causation and treatment is normative, and the notion of technical competency in dealing with illness is generally limited to practitioners within the biomedical framework. In other cultural contexts, however, the criteria for the acceptance of the status "sick" and the normative treatment of sickness may be highly variable.

For example, while the biomedical model of disease may not adhere to concepts of personal responsibility or liability for one's own illness (see Parsons' second right of the sick individual), there is ample documentation in the anthropological literature of the widespread belief that neglect of social obligation can lead to personal illness and suffering. The practice of witchcraft (Evans-Pritchard 1937; Marwick 1970) is often implicated in the event of sudden or unexplained illnesses which occur in times of social strife and failure to interact harmoniously with others. In many cases the sick individual is in fact held responsible for the onset of his own illness, either because of failure to fulfill a certain social or religious obligation, or because of a direct offense against a witch, sorcerer, or other supernatural force (see Hallowell 1977 for an insightful explication of these issues). Furthermore, it should be noted that not even the biomedical model absolves all individuals of responsibility for their illnesses, since personal behavior (e.g. smoking) may be linked causally with some disease outcomes (e.g. emphysema). These facts seriously call into question the assertion that persons always, or even generally, have a right not to be blamed for the illnesses they suffer.

A further problem with Parsons' model is that in many medically pluralistic societies, the issue of who is competent to treat an illness is more difficult to assess. Non-compliance with or failure to seek out biomedical practitioners clearly does not always prevent or limit the ascription of sick statuses to ailing individuals. From this perspective, Parsons' sick role conception is most valuable when viewed as a culturally specific analysis of social behavior in twentieth-century America. As a general analytical construct, it demonstrates the distinctly social nature of the recognition of health impairment, and the subsequent changes in role expectations and responsibilites of the sick person.

Several sociological analysts have observed that not all persons perceive and experience bodily dysfunction in the same way (e.g. Zola 1966; Mechanic 1982:1). Using current terminology, it is possible to assert that these authors demonstrate the differential perception of illness among members of various groups in society, as well as the differential ascription of the sickness label to and adoption of a sick role by persons within these groups. I would briefly like to consider two important sociological studies of such variability among ethnic sub-groups in the U.S., a Western industrialized country. In principle, anthropological researchers could apply this knowledge toward the development of appropriate research designs for studying these issues in developing areas of the world. Such research is in fact currently under way, and future work will continue to provide valuable information concerning these issues.

The nature of symptoms as contextually defined and contextually relevant labels is illuminated by Zborowski's (1952) classic analysis of reactions to "pain" by members of various ethnic communities in Boston. In examining patients' attitudes toward the perception of pain, Zborowski discovered a great deal of variability among the responses to Italian, Jewish, Irish and "old American" individuals. While Italian and Jewish patients tended to overemphasize or exaggerate the amount of pain they felt, and also were generally emotional and very vocal in their responses to pain, the members of the Irish and "old American" groups were, by contrast, much more likely to discount or minimize their level of suffering when questioned. These latter patients furthermore were, as a rule, much less open and less vocal in communicating to others the amount of pain they endured.

Zborowski argues in light of these findings that cultural components play a large part in determining an individual's response to and communication of feelings about pain. Members of the Italian and Jewish communities may be taught or encouraged at an early age to be demonstrative and open about experiencing pain, and this cultural context of the illness experience contributes to the phenomenology of illness behavior. Conversely, the Irish and "old American" cultural contexts may have encouraged the development of individuals who are stoic about pain, and who keep feelings of pain to oneself. To these persons, low level aches and pains may not be so much symptoms of a particular disorder as they are reflective of the vicissitudes of human experience, the ups and downs of daily life. Such feelings may not, therefore, be interpreted as requiring health care, but rather the "waiting out" and the passing of discomfort. Irish and "old American" persons may be reluctant even to mention minor pains until their severity increases, or until they begin to impinge upon the ability to work or carry out social obligations. These data imply that cultural factors affect the definition of what is a health problem for which assistance may be beneficial, and what is not. Health care decision-making will be affected by this definition, for disorders which are not felt to be symptoms will not inspire persons to seek treatment or to make health care decisions of any kind.

Yet another important study is presented by Zola (1966, 1983), who demonstrates that the very nature of symptom expression is culturally variable and, as well, that the sorts of complaints for which health care is sought are also contextually dependent. In a study of patients' symptoms presented for treatment at Boston hospitals, Zola discovered that Irish patients were much more likely to desire treatment for eye, ear, nose or throat problems than were Italian patients. Furthermore, fully two-thirds of the Irish individuals reported no pain associated with their symptoms, whereas a majority of Italians responded that their problems were indeed painful to them. In these cases, either the members of the Irish group did not feel that pain was a problem worthy of medical attention, or their definition of what is painful differed markedly from that of the Italians. The study dramatically illustrates that decision-making takes place in response to cultural conceptions of health and illness, and in concert with ideas concerning the validity of health problems and the need or desire to seek health care for them. The context of health care decision-making becomes more complex when multiple therapies are available in a society. Not only must symptoms be defined and recognized, but choices must be made from among the possible alternative treatments, rather than simply from among biomedical hospitals.

Of course, a major problem with the early sociological work in this area is the use of an industrialized society as the sole reference point for the definition of sickness. What these authors address is the differential recognition of pain and of symptoms in general as, on the one hand, something worthy of taking action to rectify, and, on the other hand, something for which exemptions from normal obligations and responsibilities may be legitimately granted. The formation of the sickness response is thus as much a product of the sociocultural context as of the biophysical disease reality, for similarities in disease states often do not indicate similarities in the subjective response of the individual. Zborowski and Zola consider cultural components as determinants of this response, but social factors must also be examined, inasmuch as cultural standards and values are expressed by means of social interaction with other persons in a society. In this sense, health care decision-making is a function of the microenvironmental circumstances of illness perception and advice solicitation.

It is important to note that the environment of the definition of symptoms and health care decision-making, while culturally variable, can also be conceived of as socially variable as well. The influence of other persons in a network of social interaction upon the definition of symptoms and the perception of illness is difficult to measure or quantify, but it is nevertheless crucial to the formation of the total context of the illness experience (McKinlay 1981). Koos (1954) examined illness perception among upper and lower class segments of U.S. society and found that while women of both classes reported lower back pain to be a common occurrence, the members of the lower class were much less likely to label back pain a symptom of illness or to seek health care for its alleviation. For these women, the suffering of pain was a fact of life, characterizing a "normal" or expected pattern of existence. In this instance, the values and beliefs of the members of the two groups were shown to be affected by the social category with which they identified. While Koos' use of the term "class" would be critically questioned by anthropologists today, his original observation is still of great value: variable patterns of social interaction can lead to differential definition of illness and differential criteria for the legitimate acceptance of a sick role.

Suchman (1965a) also presents evidence that, among persons in New York City, the "form of social organization" with which an individual is associated correlates to some degree with the use or non-use of medical services. While not directly focusing upon the nature of illness perception and the sick role across social classes, Suchman nevertheless observes that members of the more "cosmopolitan" social class are much more oriented to the use of "scientific" or biomedical health care facilities, while members of the more "parochial" group tended to maintain a "popular" health care orientation (1965a:2). While this conclusion has been refuted by more recent investigators (Geertsen et al. 1975), the suggestion that differential patterns of social interaction do indeed affect the processes of illness recognition and help-seeking is seemingly well-supported (Robinson 1971; Mechanic 1979, 1982:12; Locker 1981).

Fortunately, current research is beginning to address the problems of cross-cultural applicability of conclusions drawn from sociological studies in the industrialized West. This new work attempts to document variation in belief and behavior regarding the social acceptance of sickness across a wide range of environmental contexts. Good and Good (1981), for example, have argued that different cultural groups are highly variable in symptom recognition and illness classification. They present five parameters which could be investigated cross-culturally in order to document similarity or contrast in illness belief systems:

--the specificity of medical complaints;

--the style of medical complaining in various medical contexts;

--the nature of anxiety about the meaning of symptoms;

--the focus upon particular organ systems; and

--the response to therapeutic strategies.

That these factors are indeed highly variable in different sociocultural contexts is borne out by a variety of anthropological field studies. Welch et al. (1973) examine native or popular conceptions of health, illness, and health care delivery among Mexican Americans and conclude that "social factors" such as size of the community correlate with adherence to "folk" medical beliefs and practices, i.e., that social interaction is influential in determining illness perception and the seeking of health care. Lock (1980a) has shown that the Japanese are especially sensitive to disorders involving the stomach and are very concerned about the occurrence of stomach cancer. Perceived problems in a Japanese context might well be overlooked or downplayed in a completely different sociocultural environment. Similarly, Kleinman (1980) notes the tendency of Taiwanese persons, and members of Asian societies in general, to "somatize" apparently psychological problems or disturbances, an observation with which Lock (1982, 1984, n.d.) agrees with regard to the Japanese.

Further evidence of cultural ~~variability~~ ability in symptom recognition and, therefore, illness response and designation of sickness labels, comes from the study of "culture-bound syndromes" (Lebra 1976; Cassidy 1982; Fabrega 1982). These widely discussed syndromes are culture-specific con stellations of symptoms and associated beliefs of causation which are peculiar to particular areas of the world. [Two well-known examples of such syndromes, <u>susto</u> (fright) and <u>mollera caída</u> (fallen fontanelle), are discussed in detail by Rubel (1977) and J. Young (1981).] Recent work has stressed that culture-bound syndromes need not be exotic disorders of non-Western peoples (<u>windigo</u> psychosis, running <u>amok</u>), but may also include syndromes commonly diagnosed by biomedical practitioners in the West, such as protein-energy malnutrition

(Cassidy 1982). The point here is that cultural factors are chief determinants of the formation of illness experiences and socially-recognized sickness (White and Marsella 1982; Fabrega 1982). Values and beliefs are culturally relative, and these beliefs contribute to the perception of health disorders within a particular cultural context.

However, anthropologists may also wish to follow up the early sociological work initiated by Koos (1954), Suchman (1965a, 1965b), and Freidson (1970a), by investigating the influence of social, i.e. interpersonal, interaction upon the formation of perceptions of sickness and health. I would argue that the social circumstances of illness are of prime importance in determining the characteristics of episodes of sickness, for it is in the context of socially recognized sickness that the process of health care decision-making operates: the decision to recognized a symptom is a prelude to the decision to seek health care, and these decision-making processes are always framed within the greater spheres of family, community, and society.

Calnan (1983), for example, cites recent research suggesting that the order in which an ill individual consults other persons regarding their ideas of the "best" therapeutic options has a significant effect upon what form of treatment is chosen. In a sociological study of medical decisions in England, he argues that the perceived urgency of the need to seek care corresponds to the social relationship between health care seeker and adviser, with relatives seemingly less likely to recommend hospital treatment of a problem than unrelated neighbors, police, teachers, employers, or bystanders at the scene of an injury. Observing the amount of time it took individuals to decide to present health problems to a hospital emergency room, Calnan discovered that 81% of those persons who asked only neighbors or friends for advice sought medical assistance within three hours of onset (or perception) of symptoms of a disorder. A much lower percentage (67%) sought help in the first three hours when the sources of contact and referral were relatives or family members. This effect has not been satisfactorily explained, but as the result of preliminary research it demonstrates that the manner in which advice from others is solicited may affect and influence the perception of a health problem and any subsequent decisions concerning the seeking of health care or medical attention.

Further cross-cultural evidence of the importance of "lay referral systems" (Freidson 1970a) upon help-seeking is offered by Kleinman (1980), who argues that in Taiwan therapy decisions always involve solicitation of advice from family members and friends:

> "The older family members and neighbors with special experience form a 'lay referral system' that plays a major role in what type of health care is sought and how the health care received is evaluated. Eighty-five percent of the patients we studied who were treated by practitioners had selected these practitioners (or, in the case of children, had the selection made for them by parents) on the advice of family members, friends, and other members of their social networks...the lay referral system is _the chief determinant of choice of practitioner_" (Kleinman 1980:197; emphasis added).

Health care decisions are therefore not made independently, but rather develop in response to the advice and suggestions of significant others.

This research suggests that different patterns of social interaction very likely will lead to different patterns of behavior. People thus respond to what other people around them, and who are important to them, think they should do about symptoms of a health disorder. Persons suffer such disorders within a social setting, and it is in this setting that the individual himself comes to any conclusions regarding the seriousness of the problem and what, if anything, to do about it. A great deal of work in the area of familism (Abasiekong 1981; Heller _et al._ 1981) in recent years is beginning to show just how important the precise social context is to the formation of a sickness response. Whether a person consults his brother or his neighbor is likely to have an influential effect upon the health-care-seeking process, as differential recommendations are received and acted upon by the ill person.

The context of the decision-making process thus involves cultural variables which are mediated by other persons, in the course of social contact and interpersonal interaction. As such, each episode of illness is framed within a unique sociocultural environment, consisting not only of culturally-derived values and beliefs which affect the course of health care decision-making, but also of distinctive patterns of lay referral and communication with others. Additional research is needed to clarify the influential effect of consultation upon the course of health-care seeking behavior, yet I believe the familism studies demonstrate the importance of social factors in determining which form of health care is sought.

In this sense, the true context of illness is the greater <u>environment</u> in which it develops and is experienced. The concept of environment as developed above includes cultural variables, as outlined by Zborowski and Zola, as well as social variables, that is, differences in who are consulted and conferred with and whose advice is solicited when dealing with the illness. Now, in refining this concept, I would like to turn to a discussion of the differences between the local and immediate microenvironment of an illness, and the much larger national, political and economic environment, or <u>macroenvironment</u>, in which the health care decision-making process operates (Janzen 1978a).

The macroenvironment of decision-making: Choice of treatment in relation to systems of health care delivery

Just as health care decision-making is framed within a context of immediate and local interpersonal interaction, so is this process affected by the macroenvironment of medical pluralism in a society. In a certain sense, the very health alternatives available to individuals--bomohs or sinsehs in Malaysia (Heggenhougen 1980a), doctors or espiritistas in New York City (Garrison 1977; Harwood 1977)--exist in society as products of historical and political events far removed from the microenvironmental arena of decision-making. The ultimate choice of one or another alternative is in many respects constrained and limited by the institutionalization of one or another healing tradition, the licensing of practitioners, popular medical movements, and health policy at the national and international level. Decision-making cannot be properly explored without reference to the macro-context of politics and its effect upon health care delivery within a society.

The concept of a macro-analysis of medical systems is developed by Janzen (1978a), who considers that microanalytical studies at the level of the individual and the social network fail to account for the effects of differential power, resource allocation, and organization upon the structure of the health care system of a society. A focus upon the microenvironment of illness elucidates processes of "illness perception, disease occurrence, diagnosis, prevention and therapeutic efforts within specific communities," yet this alone is not sufficient for an understanding of the medical system as a "changing social system" (Janzen 1978a:121), replete with all the political turmoil and power brokerage characteristic of such systems. Historical and political evidence is therefore relevant to an understanding of the character of medical pluralism, for the current health alternatives available to the individual are themselves firmly embedded in a precise historical context of cultural development and world history.

