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Accounting for Children's Illnesses:
Epistemics and Social Relations in Mapuche Healing and Chilean Primary Care Medicine

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy
in Anthropology

by

Jennifer Rhae Guzmán

2012

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ABSTRACT OF THE DISSERTATION

Accounting for Children's Illnesses:

Epistemics and Social Relations in Mapuche Healing and Chilean Primary Care Medicine

by

Jennifer Rhae Guzmán

Doctor of Philosophy in Anthropology

University of California, Los Angeles, 2012

Professor Elinor Ochs, Chair

This dissertation examines how indigenous Mapuche children's illnesses are defined in Mapuche ethnomedicine and Chilean primary care medicine. Based on 11 months of fieldwork in the Araucanía Region of Chile, the study documents the illness account genres of *pelotun pronouncements* and *presenting concerns*, which drive the respective diagnostic processes of these two medical systems. The study draws on a data corpus that includes videorecordings of 32 pediatric acute care appointments with general practice physicians and 45 consultations with Mapuche healers. It combines ethnographic and discourse analytic methods to explore how indigenous families and the medical practitioners with whom they seek care negotiate the rights and responsibilities that are associated with representing children's illness trajectories for the purposes of diagnosis. The study asks what stands to be gained and what is at stake in the representation of illness experience and the cultural construction of clinical realities. To address this question, the study adopts a linguistic anthropological view of genre that sees generic

conventions as flexible and successful performances as social achievements. In light of this perspective, the study identifies the orienting frameworks, role expectations, and normative features of *pelotun pronouncements* and *presenting concerns* in the context of their performance. Analytic attention is given to the process of selection of a primary teller to establish what is ailing a patient, the generic regimentation of tellership rights, the evidentiary grounds on which accounts are based, and the ways participants hold each other accountable for the accounts they produce. Illustrative cases of both felicitous and problematic accounts demonstrate the range of semiotic resources that characterize each genre and show how participants orient to, legitimize, enforce, and challenge generic norms. The close analysis of these medical discursive genres is contextualized by discussions concerning the contemporary situation of ethnic discrimination and unequal medical plurality that exists in southern Chile.

This dissertation of Jennifer Rhae Guzmán is approved.

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*Dedico este trabajo a Gabriel, Diego, y Nicolás
y a las familias de Makewe que me acogieron en sus hogares*

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TRANSCRIPTION CONVENTIONS

This dissertation utilizes some of the main transcription conventions that have been developed by conversation analysts for the representation of talk in social interaction (Sacks, Schegloff, and Jefferson 1978; Sidnell 2010), as are listed below. It is important to note, however, that the transcripts throughout the document represent different levels of granularity in how they represent talk and other embodied actions. Keeping in mind that transcription is a form of representation in which choices must be made (cf. Ochs 1979), I developed transcripts for each of the excerpts from the video- or audio-recorded data depending on the analytic point that I was making and weighing the relative importance of accuracy of detail versus readability. Some transcripts include lexico-grammatical information on the second of three lines; other transcripts include only two lines: a representation of the original speech and a gloss in vernacular English.

Conventions for Representing the Temporality of Speech and the Sequencing of Turns

- [The left bracket precedes speech that was produced in overlap with another speaker
- = Equals signs signal the “latching” of two turns when there is no discernable silence between one speaker’s turn and the next
- (.) Brief, untimed pause
- (0.4) Numbers in parentheses indicate the length of a silence represented to a specificity of tenths of a second

Conventions for Representing Qualities of Speech Delivery

- . The period indicates falling intonation
- , The comma indicates slightly rising intonation
- ? The question mark indicates strongly rising intonation
- : The colon indicates the lengthening of a speech sound; the number of colons indicates the relative prolongation of the sound
- > < Speech between the greater than and less than symbols was notably rushed
- < > Speech between the less than and greater than symbols was produced slowly

- The dash indicates a sudden cut-off in speech
- hhh Audible aspiration; the number of *h*'s indicates relative length of the aspiration
- °hhh Audible in-breath; again, relative length of the in-breath is indicated by the number of *h*'s
- word Underlining beneath part of a word indicates some form of stress or emphasis that was conveyed by loudness or higher pitch or both
- WOrd Capitalization beyond the first letter of a word indicates especially loud talk
- ° Speech following a degree sign was notably quiet

Other Conventions

- words words words Speech in Mapudungun, the Mapuche language, is indicated by continuous underlining
- (word) Text in parentheses indicates a hearing about which I am uncertain
- () Spaces in parentheses indicate a stretch of speech that was inaudible or indecipherable
- ((cough)) Text in double parentheses is used to describe something going on in the interaction

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In Temuco, the staff at the *Farmacia Mapuche* answered many questions I had about their goals in promoting Mapuche medicine to *warriache* 'city dwellers' and *wingka* 'non-indigenous people'. Soledad Hueche and her colleagues are working to provide a space where diverse health-seekers can find Mapuche healers. I am grateful to them for permitting me to conduct research at their innovative healing office. The healers whom I call *machi* Esteban and *lawentuchefe* Lorena provided me with unprecedented access to their practice. Much of this dissertation is dedicated to exploring the unique kind of insight they exercise and the amazing communicative practices they employ in accounting for clients' ills. I hope that this modest portrait does justice to their skill and compassion. Finally, *muchisimas gracias* to the many

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Chapter One

INTRODUCTION

The language of medicine is hardly a simple mirror of the empirical world. It is a rich cultural language, linked to a highly specialized version of reality and system of social relations, and when employed in medical care, it joins deep moral concerns with its more obvious technical functions. (Good 1994:5)

1.1 Illness in the Araucanía

It was over rounds of sweet *mate* tea that I learned from *machi* (shaman) Noraⁱ why she was suffering from leg pains in her advanced years. Also seated around the *machi*'s table on this occasion were the *machi*'s husband, *don* Julio, and the director of the local primary care clinic, *don* Pancho. Together with us in the cooking quarters, but not partaking in the *mate* rounds, the *machi*'s daughter-in-law occupied herself in caring for her toddler son.

The official reason why *don* Pancho and I were visiting on that day was to discuss preparations for the upcoming *kurerewen* ceremony in which *Machi* Nora, accompanied by dozens of friends and supporters, would replace the aging *rewe* (altar) where she prayed every morning outside her home with a newly hewn one. It was everyone's hope that the fulfillment of this ritual obligation would ameliorate Nora's compounding health problems, which were keeping her from the strenuous demands of her shamanic practice and inhibiting her ability to carry out such daily tasks as making bread and cooking.

As she served *mate*, *machi* Nora explained to us that her current difficulties with walking and negotiating steps were due to a long-ago, chance encounter. At the time of her ill-fated

encounter, Nora was a small child. Together with several playmates, she had gone into the woods. As the machi began the story, I found myself anticipating contextual details that she did not explain. Perhaps the excursion was intended for gathering firewood. Maybe the children set out at the inauspicious hours of midday or dusk. I imagined little Nora, ducking under boughs in the sort of thick tangle of vines and tree branches that is typical of the wildest parts of Makeweⁱⁱ. But without elaborating on these matters, Nora proceeded to tell us merely that she found herself face to face with a large sow that was suckling its offspring in the underbrush. And with that revelation, the machi's story ended.

Next to me at the table, *don* Pancho nodded in immediate understanding. But the truncated story had so few details that it left me confused. How did Nora react when she stumbled on this odd scene? Did she tell her playmates? And did they come to see the animals? How would a sow get lost deep in the woods in the first place? and what finally happened to the pigs? At the time, I didn't recognize that such practical matters were inconsequential to the story the *machi* was telling. The point of this story was to identify a transgression that accounted for why elderly Nora was suffering from leg pains that grew worse rather than better with time. *machi* Nora was suffering from a form of *wekufe kutran*, illnesses that are caused by spirits. The supernatural being that had appeared as a sow was actually the *ngen mawida* 'keeper of the woods' in which young Nora had trespassed.

Don Pancho signaled his understanding of Nora's illness origin story by recounting a parallel story of his own. As a youth, *don* Pancho told us, he had dived to the bottom of the rushing Quepe River and pulled up logs from the depths. Enchanted with the beautiful forms of the water-smoothed wood and proud of his dangerous swim, young Pancho had adorned his home with his plunder. Shortly after, however, he was warned in a dream that this had been

offensive to the *ngen* ‘keeper’ of the river. Frightened at the retaliation his transgression would surely incur, young Pancho returned the logs to their watery resting place and made propitiatory amends to the keeper spirit. Reflecting on what had happened, *don* Pancho concluded his story with the assessment that his conciliatory efforts had surely saved him from suffering a serious illness later in life.

Figure 1.1: Quepe River running through Makewe



An important if subtle difference between *don* Pancho and *machi* Nora’s story is the epistemic grounds on which each of them was founded. While *don* Pancho’s story was clearly rooted in his personal memory, the generic features of *machi* Nora’s story suggest that it described an event about which she may have had no clear recollection at all. Her story lacked the sorts of contextual details and plot development that *don* Pancho’s story had. Instead, it fit the model of a well-known, Mapuche master narrative, that of a child unwittingly transgressing

against *ad mapu*, the tenets of a moral life by which Mapuche abide. Such transgressions include trampling sacred spaces and leaving the safety of the hearth at times of day when spirits are circulating. Such improprieties upset the equilibrium that is required for people's well-being and disrupt their harmony with the natural *cum* supernatural world. This can lead to health problems that manifest over developmental time and can even reach beyond the individual to affect members of her family. The story the *machi* told was similar to the sorts of illness accounts that Mapuche healers sometimes provide to indigenous clients in explanation for intractable chronic ailments, suggesting that the *machi*'s narration may have been a recontextualization of an account that a healer had told her on an earlier occasion.