Politics, or the exercise of power and authority (Smith 1974:175; Janzen 1978a:126), is a chief determinant of the viability of health care alternatives. Political activity, past or present, at national and international levels continues to exert a direct influence upon decision-making, through the regulation and legitimation of various health options, and through the establishment of "professional dominance" (Freidson 1970b) by practitioners of various healing traditions. Janzen is concerned not so much with decision-making *per se* as with an understanding of the structure of the medical system in Zaire and its historical development. Current medical options in Zaire -- the art of *nganga*, kinship therapy, biomedicine, and cult group therapy -- stand today as the result of past incorporation of various sectors of the medical system and the successful historical formation of "corporate groups" of healers.

The granting of legitimacy and authority to a corporate group requires first and foremost a popular demand or support for the therapeutic activity practiced by its members. As well, incorporation involves the development and maintenance of a coherent body of beliefs and practices, and a mechanism for the training of new practitioners. This is to say, members of the group must hold in common "a canon of official research or clinical methods, texts, therapeutic secrets or rites," or in short, "an orthodox lore" (Janzen 1978a:127).

Furthermore, processes of external legalization and internal professionalization of a corporate activity often provide legitimacy to the corporate group. These political processes affect decision-making by influencing the perceived attractiveness or viability of health options by persons in the microenvironment of sickness. Legalization refers to the regulation of practice through governmental laws imposed from without, whereas professionalization implies the "internal legitimacy a corporate group bestows on its members through codes, licenses, and idealized scientific or ethical standards" (Janzen 1978a:128).

Janzen provides convincing historical evidence that the establishment of the EJCSK (Church of Jesus Christ on Earth by the Prophet Simon Kimbangu) as the dominant Kimbanguist prophet sect in modern Zaire relates in part to the Church's coherent organization and political manipulation as a corporate body. In 1958, when the Belgian colonial government officially recognized the Kimbanguists' legal right to assemble, the EJCSK alone of all sects embarked upon a campaign to tighten internal organization and to gain acceptance as a legitimate group by the World Council of Churches. As a result, this group was most successfully able to withstand subsequent "bureaucratic consolidation," and today it enjoys the status of official recognition and widespread popular acceptance (Janzen 1978a:128). The EJCSK thus was able to exercise hegemony over competing sects due to the differential professionalization among the groups.

For decision-makers during episodes of illness, such political struggles are of great consequence, since the availability of options from which to choose is a function of the exercise of power and authority by extra-microenvironmental forces. In this sense, "the macrostructure sets many of the parameters for microstructures" (Lee 1982:629), and decision-making at the individual level is only relevant in terms of health alternatives which are present in society. Their very presence is owed to these forces.

The dominance of biomedicine in the industrialized West has been examined by several authors in terms of the successful professionalization and internal organization of biomedical practitioners (Freidson 1970b). Recently, the biomedical monopoly upon health care in the U.S. has been challenged by chiropractic (Cobb 1977), osteopathic (Baer 1981), and podiatric (Skipper and Hughes 1983) professional groups, in an effort to gain a foothold in the lucrative health care market. Cobb argues that legitimation of a therapy system such as chiropractic involves legal sanctions (licensure laws, government funding, academic sanctions), professionalization, social movements and popular demand; each of these components exerts a strong influence upon whether a particular therapeutic alternative flourishes and is maintained within a society.

One of the most significant aspects of the legitimation of chiropractic has been its inclusion as a recompensable treatment under the Workmen's Compensation, Medicaid, and Medicare health insurance programs (Cobb 1977:5). This development, primarily the result of intensive lobbying by proponents in Washington despite scientific evidence the efficacy of chiropractic treatment (Janzen 1978a:128), provides both governmental recognition of chiropractors as "true" health resources, as well as financial incentives to individuals for choosing chiropractic treatment. Here, political action at the national level, spurred by popular demand for chiropractic services, has in a very short time transformed chiropractic into a more attractive, i.e. financially realistic and socially acceptable, alternative for health care decision-making. The microenvironmental choice of this option is dependent upon the legitimation process, for the financial reimbursement offered by the government is likely a powerful influence promoting the use of chiropractic services.

Baer (1981) examines the recent rejuvenation of osteopathy in the U.S. following a long period of domination and repression by the organized biomedical profession. The development of a strong internal organization of osteopathic physicians has brought political clout to this "alternative health system," and coupled with what Baer (1981:701) refers to as "a decline in the professional dominance of regular medicine," osteopathy is becoming a more viable choice for the treatment of health problems. Any study of decision-making with regard to osteopathy must take into consideration the historical and political context of biomedical preeminence, and recent changes in health legislation and professionalization which now make osteopathy less "deviant" an alternative than even twenty years ago.

Further evidence of the importance of the macroenvironment for determining the viability of health care options is presented by Lock (1980b) in an analysis of the structure and organization of East Asian medical practice in Japan. While biomedicine is "the dominant medical system in modern Japan," more than 100 traditional herbal medicines have recently become officially available under the national health insurance program. Popularly known as the kanpo boomu, or the "boom in East Asian medicine" (Lock 1980b:245), this revival of interest in all types of traditional medicine has been accompanied by the legitimation of kanpo and its increasing acceptance as a system of valid health alternatives.

Lock offers an historical analysis of health care and pluralism in Japan which provides considerable insight into the recent revitalization of traditional therapies in the face to widespread acceptance of biomedicine. As well, this focus allows a greater understanding of the obvious tensions which currently exist between healing specialists. For example, kanpo doctors see themselves as direct competitors, rather than colleagues of standard biomedical practitioners. Although kanpo doctors have the same legal status as the biomedical physicians, "their social status has remained peripheral in official medical circles until very recently" (Lock

1980b:252). Furthermore, competition between practitioners of acupuncture, shiatsu, and moxibustion is so great that rarely do they refer patients to one another.

In Japan, lack of intensive professionalization may account for the maintenance of pluralism and the failure of any one traditional healing art to gain undisputed preeminence. The variety of health alternatives is a reflection not only of a variety of belief systems to which the Japanese people subscribe, but also of the fact that fragmentation, rather than professionalization, is the chief characteristic of traditional medical practice (Lock 1980b:252). Again, an examination of politics and social forces at a societal level illuminates the ways in which particular health care alternatives came to co-exist and interact in modern Japan. For the making of health care decision, this precise cultural, historical, and political matrix is of great importance, since it is with reference to the pluralistic macroenvironment that the choice of any alternative is made.

One further example from the Far East demonstrates the dependence of decision-making upon the exercise of power and authority outside the microenvironment of sickness episodes. Hillier and Jewell (1983) present a cogent analysis of the centrality of the Chinese state in determining the form and substance of health care delivery in modern China. Oscillating between official acceptance and disparagement, traditional Chinese medicine has undergone major transformations in recent years in response to the increasing adoption of Western biomedical practice in the 1950s and 1960s. The collapse of united clinics in the 1960s led a number of traditional practitioners to revert to private practice in rural areas. These healers and their methods were officially denounced during the Cultural Revolution, for they provided direct competition for the emerging state-supported and financed barefoot doctors. The "witchdoctors and witches" who practice traditional medicine, the state argued, use "blackmail and extortion" to take advantage of others (Hillier and Jewell 1983:320).

As well, the Cultural Revolution brought a decline in the status of Western medicine, whose advocates were in "political retreat" at the time:

> "In contrast [to Western medical physicians], barefoot doctors were a new and more devoted type of doctor, who practised acupuncture on themselves before using it on their patients...By the early 1970's it was estimated that 70 to 80 per cent of cases of illness were treated with acupuncture and herbs by barefoot doctors" (Hillier and Jewell 1983:321).

With the fall of the "Gang of Four," the political climate changed dramatically. China's renewed interest in modernization has led to a reevaluation of traditional and Western biomedical practice and their role in the national health care system. Attempts to incorporate traditional healers into the system have centered around the goal of maximizing all health resources while limiting the potential for "charlatanry" and "superstition" by traditional healers (Hillier and Jewell 1983:328-9). My emphasis here is that in modern China, political activity at a national level exerts a strong influence upon the availability of various health care options, such that the decision-maker is clearly constrained by the current political climate and health policy of the state.

As well, it is necessary to consider the international context of health care, in which the World Health Organization and other groups representing developed countries operate to promote effective health care delivery to underdeveloped areas of the Third World (Kohn and White 1976). One cannot discount the effects of international aid upon the availability and perceived accessibility of health resources, particularly biomedical drugs or therapies. Indeed, current efforts to improve health ~~services~~ in underdeveloped countries commonly involve the financing of clinics in rural areas where previously such care was unavailable. The macroenvironment affecting decision-making is thus global, as well as local, provincial, and national. Changes in international relations can profoundly alter the atmosphere of medical pluralism, and the options open for decision-making, within any particular society.

Decision-making research must therefore take into account the historical and political bases of medical pluralism and its ever-changing nature in response to extra-microenvironmental forces. This is to say that the medical system of a society is not static, but dyanamic, changing, and in a continual state of flux (Janzen 1978b). The viability of options is affected as much by legitimation, professionalization, and regulation by the state as it is by social networks and familism at the level of the individual help-seeker. Researchers must thus focus upon both microenvironmental as well as macroenvironmental contexts to appreciate the complexity to the sociocultural matrix in which illness is experienced and various health treatments sought.

The process of decision-making: interaction of microenvironment and macroenvironment

Health care decision-making thus requires that various options be assessed, and that one or another alternative treatment be selected in light of both microenvironmental and macroenvironmental contexts. In this sense, the ultimate choice of treatment method depends upon the precise context of the illness experience; alterations or changes ~~in~~ the environment will likely have an effect upon the perception of which health alternatives are most desirable. Suggestions of a relative (micro-factors), or governmental health policy (macro-factors) may influence the health-seeker to select certain health options which might not have been chosen in different contexts. The manner of health care decision-making is best described as a process which develops out of and in response to the micro- and macro-context of the illness experience. The concept of decision-making as a processual phenomenon allows for the on-going evaluation of the efficacy of health care choices, and for the subsequent selection of additional treatment methods should the chosen alternative fail to restore the individual's health.

Several authors have sought to describe the process of health seeking as a series of events or stages though which individuals pass in their efforts to restore health. Fabrega (1973) proposes that the process of health seeking may be conceived as a temporal sequence of stages, from "illness recognition" to "set up for recycling," with the transition between stages requiring active decision-making on the part of the individual in need of care. Unlike Suchman's (1965b) earlier model, Fabrega's approach does not assume a normative view of biomedicine as a therapy system; instead, emphasis is placed upon the nature of health seekers to move from one source of treatment to another, successfully accounting for the use of many different healing methods over the course of an illness.

While noteworthy in its acknowledgement of worldwide patterns of multiple therapy modalities within societies, Fabrega's analysis suffers from a failure to consider the ways in which social and cultural factors influence the perception of illnesses or disorders for which health care may be required, that is, the contextual definition of symptoms and formation of health care decisions. The very process of "illness recognition" is itself highly variable and dependent upon the subjective assessment of symptomatic criteria. This assessment is a product of sociocultural context, and even more, of the precise microenvironmental surroundings of the individual.

This variability is not brought out fully in the pathway approach proposed by Fabrega.

A culturally relevant approach to the analysis of decision-making is presented by Chrisman (1977), who suggests that health seeking behavior can be characterized cross-culturally as a series of steps taken by individuals in attempts to solve health problems. These steps include "symptom definition, illness-related shifts in role behavior, lay consultation and referral, treatment actions, and adherence" to the treatment regimen (Chrisman 1977:353). In this sense, the "natural history of illness" is wholly dependent upon the context in which it is experienced; Chrisman identifies the process of symptom definition as a predominantly cultural factor, while role shifts (the adoption of a sick role) and consultation and referral within the social network are seen as primarily social factors which influence decisions made at the individual level.

The major contribution of Chrisman's model is its focus upon the formation of a sickness career, or a passage from health to sickness to recovery, as environmentally variable. This is to say, for example, that not only will a case of measles be experienced differently by persons in different cultures, for explanatory models (EM) of illness are culturally based (Kleinman _et_ _al._ 1978), but also within the same culture the experience will not be uniform for all persons. Each episode of illness will have a unique natural history, shaped by the precise social context of recommendation and referral by family and friends. Chrisman argues that social networks are highly variable intraculturally with regard to degree of compactness of social relationships, range of extra-group contacts, and the extent of overlapping roles or multiplexity of social bonds (1977:364-5). These factors can be highly influential in determining who will offer advice to the ill individual, the nature of the suggestions given, and whose recommendations will ultimately be acted upon. Since "the experiences of others aid an individual in making decisions about possible health actions" (1977:370), and since no two individuals experience illness at the same time or as part of precisely the same network of social interaction, the decisions made by individuals are likely to be unique responses to particular configurations of social recommendation and lay referral. Unfortunately Chrisman does not concentrate upon decision-making behavior per se, although his analysis very clearly indicates that choice of health care alternative depends entirely upon the sociocultural matrix of ill individual.

A more explicit consideration of the processual nature of decision-making, although somewhat less culturally relevant, is the model of "sickness as a decision-making career" suggested by Twaddle (1979). From a sociological perspective, Twaddle suggests that sickness is a strictly social event involving a set of "logically necessary" decisions to be made by the individual within the context of a social network. In acknowledging the presence of illness and a need for health care, there must be a recognition by the decision-maker that:

1) a change from normal health has occurred;
2) the change is significant;
3) help is required to restore health;
4) one or another form of help must be selected (lay, religious, medical);
5) a particular treatment agent of the form selected must be chosen;
6) a degree of cooperation with the health care supplier is required (Twaddle 1979:134-146).

The limitations of this approach are apparent in the distinction among lay, religious, and medical health care providers as necessarily different types of healers within a society. To be sure, religion and medicine are often integrated, and even at times indistinguishable from one another, as in the case of Catholic Spiritualist healers in Mexico (Finkler 1980, 1981b) or Puerto Rican espiritistas in New York (Harwood 1977). Twaddle's sociological focus is best applied to decision-making in Western industrialized societies, but this approach may be generally modifiable for cross-cultural analyses for it correctly identifies the decision-making process as dynamic and interactive, rather than a static phenomenon.

Thus I would argue that health care decision-making involves the recognition of potential health problems, and the consideration of various courses of action which might lead to the alleviation of these problems. The form of treatment chosen may vary widely from culture to culture, but the common element cross-culturally is the process of health assessment and the arrival at a decision about "what to do." This model does not assume that the actual decision-maker is necessarily the sick individual: Janzen (1978b) clearly indicates that in Zaire the "therapy managing group," consisting of close relatives of the sufferer, is chiefly responsible for determining the therapeutic course of action. However the group's choices are greatly affected by the context of the particular illness episode, for dissent within the group may ultimately lead to different choices, or different sequences of choices.

The conclusion that health care decision-making is a contextual process suggests that a thorough analysis of both the micro- and macroenvironments of illnesses is required in order to better understand the nature of health care choice in medically pluralistic societies. The study of decision-making must therefore proceed by way of clear and focused research into the environmental context of illness experiences and the "career" of the sick individual (Twaddle 1979, 1981; McKinlay 1981). Decision-making, like sickness, takes place over time and cannot be reduced to a single, decontextualized event. Rather, many factors interact to create a unique context for each illness episode, and this context is crucial to the formation of health care decisions.

I now wish to turn to an analysis and critique of the actual study of health care decision-making, and to offer some suggestions for the interpretation of health care choice within the context of the illness experience. Some methods are perhaps better suited than others to capture the contextual essence of decision-making. Quantitative analyses which decontextualize decision-making fail to take into account the changing, fluid nature of illness contexts, and thus do not provide an adequate basis for explaining the meaning of health care decisions to the persons who make them. In this regard, quantitative studies may supplement, but not supplant in-depth analyses of decision-making at the individual level. These issues are taken up more fully in the chapter below.

Chapter III. The Study of Health Care Decision-Making: Interpretive Frameworks and Methodological Approaches

In the previous chapter I dealt primarily with the ways in which environmental context molds and shapes the processes of illness perception and decision-making. I now wish to focus more closely upon the various approaches and methodologies utilized by social scientists to study health care decision-making in cross-cultural perspective. The analysis of differential use of medical resources has a relatively long history within sociology (Colson 1971:227), but truly anthropological investigations of decision-making are more recent developments, resulting primarily from a greater appreciation of illness behavior as socially and culturally contextual, and a greater awareness of the problems inherent in utilizing Western sociological methods and assumptions in cross-cultural research.

Much of the early literature in medical sociology on decision-making and the use of health resources is based upon research carried out in Western industrialized nations (Britain, U.S.). As such, the view of biomedicine as the normative or usual treatment system is often an implicit assumption of the research design (Kasl and Cobb 1966; Colson 1971). Decision-making in these studies generally concerns not so much the selection of specific alternatives, but rather the decision of when to "seek out competent help," that is, to adopt a sociologically defined sick role (Parsons 1951; Segall 1976). The particular resource chosen is seen to be of relatively minor importance in analyzing the sequential transition "from person to patient" (Zola 1983:109), and back to person. Since a biomedical choice is held to be standard or normal, any use of "alternative" health care facilities is seen as an aberration, an unusual event.

Anthropologists, on the other hand, have long recognized that many different sorts of indigenous or non-biomedical health resources are utilized by members of societies in which biomedicine is not a dominant tradition. Recent research has confirmed that medical pluralism continues to flourish in these communities despite predicitions of biomedical hegemony upon the introduction of Western medical practices (Leslie 1980; Lock 1980a; Waxler 1984). However, anthropological investigators are relative newcomers to the field of decision-making, and controlled studies of the reasons for a continued reliance upon multiple forms of therapy have been lacking. Thus the parameters of decision-making processes which lead to the choice of one resource or another in pluralistic societies are still poorly understood.

Several different interpretive frameworks for the analysis of health-seeking behavior have emerged in recent years, and different methodologies have been proposed for the actual study of health care decision-making by researchers seeking to characterize the nature of medical choice and the use or non-use of various resources in pluralistic societies. In general, field reports of decision-making have tended to be either qualitative and descriptive, or quantitative and statistical, although efforts to integrate these approaches are beginning to appear (Young and Garro 1982). Following a discussion of early anthropological interest in decision-making and the utilization of health care resources, these methodologies will be explored in greater depth. Qualitative "patterns of resort" and "pathways" analyses, which focus upon illness behavior in a social and cultural context, as well as currently popular models of the "determinants of use of care" (Kroeger 1983) will be examined with regard for their ability to conceive of decision-making as a process intimately related to the sociocultural matrix of the illness experience.

Quantification of social variables, and the subsequent development of formal models of decision-making, have been urged by some investigators in order to facilitate cross-cultural comparisons of decision-making behavior (Kroeger 1983:147). Formal modeling allows for the testing of hypotheses and the identification of key factors or variables which correlate with certain health care choices; medical sociologists and anthropologists are bringing such studies to ever-increasing levels of mathematical sophistication (J. Young 1980, 1981a, 1981b; Pescosolido 1982; Young and Garro 1982). However, a reliance on quantitative studies, at the expense of qualitative ones, may be inappropriate for the anthropological study of a phenomenon as dynamic and contextual as the independent, sequential, or multiple utilization of health care alternatives by persons in times of illness. I hope to demonstrate some of the limitations of rigid, quantitative approaches to the study of health care choice, inasmuch as decision-making as a continuous process is decontextualized (Comaroff 1983) and considered apart from its environment in both the collection of data for such studies and the subsequent statistical interpretation of the results.

This is not to say that statistical approaches are irrelevant to the study of choice of health care; indeed, quantitative data is essential if we are to derive generalizations and patterns of decision-making from a wide variety of individual cases of help-seeking within a society. Rather, I would stress that the temporal element of the health-seeking career of the individual is often lost in this framework of analysis. Decision-making as an on-going process may be more fully understood in terms of the total context of particular illness experiences and a thorough exploration of this context requires the direct observation and analysis of illness behavior, i.e., of individuals actually seeking health care and making health care decisions. As I have emphasized above, decision-makers are guided in their perceptions of health problems and appropriate courses of therapy by microenvironmental and macroenvironmental forces, and for the individual this constellation of influences which affects the ultimate choice of treatment is unique to each illness episode. Statistical methods may clarify the extent to which recurring factors of context (cost, accessibility, household income, age, disease etiology) correlate with health care decisions in aggregate, thereby minimizing the uniqueness of each individual case; yet they do not provide a basis for understanding the meaning of these decisions to the health seekers themselves. Analyses of broad population samples which correlate key factors with health care choices (e.g. Titkow 1983; Uyanga 1983) often reduce decision-making to a single event, rather than an on-going series of interacting, interconnected events. These studies may benefit from additional in-depth research of decision-making at the level of individual health seekers.

Early investigations

Attempts to account for the differential use of health care resources by members of preindustrial or non-Western societies first appear in the anthropological literature more than thirty years ago. In an important early article, Erasmus (1952) laid the groundwork for cross-cultural research in this area by describing the folk medical beliefs and practices of persons in urban Quito, Ecuador. In contrasting folk medicine to the newly introduced ideas and methods of "modern" or scientific medicine, Erasmus focuses upon local or indigenous concepts of disease causation and methods of treatment. His study of the folk medical system, and the use of various forms of folk treatment and therapy by the population, is examined in more detail below.

Folk medicine is the primary source of health care for the poorer residents of Quito, though acculturation to modern medicine is evident in an increasing knowledge of modern disease terms and use of physicians' services. The term "folk medicine" implies a variety of traditional curing procedures and herbal remedies used by the local populace to treat illness which, for whatever reason, are not brought to the attention of modern doctors in the city. Folk concepts of disease etiology provide a basis for the understanding of illness, as well as a rationale for its treatment. Illness is commonly attributed to "contagion," or infection with "bad body humor" (Erasmus 1952:413). This substance, which exudes with perspiration, may re-enter the pores and infect the blood if one does not bathe frequently. Bad humor may also be passed to other persons, and cause illness, through close contact or sexual relations. Ailments believed to be caused by contagion include skin diseases, infected wounds, and syphilis.

Illness may also be casued by "mechanical" means, such as experiencing sudden temperature changes, eating harmful foods, or suffering a blow to the body. Exposure to cold air when one is overheated is considered especially dangerous and can lead to dysentery, pneumonia, urinary difficulties, rheumatism, measles, partial paralysis, or malaria. Foods which are inherently "cold" or those which have been cooked and allowed to cool can also cause illness and tend to be avoided. Body blows can cause tumors and meningitis. In addition to contagion and mechanical causes, illnesses may be ascribed to "psychological" causes. Persons may suffer "anger sickness" due to jealousy or quarrels, with such symptoms as diarrhea, vomiting, fever, or depression. Erasmus argues that these are all believed to be essentially natural causes of illness which do not involve the intervention of supernatural agents or forces.

Certain ailments, on the other hand, are definitely considered to have a supernatural etiology. These include "fright" (susto -- see Rubel 1977) "malevolent air," and illness due to evil eye (Erasmus 1952:413-4). Children are the predominant sufferers of these maladies, but adults are also victims of supernatural illnesses caused by witchcraft. Symptoms of all illnesses of this sort are generally non-specific, but fever, vomiting, and diarrhea in children are often taken to indicate a supernatural etiology.

Erasmus suggests that the assessment of disease etiology is important in determining the ultimate choice of treatment. Most problems are initially treated at home with herbal solutions, broths and poultices, unless a supernatural cause is suspected; if this is the case a folk medical specialist is sought to "clean" the patient by rubbing with special plants, eggs, or guinea pigs:

> "In a sense, every adult is a medical specialist. The folk share a common knowledge concerning the diagnosis, classification, and treatment of symptoms and are most likely to consult a curer only when their own household remedies fail. If a supernatural cause is suspected, however, only the curer is considered capable of properly administering the 'cleaning' treatment" (Erasmus 1952:415).

In general, then, illnesses which are naturally caused are treated at home, whereas those of supernatural origin are taken to folk specialists such as curers and herbalists for treatment. Erasmus notes that in many cases an "informant will admit he goes to the [biomedical] doctor only when his own remedies or those of the curer have failed" (1952:416). While people seem to have great faith in the doctor's ability to cure diseases with modern names (diphtheria, tuberculosis, venereal disease, appendicitis) they do not classify their own ailments in this terminology until a doctor is consulted, after folk medicine has failed to help them.

Several problems, however, are immediately apparent in Erasmus' analysis of health care choices. First, although the operating principle of decision-making is said to be the initial assessment of disease etiology, no information is offered as to how this determination is made, by whom, and according to what criteria. The process of symptom recognition is not objective but rather microenvironmentally contextual, and data is lacking on the manner by which health problems are perceived and subsequently diagnosed by persons in a context of social interaction and communication. Second, very little is mentioned concerning the various types of folk specialists, beyond their identification as curers or professional herbalists. We are led to believe that all folk medical options are essentially similar when in fact their methods and philosophies of healing may be quite divergent. Third, Erasmus speaks in vague generalities and discusses what "the folk" do when they become ill, when it is probable that illness behavior is highly variable in the seeking of folk therapy. A few case studies of persons who became ill and the folk treatment(s) they sought would be a welcome contribution to the data on concepts of etiology and rules of choice based on determination of illness cause.

To complicate matters, Erasmus himself notes that etiological basis is not the only consideration in deciding which health resource to utilize. Indeed, factors of social status and group identification enter into the decision of whether to use folk therapies at all:

> "Among white collar and professional classes in Quito a feeling exists that only people of inferior status use herbal remedies and go to folk curers. The 'better' people are supposed to rely on drugstore remedies and doctors...It would seem that acceptance of the doctor and his remedies is related in some degree to prestige, independently of an understanding of modern etiology" (Erasmus 1952:420).

Absent from his discussion is any mention of such macro-factors as the accessibility of modern health resources, or cost of doctors' services which, in relation to the income of poor urban dwellers, may prevent persons from seeking a doctor's assistance even if they so desire it. In this sense, people may be economically constrained to folk medical choices if modern medical care is not a financially viable option. In each instance of help-seeking it would be fruitful to assess the interrelationship of micro- and macroenvironmental factors in order to determine which features other than etiology enter into the decision to make use of one health resource over any other.

Two other workers, following the lead of Erasmus, are noteworthy for their early research into the differential use of health resources in developing countries. Foster (1958) suggests that Erasmus' concept of choice based on etiology may have worldwide applicability as a "folk dichotomy" which guides choice of treatment method in many preindustrial societies. In seeking to account for the reason some illness episodes in Latin American countries are taken to biomedical practitioners and others to native healers for treatment, Foster proposes an etiological basis for the decision (an extension of Erasmus' proposal), whereby the perceived cause of an illness limits the expected effectiveness of various therapeutic efforts. Those disorders which are believed to be caused by means of "natural" phenomena are amenable to the manipulations of modern doctors and may be cured without resort to an indigenous healer. However, illnesses which are diagnosed to have a "supernatural" causation will not be taken to a physician because such a move will not have any positive effect upon the outcome of the illness. These sorts of disorders are only curable by means of traditional healing practices. Choice of health care resource is thus based upon whether "folk diagnosis says that the illness is one in the native curer's, not the Doctor's, domain" (Foster 1958:18).

Unfortunately many of the same criticisms of Erasmus' work apply to this study as well. Foster does not describe a method for testing his hypothesis, and the question of what constitutes an episode of illness and how a diagnosis of etiology is reached in different sociocultural contexts is never taken up. The "folk dichotomy" is suggested to be a generally valid "rule" which guides health care decisions; yet many persons do not adhere to generalized patterns of behavior or "rules," especially in the case of illness and help-seeking, and it is important to consider why such variation exists and the extent to which the rules fail to explain observed behavior. To be sure, the use of health services is a great deal more complex than an either/or choice, and the possibility of subsequent or simultaneous treatment by several different practitioners is not adequately dealt with using a single variable approach.

In a similar type of analysis, Gould (1957) suggests that treatment decisions often vary with initial assessments of illness severity, rather than strictly etiological considerations and proposes to analyze the choice of traditional or Western healers by residents of a northern Indian village in terms of the <u>acute</u> or <u>chronic</u> nature of health problems. This distinction is the operating principle in guiding health care decisions, argues Gould, for those disorders which develop suddenly and which cause severe, acute symptoms ("critical incapacitating dysfunctions") are most often treated by a Western physician. Alternatively, less severe disorders of an ongoing, chronic nature which develop slowly are generally seen by traditional practitioners. As in Erasmus' and Foster's analyses, Gould's distinction of choice on the basis of severity is a "rule" or generality which may or may not hold true in any particular case. Implicit in this assertion is the notion that persons actively choose healers on the basis of this single characteristic, although no methods are proposed by which to investigate this assertion more fully. Other criticisms mentioned above are also valid here. Despite these objections, however, the early investigators set the stage for future decision-making research by focusing upon the use of folk and traditional health resources in non-Western, developing, or preindustrial societies. This work led directly to the study of "hierarchies of resort" to various health care alternatives (Schwartz 1969), and the concepts of sequential decision-making and the use of health resources over a period or periods of time.

Patterns of resort

In a pioneering study, Schwartz (1969) discusses health care decision-making among the Manus of the Admiralty Islands in an historical context of European contact and acculturation of the Manus to European values and beliefs. Continuous interaction between Melanesian populations and Europeans has occurred since initial contact by European explorers in the sixteenth century, resulting over time in a certain amount of culture change and modification of traditional Manus lifestyles. Intensive missionary work eventually led to the mass conversion of the Manus to Christianity around 1930 and the adoption of an associated system for the interpretation and treatment of illness, one which emphasized the nature of illness as a punishment from God for such moral transgressions as anger, selfishness, and jealousy (Schwartz 1969:202).

However, this new understanding of illness has not wholly supplanted traditional Manus beliefs of illness causation and effective treatment. For example, sorcery is commonly suggested when adults fall gravely ill, and moral illness attributed to punishment by the ghost of one's own lineage is also still considered a possibility. The traditional (T) and Christian (C) explanatory models provide alternative therapies for health restoration. The differences between them lie in the accepted underlying cause of illness and the controlling power to which the appeasement, retribution, or compensation is offered.