Machi Nora and *don* Pancho's narratives provide a first glance at how people in Makewe perceive and address the hardships of illness. In this rural district of Chile's Araucanía Region, neighbors and relatives routinely tell and retell stories about unfolding and past illnesses wherever they meet, whether it be at the kitchen table, in the fields, or on the winding dirt roads through the countryside. The south of Chile is a hard place to stay healthy. Work on the farms is strenuous and back-breaking. The climate swings between stiflingly hot and dusty in the Summer to frigidly cold and extremely wet in the Winter. Homes are poorly insulated, and few families enjoy such luxuries as indoor plumbing. Heating is generally from wood-burning stoves and sometimes open hearths, which exacerbate respiratory symptoms throughout the cold months. In addition, the health of farm animals and crops is precarious, meaning families are constantly at risk for financial and food insecurity. Children's health is viewed as particularly uncertain, and a number of child-specific syndromes including *mal de ojo* 'evil eye' and *empacho*, a digestive disorder, are likely to befall children in their early years. In the face of these circumstances,

families are vigilant of children's health and go to great lengths to acquire care from professionals and healing specialists when children display signs of illness.

Figure 1.2: Winter morning landscape in Makewe



Nora and Pancho's stories also illustrate the great importance that behavior and events during childhood and youth pose for Mapuche people's long-term health and life trajectories. As was illustrated by *machi* Nora's story, children's inexperience and lack of understanding can complicate their health for years to come. Fortunately, many older Mapuche assured me, adults can guide children with stories and conversation to develop their awareness of the responsibilities they have to respect others and the natural world. With guidance, children become more able to care for their own health and the health of others as they grow. And, as *don*

Pancho's narrative illustrated, many missteps can be remedied, even before symptoms of illness surface.

These understandings about how illnesses are caused and avoided make up part of a larger cultural framework of explanation and medical knowledge that is a resource to Mapuche families when trying to make sense of children's illnesses and seek their resolution. Today, more than 130 years after the forced assimilation of the Mapuche territory and people into the Republic of Chile, Mapuche families in Makewe draw on healing resources that they consider part of the legacy of their ancestors as well as on biomedical resources that they consider efficacious for treating Western diseases. This context of medical plurality entails that families seeking healing for children's symptoms regularly interact with a variety of healing practitioners and weigh the interpretations and therapeutic options that each of these offer.

Two medical systems to which families in Makewe often take recourse for children's care are primary care medicine, which is available in the out-patient clinic of a government subsidized medical center called *Hospital Makewe*, and Mapuche ethnomedicine, which is practiced by individual healers in their homes and, sometimes, in urban medical offices. In each of these settings, families participate in the distinctive, institutionally sanctioned storytelling activities that characterize the respective medical systems. And each of these genres affords a distinctive diagnostic process, with its particular constellation of generic-discursive, technological, and embodied resources for detecting and interpreting children's ailments. In the process of pursuing help for children's illnesses then, families entertain, question, contribute to, and ultimately make decisions based on alternative and sometimes incompatible explanations for children's symptoms.

During consultations, families and practitioners have to communicate to one another the nature of a child's illness and the trajectory it has taken prior to the consultation. This interactional task of accounting for a child's illness constructs a particular version of reality in which the knowledge and actions of the patient and her caregivers are implicated. The resulting account of the ailment is shaped by cultural knowledge as well as by the generic norms for participation in the activity. And while the obvious clinical aim of the task is to work toward a diagnosis, the activity also involves, as is noted in the epigraph to this chapter, a particular "system of social relations...and deep moral concerns" (Good 1994:5).

This project documents and compares the illness account genres that drive the respective diagnostic processes of Mapuche traditional healing and Chilean primary care medicine. These genres are referred to in the dissertation, respectively, as *peloton pronouncements* and *chief complaints*. Regarding the former, Mapuche healers engage in a process of illness assessment that is referred to in Mapudungun, the Mapuche language, as *pewutün* 'divination' or *peloton*, which can be glossed as 'looking into' or, more properly, as 'the act of seeing clearly'. The term derives from the verb *pelotu-* 'to give light, to see clearly' (Smeets 2008), which can be further traced to the root *pelo-* 'to get light, to be able to see'. The morpheme *-n* is a nominalizer that "indicates an event as such" (192). Thus the word *peloton* describes an event of seeing clearly or an event of giving light. The performance of *peloton* as a diagnostic activity involves the production of a verbalized illness representation that is treated as an authoritative pronouncement concerning an ailing person's affliction. In contrast, in acute primary care, patients and familial caregivers produce an initial verbal account of the patient's health problem at the beginning of consultations. Adopting the terminology that is used in medical sociology to refer to this genre of

illness representation, I use the synonymous terms (*chief*) *complaint* and (*presenting*) *concern* interchangeably throughout the text.

While the bulk of the data that is presented in the dissertation centers on details of the face-to-face interaction that occurs between practitioners (i.e. physicians and healers), child patients, and parental caregivers during consultations, discussion of these institutional practices is complemented by an exposition and discussion of ethnographic and interview data that were gathered both within these institutional settings and beyond, in the Makewe community and the homes of four focal families.

The research builds on work in medical anthropology that considers how individuals make sense of illness experience as well as work in linguistic anthropology on genre and communicative competence. The study moves beyond the classic focus on medical authority that characterizes much of the work on medical discourse (Kuipers 1989) to illuminate how *accountability* is discursively managed in healing encounters, specifically in light of locally sanctioned social roles pertaining to the sick, their familial caregivers, and healing practitioners. As a whole, the study engages with research on: the cultural construction of clinical reality, institutional genres of illness narratives, and the epistemics of illness experience.

1.2 Key Terms

At the outset, it is important to define several terms and key concepts that ground the study. First, I adopt Kleinman, Eisenberg, and Good's (1978) classic distinctions between disease, illness and sickness. While all three of these terms are related to the human experience of ailment or malady, they are not synonymous. Within the field of biomedicine, the notion of disease refers to pathological processes or states in the physiological body of an individual. Diseases are understood to have characteristic symptomatology and etiology. And knowledge of

these is gained by physicians in their professional training. Illness, by contrast, involves culturally shaped responses with which individuals and groups meet, understand, interpret, label, evaluate, and treat ailments. Importantly, there are normative ways of doing each of these things, socially acceptable and unacceptable forms of illness behavior. Bridging these two concepts, sickness is “a complex, fluid, total phenomenon” (252) that incorporates biological, psychological, and sociocultural elements. Both disease and illness are viewed as kinds of explanatory models about sickness, with sufferers generally concerned with illness problems and physicians less so, focused as they are on identifying and treating disease.

The breakdown of different health care systems that co-exist in an area may be either professional, traditional/ethnomedical, or popular. For the purposes of the southern Chilean context, the official, professional health care system is a local variety of biomedicine. Popular forms of health care that predominate in Chile can be traced to Spanish colonial medicine and, as a result, display similarities with popular health care systems throughout Latin America (Foster 1987). The traditional or ethnomedical system that is indigenous to the region is Mapuche medicine.

Each of these health care systems has its own forms of medical knowledge and practices, including diagnostic practices that are used to determine the nature of particular cases of sickness. All diagnostic processes, with their particular technologies and forms of reasoning, yield what has been referred to as a “cultural construction of clinical reality” (Kleinman, Eisenberg, and Good 1978). Though the word ‘clinical’ has the unfortunate connotation of a biomedical setting, the notion of clinical reality is intended to refer to an achievement that results from diagnostic practice, regardless of the healing system in which it is accomplished. Thus, for

a single case of sickness, very different clinical realities may be reached in a family's conversations with a primary care physician and with a Mapuche healer.

It is important to note that the notion of a clinical reality differs from that of a diagnosis. While diagnosis refers to a category label that is officially attached to a sickness, for the purposes of this study, clinical reality refers to the broader scope of *a socially ratified characterization of an occasioned sickness pursuant to its treatment*. My characterization of clinical reality as a socially ratified characterization aims to clarify that this reality is a publicly negotiated artifact, not merely a disease label and certainly not a mental representation. This perspective affords the study of clinical reality as something observable and amenable to analysis. While it is certainly true that individuals come to clinical interaction with personal explanatory models, and diagnoses are strongly influenced by clinical and other culturally available explanatory models, ultimately a publicly negotiated definition of the problem-at-hand is reached and acted upon.

The following sections of this chapter begin with brief discussions of the anthropological literature on diagnosis followed by a review of primarily sociolinguistic and linguistic anthropological literature concerning how speaking rights and epistemic privilege are accorded to individuals with regard to their embodied, personal experience. In light of this literature, I discuss the underlying epistemics that are entailed by biomedical notions of 'symptoms' and 'signs' of illness and I present a distinction between symptom experience and symptom representation. Finally, I review the discursive relevance that is accorded to individuals' knowledge of illness symptom in different healing traditions before providing an overview of the dissertation chapters.

1.3 Diagnosis

The standard definition of medical diagnosis involves the application of a particular, institutionally sanctioned form of reasoning to evaluate the nature of an ailment based on the symptoms and signs that a patient presents in a clinical setting. By contrast, my use of the term applies to the naming of a sickness by whatever means are authoritative in a particular health care system. Importantly, this definition is not restricted to practices that rely on the evaluation of symptoms. For the purposes of the study, diagnostic practices may be divinatory rather than deductive or may rely on signs of illness other than an individual's bodily or behavioral expressions of distress. It is important to note that, while there is always a risk involved in using terms from the medical sciences to refer to practices in other health care systems (Good 1994), I have chosen to adopt the term 'diagnosis' because it affords a contextualization of the study among other studies of diagnostic process, and this contextualization outweighs the drawbacks of the term's ordinary connotations. My application of the term 'diagnosis' to activities in Mapuche ethnomedicine does not imply that these practices are in any way a variation on Western medical diagnosis.

Diagnosis is a polysemic notion that references both process and product. On the one hand, diagnosis is a goal-oriented form of practice that aims to establish an authoritative definition for a unique case of sickness. Yet diagnosis is also the result of diagnostic practices. From an empiricist perspective, diagnoses are classificatory information and reflect an objective reality. This sort of conceptualization is implicit, for example, in references to "physicians' delivery of diagnosis" or "delivery of diagnostic news" (Heath 1992; Peräkylä 2006). But, as many authors have demonstrated (e.g. Kleinman 1982; Kugelman 2009), diagnoses are more properly cultural constructs that reproduce historically situated understandings of human ailment.

Like other socially assigned labels, diagnoses can deeply affect people's lives, burdening them with stigma (Polich 2005), or, in more positive cases, legitimizing perplexing problems or providing a sense of self-worth (Killingsworth et al. 2010). In a final sense, a diagnosis is a kind of material good that is provided to a client by a practitioner. As such, it has an exchange value that entitles the bearer to certain rights and privileges that vary according to the political economy, sociocultural milieu, and situational circumstances in which it is produced or invoked (Galasso 2005).

Several key observations that have been made about the organization, import, and social implications of diagnosis in different medical systems and societies can be synthesized with the following points. First, the interactional and cultural organization of diagnostic processes shape their results (Gaines 1979; Nuckolls 1991; Wilce 1997; Zola 1987). Diagnoses play a role in how people make sense of illness (e.g. Garro 1994) and can sometimes have therapeutic effects themselves (Milne and Howard 2000). And finally, diagnosis is an ethical practice with important implications for individuals and communities (Armstrong 2003; Gammeltoft 2007; Jutel 2011; Rosenberg 2007; Scheper-Hughes 1988).

1.4 An Ordinary Epistemics of Subjective Experience and Related Speaking Rights

Philosophers and scholars of language have long noted the special authority that is granted to individuals concerning knowledge of their own sensations and phenomenal states. For some, the source of this authority is the unique certainty that is associated with self-knowledge (Lewis 1946; Chisholm 1981; Jackson 1973). For others, it derives from the unique method through which self-knowledge is reached (Hill 1991; Kripke 1980; Russell 1917); for still others, it stems from our agentive capacity for self-constitution (Moran 2001).

Yet, while debates concerning what makes self-knowledge special remain unresolved, what is clear is that assertions or avowals concerning subjectively perceived states are routinely treated as authoritative (Wright 1989). Individuals are recognized as having privileged epistemic access to their own subjective, personal life and speak accordingly about their interior life and subjectively perceived states. At the same time, interlocutors in conversation recognize and keep track of the relative epistemic statuses that obtain between themselves and their conversational partners regarding the propositional content of talk. They organize their contributions to unfolding interaction in ways that respect the epistemic privileges of others through less-than-authoritative stance displays. In this section, I review some of the key literature that sustains these observations about the role of epistemics in ordinary conversation.

Research by pragmatician Akio Kamio and his colleagues reveals that speakers orient to information about their own lives in a proprietary fashion. Speakers exercise their ownership of personal information by eschewing mitigation in favor of direct grammatical forms when talking about their personal lives (Kamio 1994, 1995; Kawanishi 1994). For example, the pragmatic unacceptability of a statement such as “I hear I have a headache” (Kamio 1994:70) demonstrates that speakers not only may but must, normatively, take an authoritative stance with respect to information gleaned from their own first-hand experience, whether this be internal (e.g. thoughts and emotions), external (e.g. the result of observation), or “personal to the speaker” (e.g. a spouse’s name or the age of one’s child). The converse also holds. Speakers use indirect forms when referring to details in the lives of their interlocutors. These preferences provide evidence for what Kamio coined the “territories of information” model whereby speakers design their talk in ways that respect the boundaries of their own and others’ ostensible knowledge. Work in linguistics on the topics of epistemic modality and evidentiality (e.g. Chafe & Nichols 1986;

Egan & Weatherson 2011; Lyons 1977) demonstrates how issues concerning the source and security of (self) knowledge are lexically and grammatically encoded cross-linguistically.

In addition to pragmatic analyses by Kamio and his colleagues, investigations of naturally occurring conversation also provide evidence that speakers monitor and respond to the boundaries of their own and others' respective territories of information in the course of interaction, though different authors have referred to this pairing of cognitive and interactional phenomena with an eclectic set of variably opaque terms. Perhaps the broadest and most transparent label that has been used to refer to the knowledge that an individual legitimately controls is *epistemic domain* (Stivers and Rossano 2010). This term is preferable to Kamio's 'territories of information' for two reasons. First, the geographical metaphor of a 'domain' enables a spatial conceptualization that can account for overlapping knowledge across more than one participant while avoiding the connotation of a literal tract of land as is evoked by the term 'territory'. 'Domain' more readily carries the connotation of a scope of knowledge. Second, Stivers and Rossano's term avoids the suggestion of some idealized data set of 'information' that ostensibly resides in the mind of an individual, making *epistemic domain* the most useful term for discussing how individuals' epistemic stances are negotiated publicly in talk.

An early and enduring attempt to outline how the monitoring of epistemic domains occurs in talk comes from Labov and Fanshel's (1977) extremely detailed analysis of how two interlocutors spoke about events that had transpired in the life of just one of them. Their study produced a typology that discriminated between five possible constellations of interlocutors' knowledge states or *epistemic statuses* (Heritage & Clayman 2010), taking into account their respective participant roles as speaker or hearer for a particular utterance. Most basic are the authors' distinctions between A-event and B-event statements. A-event statements refer to

matters about which the speaker but not the addressee knows. B-event statements refer to matters known to the addressee but not the speaker of an utterance.

Importantly, A- versus B- event statements are construed as different sorts of actions in conversation. A-events statements are generally treated at face value as unproblematic assertions. In contrast, statements about B-events are treated as requests for confirmation. This construal of B-event statements as a kind of request for information stems from a tacit understanding among interlocutors that the hearer knows better about her own life than does the speaker. Therefore statements made by the less knowledgeable party *ipso facto* stand to be verified by the more knowledgeable party.

While Labov and Fanshel's event statement typology emerged from the close analysis of a psychotherapeutic interview, they posited that the distinctions were pertinent beyond this narrowly institutional context. Concerning how epistemic privileges operate in conversation, the authors made this observation, "[A] speaker can be confident that there are many areas where he himself is the undisputed expert. These are his personal and private emotions, experience, and all of the events that make up his biography. If he chooses to speak of his innermost feelings, his fatigue, his anger or guilt, the other party is not as free to contradict him as if he had spoken of the temperature or predicted an economic recession" (34). Put simply, under ordinary conversational circumstances, individuals exercise nearly undeniable primary epistemic rights with respect to their own affairs and may speak about them with authority. As long as the events in question are not particularly dubitable and are not also part of the life experience of the hearer, it is difficult to dispute a speaker's assertions about his own experiences.

Studies of the varied conversational acts of lying, "fishing," and telling personal news support the assertion that social actors enjoy primary epistemic and speaking rights regarding

matters that are uniquely known to them and slightly modified rights regarding matters that lie not only in their own but also in an interlocutor's epistemic domain. In his reflections on the social acceptability of 'lying' in answer to the casual question "How are you?", Sacks (1975) pointed out that an individual wields the prerogative to reveal or obfuscate information about his subjective state, the most intimate territory of his epistemic domain. The range of acceptable—and variably disingenuous—answers to *how are you?*, from the most forthright to the most vague, covers the propositional domain of "things you know on your own behalf" as a result of "monitoring" (72; see also Kleinman 1988). Thus, responses to *how are you?* are canonical A-event statements, and regardless of whether they describe an individual's personal state with terms such as "tired" or "hungry" or evaluative descriptors such as "good" or "lousy," claims that emerge in this context are generally impermeable to counter argument, even while claims based on other forms of experience (e.g. observation) may be disputed.

Building on Sacks' crucial distinction, Pomerantz (1980) differentiated between *type-1* and *type-2 knowables*. Type-1 knowables comprise things "that subject-actors as *subject-actors* have rights and obligations to know" (187). This sort of information has a fairly indisputable epistemological grounding in monitoring processes. In contrast, when a knowing is "occasioned," flowing from an experience in the world, it fits the *type-2 knowable* model. The once-removed epistemological grounding of type-2 knowledge, and its availability as a resource for soliciting information from a party with more authoritative knowledge, is evident in the conversational practice of "fishing" (i.e. the strategic use of a B-event statement to solicit information from an interlocutor). The practice is exemplified by the assertion, "I saw you drive by last night" (188), which indexes the speaker's original act of observation at the same time that it invites the addressee, who was the agent of the driving, to elaborate on the destination or

purpose of the trip. Finally, individuals shape even stories about their own lives in response to what others know about them. For example, Goodwin (1979) demonstrated that a speaker can finely tune his unfolding description of a personal event in his own life—even over the very short span of a single sentence—to make the story newsworthy first for one primary addressee in a multi-party interaction and then another.

Finally, research investigating the question of the opacity of other minds (see, for example, the special issue on the topic edited by Rumsey & Robbins 2008) provides cross-cultural evidence that individuals generally exercise primary epistemic rights to know and speak about their own biographical and internal life. In fact, research in this vein suggests that the conversational norms observed in English for respecting the primary epistemic *cum* speaking rights of subject-actors may be among the least constraining cross-culturally. It has been observed that many speech communities in the Pacific region have sanctionable proscriptions against nearly all verbalization of hypotheses concerning the thoughts, emotions, or intentions of others. Notably, Duranti (2008) has suggested that these proscriptions, rather than indexing a local theory of mind that contrasts with dominant Western theories, may actually be a manifestation of a “pan-human preoccupation with reducing one’s accountability.” What is important to the discussion here is Duranti’s point that the regulation of talk about the interior lives of others reveals more about the public negotiation of social relations in an activity or community than it does about native psychologies.