In addition to these two models or systems of causation belief and treatment, a third amoral or impersonal system of biomedical therapy, labelled European (E), may also be utilized for the alleviation of health problems. European medicine is seen by the Manus as a mode of treatment rather than a source of knowledge regarding the underlying or ultimate cause of a disease. It treats symptoms without providing an answer to the question of why the individual became ill.

Schwartz identifies "acculturative" and "counter-acculturative" sequences or patterns of resort to each of the three types of explanation and treatment. An acculturative sequence is one in which European medicine is the therapy of first resort. If, following this treatment, the illness does not subside, then more powerful explanations of the disorder are sought and other treatment methods are tried. In this case, "the sequence starts with more recent, modern modes, and the trend is toward earlier cultural modes" (Schwartz 1969:204); the pattern of resort would thus be E-C-T, or from European to Christian to traditional therapies. Conversely, a counter-acculturative sequence of T-C-E, or from traditional to Christian and finally to European therapies, is seen in many instances, where "the first resort is to an earlier mode, and the trend, in the event of failure, is then to seek more recently introduced modes" (Schwartz 1969:204).

Illness causation beliefs (in accordance with Foster's prediction) often provide the basis for acculturative or counter-acculturative sequences. Disease which results from soul damage by supernatural agents, or from in-group cursing by an aggrieved relative, or from sorcery, is most commonly dealt with in counter-acculturative fashion, since these illnesses lie "beyond the pale of European medicine, knowledge, and power" (Schwartz 1969:203). Traditional cures such as herbal remedies and hot leaf applications are first prepared at home; one or a series of traditional curers may then be consulted, and eventually a shift toward Christian interpretation of the illness may ensue; and as a final resort, hospital treatment is sought for advanced stage illness. Schwartz argues that the failure of biomedical treatment to effect a cure in many of these advanced cases further substantiates what the Manus had suspected all along: that the illness was the result of supernatural forces and could not be helped by any sort of European medical intervention.

However groundbreaking Schwartz's study, it is beset with difficulties and omissions. The author admits that her conclusions are based upon "a set of cases collected incidentally as we worked on other problems" (1969:205). Decision-making was not a central focus of the investigation but rather a side interest explored during the course of research on Manus social and cultural organization. Of course, as I have argued above (Chapter I), an intensive knowledge of the values, beliefs and social organization of a society is a prerequisite for cogent criticism and analysis of health and illness in that society. The medical anthropologist must first be a competent sociocultural anthropologist, for the "medical" sphere of a society articulates with and cannot easily be separated from religious, legal, political or economic domains (Comaroff 1983). Yet this general anthropological preparation does not obviate the need for clear and focused research into the issues of decision-making and help-seeking behavior. In this context, Schwartz's article represents little more than the author's initial hypotheses and speculations about the manner in which health care decisions are made in Manus society. While allowing for the possibility and, indeed, even the likelihood of the use of more than one health resource over time, this model accounts for these decisions in terms of belief of disease etiology alone. As in Foster's "folk dichotomy," an assessment of the origin of an illness provides the rationale for treatment. Thus it is a characteristic of the illness, and not of the sufferer, which chiefly determines choice.

This view seems overly reductionistic, for it interprets causation beliefs to be the sole basis for help-seeking behavior; and if this is truly the case, further data must be presented in support of this assertion. Excepting a few brief examples, Schwartz avoids discussion of actual illness episodes and decision-making which she witnessed firsthand, nor does she discuss the reasons given by help-seekers for the particular choices they made. Furthermore, no effort is made to examine the microenvironment of illness incidents -- the influence of social networks and advice solicitation upon the folk diagnosis and subsequent health care decisions, the economic status of the individual at the time of the health crisis, or psychological factors which may affect the decision to interpret an illness as treatable by traditional, Christian, or European means.

As well, the issue of the macroenvironment of health care delivery on the Admiralty Islands and its effect on health care choice is not considered to any great degree beyond a preliminary discussion of the introduction of European medicine and the changing nature of resource accessibility after

World War II. In fact, Schwartz does mention that, following the Japanese occupation of the islands,

> "the Admiralties became one of the largest American bases in the South Pacific. Large base hospitals and an abundance of medical supplies were established with treatment facilities for natives. This coincided for the first time with the availability of antibiotics, sulfa drugs and penicillin as well as more effective anti-malarials" (1969:203).

In a short period of time, the entire therapeutic resource base from which to choose expanded dramatically, making European or biomedicine for perhaps the first time an accessible treatment option to many members of the population. Prior to this development, the choice of European medicine was made difficult by its relative scarcity and geographic isolation from large numbers of people. Yet with the advent of American influence, the macroenvironment of decision-making changed dramatically. I would argue that the processes of health care choice cannot be adequately examined without reference to the context of the accessibility of health care and other macroenvironmental influences. This includes not only the geographical distance of facilities and difficulty of travel for the help-seeker (Annis 1981; Young and Garro 1982), but also the cost of services relative to the personal funds of the health seeker, and importantly, the quality of care provided regardless of distance or cost. These issues seem not to have received thorough consideration in the analysis of Manus resort hierarchies, though they greatly affect the ultimate choice of health options by decision-makers.

Despite these criticisms, however, the importance of Schwartz's work should not be underrated. As a preliminary analysis of health care choice in a non-Western, medically pluralistic society, it provides a foundation for future decision-making research by anthropologists in a wide variety of cultural settings. The temporal nature of help-seeking is stressed in "patterns of resort" analyses, for it is assumed that persons may use one resource, then another, and then another in efforts to achieve the restoration of health. In many ways this work foreshadowed the development of "help-seeking career" models (Chrisman 1977; Twaddle 1979, 1981; McKinlay 1981) which consider decision-making in terms of sequences of events and the continual re-evaluation of health care choices over time.

In recent years several field studies have emerged which base their analyses upon interpretations of pattern or hierarchies of resort. Woods (1977) examines the use of "alternative curing strategies" by members of a Guatemalan Mayan population and seeks to discover the logic of choices among "modern," "folk Ladino," and "folk Indian" medical systems. In an attempt to determine which health resources are utilized first and most often, Woods collected data on the sequence of resource choice and the pattern of usage when more than one treatment was employed for an illness episode.

While most illnesses recorded during this period (64%) resulted in the choice of only one health care option, a substantial portion involved the sequential movement from one alternative to other methods. These health care options include self-help therapies (home or pharmacy remedies), Indian or Ladino lay curers and nurse-nuns (minor resources), and shamans, pharmacists, and biomedical doctors (major resources). The most common pattern of resort, argues Woods, is the movement from self-help treatments to minor resources to major resources, according to the persistence and severity of symptoms for which relief is sought.

As well, a general trend towards the use of "modern" or biomedical alternatives is evident in the community, and for many individuals the pattern of utilization is commonly from traditional to "transitional" to modern medical resources. Transitional health resources are those which serve as a "bridge" between traditional and modern medicine (Woods 1977:38). One such resource is the pharmacist, who is knowledgeable of Indian traditions, but who carries his instruments in a black bag, wears a white smock, and is called "doctor" by many of the villagers. Woods also notes that this pattern of resort is not evident in all illness episodes: some individuals in the study exhibited a modern-transitional-traditional sequence ("acculturative" in Schwartz's terminology), and some the concurrent, rather than strictly sequential use of multiple health care options (cf. dual use: Press 1969).

Interacting features of the microenvironment of the illness experience and the macroenvironment of health care delivery cause the choice of biomedical services to seem attractive to Mayan villagers in some respects, and repulsive in others. Both the shaman and the pharmacist are more expensive than the doctor (Woods 1977:40), and the cost of other modern medical resources (nurse-nuns) is negligible thanks to government support. This would seem to promote the use of biomedical health options and discourage reliance upon the more expensive traditional alternatives. However, on the other hand, villagers often complain of the doctors' impersonal manner of interaction with patients and their failure to offer patients any information about the ailment or its cause (1977:48). This criticism is not unique to the Mayan plantation, but rather has been cited as a major reason persons in non-Western or preindustrial societies the world over avoid seeking health care from biomedical personnel (Kroeger 1983). In this sense, the impersonality of these health care providers may encourage the continued utilization of non-biomedical options. Health care decision-making, then, involves the assessment of microenvironmental variables -- psychological attitudes toward health personnel, the advice and recommendation of others in a network of social interaction and lay referral (Freidson 1970a), as well as macroenvironmental factors, which may include economic, geographic, and political influences upon the ultimate choice of health alternative.

Though Woods successfully demonstrates the complexity of the environment of health seeking, the resultant analysis of patterns of resort less than satisfactory. The complexity in fact seems to demonstrate that no clear-cut pattern exists. People have many different reasons for the choices they select, and these depend on the circumstances of particular illness episodes. I would argue that the unique context (micro and macro, for both are constantly changing) of each incident of help-seeking provides different criteria for decision-making at the level of the individual. There may be no reason to assume that the same person will necessarily exhibit the same pattern of resort on two separate occasions, because the context of illness is itself different in each case.

Further data on patterns of resort are presented by Garrison (1977) in a discussion of the use of <u>espiritistas</u>, or spiritists, by members of a Puerto Rican community in New York. Normally, persons turn to spiritists for help in managing "somatic, intrapsychic, and interpersonal difficulties" which are not initially relieved by a biomedical doctor's healing efforts. In this sense the spiritist serves as a secondary health resource: the great majority of spiritist clients (81-85%) had seen a doctor within a one-year period prior to the time of interview and had been dissatisfied with the outcome of therapy they received (Garrison 1977:102).

If spiritist treatment fails to alleviate a client's problems, the aid of a psychiatrist may then be sought. In most cases the psychiatrist, unlike the spiritist, is not seen as "a source of help with the problems of living;" psychiatric consultation is reserved for treatment of the "hopelessly mentally ill," or for the prescription of pills for "nerves." Patients thus utilize psychiatrists as a tertiary health resource, the resort pattern commonly being from doctor to spiritist to psychiatrist (Garrison 1977:162-3).

Yet Garrison acknowledges that not all community members exhibit this pattern of resort. After all, some 15% of spiritist clients by-passed initial treatment by a doctor, and many persons see psychiatrists without ever resorting to spiritist therapy. Like other studies of this kind, Garrison's analysis describes trends and generalities, but does not address the decision-making processes of individual health seekers to any significant degree.

Nichter (1978) is somewhat more successful in analyzing patterns of resort and use of therapy systems in rural South India, though here also no general conclusions hold true in every case. The health care environment of this region is very complex: a great number of registered medical practitioners (RMPs) with varied backgrounds and levels of training are licensed to practice. Indigenous medical practitioners include folk herbalists, exorcists, sorcerers, astrologers, and Ayurvedic healers. Some RMPs hold diplomas from colleges of classical Ayurveda, while others have informal training from family members or are self-taught (Nichter 1978:34). Furthermore, increasing numbers of M.B.B.S. doctors are moving into the region, making biomedical treatment a seemingly more accessible health care alternative.

Nichter suggests that an individual's economic position, caste, and level of education, as well as the nature of the illness suffered and the availability of medical resources, all enter into the decision of health care utilization and sequence of resort. Poor persons generally choose the less expensive treatment of an Ayurvedic practitioner, especially if drugs are needed for an extended period of time. More educated villagers tend to utilize biomedicine first, but they are also more likely to simultaneously consult an Ayurvedic physician if allopathic medicine does not produce immediate results. The belief that biomedical treatment alleviates symptoms but not the essential causes of an illness (and may in fact be responsible for side effects or subsequent ailments) serves to promote the use of other treatment methods.

The most important finding of Nichter's research thus is that the choice of health care in South India is a complicated decision which cannot be reduced to individual factors alone. The chronic/acute dichotomy proposed by Gould only partially explains these data; acute children's illnesses, for example, are generally treated initially by traditional practitioners, contrary to Gould's prediction (Nichter 1978:44). Even with regard to cost, the assertion that "poor people choose the least costly alternative" may not characterize every instance of help-seeking.

I would briefly like to mention here the work of Finkler (1980), whose focus upon the efficacy of non-medical treatments in rural Mexico involves a consideration of patterns of resort to biomedical or Spiritualist treatment methods. [This and later research (Finkler 1981a, 1981b) is discussed more fully in the following section.] While the major thrust of this study is to evaluate treatment outcomes, Finkler identifies three distinct patient groups which seek Spiritualist therapy, representing different patterns of resort to therapeutic measures.

Regulars are converts to Spiritualism who consult temple healers first in all cases of illness for which outside help is sought. If a cure does not ensue following this treatment, then temple regulars will seek biomedical attention. *First-comers* are persons who, having not been cured by a medical practitioner, seek Spiritualist therapy as a last resort. Finally, *habitual temple users* are persons who have been successfully treated once at the Spiritualist temple and who return for treatment of illnesses which are not "grave" or life-threatening. In the event of (culturally defined) serious conditions, such as illnesses requiring bed rest or associated with fever, habitual users resort first to medical doctors. But for such minor problems as diarrhea without fever, pain in the stomach, *susto*, or insomnia, Spiritualist therapy is preferred.

The pattern of resort is thus different for each group of temple users. First-comers use other health care alternatives first, and Spiritualist therapy is tried when all else fails. Regulars, on the other hand, resort to Spiritualism first for all health care needs regardless of the type of symptoms or their severity, and use biomedical services only if relief is not forthcoming. Habitual users are discriminatory in their resort to Spiritualist healers; if symptoms indicate a non-grave illness, choice of Spiritualist therapy is likely. However if symptoms suggest a more serious problem, medical treatment is sought.

In this analysis Finkler stresses the heterogeneity of the population and the different sorts of resort patterns exhibited by Spiritualist clients. Her research clarifies issues of intracultural differences in help-seeking and demonstrates that resort may not be predictable, especially in the case of habitual temple users. However, further research is required to verify that these patterns of resort are consistent over time; do any habitual users subsequently become regulars, or do any regulars ever seek medical treatment before Spiritualist therapy? Again, the issue of consistency in following hierarchies of resort is assumed, when in fact different illness contexts may lead to different sequences of therapy resort.

Finkler's analysis does not end with an illumination of patterns of resort alone. In this and subsequent writings (1980:284; 1981a) she stresses that "illness networks" of referral are influential in determining whether Spiritualist treatment is sought, implying that the social context of illness guides health care decisions. In this regard, resort to Spiritualist healers is a response to the microenvironment of illness, for lack of an "illness network" (cf. lay referral system: Freidson 1970a; lay consultation and referral processes: Chrisman 1977:357-8) promoting Spiritualism generally precludes its use.