The lines of investigation on epistemics and conversational practices that I have outlined here describe a multitude of ways in which interlocutors regulate their own and others’ conversational contributions with respect to one another’s’ epistemic domains. Recent work also confirms the observations of these scholars and offers more detailed accounts of how

interlocutors attend to different social actors' relative statuses in the local epistemic ecology and tailor their speech in ways that acknowledge relative distributions of knowledge (e.g. Avineri 2010a; Goodwin 1979, 2011; Goodwin & Goodwin 1987; Heritage and Raymond 2005; Raymond and Heritage 2006, Turner n.d.). These studies underscore the assertion that continuous attentiveness to one's own and others' ostensible epistemic status and semiotically encoded epistemic stance are fundamental features of cognitive and social engagement in talk.

In sum, findings from research in multiple sociocultural and linguistic communities suggest that there is a fairly common ethnoepistemological principle recognizing first person authority over private, subjective experience. In addition, this epistemic privilege appears to come with attendant speaking privileges that are recognizable in the interactional norms of many speech communities. This ordinary epistemics is both reflected and renewed by the stances speakers take in conversational exchanges about their own and their interlocutors' life experiences.

1.5 The Epistemics of Symptoms and Signs of Illness

In the realm of Western biomedicine, the epistemic authority that subject-actors exercise in ordinary conversation with respect to personal knowledge is generally upheld. Analysis of talk between doctors and patients indicates that the latter are granted speaking rights and epistemic authority over matters related to the subjective experience of illness, even while most other matters discussed in clinical settings fall under the expertise, and therefore the epistemic domain, of medical professionals (Lacoste 1981). In this section, I review literature showing that the separation of symptom experience as a special domain over which sufferers maintain epistemic priority reflects an ideological stance in biomedicine, one that borrows from and builds on the ordinary epistemics elaborated above and simultaneously obfuscates the degree to which the

subjective experience and perception of illness is shifting, value laden, and culturally shaped. First, I discuss how the subjective nature of illness experience and the legitimation of subject-actors' insights about it are codified in the semantics of the medically defined terms *symptoms* and *signs*. Next, a review of anthropological literature on illness experience highlights how, contrary to Western medical ideologies, sufferers' perceptions and interpretations of illness are, in fact, unstable and indeterminate, influenced by a host of cultural, historical, social, and clinical factors.

The ontology of symptoms that characterizes Western biomedicine involves an odd juxtaposition of features. On the one hand, symptoms are proper to a particular disease such that each and every disease has a characteristic symptomatology (Rosenberg 2007). Because symptomatology has been carefully catalogued, physicians are able to use patient accounts of symptoms as an important source of information in the diagnostic process. In this sense, symptoms are treated as natural facts, as indicators of disease. Yet, at the same time, symptoms are part of the subjective experience of a sick person, as is noted in medical definitions. The definition appearing in Merriam-Webster's Medical dictionary defines symptoms as "subjective evidence of disease or physical disturbance observed by the patient." Thus, while symptoms legitimately index a pathological condition, they are also subjective and ostensibly perceived only by the sufferer. Echoing the same qualities, the definition appearing in Stedman's Medical Dictionary stipulates that symptoms are "[a]n indication of disorder or disease, especially when experienced by an individual as a change from normal function, sensation, or appearance. Also called sign" (2002). Here symptoms are framed as emergent from the experience of an individual, whose perception of deviation from normal somatic experience is treated as *prima facie* evidence of pathologyⁱⁱⁱ. And it is on this point that the notion of *symptom* bifurcates along

an objective-subjective dichotomy: at the same time that symptoms are proper to a particular disease, they also properly ‘belong’ to a sick person. In other words, symptoms are type-1 knowables, belonging to the most intimate and exclusive part of a person’s epistemic domain.

Although Stedman’s definition indicates that the term *symptom* is often treated as synonymous with *sign*, Good (1994) clarifies precisely how the two are differentiated in clinical biomedicine. Signs are understood to be “physiological abnormalities that can be measured by clinical and laboratory procedures” (8), while symptoms are “expressions of the experience of distress, communicated as an ordered set of complaints” (ibid). For clinical purposes, this distinction is useful because it distinguishes between those illness-related phenomena that are readily apparent to medical professionals and those that are apparent to patients. However, the distinction is an oversimplification. First, the two-way distinction presumes a dyadic relationship between practitioner and patient and, in this way, fails to account for the sorts of illness-related phenomena that are perceivable to layperson caregivers. A three way distinction would provide a more nuanced way of distinguishing illness indicators by the criterion of who can perceive and interpret them. This would be especially useful for talking about pediatric care, where adult caregivers’ accounts are rife with descriptions of readily perceptible indicators of illness that laypersons are likely to note and which do not require measurement by clinical or laboratory procedures.

1.6 Symptom Experience and Symptom Representation

Another distinct problem inherent in how clinical medicine defines symptoms is a collapsing of the very distinct processes of symptom experience and symptom accounting. An understanding of symptoms as “expressions of the experience of distress” mistakes the publicly constituted artifact of a “set of complaints” as a mimetic object that naturally reflects a sufferer’s

subjective, embodied experience. Good refers to this referential interpretation of discourse as the “empiricist theory of medical language” (9) and notes that it is a key feature of the folk epistemology of clinical medicine. In order to talk about the distinction between (1) the embodied and meaningful experience of distress and, (2) the verbal representation of this distress with the aim of seeking diagnosis or therapy, I use the terms *symptom experience* and *symptom representation* (or *illness account*), respectively.

A phenomenological perspective is helpful for discerning precisely what *symptom experience* involves. First, even experientially, the designation of some occurrence as a symptom is not pre-reflective. According to Husserl’s (1962) notion of the natural attitude, the complex flow of bodily experience—blinking, breathing, the sensation of cold or pain—is perceived as a whole until we adopt a reflective or theoretical attitude toward some aspect of this experience and inhere it with meaning (see also Duranti 2009; Schutz 1945). In the adoption of a reflective attitude, a person selectively attends to a particular occurrence or sensation, evaluating what it implicates and possibly determining that it means she is sick.

Viewed through a phenomenological lens, Kleinman’s (1988) classic definition of illness can be decoupled to illustrate this point, “Illness is the lived experience of monitoring bodily processes such as respiratory wheezes, abdominal cramps, stuffed sinuses, or painful joints. Illness involves the appraisal of those processes as expectable, serious, or requiring treatment” (4). The process Kleinman describes can be broken down into the two closely related but distinguishable actions of monitoring (in the natural attitude) and appraisal (the reflective attitude). These tightly intertwined and subtle steps amount to a noetic process that constitutes dysphoric bodily phenomena in certain determinant ways. Thus, meaning-assigning appraisal

may determine that a given physical sensation is *symptomatic* (of something), a step that precedes any evaluation about whether a condition warrants a certain kind of action in response.

Medical anthropologists examining illness experience have illuminated a number of ways that symptom experience and symptom representation are culturally, historically, and socially influenced and organized processes, suggesting that all knowledge of and communication about symptoms, however experientially grounded, is also sociohistorically situated. First, there is abundant documentation of the ways cultural knowledge systems inform how people categorize and attribute symptoms to particular causes or diseases (Baer 1993; Bailey 1991; Christensen 1999; Garro 1988, 1994, 1995; Schoenberg and Drew 2002; Storck, Csordas, & Strauss 2000). Furthermore, it is widely recognized that the sensory perception of symptoms can be influenced by a “meaning response” (Moerman 2002; Moerman and Jonas 2002), referred to commonly as placebo or nocebo effects (Hahn 1997; Hahn and Kleinman 1983). Research into such effects reveals that when certain ideas about disease or healing processes resonate for an individual, they can lead to changes in the experience of symptoms, even when there may be no organic pathology present (Melamed, Froom, and Green 1997).

In complement, work on somatization emphasizes the potentially polysemous nature of symptoms, highlighting cases where they are indicative of psychological forms of distress, an indexical relationship that complicates the clear-cut symptomatology on which biomedical science is grounded. Research in this vein has demonstrated that dysphoric bodily phenomena can function as a communicative medium through which the ill can express social suffering when circumstances of trauma, stigma, or structural violence constrain other communicative forms (Kleinman 1982; Mendenhall et al. 2010; Nichter 1981). In these cases, symptoms are ambiguous, metaphorical (Kirmayer 2000), or have a complicated rather than straightforward

relationship to physiological pathology. Such studies speak to the symbolic quality of symptoms as indicative of social ills in the local world of the sick individual.

Finally, at the same time that the perception of symptoms and their interpretation are shaped by multiple influences, individuals' options for presenting their symptoms to medical practitioners can also be constrained by finances, bureaucratic apparatuses, and other life circumstances that delimit the range of medical resources that are available to individuals, families, or groups as a result of their relative social, ethnic, economic, gender, generational, or political positionalities within a particular political-economic and medical milieu (Brodwin 1997; Farmer 1999; Hunt et al. 1989; Young and Garro 1994).

1.7 Symptom Accounts across Healing Traditions

Notwithstanding the complexities that are involved in the perception, interpretation, and representation of symptoms, primary care medicine operates under the assumption that a patient has *a priori* epistemic access to perceptible illness phenomena. As a result, the onus for identifying symptoms falls to patients, and successful diagnosis hinges on patients' adequate description of a health problem at the outset of the clinical encounter. Research on clinical discourse stresses that physicians should avoid interrupting patients' illness accounts, allowing patients the interactional space to elaborate at length on the problems they are experiencing (Korsch & Negrete 1972; Beckman & Frankel 1984; Roter & Hall 1992). Illness accounts, which include the description of symptoms, are clinically construed as requests for medical treatment (Byrne & Long 1989; Parsons 1964; ten Have 1989) and entail a physician's obligation to diagnose the presented problem and proffer appropriate therapy. In pediatric primary care, parents are often recruited to provide the requisite illness account (Clemente et al. 2008; Stivers 2001, 2007; Stivers and Majid 2007). The underlying assumption in these cases is that these

adults exercise first-hand knowledge that stems from their lived experience of caring for the child in the home environment^{iv}.

Yet not all healing traditions consider individuals' illness accounts authoritative. The epistemic framework and institutional norms for participation in a given medical paradigm can validate or delegitimize, build on or suppress individuals' awareness of their own embodied distress (e.g. Wilce 1995, 1997). In other words, the insights of the sick can occupy relatively higher or lower rungs in the particular hierarchy of evidence that obtains in a healing tradition. Practices that are patient concern-driven, including primary care, homeopathy (Ruusuvuori 2005), and some forms of psychotherapy (Carr 2010; Labov & Fanshel 1977), treat patients' illness accounts as a fundamental starting point. Therapy in these practices aims at resolving, healing, or reinterpreting the problems patients present. Other traditions may systematically subordinate patient insights to those that can be gained from an expert's examination of the patient's body. In contrast, many divinatory and religious healing practices may or may not solicit clients' accounts but place little emphasis on symptoms per se, focusing instead on the identification of etiological agents (Csordas 2002, Evans-Pritchard 1937, Milne & Howard 2000; Wilce 2001).

1.8 Overview of the Dissertation Chapters

In his early review of the anthropologies of illness and sickness, Allan Young set an ambitious goal for anthropologists saying, "What they can claim, and what would set their accounts of sickness off from those of others, is a critical understanding of how medical facts are predetermined by the processes through which they are conventionally produced in clinics, research settings, etc. Thus, the task at hand is not simply to demystify knowledge, but to critically examine the social conditions of knowledge production." (1982:277). While I do not

ascribe to the idea that medical facts can be predetermined in any absolute manner, this dissertation study does aim to meet Young's challenge by offering a close interpretation of the interactional processes and proximate and distal social conditions that shape the conventional production of medical facts in two of the main institutional settings where indigenous children's illnesses are treated in Southern Chile.

The study documents what is at stake for indigenous Mapuche children, their familial caregivers, and the biomedical and indigenous healing practitioners who treat them when they engage with each other to establish the clinical reality of children's ailments under specific interactional, structural, and cultural conditions. The study addresses the following questions: (1) how are the features, meaning, origin, and timing of children's illnesses socially negotiated in face-to-face interaction in consultations? (2) what parties are treated as knowledgeable about different aspects of illness? (3) How they are held accountable for this knowledge? (4) What social risks are involved in representing illness in the context of these activities?, and (5) What broader responsibilities to care for and respond to children's illnesses are tied to the responsibility of representing illness?

The study combines both ethnography and a micro-analytic approach to analyze the beginning phases of medical consultations, when everyone present is involved in the task of defining the illness that will be addressed in the consultation. I document and analyze the production of accounts at two levels, the performance and the text. On the one hand, the study investigates illness accounting as an interactional achievement and a performance that is part of a larger goal-oriented activity. In complement, the accounts themselves are examined as texts that have both interactional and denotational properties, both of which contribute to their felicity. By examining illness accounting from both of these perspectives, the dissertation aims to shed light

on the social relations that are involved in Mapuche children's health care. With respect to the interactional order that shapes illness accounts, I describe the context of activity, participation framework, sequential organization, and linguistic and non-linguistic embodied practices that characterize the production of illness accounts in each of these settings. With respect to the denotational textual aspects of illness accounts, I identify key linguistic and paralinguistic features that characterize the verbal accounts of illness that are exchanged in consultations. I describe what makes an account acceptable and I complement this with an analysis of how participants responded to accounts that, in their estimation, were problematic. This combined approach of looking at successful and contested accounts affords insight into how parents, patients, and professionals communicated to one another not only their concerns about children's health but also their expectations of one another with respect to children's care.

Through the analysis of felicitous and infelicitous illness accounts, the dissertation identifies the normative interactional and textual expectations for these speech events and the social consequences of not meeting these expectations. In this sense, it treats illness accounting as a moral practice that involves social risks. In the acts of description and reciprocity, parents, children, and medical practitioners hold one another accountable for knowing and providing certain information and behaving in certain ways, and they risk disapprobation for their failures to do so. The organization of the dissertation chapters is as follows:

Chapter 2 provides the ethnographic background contextualizing the study.

Chapters 3 and 4 examine how consultations are launched in Mapuche healing consultations and acute pediatric primary care consultations, respectively. Analysis and discussion address how actions early in consultations are used to orient participants to their respective rights and responsibilities for the forthcoming activity of establishing the medical

problem for which diagnosis and treatment are needed. The discussions in these chapters consider how the allocation of speaking responsibilities in each setting corresponds to differing epistemic assumptions concerning the distribution of legitimate knowledge about illness experience as well as how these assumptions and participation rules shape the social relations between practitioners, patients, and parental caregivers.

Chapter 5 focuses on a consequential kind of interactional challenge that contemporary Mapuche healers face in the provision of healing services to an increasingly non-Mapuche clientele. Because non-indigenous parents bringing children for consultation with a Mapuche healer for the first time are well versed in the speech genres of Western primary care medicine and often unfamiliar with the Mapuche diagnostic genre of *pelotun*, they are likely to participate in the activity in unconventional ways. Parents' volunteered accounts of children's illnesses can pose an interactional dilemma for healers, whose authority hinges in large part on their control of tellership in illness accounting. This chapter examines the generic regimentation of tellership rights as they played out in real-time in two Mapuche healing consultations and considers the implications these negotiations have for the legitimation of Mapuche medical authority and the ontology of diagnoses in the sociocultural context of asymmetrical medical plurality that exists in the Araucanía.

Chapter 6 documents the key linguistic and interactional features of *pelotun* accounts. It highlights ways that practitioners and their clients coordinate their participation to co-construct accounts that will be meaningful to all of the participants involved and to affirm the special knowledge that healers have about illness. It identifies how the historicity of illnesses is framed and makes the argument that this representation of the timing of illness contributes to the persuasiveness of the genre.

Chapter 7 documents the discursive norms surrounding how to represent the timing of children's illnesses in chief complaints in Chilean pediatric primary care. The chapter examines multiple cases of felicitous accounts and identifies the linguistic resources that parents use to frame the history of children's ailments in terms of calendar time, a measure that is significant because it is objectively verifiable. The chapter the presents a case study in which a mother and youth failed to present a felicitous illness account and tracks how the timeliness of the youth's medical appointment was treated as problematic and, ultimately, an accusation of malingering was issued. Discussion of the case addresses not only what occurred during the appointment but also the broader sociohistorical context of Mapuche-Chilean relations, which arguably contributed to the failure of the family's account. This final analytical chapter of the dissertation illustrates what is at stake socially for Mapuche participants in primary care encounters when they represent children's illnesses to non-indigenous physicians.

Chapter 8 concludes the dissertation with a discussion of the study findings.

1.9 Research Methods

Data for this project were collected in the city of Temuco and in Makewe, the rural district immediately across the Cautin River from Temuco. Data were collected during two separate periods, the first was during Summer 2008 and was carried out with support from the UCLA International Institute, UCLA Latin American Institute, UCLA Institute for American Cultures, and the UCLA Department of Anthropology. The second research period lasted from March through December 2009 with funding from the Fulbright Institute for International Education. Permission to conduct the study was granted by the UCLA Institutional Review Board and the administration of *Hospital Makewe*.

1.9.1 Data Collection at the *Hospital Makewe* Primary Care Center

Research was conducted at the primary care center of the *Hospital Makewe*, where residents of the Makewe district receive medical attention. Data collection methods included participant observation and field note taking, photography, videorecording of medical consultations, and semi-structured interviews. A total of 51 consultations were recorded at the primary care center that is part of the Makewe Hospital and primary care clinic (PCC). Participant practitioners in the research included three general practice physicians who conducted acute care visits, a kinesiologist who conducted follow-up visits with children who had been diagnosed with respiratory infections and were on antibiotic treatment, and a *médico auxiliar* ‘nurse’s assistant’ who conducted well-child consultations at the medical center. Two of the practitioners were men, and three were women. Only excerpts from consultations with the physicians are presented in the dissertation.

Potential participant families were recruited in the primary care waiting area, where I approached parents who had children with them to explain the study and invite them to participate. I interviewed families who consented to participate in the study in one of the unoccupied examination rooms to ensure the privacy of our conversation. Interviews were audiorecorded. The interview schedule was an adaptation of Kleinman’s explanatory model interview and inquired about the parent’s interpretation of the child’s illness for which medical services were being sought. Questions in the interview also solicited the history of the illness, including what treatment had been pursued at home and whether and with whom the family had sought care prior to the present visit to the primary care center. Finally, the interview documented basic patient information, including the age of the patient and where the family lived as well as how the adult caregiver was related to the child. Most adult caregivers were

mothers or fathers, but there were also several cases of grandparents or aunts who were accompanying children patients. Participant families received a small toy of the child's choice to thank them for their participation. Toys included stuffed animals, coloring books, crayons, and small trucks and dolls.

On any given day, I worked with only one medical practitioner. Because each practitioner had her own consultation room, I was able to mount the video-camera on a "magic arm" clamp in a corner of the room before the practitioner began attending patients for the day. When participant families were called in for their consultation, I entered the room with them and turned on the videocamera. I exited the room immediately and was not present during consultations. I left a remote control for the camera with the medical practitioner, who could turn off the camera as necessary, either at the end of the consultation or at the request of any of the research participants. I entered the consultation room when participant families concluded their appointment to ensure that the camera was turned off.