Finally, Kleinman (1980) attempts to analyze patterns of resort through the use of intensive interviewing techniques and the reconstruction of help-seeking behavior of Taiwanese families. These data prove useful in elucidating the processes of decision-making with regard to self-treatment with diet, tonic, herbs, etc.; Western-style doctors or pharmaceuticals; Chinese-style practitioners; or tang-ki or other sacred folk healers. Over 150 families were interviewed regarding the sicknesses suffered by family members during the previous month, the treatment decisions and reasons for those decisions, the sequence of use of treatments or practitioners, and an assessment of the outcome of the treatments chosen (Kleinman 1980:181). This method allows for the collection of information concerning actual illnesses and incidents of help-seeking which were not directly observed by the fieldworker, but which occurred recently enough to be remembered and described in detail by family members.

Kleinman notes that in every case recorded several variables interacted to determine which source of therapy was sought, including such fixed factors as age and sex of the patient, but more importantly such unpredictable features as "past experiences with health care" and the "nature of [the] patient's social network and lay referral system" (1980:185). Three patterns of resort are implicated by the elicited data: these are labelled <u>simultaneous resort</u> (use of multiple therapies concurrently, usually in the case of a serious childhood sickness); <u>hierarchical resort, exclusive type</u> (use of different therapies sequentially but not simultaneously, usually in the case of an acute but non-life-threatening adult sickness); and <u>hierarchical resort, mixed type</u> (continuation of the use of previous therapies even as new ones are sought, usually in the case of a chronic or recurrent adult sickness).

The strength of this model lies in its recognition of variability of resource choice at the individual level. While Kleinman argues that persons use health resources simultaneously or sequentially, he does not prescribe the order of resort. Although self-treatment is invariably the therapy of first resort, the next step may be the choice of a Western-style doctor, <u>or</u> a Western-style pharmacist, <u>or</u> a Chinese-style practitioner, <u>or</u> a Chinese-style pharmacist, depending upon the exact nature of the illness suffered and the evaluation of the efficacy of previous choices within the context of social interaction and lay referral. Kleinman further suggests that <u>semantic illness networks</u> (1980:187) provide a logic for therapy choices, for particular sickness labels imply particular treatments which will be beneficial to the individual.

Three case studies of health care decision-making are presented as illustrative of the complexity of the health seeking process (Kleinman 1980:190-3). In each instance the individual's choice of health option was dependent upon the illness label initially applied to the condition, the subsequent perception of treatment outcome, and the reconsideration of the accuracy or appropriateness of sickness labels over time. By describing the pathway of help-seeking for these individuals, Kleinman has pointed out the inherent difficulty in trying to predict behavior at the individual level. Indeed, without these case illustrations, his model of resort patterns could be read to argue that health care choices always follow set rules or are necessarily predictable outcomes of illness episodes. In this sense, hierarchies of resort tend to present a falsely simplified view of decision-making processes by suggesting that health seeking is an ordered and logical sequence of events. Kleinman's analysis of individuals and their actual decisions in times of health crises serves to emphasize the limits of predictability based on hierarchies of resort.

The great benefit of all patterns of hierarchies is their explication of recurrent sequences of health care decisions across microenvironmental contexts. That is to say, patterns of resort clarify the extent to which persons in society exhibit similar health-seeking behavior in similar, but not identical circumstances of illness. Yet on the other hand, one of the major problems of these analyses is their inapplicability at the level of the individual. For any illness, what determines the actual therapy choices made by the individual or members of his social network? How are we to know if an individual will follow the prescribed pattern or if he will "deviate" in some way from the norm? And is not this deviance a major interest of decision-making researchers and analysts? Several investigators, in an effort to understand more fully the meaning of health care decisions to the individuals who make them, have turned to an exploration of decision-making "pathways" and the sequences of choices make by health-seekers during actual times of health crisis. Both Janzen (1978b) and Finkler (1980, 1981a, 1981b) attempt, through the methodology of participant observation and case analysis, to clarify why particular individuals in need of health care make the decisions they do, in their particular micro- and macroenvironmental contexts, and the rationales they provide for these decisions. Following the pathway of health-seekers, from illness onset to recovery (Fabrega 1973; Igun 1979; Kroeger 1983) provides a measure of insight into the reasons behind health care decisions in a manner that abstract analyses of resort patterns, using cross-sectional population data, may not provide. The pathway approach to the study of decision-making, with its benefits and problems, is taken up more fully below.

Pathways of help-seeking

One way to appreciate the complexity of health care decision-making is to observe firsthand the actual behavior of persons seeking health care. Data collection by means of participant observation allows a view of the social and cultural context of illness and help-seeking that is hard to obtain by means of surveys or other impersonal methods. Janzen's (1978b) landmark study of the "quest for therapy" by members of BaKongo communities in Lower Zaire convincingly demonstrates the importance and value of this approach in studying health care choices in medically pluralistic societies. Such a method attempts to clarify the pathway of help-seeking, the sequence in which health care choices are selected and evaluated, and new decisions made in light of previous therapy outcomes.

Initially, Janzen sought to use formal eliciting techniques (componential analysis) to gather data on BaKongo beliefs and attitudes and courses of therapeutic action in the event of illness. These data would have represented hypothetical cases of illness and what to do about them. However, it was soon discovered that:

> "efforts to administer interviews in KiKongo resulted in some bafflement on the part of our otherwise willing interlocuters, having to do with a type of 'it-all-depends' perplexity, and a great deal of variety in the results. Responses to such questions as 'What kinds of illnesses are there?' or 'How is such-and-such an illness treated?' resulted in totally disparate types of answers" (Janzen 1978b:33).

To complicate matters, Janzen then realized that questions about hypothetical situations were inappropriate on account of the fact that "respondents would *say* one thing...but then in the throes of decision-making *do* another." This led to the total abandonment of his "initial primary concern 'with what people think' [in favor of] a concern with 'what they do,' and how that is rationalized" (Janzen 1978b:33). Following directly the work and advice of Victor Turner (1967, 1968), Janzen found that the "intensive case method" of study would prove most useful in determining what health care choices people make, and why they believe they make them. Since "the quest of a sick BaKongo for treatment often takes him/her tens, scores, even hundreds of miles" in seeking relief from illness, logistical problems dictated that only a handful of cases could be followed through the entire course of help-seeking (Landy 1983:224).

The dichotomy between *kisi-nsi* (native culture) and *kimundele* (foreign culture) is pervasive in Kongo society, and medical practices are interpreted either as indigenous traditional techniques, or as imported, Western methods. This perceived distinction does not, however, prevent individuals from utilizing different kinds of therapies sequentially, or occasionally simultaneously. Most minor ailments are initially felt to be natural of "of God," and may be treated either by a traditional healer or by Western methods. It is only when an individual fails to respond to initial treatment that the ailment is suspected to be "of man," or to have resulted from "the sufferer's self-abuse, outside or mystical aggression, or structural and social causes" (Janzen 1978b:221).

The consideration of etiology is thus important to the ultimate choice of therapeutic alternative. Janzen identifies four "therapy systems" in operation in Lower Zaire--"the art of nganga, kinship therapy, purification and initiation, and Western medicine"--which interact to form an integrated and unified regional health care system (1978b:193). Only the first three of these, the indigenous or traditional therapy systems, are seen to be effective in combatting "of man" illnesses, such as those caused by witchcraft, failure to fulfill social obligations, or breach of taboo (e.g. incest). The question of resort patterns is not developed by the author, beyond mentioning that illnesses which linger or recur tend to be seen by traditional rather than Western healers.

The Quest for Therapy devotes itself to a "thick description" (Geertz 1973) of the decision-making of six individuals whose multiepisodic illnesses were followed for periods of one week to several months or years. Janzen documents the fact that in each case, the principal decision-makers were not the individuals suffering the disorders, but rather the members of their families and close relatives, who formed a "therapy managing group" (1978b:4) which assumed complete responsibility for selecting treatment options. The case of one woman, Luzayadio, who fell ill shortly after giving birth and subsequently "played a very minor, passive part as decision-maker" in the determination of her therapy (Janzen 1978b:68) serves to illustrate the importance of this group in the determination of health care choice from a variety of alternatives.

Luzayadio was born in 1950 to a woman of the Nsundi clan and man of the Kimbanga clan, and lived uneventfully in her father's village until the age of seventeen. At this time she became romantically involved with Kitoko, a man of her father's clan. Her pregnancy by him caused a great deal of controversy in the village because he was "of her father's generation, in the relationship of a 'father's brother' to her" (Janzen 1978b:68). Though her mother objected, Luzayadio's father urged the two to marry, so Kitoko made a payment to her mother's brother signifying his intent and left for Congo Brazzaville to earn the bride payment. Luzayadio gave birth in November 1968 after a normal pregnancy and delivery, but in January she became weak and experienced a swelling of the limbs. It became difficult to walk up steep paths in the fields, so she first consulted a retired mission nurse who gave her an injection of penicillin. She also received treatment from a local curer, who made superficial scratches on her skin which he rubbed with plant substances.

Upon examination by an M.D., she was found to have limb edema, hepatomegaly, swelling of the face, and an enlarged heart. She was given biomedical treatment for parasitic infection (emetine and chloraquin), but within a few days her family terminated the treatment and arranged for a meeting of Nsundi and Kimbanga clans to determine whether there was hostility between the groups which could have caused her illness. No tensions were revealed, and the disease was decided to be "of God," rather than "of man." However, Luzayadio was requested to ask forgiveness of her maternal clan, and members of the clan asked for her forgiveness, in order to assure that undisclosed evil intentions were eliminated in case the illness was actually "of man"; for the same reason, representatives of her paternal clan asked for her forgiveness. Since Luzayadio's mother considered her impending marriage to Kitoko to be "incestuous," there was unresolved tension between her mother and father, and "the subsequent course of therapy depended on the analysis of this conflict" (Janzen 1978b:69). If she had not become ill, her marriage likely would have been approved; but her illness provoked a controversy of whether the marriage was right, and hence the tension between clans.

Her condition did not improve over the next week, and upon examination again by the M.D. she was found to have cardiomegaly, heart murmurs, and other signs of severe heart failure. She was treated with inadequate medication and died several weeks later. After her death, suspicions were raised about the relationship between the illness and her "incestuous mating." Luzayadio's maternal clan refused gifts from her paternal clan, whom they suspected of being in some way responsible for her death. In the end relations were restored to normal, but the suspicion of incest continued to serve as a reminder that Luzayadio's health problems may have been brought about by her union of questionable status.

Janzen emphasizes that all throughout her illness, Luzayadio did not have much say in the type of health care she was to receive. Instead it was the members of her therapy managing group, comprised of persons in her immediate family, who participated in the actual choice of therapeutic alternatives. Furthermore, the exact membership of this group changed over time, with some family members proving to be more influential than others at various stages in the progression of her illness. Because the clans could not resolve the issue of whether her forthcoming marriage to Kitoko was proper, they could not be sure Luzayadio had not brought the illness upon herself and was experiencing her due punishment. No effective therapy was sought for her problems because of the failure of the members of the therapy managing group to arrive at a consensus.

This case dramatizes the socially contextual nature of the quest for therapy, as well as a central feature of the process, which is that the ill individual generally exercises little influence in the decision-making process. Other cases described in detail by Janzen support the contention that the therapy managing group is really the chief decision-making body, and that health care choices are often out of the hands of the person suffering the illness.

The strength of Janzen's analysis is the demonstration that the choice of health care and sequence of alternatives chosen "all depends" upon the precise context of the illness experience. Indeed, in no two cases were therapy decisions exactly the same, since each episode of help-seeking involved not only a unique set of symptoms but also a unique group of persons "managing" the administration of therapy. Furthermore, the health care system of Zaire continues to change under the influence of international development and the introduction of biomedical clinics in rural areas; future health care decisions will necessarily involve a consideration of this changing macroenvironment of resource accessibility and efficacy of Western methods.

Admittedly, one of the biggest problems with an observational approach to the study of help-seeking pathways is the inability to follow the illness behavior of more than a small handful of persons. It is wholly possible that in choosing six cases to follow intimately, the investigator will select ones which are unrepresentative of the rest of society. In this regard, the methodology of direct observation of decision-making does not provide a broad overview of the health-seeking behavior of a large segment of the population. Yet Janzen recognizes this limitation from the outset, and although only a few cases are presented, the entire sequence of events in each instance is recorded in all its richness of contextual detail. Such a method avoids the pitfalls of what A. Young (1981) calls the "rational man" assumption of decision-making, i.e., the expectation that health care decisions necessarily follow a certain logic or rationality, or that decision-makers themselves see their choices as rational ones. Such an assumption need not be valid, for in health crises people may act in fashions they recognize to be irrational or illogical, if such behavior holds the faint possibility that a cure may ensue. The documentation of acutal help-seeking pathways is a useful methodology in this regard, for it lays bare the reality of decision-making processes, rather than glossing over a simplified version of expected patterns of choice.

Some of these methodological problems are overcome by Finkler (1980, 1981a, 1981b), in her research on the choice of non-medical treatments in rural Mexico. Direct observation of Spiritualist healing sessions and interviews with persons seeking Spiritualist therapy form the basis of her investigation. In this regard, Finkler focuses directly upon actual accounts of help-seeking and the decisions people make in response to illness, rather than questioning them about past or hypothetical instances of help-seeking behavior. Through personal contact with clients coming to Spiritualist temples for treatment, and by means of intensive interviews and follow-up studies, every effort was made to determine why persons sought Spiritualist help, and how effective they felt such therapy proved to be.

Finkler recognizes the temporal element of the illness experience, and that the evaluation of satisfaction with treatment requires following persons from the time they decide to seek help to the time of problem resolution. The only appropriate way to investigate these issues is through continued interaction and communication with the help-seekers throughout the course of their illnesses, and to follow their help-seeking pathways over time. Although this research is specifically concerned with the assessment of treatment outcomes, it does address several topics directly relevant to an understanding of decision-making. For example, Spiritualist therapy is but one treatment alternative available to persons in Hidalgo state; the choice of this option depends in large part upon the recommendations and advice of other persons in a network of social interaction. Individuals who choose Spiritualist therapy almost invariably have received support for this decision from members of their "illness network," whereas those without such support generally do not seek this form of treatment.

By developing a rapport with Spiritualist clients and interviewing them in their homes over a period of several weeks, Finkler was able to gather data regarding current health problems, decisions made in response to these problems, and the benefit of various treatments to the help-seeker. This method has the advantage of allowing larger numbers of people to be studied than Janzen's technique of direct observation, and it avoids the problem of asking people about events which occurred long enough in the past to be forgotten or poorly remembered. On the other hand, Finkler's focus specifically upon Spiritualist therapy does not permit a detailed consideration of decision-making which involves choices other than this treatment alternative. To be sure, further research is needed to clarify the ways in which many different therapeutic options are utilized by members of this population; perhaps the use of interviewing techniques may be modified to include persons who seek health care from resources other than Spiritualist healers. This broadened focus could well lead to "a comparative study of health seekers" (Finkler 1981a) which analyzes the decision-making processes of persons actually seeking health care from a great variety of resources in the community.

Both Janzen and Finkler attempt to provide a broader understanding the contextual nature of health care decision-making by looking at actual cases of help-seeking and the factors involved in arriving at these decisions. Both authors succeed particularly in demonstrating that the social context of illness is important in determining the ultimate choice of therapy in pluralistic settings. Health care decisions are not made independently but evolve out of a process of advice solicitation and negotiation with other persons in networks of social interaction. Direct observation of help-seeking behavior by the fieldworker provides insights into the importance of environmental context in determining the pathway of choice that other methods may not capture.