Figure 1.3: Videocamera mounted above an examination table in the primary care center



In addition to interviews with patient families, I also conducted and audio-recorded semi-structured interviews with staff at the primary care center. Interviews were conducted with two of the general practice physicians, the nurse's assistant who conducted well-child consultations, the on-site social worker, the Mapuche Association patient liaison, and the director of the medical center, *don* Francisco Chureo—the latter on several occasions. To thank these administrative and professional participants for their collaboration in the project, each received a small gift at the conclusion of the research.

Over the course of the research period, I conducted extensive participant observation at the primary care center, with much of my time spent talking to patients and their families in the waiting rooms. On several occasions, I joined the staff for tea or at lunch hour. I also observed how medications were handled and distributed at the on-site dispensary, and I observed the administrative process at the reception desk. I was fortunate that several members of the administration, especially *don* Francisco, took an interest in helping me understand the workings of the medical center. As a result, I was invited to participate in a number of activities that were held on site. These included a meeting that was held to discuss with members of the community upcoming plans for the rebuilding and expansion of the hospital. The project was part of an effort on the part of the regional health authority to bring the hospital into compliance with and more formally integrated into the network of public medical centers in the Araucanía Region. Other activities I attended were oriented toward community building, including an elaborate *We Tripantu* 'new year' ceremony that was followed by a large banquet, all of which was funded by the Indigenous Association that managed the medical center.

As a form of reciprocity, I occasionally provided rides to Hospital Makewe administrative staff for a variety of purposes. These occasional outings provided me with insight

into the ongoing projects and concerns of the medical center administration, which ranged from visiting local community members to discuss ideas for improving care and attention at the medical center, to meeting with a senator to advocate for a new hospital in an adjacent community, to recruiting and organizing volunteers with expertise in roof thatching to carry out the substantial project of replacing the roof of the on-site *ruka* at the medical center. At the conclusion of the research period, I gave a gift of several toys to be made available to children who were waiting to see the doctor, and I purchased paint and materials to repaint the hospital kitchen.

1.9.2 Data collection at the Mapuche Healing Center in Temuco

The second institutional site where data were collected was the Mapuche Healing Center in the city of Temuco. The same methods of participant observation, photography, videorecording of consultations, and interviewing were carried out at the healing center as were used at the primary care center. At the Mapuche Healing Center, a total of 45 consultations were recorded. These included consultations with the *machi* ‘shaman’ and the *lawentuchefe* ‘herbal healer’. Because healers at the Mapuche healing center saw very few children, most of the consultations recorded at this site were for adult patients. The corpus of recorded consultations includes seven consultations that were made regarding the health of three minors (one consultation for a 15 y.o. male, one consultation for a 3 y.o., and five consultations for a 12 y.o. male). Potential research participants for this phase of the project were recruited while they waited in the reception area before seeing a healer with whom they had scheduled an appointment. To thank participants for their contribution to the research, I paid for one of the herbal remedies that were produced by the Mapuche Pharmacy and that were routinely prescribed by the healers. The value of these herbal tinctures was between \$5-7 US each.

Figure 1.4: The ethnographer with *lawentuchefe* Lorena outside the healer's home



The protocol for participation in the study included the video-recording of the client's consultation and an audio-recorded interview with the researcher. In general, these data collection procedures were conducted in the same way they were at the primary care center in Makewe. The video-camera that recorded consultations was mounted in a corner of the consultation room. I turned the camera on at the beginning of each consultation and returned to the room to turn it off at the conclusion of the consultation. I interviewed study participants in an unoccupied consultation room to ensure the privacy of interview conversations. On the few occasions when both consultation rooms were in use, I conducted interviews in the hallway outside the Mapuche Healing Center or, when there were no other clients present, in the reception area. The interview protocol used at the Mapuche healing center was the same used for interviewing study participants at the primary care center.

In addition to conducting interviews with research participants and recording consultations, I conducted participant observation in the reception area of the healing center,

which provided ample opportunities for less structured, spontaneous conversations with clients and the healing center staff. My field notes document information I gleaned from being a participant observer in this setting.

Finally, I conducted semi-structured interviews with each of the participant healers in the study, the *machi* and the *lawentuchefe*. These interviews provided information about the background of each of the healers, the history of how they had come to practice in this setting, and their insights on issues that included the practitioner-patient relationship and the importance they saw in providing Mapuche healing services to Mapuche and non-Mapuche clients.

1.9.3 Data collection at the *Farmacia Mapuche* in Temuco

For a brief period of the research year, I spent time as a participant observer at the Mapuche Pharmacy in downtown Temuco. Though it was technically an independent enterprise from the Mapuche Healing Center, there were several ways the pharmacy and healing center were interdependent on one another. Clients who arrived at the pharmacy looking for a referral to a Mapuche healer were directed to the Mapuche Healing Center, and the practitioners at the Healing Center regularly prescribed herbal tinctures that were produced by the pharmacy. These herbal remedies were sold at the reception desk in the Healing Center as well as directly from the pharmacy store-front a few blocks away. While the *machi* and *lawentuchefe* who attended patients at the healing center had not been directly involved in the development of the herbal tinctures that were sold at the pharmacy, they did participate actively in events that were sponsored at the pharmacy, including the annual *We Tripantu* new year ceremony and banquet that was open to the general public.

I generated field notes from my observations at the pharmacy, took photos of the store-front space of the pharmacy, interviewed staff who worked there, and audio-recorded several

interactions between staff and clients. These data are not formally presented in this dissertation, though they were valuable to me for understanding the commercialization as well as the medicalization and pharmaceuticalization of Mapuche healing resources.

Figure 1.5: Storefront of the Mapuche pharmacy in Temuco during a public ceremony



Figure 1.6: Staff working at the Mapuche pharmacy



1.9.4 Data Collection in Makewe

In addition to collecting data in the institutional settings described above, I also spent extensive time with families in the Makewe region and participated in community celebrations and events. Events in which I participated and sometimes filmed included: church services, community meetings, elementary school celebrations for *We Tripantu* (new year), *Dieciocho* (national independence day), Christmas, and the community-wide biennial *ngillatun* (harvest ritual) ceremony.

Figure 1.7: Community meeting in Makewe regarding a road pavement project



Four families in Makewe participated formally in the research as ‘focal families’. These families were recruited from among the research participants at the primary care center. Research with the focal families involved multiple home visits, most of which were dedicated to participant observation and field note taking. During these visits, I accompanied children in their

daily routines. I often helped children with homework and joined in with household and farming chores. We also watched TV together and took many walks through the countryside. I joined families in their occasional visits to grandparents and other extended family who lived nearby and gave rides when families wanted to visit family members who lived further away. The families also invited me to attend children's birthday celebrations and school activities. A few of these visits for family celebrations were made in the company of my husband and three-year-old son. On several occasions, I provided rides for members of the focal families to or from the primary care center and, when necessary, to see specialists at the public hospital in Temuco. On a few visits with each family I made videorecordings of children's quotidian activities, including one family meal in each family. In addition, three formalized data collection activities were conducted with each focal family over the course of the research period.

Figure 1.8: Working on homework^y



Figure 1.9: Visiting a seasonal pond during a home tour



Figure 1.10: Children watch a neighbor plow his field with a rented tractor



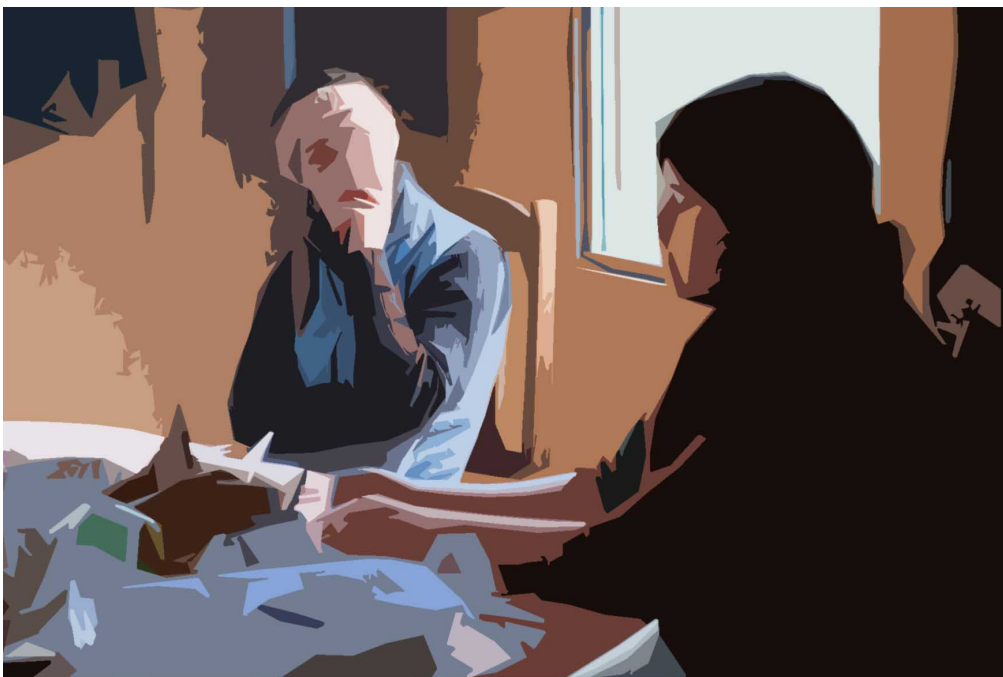
Figure 1.11: Children between rows planted with strawberries during a home tour



Child-guided Home Tour: On my first home visit to each focal family, I asked the children of the family to take me on a guided tour of their home and farm. During this tour I took photos, and one of the children (normally the eldest) wore an audio-recording device that recorded his comments about the spaces we visited.

Health Interview: After I had visited a family a few times, I scheduled a dedicated visit when I could interview the parents in their home at a time when the children would not be present (normally during school hours). On this occasion, I conducted and videorecorded an in-depth health interview with the parents that lasted between two and three hours. My interview schedule was adapted from the family health interview protocol that was developed by researchers Linda Garro and Carolina Izquierdo (2004) and used initially for research with middle-class families in Los Angeles, California.