In this light, I now wish to turn to a discussion of quantitative analytical approaches to the study of decision-making and the development of formal models of health care choice. Quantitative analyses attempt to identify key determinants, variables or factors of context which correlate with the utilization of particular health care resources, and to predict health care decisions on the basis of such data. These methods, while providing useful descriptive data on patterns or health care utilization, necessarily decontextualize the health-seeking process in the course of statistical analysis and model building. Formal models cannot take into account the variability of micro- and macroenvironmental contexts of illness experiences at the level of the individual and may therefore distance us from a true understanding of meaning of health care decisions to persons seeking health care.

Quantitative data analysis and formal modeling

Developing out of quantitative sociological approaches to the study of social phenomena, formal modeling of decision-making has been proposed by some workers as a means for assisting in the cross-cultural investigation of health care choice (Kroeger 1983). Quantitative analyses of decision-making behavior require the definition and numerical measurement of various economic, demographic, social, or psychological characteristics, and the subsequent determination of correlations between measured variables and observed rates of utilization of medical services. The dependent variable, choice of health alternative, is thus seen to be a function of the many independent factors analyzed; and if developed properly, proponents suggest that formal models may predict decision-making behavior based on an assessment of the proposed variables (J. Young 1981a; Pescosolido 1982).

Quantitative methods are often applied in attempts to elucidate the most important "determinants of use of care" (Kroeger 1983), or variables which correlate strongly with the differential utilization of health care resources by various segments of societies. Some sociomedical researchers, for example, have suggested quantitative analysis as a way to determine "the degree to which new [biomedical] resources are being utilized" upon their introduction to Third World societies (Colson 1971:226). Thus, statistically significant associations between the designated variables and the relative use of various health care resources may be used to provide clues to health planners as to why biomedical facilities are often underutilized in developing countries.

Kroeger (1983) summarizes the work of several researchers who employ quantitative analytical approaches for the study of health care choice

(Fig. 1). The variables examined in these studies may be organized into three groupings:

1) *Characteristics of the subject* refer to features of individual health seekers which correlate with the differential use of health care resources. These characteristics may be relatively easily conceptualized and measured, such as "economic" factors (household income) and "sociodemographic" variables (age, sex, marital status, household size). They may also be quite nebulous and difficult to apprehend, such as "socialpsychological" factors (degree of cultural adaptation, acculturation to Western values (McKinlay 1972)).

Medical sociological research in industrialized countries has dealt primarily with characteristics of individuals and their correlation with the differential use of hospitals or biomedical treatment facilities. This work has resulted in an extensive literature outlining various individual factors which predict use patterns (Anderson 1968; Mechanic 1968; McKinlay 1972). For example, Ludwig and Gibson (1969) report that 37.3% of persons whose household income is less than $150 per month had not visited a clinic or hospital in the previous six months, while only 10.0% of members of high-income households (more than $500 per month) had similarly failed to utilize health care services. Thus, household income is an economic "predisposing factor" (Kroeger 1983:148) which influences persons in health care decisions.

This approach has been modified by some workers to study "characteristics of the subject" in non-Western societies which may correlate with patterns of health resource utilization. Colson proposes that *acculturation* may be analyzed in terms of:

> "the amount of formal education, spatial mobility, age, amount of cross-cultural contact, degree of participation in traditional

Figure 1

Explanatory variables of health care choice

<u>Characteristics of the subject</u>

- -age
- -sex
- -socioeconomic level
- -occupation
- -ethnic group
- -marital status
- -household size
- -formal education
- -degree of cultural adaptation
- -assets (land, livestock, cash)
- -interaction with family, neighbors, community
- -innovators

<u>Characteristics of the disorder and their perception</u>

- -chronic / acute
- -severe / trivial
- -etiological model (natural, supernatural)
- -expected benefits of treatment (modern, traditional)
- -psychosomatic / somatic

<u>Characteristics of the Service (Enabling Factors)</u>

- -accessibility
- -appeal (opinions, attitudes towards traditional and modern healers)
- -acceptability, quality, communication
- -costs

(Kroeger 1983:149)

> religious activities, occupational mobility, and aspect of material culture" (1971:228).

Though difficult to quantify and measure accurately, this model holds that variability in acculturation may predispose persons to one or another health care alternative during times of ilness.

2) <u>Characteristics of the disorder and their perception</u> refer to persons' beliefs regarding the nature or etiology of the illness for which help is sought. Foster's "folk dichotomy" (1958; see above) is widely cited in support of the view that choice correlates highly with features of the disorder, rather than of the sufferer. This dichotomy of treatment method (supernatural etiology: traditional healer; natural etiology: biomedical treatment) is suggested by recent research to be operative in areas of the world as widely separated as the Ivory Coast (Lasker 1981:158) and Ecuador (Kroeger 1983:151). Colson (1971) argues that in a rural Malaysian village, perceived etiology has a significant effect upon choice of therapy: native health practitioners are most often seen for illnesses believed to be caused by "supernatural agents, breach of taboo, or breach of ethical precept," whereas illness believed to be caused by natural agents are commonly taken to the biomedical clinic. Other workers, however, have questioned the universal validity of this principle based on research in different culture areas (e.g. the Manus, Schwartz 1969).

Other characteristics of the disorder which have been proposed to account for choice of health care include the perception of an illness as chronic or acute (Gould 1957), severe or trivial, or the expected benefits of one or another treatment method in light of etiological belief. These are factors of cultural interpretation which influence individuals in the decision-making process.

3) <u>Characteristics of the service (enabling factors)</u> refer to those features of the health care delivery system which promote or discourage the use of various resources within the community. Such variables as the geographical <u>distance</u> of medical services and the <u>time</u> required to travel for treatment are important factors affecting the rate of utilization of health services, especially in rural areas. Another important variable of the health service is anticipated <u>cost</u> of treatment. Though cost is, strictly speaking, a factor of the service itself, it affects medical choice in relation to the financial resources of the health seeker and is not independent of the "characteristics of the subject" as defined above. Decisions must be made concerning the availability of funds, expected fees of the practitioner, and the potential benefit of investing limited resources in one or another treatment method. These factors are not easily teased apart by means of a consideration of cost of services in isolation.

Other service-related variables often considered by investigators are the relative "appeal" of traditional vs. biomedical healers to the members of a community; the level of "communication" between healer and patient; and the "quality" of health care administered (Kroeger 1983:149). Though such factors may be difficult to apprehend and consider in isolation from the rest (and especially difficult to quantify), proponents of "determinants" models argue that they significantly affect health care decision-making and the use or non-use of services (Young and Garro 1982). Woods (1977; see above) provides support for this assertion by describing how the impersonal manner of biomedical doctors on a Guatemalan plantation (lack of "appeal," poor "communication") inhibits Mayan residents from seeking their assistance. Health researchers further suggest that changes in any of these characteristics, especially cost and distance, may significantly alter the rate at which health services are utilized by members of a population (Fiedler 1981:129).

Quantitative analysis, in leading to the isolation of key variables or determinants of behavior, provides a statistical framework for the prediction of health care choice based on these variables. Annis (1981:520), for example, reports that in a sample of 1800 patients visiting government health facilities in rural Guatemala, 66% travelled fifteen minutes or less, whereas only 12% travelled one hour or more, and only 2% travelled two hours or more. On the basis of these data, one may conclude that the greater the distance of health services, the less likely persons will resort to them. More recently, in a study of the effects of distance and geographic location upon the use of "Western-type health facilities" in rural Nigeria, Stock (1983) demonstrates that <u>per capita</u> utilization declines exponentially with increasing distance from the biomedical health center. The implications of this finding are that: 1) with the development of more biomedical facilities in rural areas, more people will resort to them; and 2) this is a desirable end result toward which national health policy should be directed.

Egunjobi (1983:585) identifies factors which influence the choice of hospital in northern Oyo State, Nigeria: in descending order of significance these are "nearness, quality of service, relative living in hospital town, finance, ease of transport, religion, and connections with hospital staff." Yet Egunjobi is quick to point out that the most influential factor, nearness of the hospital, accounts for only 31.8% of the observed variance in choice of services. In other words, almost "70% of patients' behaviour are explained by other factors," so that a combination of variables must be used to predict health care choice with any degree of accuracy. Similarly, Feldman (1983:1887) cites "the importance of gender, age, and class factors in influencing the utilization of different health care providers" in rural Bangladesh. These factors, considered together, provide the best clues as to which alternative will be chosen; any one variable taken alone is insufficient to account for rates of utilization.

One of the more innovative attempts by anthropologists to elucidate determinants of health care choice is the development of a formal <u>decision-making model</u> by J. Young (1978, 1980, 1981a, 1981b) and Young and Garro (1982). Based upon field research in Pichátaro, a rural Tarascan village in west-central Mexico, the model presupposes that a common culture provides members of the community with "shared standards or rules for solving problems and selecting particular courses of action" (J. Young 1981a:5). Health care decisions are thus patterned and predictable, following a culturally prescribed set of values and ideas concerning the "best" or most appropriate choice of therapy in a given case of illness; over time, persons "develop and come to rely upon specific standards for making choices involving the treatment of illness" (J. Young 1980:107). In attempting to demonstrate "the link between cultural knowledge ('beliefs') and purposive action" (J. Young 1980:106) in the making of health care decisions, Young and Garro seek to discover the factors which Pichatareños themselves consider most important in determining the form of treatment, and subsequently to develop a model which will predict health care choice on the basis of these factors.

Young specifically rejects Janzen's "thick descriptive" or explanatory approach, for it focuses upon "unusually complex and problematic cases, at the expense of the more routine...kinds of illnesses people deal with in daily life" (J. Young 1981b:501). The six cases studied in depth by Janzen, though presented in full contextual detail, have little generality and cannot be considered representative of the general population at large; in this regard they may not be used to create a model of decision-making behavior of wide applicability. Rather, a formal modeling approach is taken which will lead to the development of a prediction formula for health care choice in more common, less complex cases of illness.

Data on "principal decision criteria" (J. Young 1981a:132) were collected using formal eliciting techniques, in order to discover the ways in which "potentially complex decisions are reduced or simplified to information-processing tasks of manageable proportions;" in this regard, formal elicitation provides insight into "the underlying cognitive processes involved in decisions" (J. Young 1981b:501). Community members were questioned regarding hypothetical instances of illness and the decisions they would make given a wide variety of circumstances ("what would you do if..."). Four key factors were ultimately determined to weigh heavily in the choice of health care: gravity of an illness, knowledge of a home remedy for the illness, "faith" (in the potential effectiveness of folk vs. medical treatment), and accessibility of health services (cost, transportation). These variables accounted for the greatest amount of variance in the hypothetical choice of health care, and they alone are included in the formal decision model.

Health care decisions in Pichátaro may therefore be predicted according to the shared "rules" of decision-making uncovered by this research. A decision table (J. Young 1981a:154; Fig. 2) and a decision tree (J. Young 1981b:503) are presented which illustrate expected initial choices of health alternative on the basis of an assessment of the four important variables. For example, an illness which is considered 1) "moderately serious" and for which 2) a home remedy is not known or unavailable, and which is 3) suffered

Figure 2

Decision Table for Initial Choice of Treatment

Rules:	1	2	3	4	5	6	7	8	9
Conditions:									
Gravity[a]	1	1	1	2	2	2	3	3	3
Known Home Remedy[b]	Y	N	N	Y	N				
Faith[c]		F	M	(F)	F	M	F	M	(M)
Accessibility[d]								N	Y
Choices:									
Self-treatment	X			X					
Curer		X			X		X		
Practicante			X			X		X	
Physician									X

[a] 1 = Nonserious; 2 = Moderately Serious; 3 = Grave.
[b] Y = Yes; N = No.
[c] F = Favors folk treatment; M = Favors medical treatment.
[d] Y = Money and transportation available; N = Either money or transportation not available.

(J. Young 1981a:154)

by a person who has greater faith in Western than folk medicine (see Fig. 2, Rule 6) will, according to the model, most likely choose a <u>practicante</u> (local, non-licensed practitioner of Western medicine), rather than a physician, folk curer, or self-treatment. Similarly, a grave illness suffered by a person with more faith in Western than folk treatment, and who has sufficient money and transportation (see Fig. 2, Rule 9) will likely be taken to a physician. In theory, all episodes of illness may be reduced to a combination of these factors, analyzed according to the decision table or tree, and considered in terms of the most probable course of help-seeking.

In order to test the model, Young collected data on actual health care decision-making in Pichataro through a biweekly survey of 62 households. Respondents were asked to report detailed descriptions of illnesses that had occurred, and treatment choices made in each case. In all, information on 323 illness episodes were used to compare reported decisions against the model based upon formally elicited data (J. Young 1981a:11). According to these responses, the decision-making model correctly accounted for or "predicted" 82.6% of all treatment choices, after adjustment for routine self-help choices (J. Young 1981a:166, 1981b:505). Therefore, a high degree of accuracy for the model is suggested by the test data.

Despite the success of such prediction models, some problems remain unresolved in using statistical frameworks for the study and interpretation of decision-making. Many of the criticisms one might make of quantitative techniques and formal modeling are not limited to health research alone; however the situation is especially acute in this case due to the importance of environment and context in shaping and guiding health care choice.

First, the definition of factors to be used in such studies is a very difficult task. Researchers tend to discount the problems inherent in defining and quantifying such factors as degree of acculturation to Western values (Colson 1971), or quality of health care provided (Kroeger 1983), but these characteristics defy accurate description and measurement in cross-cultural settings. Furthermore, social and economic factors are dynamic and change over time; even easily measured variables such as household income may be not be constant from one season or one year to the next. Classification of persons therefore depends upon the exact time they are questioned by the researcher, and their categorization as one or another "type" may be an artifact of the research design.

Second, quantitative analyses often infer causality from statistical correlation, and imply that determining factors are consciously assessed and considered in processes of health care decision-making. Indeed, such variables as age, sex, household income, and social class often are found to correlate with relative utilization of health services (Colson 1971; Heller et al. 1981; Lasker 1981; Okafor 1983). But it is not clear that decision-makers necessarily take these particular factors into consideration when choosing health care. In many cases, of course, decision-makers do choose particular alternatives on the basis of age, sex, and other variables; but it is not clear that other correlating factors, such as "relative living in hospital town" and "connections to hospital staff" enter into the conscious calculation of choice of treatment. Quantitative correlations can describe populational patterns, but qualitative research is necessary to discover whether these factors are meaningful to health-seekers. Thus a true explanation of why particular decisions are made may not emerge from a statistical analysis of correlated factors alone.