Figure 1.15: Ethnographic interview with a focal mother at home



Children’s Illness Story-telling Activity: Toward the end of the data collection period, I conducted and video-recorded an activity with the focal children that was designed to elicit from them the story of an illness episode they remembered. I provided the children with large sheets of paper and colored pencils, and I asked them to draw a picture of a time when they had been sick. Parents were present during this activity, and I did not discourage them from participating in the activity as they saw fit. When the children had finished drawing and coloring their pictures, I asked each one to tell me about her picture and what had happened. The entire activity took at least an hour with each family.

In addition to formal research activities with the four focal families, I also spent time with several other families less formally. These included the extended family of the local *lonko* ‘headman/chief’ and the family of *machi* Nora, whose story I have retold at the beginning of this

chapter. I became friends with these families, whose many kind and insightful conversations provided a much richer understanding of Mapuche family life, healing, cosmology, and politics than I could otherwise have gained.

Notes to Chapter One

ⁱ All names in the dissertation are pseudonyms with the exception of *don* Francisco Chureo, director of *Hospital Makewe* at the time of the research and founding member of the *Asociación Indígena por la Salud Makewe-Pelale*.

ⁱⁱ The area where I conducted research for this project is best known as *Maquehue*, the spelling of which utilizes Spanish orthographic conventions to represent a Mapuche place name. As a small gesture of recognition that the area is Mapuche territory and the name is a Mapuche word, I prefer the alternative spelling *Makewe*, which uses orthographic conventions for written Mapudungun, the Mapuche language. The name means ‘place where there is an abundance of *maqui* (*Aristotelia chilensis*) trees’.

ⁱⁱⁱ Although these definitions extend to the sufferer/patient primary epistemic rights with regard to the experience of symptoms, the capacity to accurately perceive and interpret symptoms is also understood to be compromised by a variety of diseases, complicating the notion that first hand experience of symptoms is necessarily a position of epistemic privilege. On the one hand, conditions such as frontotemporal dementia (Avineri 2010b), addiction (Carr 2010), and a variety of metapathologies (Hahn 1995) are understood to impair an individual’s reliable insights about their own illness. In addition, disorders such as schizophrenia are understood to adversely affect a person’s general ability to communicate about experience in intelligible ways (Biehl 2005; Wilce 2004).

^{iv} While this assumption holds in general, in any given case, a physician’s choice to pose an inquiry to a parent versus a child may also reflect other considerations, including racial, gender, and class biases (Stivers & Majid 2007) or attitudes about disclosure (Clemente 2005).

^v Many of the images used in the dissertation, including this one, have been modified using filters in Photoshop Elements software in order to render the research participants less recognizable. Because this processing makes some details of interaction (e.g. gaze direction) more difficult to see, I have used arrows and other semiotic devices in frame grabs that appear in transcripts in order to highlight features that are important for understanding the unfolding interaction.

Chapter Two

THE ETHNOGRAPHIC SETTING

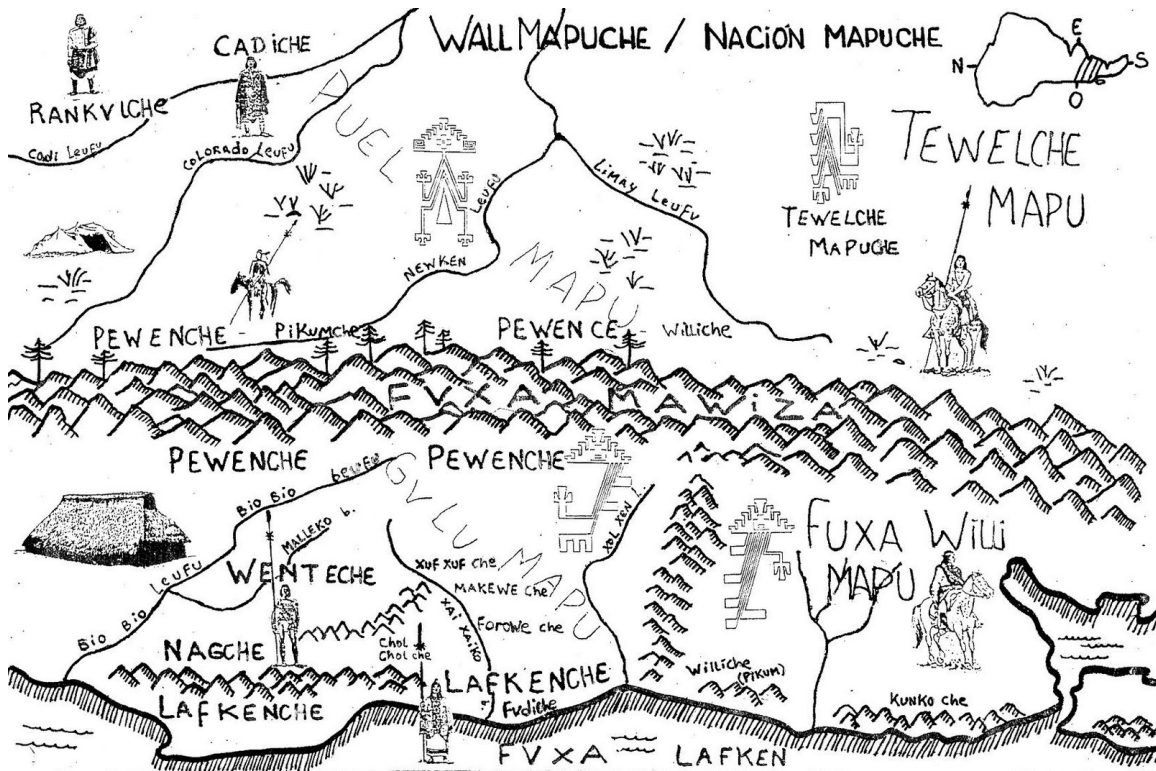
2.1 *La Frontera* and Its Inhabitants

For contemporary Chileans, the Mapuche are the cultural other in the national population. They are strangers in the house. Stereotypes of the Mapuche swing between notions of noble savages and recalcitrant Indians (Bengoa 2000). Though the republic lay claim to the autonomous Mapuche territory more than 120 years ago, the regions of the Mapuche homeland, where Mapuche people still make up a large part of the populous, continue to be referred to as *la frontera* "the border" or "the frontier" a reference to the one-time boundary that was recognized by the Spanish crown between its colonial claims and the lands of the autonomous Mapuche peoples. So to imagine the area where I conducted fieldwork as a border territory is to adopt a deep-seated local understanding about the land and the people who live there. The Mapuche differentiate themselves from non-Mapuche Chileans, whom they refer to with the Mapudungun term *wingka*. Sometimes glossed as 'new usurper', the word *wingka* is a compound of *we-* 'new' and *inka* 'Inca'. The term was first applied to Spanish colonists and later to Chileans, denoting them as the successors to the imperialistic Incas, the new usurpers of Mapuche territory. The term is sometimes applied more generally to any non-indigenous person, for example a foreign ethnographer.

Map 2.1: *La Frontera* – the *Bio-Bio* and *Araucanía* Regions of Chile



Map 2.2: The Mapuche Nation. Image courtesy of the artist, Pablo Mariman.



Today, Chile is among the most economically and politically stable nations in Latin America, but it is also a nation characterized by entrenched inequalities. Chileans generally enjoy a higher standard of life than is found in most other nations in the region, but their country is one of Latin America's most unequal in terms of the distribution of wealth. Chileans in the wealthiest 20% of the population earn fourteen times more than the nation's poorest 20% (Pan American Health Organization [PAHO] 2007) and while such inequities tend to be interpreted in terms of class differences, this interpretive frame actually obscures the roles that racism and ethnic segregation play in long-standing inequities.

Chile's indigenous citizens are far more likely to be poor than their non-indigenous compatriots. According to the Pan American Health Organization (PAHO 2007), fewer than one fifth of Chileans live below the poverty line, but close to one third of indigenous people in rural areas (31.6%) and more than a quarter of indigenous citizens in urban areas (27%) live in poverty. The Araucanía Region, also referred to as the Ninth Region, where research for this dissertation was conducted, is considered the center of the historical homeland of the Mapuche and continues to have the highest index of indigenous inhabitants of Chile's regions, with nearly one quarter of residents identifying as indigenous.

Not coincidentally, the Araucanía has the nation's highest poverty rates and lost more inhabitants to internal migration than it gained in the period from 1992-2002 (Instituto Nacional de Estadísticas 2003). This pattern of out-migration from the region is due to the more generalized pattern of rural to urban migration by Mapuche youth and young adults who leave their natal households in the indigenous communities to earn money elsewhere either temporarily, annually, or permanently. For the most part, Mapuche women find employment in domestic labor, while Mapuche men most commonly find work in construction, agriculture, or

bakeries (Bengoa 1996; see Orellana-Rojas 2006 and Santelices 2006 for ethnographic portraits of the Mapuche migrant experience). The trend of internal migration by Mapuche workers is reflected in the current geographical distribution of Chile's Mapuche. Although fully one third remain in the Araucanía, another 30% now live in the greater metropolitan area of the capital city, Santiago.