Third, the isolation of key factors of decision-making serves to decontextualize a process which, as I have argued above, is intimately related to the environmental context of the illness experience. These variables are, by virtue of the research design, removed from the immediate circumstances of symptom recognition and interaction with significant others in a social network, and are subsequently interpreted on their own as separate criteria upon which health care decisions are based. The act of decision-making is seen as a calculation or equation using the most "discriminating" factors; it is presented, therefore, as an essentially static phenomenon removed from any temporal frame of reference. The arrival at one or another choice takes the form of a unique and single determination of "what to do" based on an assessment of assets, level of education, severity of illness, distance to facilities, and so forth.

One may argue that illness contexts are comprised of factors which recur, and that these features may be evaluated systematically to outweigh the particularism of each individual case. In this sense the decontextualization of health care decisions may provide information concerning the relationship between recurring factors (age, sex, etiological belief, distance of health services) and the choice of alternatives across a broad sample of health seekers. Yet inasmuch as the microenvironmental influences on decision-makers, including patterns of consultation and lay referral, are variable from illness episode to episode, it may be difficult to fully apprehend the meaning of health care decisions without clear and focused research into the interaction between micro- and macroenvironmental contexts of sickness and health-seeking.

The decision-making process is quite complex, and involves a continual re-evaluation, over time, of the <u>need</u> for health care and the efficacy of prior treatment. Though many factors of context are recurrent, each illness episode takes place at a different time and place from all other episodes, and in the presence of a different set of persons who mediate the socialization of illness into sickness (A. Young 1982). A thorough understanding of the meaning of health care decisions, then, requires their analysis within the framework of sickness micro- and macroenvrionments, for it is this context which provides the basis for illness perception, and the subsequent choice of therapy by the help-seeker. Though quantitative methods and formal models provide information about societal patterns of choice and help-seeking, they do not adequately explain health care decisions at the level of the individual. In this regard, quantitative analyses are informed by qualitative studies; these research strategies are perhaps best seen to be complementary, rather than competitive, for each provides a measure of insight the other may inadequately provide.

Formal models, however, seem to be weakest in their attempts to predict health care choice at the individual level, and this results from an inability to conceive of particular episodes of illness as variable at the microenvironmental level of social interaction solicitaion of advice. Janzen (1978b), as noted above, stresses the importance of a therapy managing group for determining treatment choices in Lower Zaire: the changing membership of this group over time leads to changing ideas about the best treatment for the sick individual. Waxler (pers. comm.) observes that many therapy decisions in Sri Lanka are totally unpredictable, a case in point being

> "a family that plans to take a patient one direction on the train to an Ayurvedic doctor but meets a stranger on the platform who recommends a hospital in the other direction so they go there."

Though J. Young (1981a, 1981b) claims greater than 80% accuracy in predicting health care choice, there remains a residual percentage of decisions which are not accounted for successfully on the basis of isolated factors alone. These cases illustrate the variance between the hypothetical or ideal self, the rational decision-maker ("what would you do if..."), and the actual self seeking assistance in a time of health crisis. Formal models are unlikely to be able to predict health care choice with any more accuracy than Young's model, because of this inherent variability of microenvironmental influences upon persons in need of health care.

Anthropologists studying health care choice are beginning to recognize both the benefits and limitations of quantitative data analysis and formal modeling. Sargent (1982), for example, in researching obstetrical care choices among the Bariba of Benin, relies upon participant observation and formal interviewing techniques, as well as a review of maternity clinic records, to provide insight into the context of decisions which statistical methods alone would not provide. Eyton and Neuwirth (1984:447) argue forcefully against the sole reliance on Western sociological methodologies (including quantitative data analysis) in cross-cultural research and propose that "open-ended interviews be used in societies of which our knowledge concerning salient cultural differences is fragmentary." Anthropological contributions to the study of decision-making may thus lie not only in the development of formal models to be used cross-culturally (Garro 1982), but also in the demonstration of the limits of their applicabilty.

Chapter IV. Decision-Making Research and International Health: The Ethics of Intervention

I would like to close my examination of health care decision-making with a brief look at the practical implications of research in this area. One question that seems to be overlooked by researchers and critics alike is, Why do we want to know about the processes of health care choice in medically pluralistic societies? On the one hand, academic anthropologists may be concerned with this issue solely for its provision of insight into the logic (or illogic) of human behavior in times of crisis or threat of crisis. Health care decisions, as I have argued, are made in response to a context of illness which includes both microenvironmental aspects (social networks, lay referral, finances available to spend on health care) and macroenvironmental features (professional dominance and hegemony, political promotion of health services). "Pure" scholars may wish to discover the relationship of contextual variance to choice of health option in a variety of cultural settings, industrial and preindustrial, Western and non-Western.

Yet on the other hand, decision-making research may be of interest to "applied" anthropologists who seek to improve the quality of health services to areas of the developing world; the discovery of reasons why certain facilities are underutilized, for example, may lead to policy initiatives at the national and international level which will remove the impediment to the utilization of services. This motive appears to underly much of the sociomedical research undertaken cross-culturally, especially in the Third World (Kroeger 1983), the goal being to provide more and better biomedical health care facilities to those regions where traditional or indigenous healers are the primary health resources of a population. Colson sums up this attitude succinctly as follows:

> "Throughout the developing world, traditional systems of medical care are being supplemented with or completely replaced by knowledge and personnel that are an extension of modern Western medical science...One critical facet of these efforts is the degree to which the new resources are being utilized. The most modern, well-funded, and competently staffed program conceivable would be useless if the people for whom the program is designed radically underuse it, or even totally ignore it. This suggests a need to examine the manner and degree of receptivity to these attempts at induced change in health behavior" (1971:226).

Thus, a primary function of decision-making research might be to find out why biomedical clinics and hospitals are underutilized (distance? cost? incompatibility of world view of patient and healer?), and then to take steps to correct the problem, so that eventually persons will come to rely upon "modern" health services in these areas of the world.

Many anthropologists, however, find the idea distasteful that they should serve as intermediaries between a culture and Western health planners seeking to radically alter that culture. Indeed, this is the important ethical dilemma facing medical anthropologists today: to act accordingly would reduce them to the role of traitor to the cultures they have come to understand, for they would ultimately play a pivotal part in effecting a cultural drift toward the behavior and values of Western industrialized society. In the course of promoting the use of biomedical health facilities, they would be encouraging the abandonment of centuries-old practices and beliefs which they set out to document and interpret in the first place. Health planners, of course, would see this not as a negative development but as a move toward the World Health Organization's goal of "health for all by the year 2000."

Most disturbing is the value judgment that biomedicine as a system of treatment and health care delivery is necessarily "better" than indigenous or traditional treatment systems which continue to flourish the world over. International health planners seem to hold (in spite of overwhelming evidence to the contrary) that once biomedicine is made available and accessible (geographically, financially), people will flock to it and discard their "superstitious" healing methods (Waxler 1976; Leslie 1980; Lock 1980a); that they have failed to do this must represent the continued inaccessibility of biomedical services in Third World areas.

Herein, then, lies the role of the anthropologist: to demonstrate the value and usefulness of medical pluralism, and to illustrate the ways in which traditional health care may serve the needs of a population without being totally supplanted by biomedicine. Decision-making research will continue to reveal the importance of multiple health care options to members of a population, for even when biomedicine is made fully available, persons maintain their preference for alternative treatments and alternative healing methods. One means of illustrating the potential effectiveness of various therapies or systems of treatment is to link health planning initiatives to studies of "outcomes" of persons treated by non-biomedical healers. While the efficacy of treatments is a difficult topic to research, preliminary reports suggest that many non-medical healers enjoy large measures of success in treating psychological and other health problems which are not alleviated by means of biomedical therapy.

In a two-part study of outcomes of the clients of Spiritualist healers in Mexico, Finkler (1980, 1981b) demonstrates that Spiritualist therapy provides a viable alternative to biomedical treatment for problems which doctors have been unable to cure. To assess outcome of Spiritualist treatment, Finkler administered the Cornell Medical Index to clients at the outset of therapy, and then one to two weeks later; as well, clients were independently classified as failures (if prescriptions were followed but symptoms persisted), successes (if symptoms were reported to be relieved), and inconclusives (who had either failed to follow the prescriptions or had seen a medical practitioner concurrently).

While Spiritualist healers were found to fail more than succeed in treating patients (35% failures to 25% successes), those persons whose symptoms were alleviated by therapy showed a statistically significant drop in CMI score, indicating an amelioration of psychological distress. The critical question remains whether Spiritualist healers should be "allowed" to provide health care services when only one quarter of persons who resort to them are successfully relieved of their symptoms. Yet Finkler goes on to note that for four types of disorders -- simple diarrheas, simple gynecological disorders, somatized syndromes, and minor psychiatric disorders -- are frequently successfully treated with Spiritualist therapy, and in this light the services of Spiritualist healers are beneficial to some individuals.

Studies of patient outcomes are essential to the promotion of world health, yet they are by no means easy to undertake or verify. Presumably some health care alternatives are more effective in treating illnesses than others, and through clear and focused analyses of outcomes anthropologists can make information regarding this efficacy available to health planners and health seekers; attempts to maximize health care resources may themselves prove more effective if anthropologists begin to concentrate on which health care options help more people. This research is in fact currently under way in a wide variety of cultural settings (e.g. Kleinman and Gale 1982).

Following advances in symbolic anthropology (Turner 1967, 1968), several authors have suggested that the manipulation of symbols is a potent source of healing power, and that healers throughout the world rely upon symbolic therapy to effect health restoration. Kleinman (1973:206) speaks of "medicine's symbolic reality," that is, the idea that medicine is "a cultural system in which symbolic meanings take an active part in disease formation, the classification and cognitive management of illness, and in therapy." Health care providers in every culture make use of powerful symbols which reinforce the concept that help is being provided for the patient, and that the healer has the ability and knowledge required to cure whatever the illness may be. Comaroff (1982) argues that:

> "the onset of illness frequently occasions the perception of more deep-seated contradictions in the encompassing sociocultural order. The healing process mobilises potent symbolic resources, for in attempting to redress the breaches caused by illness, however these are perceived, <u>healers</u> <u>everywhere</u> <u>manipulate</u> <u>symbolic</u> <u>media</u> which identify physical with social order" (pp.51-2; emphasis added).

The point to be related to international health planners is that biomedical physicians do not have a monopoly upon the mobilization of "symbolic resources;" indeed, culturally relevant symbols are effectively utilized by healers of many traditions, and these individuals must not be ruled out as health care providers simply because they do not operate within the biomedical model of disease causation and cure.

Nichter (1978:46) firmly states that "health planners can be aided by anthropological insights," and that anthropologists should continue to provide information regarding the value of plural medicine in varied cultural contexts. Nichter's study, based on field research in South India, confirms the notion that networks of interaction and referral among traditional healers, and even between traditional and allopathic (biomedical) practitioners, are feasible and should be promoted in the context of health development programs:

> "The effective treatment of multiple aspects of illness required the combined efforts of complementary therapy systems (or types of specialists) and a traditional network of referral has existed between vaidya, astrologers, and exorcists....[and] many rural based traditional practitioners included trained allopaths in their referral networks" (1978:45-6).

Anthropologists should look for ways to foster cooperation among the various traditional and allopathic healers in this region, for the health needs of the population are not well served by excluding health care providers simply because they do not follow the biomedical model. Yet the question of iatrogenesis and healer-induced harm cannot be brushed aside, with the assumption that all "traditional" or "folk" healers serve their patient populations adequately. Anthropologists must explore not only illness outcomes but the potential exacerbation of existing problems by healers of all traditions, in order to provide sound recommendations for the development of health policy in varied cultural contexts.

These are only a few of the ethical problems facing medical anthropologists today; the issues are complicated, and by no means have I exhaustively covered the practical implications of decision-making research or the implications of failing to undertake such research. I do think, however, that anthropologists should not sit idly by and watch international health planners use their research to "clean up" medical systems in developing countries; in this regard, failure to act could lead to a renewed effort to establish biomedicine across the world at the expense of other effective healing traditions. It is incumbent upon decision-making researchers to demonstrate that medical pluralism is the rule, not the exception (even in the "industrialized West": Cobb 1977; Baer 1981), and that people continue to want health care choices rather than standard or normative treatment. Biomedicine, furthermore, is hardly 100% successful in "curing" illnesses, and several studies have shown alternative or non-medical therapies to be effective in treating conditions which could not be helped through biomedical treatment (e.g. Look 1980a; Kleinman 1980; Finkler 1980, 1981b).

Beyond the scope of this study is the difficult question of whether traditional health care providers should be licensed to practice, or whether governments should best stay out of the regulation of health care delivery by non-biomedical healers. I would like to end here, having raised these problematic issues, with the prediction that further investigations of decision-making processes will provide additional support for the position that medical pluralism promotes world health. The ethical dilemma facing researchers of health care choice is whether to allow these data to go unnoticed by "applied" health planners.

REFERENCES CITED

Abasiekong, E.M.
1981 Familism and hospital admission in rural Nigeria -- a case study. Social Science and Medicine 15B: 45-50.

Annis, S.
1981 Physical access and utilization of health services in rural Guatemala. Social Science and Medicine 15D: 515-523.

Baer, H.A.
1981 The organizational rejuvenation of osteopathy: a reflection of the decline of professional dominance in medicine. Social Science and Medicine 15A: 701-711.

Calnan, M.
1983 Social networks and patterns of help-seeking behaviour. Social Science and Medicine 17: 25-28.

Cassidy, C.M.
1982 Protein-energy malnutrition as a culture-bound syndrome. Culture, Medicine and Psychiatry 6: 325-345.

Chrisman, N.
1977 The health seeking process: an approach to the natural history of an illness. Culture, Medicine and Psychiatry 1: 351-377.

Cobb, A.K.
1977 Pluralistic legitimation of an alternative therapy system: the case of chiropractic. Medical Anthropology 1(4): 1-23.

Colson, A.C.
1971 The differential use of medical resources in developing countries. Journal of Health and Social Behavior 12: 226-237.

Comaroff, J.
1982 Medicine: symbol and ideology. In P. Wright and A. Treacher, The Problem of Medical Knowledge. Edinburgh: Univ. of Edinburgh Press, pp. 49-68.

1983 The defectiveness of symbols or the symbols of defectiveness? On the cultural analysis of medical systems. Culture, Medicine and Psychiatry 7: 3-20.

Cosminsky, S. and M. Scrimshaw
1980 Medical pluralism on a Guatemalan plantation. Social Science and Medicine 14B: 267-278.

Dean, K.
1981 Self-care responses to illness: a selected review. Social Science and Medicine 15A: 673-687.

Dunn, F.L.
1976 Traditional Asian medicine and cosmopolitan medicine as adaptive systems. In C. Leslie, ed., Asian Medical Systems. Berkeley: Univ. of Calif. Press, pp. 133-158.

Egunjobi, L.
1983 Factors influencing choice of hospitals: a case study of the northern part of Oyo State, Nigeria. Social Science and Medicine 17: 585-589.

Eisenberg, L.
1977 Disease and illness: distinctions between professional and popular ideas of sickness. Culture, Medicine and Psychiatry 1: 9-23.

Elling, R.M.
1981 Relations between traditional and modern medical systems. Social Science and Medicine 15A: 87-88.

Erasmus, C.J.
1952 Changing folk beliefs and the relativity of empirical knowledge. Southwestern Journal of Anthropology 8: 411-428.

Evans-Pritchard, E.E.
1937 Witchcraft, Oracles and Magic among the Azande. Oxford: Clarendon.

Eyton, J. and G. Neuwirth
1984 Cross-cultural validity: ethnocentrism in health studies with special reference to the Vietnamese. Social Science and Medicine 18: 447-453.

Fabrega, H., Jr.
1973 Toward a model of illness behavior. Medical Care 11: 470-484.

1982 Culture and psychiatric illness: biomedical and ethnomedical aspects. In A.J. Marsella and G.M. White, eds., Cultural Conceptions of Mental Health and Therapy. Dordrecht: D. Reidel, pp. 39-68.

Fabrega, H., Jr. and P.K. Manning
1979 Illness episodes, illness severity and treatment options in a pluralistic setting. Social Science and Medicine 13B: 41-51.

Fabrega, H., Jr. and D.B. Silver
1973 Illness and Shamanistic Curing in Zinacantan. Stanford: Stanford Univ. Press.

Feldman, S.
1983 The use of private health care providers in rural Bangladesh: a response to Claquin. Social Science and Medicine 17: 1887-1896.

Fiedler, J.L.
1981 A review of the literature on access and utilization of medical care with special emphasis on rural primary care. Social Science and Medicine 15C: 129-142.

Finkler, K.
1980 Non-medical treatments and their outcomes. Culture, Medicine and Psychiatry 4: 271-310.

1981a A comparative study of health seekers: or, why do some people go to doctors rather than to Spiritualist healers? Medical Anthropology 5(4): 383-424.

1981b Non-medical treatments and their outcomes. Part two: focus on adherents of Spiritualism. Culture, Medicine and Psychiatry 5: 65-103.

Foster, G.M.
1958 Problems in Intercultural Health Practice. Pamphlet No. 12. New York: Social Science Research Council.

Frankenberg, R.
1968 The beginning of Anthropology: the challenge of the New Africa to the sociological study of small-scale social processes. Proceedings of the VIIIth International Congress of Anthropological and Ethnological Sciences, Tokyo, vol. 2.

1980 Medical anthropology and development: a theoretical perspective. Social Science and Medicine 14B: 197-207.

Freidson, E.
1961 Patients' Views of Medical Practice. New York: Russell Sage.

1970a Profession of Medicine: A Study of the Sociology of Applied Knowledge. New York: Dodd, Mead and Co.

1970b Professional Dominance: The Social Structure of Medical Care. New York: Atherton.

Garrison, V.
1977 Doctor, espiritista or psychiatrist?: health-seeking behavior in a Puerto Rican Neighborhood of New York City. Medical Anthropology 1(2): 65-191.

Garro, L.Y.
1982 The ethnography of health care decisions. Social Science and Medicine 16: 1451-1452.

Geertsen, R., M. Klauber, M. Rindflesh, R. Kane and R. Gray
1975 A re-examination of Suchman's views on social factors in health care utilization. Journal of Health and Social Behavior 16: 226-237.

Geertz, C.
1973 Thick description: toward an interpretive theory of culture. In C. Geertz, *The Interpretation of Cultures*. New York: Basic Books, pp. 3-30.

Good, B. and M. Good
1981 The meaning of symptoms: a cultural hermeneutic model for clinical practice. In L. Eisenberg and A. Kleinman, eds., *The Relevance of Social Science for Medicine*. Dordrecht: D. Reidel, pp. 165-196.

Good, C.M., J.M. Hunter, S.H. Katz and S.S. Katz
1979 The interface of dual systems of health care in the developing world: toward health policy initiatives in Africa. *Social Science and Medicine* 13D: 141-154.

Gould, H.A.
1957 The implications of technological change for folk and scientific medicine. *American Anthropologist* 59: 507-516.

Hahn, R.A. and A. Kleinman
1983 Biomedical practice and anthropological theory: frameworks and directions. *Annual Review of Anthropology* 12: 305-333.

Hallowell, A.I.
1977 The social function of anxiety in a primitive society. In D. Landy, ed., *Culture, Disease, and Healing*. New York: Macmillan, pp. 132-138 (Orig. 1941).

Harwood, A.
1977 *Rx: Spiritist as Needed. A Study of a Puerto Rican Community Mental Health Resource*. New York: John Wiley and Sons.

Heggenhougen, H.K.
1980a Bomohs, doctors and sinsehs -- medical pluralism in Malaysia. *Social Science and Medicine* 14B: 235-244.

1980b The utilization of traditional medicine -- a Malaysian example. *Social Science and Medicine* 14B: 39-44.

Heller, P.L., H.P. Chalfant, G.M. Quesada, and M. Rivera-Worley
1981 Class, familism and utilization of health services in Durango, Mexico: a replication. *Social Science and Medicine* 15A: 539-541.

Hillier, S.M. and J.A. Jewell
1983 Chinese traditional medicine and modern Western medicine: integration and separation in China. In S.M. Hillier and J.A. Jewell, eds., *Health Care and Traditional Medicine in China, 1800-1982*. London: Routledge and Kegan Paul, pp. 306-335.

Igun, U.A.
1979 Stages in health-seeking: a descriptive model. *Social Science and Medicine* 13A: 445-456.

Janzen, J.M.
1978a The comparative study of medical systems as changing social systems. Social Science and Medicine 12: 121-129.

1978b The Quest for Therapy in Lower Zaire. Berkeley: Univ. of Calif. Press.

Kasl, S. and S. Cobb
1966 Health behavior, illness behavior, and sick role behavior. Archives of Environmental Health 12: 246-266.

Kleinman, A.
1973 Medicine's symbolic reality: on a central problem in the philosophy of medicine. Inquiry 16: 206-13.

1978 Concepts and a model for the comparison of medical systems as cultural systems. Social Science and Medicine 12: 85-93.

1980 Patients and Healers in the Context of Culture. Berkeley: Univ. of Calif. Press.

Kleinman, A., L. Eisenberg and B. Good
1978 Culture, illness and care. Annals of Internal Medicine 88: 251-258.

Kleinman, A. and J.L. Gale
1982 Patients treated by physicians and folk healers: a comparative outcome study in Taiwan. Culture, Medicine and Psychiatry 6: 405-423.

Kohn, R. and K.L. White, eds.
1976 Health Care: An International Study. London: Oxford Univ. Press.

Koos, E.L.
1954 The Health of Regionville. New York: Columbia Univ. Press.

Kroeger, A.
1983 Anthropological and socio-medical health care research in developing countries. Social Science and Medicine 17: 147-161.

Landy, D.
1983 Medical anthropology: a critical appraisal. In J.L. Ruffini, ed., Advances in Medical Social Science, vol 1. New York: Gordon and Breach, pp. 185-314.

Lasker, J.N.
1981 Choosing among therapies: illness behavior in the Ivory Coast. Social Science and Medicine 15A: 157-168.

Lebra, W.P., ed.
1976 Culture-Bound Syndromes, Ethnopsychiatry, and Alternate Therapies. Honolulu: Univ. Press of Hawaii.

Lee, R.P.L.
1982 Comparative studies of health care systems. Social Science and Medicine 16: 629-642.

Leslie, C.
1976 Introduction. In C. Leslie, ed., Asian Medical Systems. Berkeley: Univ. of Calif. Press, pp. 1-12.

1980 Medical pluralism in world perspective. Social Science and Medicine 14B: 191-195.

Lock, M.
1980a East Asian Medicine in Urban Japan. Berkeley: Univ. of Calif. Press.

1980b The organization and practice of East Asian Medicine in Japan: continuity and change. Social Science and Medicine 14B: 245-253.

1982 Traditional and popular attitudes towards mental health and illness in Japan. In A.J. Marsella and G.M. White, eds., Cultural Conceptions of Mental Health and Therapy. Dordrecht: D. Reidel, pp. 215-233.

1984 Licorice in leviathan: the medicalization of care for the Japanese elderly. Culture, Medicine and Psychiatry 8: 121-139.

n.d. Transformation of social problems into a biological idiom: the case of the Japanese elderly. Unpublished ms.

Locker, D.
1981 Symptoms and Illness: The Cognitive Organization of Disorder. New York: Tavistock.

Ludwig, E. and G. Gibson
1969 Self perception of sickness and the seeking of medical care. Journal of Health and Social Behavior 10: 125-133.

Marwick, M., ed.
1970 Witchcraft and Sorcery. Harmondsworth: Penguin Books.

McKinlay, J.B.
1972 Some approaches and problems in the study of the use of services--an overview. Journal of Health and Social Behavior 13: 115-152.

1981 Social network influences on morbid episodes and the career of help seeking. In L. Eisenberg and A. Kleinmen, eds., The Relevance of Social Science for Medicine. Dordrecht: D. Reidel, pp. 77-107.

Mead, G.H.
1964 Selected Writings, A.J. Renk, ed. Indianapolis: Bobbs-Merrill Company.

Mechanic, D.
1962 The concept of illness behavior. Journal of Chronic Diseases 15: 189-194.

1979 Future Issues in Health Care. New York: Free Press.

1982 The epidemiology of illness behavior and its relationship to physical and psychological distress. In D. Mechanic, ed., Symptoms, Illness Behavior, and Help-Seeking (Monographs in Psychosocial Epidemiology, v. 3). New York: Prodist, pp. 1-24.

Nichter, M.
1978 Patterns of resort in the use of therapy systems and their significance for health planning in South Asia. Medical Anthropology 2(2): 29-56.

1980 The layperson's perception of medicine as perspective into the utilization of multiple therapy systems in the Indian context. Social Science and Medicine 14B: 225-233.

1983 Paying for what ails you: sociocultural issues influencing the ways and means of therapy payment in South India. Social Science and Medicine 17: 957-965.

Okafor, S.I.
1983 Factors affecting the frequency of hospital trips among a predominantly rural population. Social Science and Medicine 17: 591-595.

Parsons, T.
1951 The Social System. New York: The Free Press.

Pescosolido, B.A.
1982 Medicine, Markets and Choice: The Social Organization of Decision-Making and Medical Care. Unpublished Ph.D. dissertation, Yale University.

Press, I.
1969 Urban illness: physicians, curers and dual use in Bogota. Journal of Health and Social Behavior 10: 209-218.

1980 Problems in the definition and classification of medical systems. Social Science and Medicine 14B: 45-57.

Robinson, D.
1971 The Process of Becoming Ill. London: Routledge and Kegan Paul.

Rubel, A.J.
1977 The epidemiology of a folk illness: susto in Hispanic America. In D. Landy, ed., Culture, Disease, and Healing. New York: Macmillan, pp. 119-128 (Orig. 1964).

Sargent, C.F.
1982 The Cultural Context of Therapeutic Choice: Obstetrical Care Decisions among the Bariba of Benin. Hingham, Mass.: D. Reidel.

Schwartz, L.R.
1969 The hierarchy of resort in curative practices: the Admiralty Islands, Melanesia. Journal of Health and Social Behavior 10: 201-209.

Segall, A.
1976 The sick role concept: understanding illness behavior. Journal of Health and Social Behavior 17: 163-170.

Skipper, J.K. and J.E. Hughes
1983 Podiatry: a medical care specialty in quest of full professional status and recognition. Social Science and Medicine 17: 1541-1548.

Smith, M.G.
1974 A structural approach to comparative politics. In M.G. Smith, ed., Corporations and Society. London: Duckworth.

Stock, R.
1983 Distance and the utilization of health facilities in rural Nigeria. Social Science and Medicine 17: 563-570.

Suchman, E.A.
1965a Social patterns of illness and medical care. Journal of Health and Human Behavior 6: 2-16.

1965b Stages of illness and medical care. Journal of Health and Human Behavior 6: 114-128.

Titkow, A.
1983 Illness behaviour and action: the patient-role. Social Science and Medicine 17: 637-646.

Turner, V.W.
1967 The Forest of Symbols: Aspects of Ndembu Ritual. Ithaca: Cornell Univ. Press.

1968 The Drums of Affliction: A Study of Religious Processes among the Ndembu of Zambia. London: Oxford Univ. Press.

Twaddle, A.C.
1979 Sickness Behavior and the Sick Role. Cambridge, Mass.: Schenkman.

1981 Sickness and the sickness career: some implications. In L. Eisenberg and A. Kleinman, eds., The Relevance of Social Science for Medicine. Dordrecht: D. Reidel, pp. 111-133.

Unschuld, P.U.
1975 Medico-cultural conflicts in Asian settings: an explanatory theory. Social Science and Medicine 9: 303-312.

Uyanga, J.
1983 Rural-urban migration and sickness/health care behaviour: a study of Eastern Nigeria. Social Science and Medicine 17: 579-583.

Waitzkin, H.
1983 The Second Sickness: Contradictions of Capitalist Health Care. New York: The Free Press.

Waxler, N.E.
1976 Social change and psychiatric illness in Ceylon: traditional and modern conceptions of disease and treatment. In W.P. Lebra, ed., Culture-Bound Syndromes, Ethnopsychiatry, and Alternate Therapies. Honolulu: Univ. Press of Hawaii, pp. 222-240.

1984 Behavioral convergence and institutional separation: an analysis of plural medicine in Sri Lanka. Culture, Medicine and Psychiatry 8: 187-205.

Welch, S., J. Comer and M. Steinman
1973 Some social and attitudinal correlates of health care among Mexican Americans. Journal of Health and Social Behavior 14: 205-213.

White, G.M. and A.J. Marsella
1982 Introduction: cultural conceptions in mental health research and practice. In A.J. Marsella and G.M. White, eds., Cultural Conceptions of Mental Health and Therapy. Dordrecht: D. Reidel, pp. 3-38.

Woods, C.M.
1977 Alternative curing strategies in a changing medical situation. Medical Anthropology 1(3): 25-53.

Worsley, P.
1982 Non-Western medical systems. Annual Review of Anthropology 11: 315-348.

Young, A.
1981 When rational men fall sick: an inquiry into some assumptions made by medical anthropologists. Culture, Medicine and Psychiatry 5: 317-335.

1982 The anthropologies of illness and sickness. Annual Review of Anthropology 11: 257-285.

Young, J.C.
1978 Illness categories and action strategies in a Tarascan town. American Ethnologist 5: 81-97.

1980 A model of illness treatment decisions in a Tarascan town. American Ethnologist 7: 106-131.

1981a Medical Choice in a Mexican Village. New Brunswick: Rutgers Univ. Press.

1981b Non-use of physicians: methodological approaches, policy implications, and the utility of decision models. Social Science and Medicine 15B: 499-507.

Young, J.C. and L.Y. Garro
1982 Variation in the choice of treatment in two Mexican communities. Social Science and Medicine 16: 1453-1465.

Zborowski, M.
1952 Cultural components in responses to pain. Journal of Social Issues 8: 16-30.

Zola, I.K.
1966 Culture and symptoms —an analysis of patients' presenting complaints. American Sociological Review 31: 615-630.

1983 Socio-Medical Inquiries: Recollections, Reflections, and Reconsiderations. Philadelphia: Temple Univ. Press.