2.2 Brief history of the Mapuche in Chile

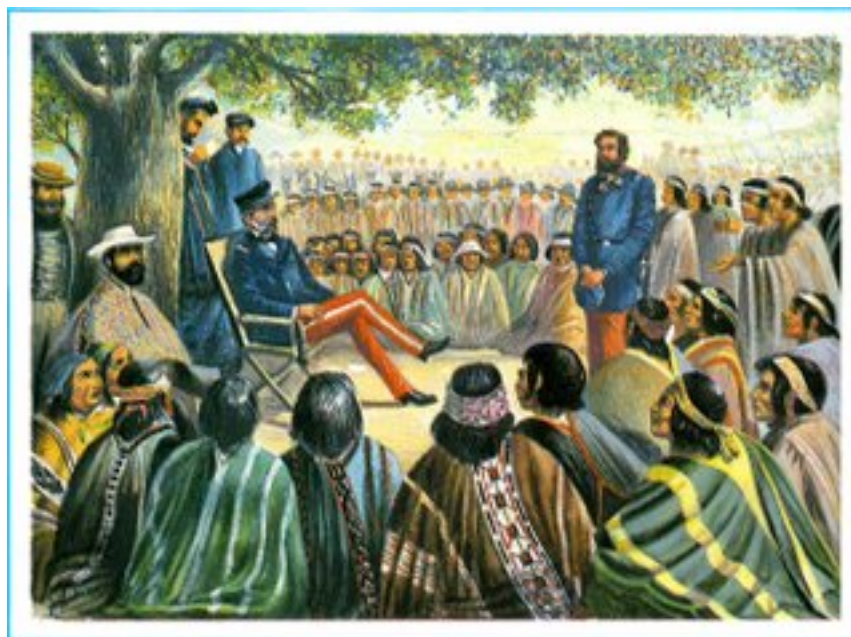
The Mapuche people are descendants of the indigenous groups who lived between the Aconcagua River and the Chiloé Archipelago prior to European contact and who are referred to by contemporary Mapuche as *Reche* 'true people'. The Mapuche have also commonly been referred to as *Araucanians*, though the term has fallen out of favor due to its colonial origins. The Mapuche are perhaps most renowned among South American indigenous groups for their successes in resisting assimilation into the Incan Empire and later the Spanish Empire.

Figure 2.1: Mapuche-Inca Battle Depicted by Guaman Poma



It was only after a protracted struggle with the Chilean state during the better part of the nineteenth century that the Mapuche finally lost their autonomy in 1881, when their territory was ceded to the Chilean Republic. At this time, the Mapuche were forcibly settled onto lineage-based reservations that were aptly named *reducciones* ‘reductions’. At this time, the Mapuche were deprived of governmental and territorial autonomy by the Chilean state, a political move that undermined Mapuche political, economic, and social institutions at the same time that it made Mapuche individuals and communities answerable to Chilean state authorities. With the vast areas of fertile land that were lost to the Mapuche in their settlement onto *reducciones*, the Chilean government carried out a campaign to populate the newly conquered territory with Europeans and Chilean *criollos* (Spanish descendants). The former were recruited to immigrate with promises of free land, and the latter were permitted to purchase land in auctions with favorable prices.

Figure 2.2: 1869 depiction of an encounter between Chilean military leader Cornelio Saavedra Rodríguez and Mapuche leaders during the Occupation of the Araucanía



The subsistence strategy on the Mapuche reservations during much of the twentieth century involved a combination of farming and pastoral pursuits. During this same time, in response to multiple factors that included soil degradation and population growth, many Mapuche left the rural reservations of the south and migrated to urban centers, most predominantly to Chile's capital city, Santiago, where a full thirty percent of contemporary Mapuche live today. Over the course of the twentieth century, the Mapuche continued to lose portions of the land that was originally titled to them through a variety of legal and extra-legal processes, exacerbating problems of endemic poverty and disrupting endogenous forms of cooperative agriculture and community labor (Mallon 2005).

The late twentieth and early twenty-first century is proving to be a historically consequential period for the Mapuche, who, like many other indigenous peoples across Latin America, are responding to changing political landscapes and policies with new forms of civic, economic, and political participation. Perhaps the most significant turning point in recent Chilean history was the return to democracy in 1990. Democratic elections in 1989 ended seventeen years of authoritarian rule under the military regime of Augusto Pinochet, who seized power in a 1973 coup d'état against the democratically elected socialist president, Salvador Allende. In the 1980s Mapuche leaders and organizations were actively involved in the movement to restore democracy and forged political alliances with the *Concertación*, a group of center-left political parties whose presidential candidate, Patricio Aylwin, became the first president of the post-dictatorship era. Little headway was made during the Aylwin administration with respect to Mapuche petitions for redress of historical wrongs, but the Mapuche mobilization of the 1980s and 1990s produced new and strengthened ethnic organizations that have shaped a new identity politics in indigenous Chile (Aylwin 1998; Bengoa 2007; Mallon 2005; Mariman 1994). Part of

this shift has involved efforts to valorize Mapuche language and cultural practices, and at least since the 1990s indigenous leaders have increasingly called for and participated in changes in public education (Quilaqueo, Quintriqueo, and Cárdenas 2005) and health care.

In the early 1990s, legislation was passed to officially recognize the multi-ethnic character of the Chilean population. This legislation provided for the recognition of eight *pueblos originarios* ‘First Peoples’: Mapuche, Aymara, Atacameño, Quechua, Rapa Nui, Colla, Alacalufe, and Yámana. The legislation stopped short of recognizing the indigenous groups as ‘nations’ or granting them governmental autonomy. One result of this official recognition of the *pueblos indigenas* was the collection of more reliable information concerning Chile’s indigenous citizens and residents than was formerly available^{vi}. Since that time, two national censuses have been conducted.

Figure 2.3: Chile’s cultural diversity appears as a theme in mural art in Temuco



According to the most recent census data (collected in 2002), 4.6% of Chileans self-identify as belonging to one of the eight *pueblos originarios*, the vast majority (87%) of whom consider themselves Mapuche (n. 604,349). The Mapuche alone, therefore, constitute four percent of Chile's fifteen million (n. 15,116,435) inhabitants. This estimation is low, however, relative to numbers from other sources, including the immediately previous census in which the wording of ethnic self-identification questions differed. Indeed, this previous census, conducted in 1992, accounted for nearly one million Mapuche, which constituted closer to 9% of the total population in the country at the time (Espina 1998). Gundermann and colleagues (2005) make a compelling argument that the apparent reduction in the number of Mapuche and other indigenous people in Chile over the course of a decade does not reflect true demographic shift but rather changes in the instrument that was used to classify inhabitants' ethnicity.

2.3 Mapudungun

There is no settled consensus on how many of Chile's Mapuche speak Mapudungun, their heritage language, nor about how many speak or are literate in Spanish. Adelaar and Muysken (2004), in their volume on Andean languages, are agnostic on the prognosis for Mapudungun as a language and indicate only that "it may be assumed that a substantial part of the Mapuche population in this area [the traditional homeland of the Mapuche] continue to speak it" (510). At the same time, most Mapuche today speak at least some Spanish, a result of prolonged contact and obligatory participation in the Chilean educational and economic systems (Bengoa 2007). Rural to urban migration generally results in the loss of Mapudungun in a single generation (Lagos 2005), which means that the majority of urban Mapuche are Spanish monolinguals. Today, it appears that a substantial number of rural-born Mapuche children are also learning Spanish as their first language. Signs of this shift in rural language use were noted at least as

early as 1976 (Melville 1976). A common linguistic ideology in Chile attributes the survival of Mapudungun to a purported cultural proclivity of the Mapuche to resist incursions from outsiders (Brown 1995; Hurtig 2006). Overall, Chilean linguists appear to agree that Mapudungun is declining as a first language at the same time that some young adults of Mapuche heritage are beginning to learn it as a second language (Catrileo, personal interview September 1, 2006; Lagos 2005), a shift that is evidenced by the publication of several pedagogically aimed books on Mapudungun in recent years (Catrileo 2002; Harmelink 1994, 1996; Zúñiga 2006).

2.4 A Public Health Portrait of Chile

Overall, Chile has an extensive, functional infrastructure for medical care. Over seven percent of the GDP in Chile is allocated to health care, and the national public health portrait reflects an advanced stage of epidemiological transition such as is typical of the highly developed countries of the Global North. Mortality due to chronic diseases, most prevalently cardiovascular disease, diabetes, and cancer (PAHO 2007), has outpaced mortality due to infectious diseases. However, major depression and alcoholism are widespread, and the country struggles with one of the highest psychiatric disease burdens in the world (Vicente et al. 2007; see López 2004 for an overview of mental health challenges and care services in Chile).

In terms of children's health, substantial attention and funding is allocated by the Chilean government toward preventative and curative medical care for pregnant women, infants and children. Prenatal and postnatal care is widely available, except to individuals in the most remote areas, and public health services administer highly successful vaccination and supplemental nutrition programs that are among the longest standing nationally funded public health programs on the continent (Robles 1993; Ugalde 1992; Weil 1992). The country boasts low infant mortality rates (7.8 deaths per 1,000 live births) and has achieved significant reductions in many

health concerns. Yet, despite these advances, acute respiratory infections, child abuse, obesity, and tobacco use continue to pose serious and intractable threats to children and young people's well-being (PAHO 2007).

2.5 Health Disparities and *El Problema Mapuche*

There are a number of diseases that affect the Mapuche at disproportionately higher rates than are found in the general Chilean population (Aliaga & Serra 2001; Heise et al. 2009; Moloney 2010; PAHO 2007; Robles 1993; Rojas 2007). And the health of indigenous Mapuche children is a particularly pressing matter, as they continue to experience measurable health inequalities compared to their non-indigenous peers (Aliaga n.d.; Rojas 1997). Abundant research points to significant, long-term negative impacts on Mapuche individuals' well-being as a result of numerous deleterious environmental factors. Among these, are chronic and cyclical food insecurity (Clark 2004), endemic poverty, and the rudimentary living conditions that are found in many Mapuche *comunidades*. Yet, while most state policies vis-à-vis the Mapuche frame what has been referred to as *el problema Mapuche* 'the Mapuche problem' as essentially one of poverty and lack of financial opportunity, there is ample evidence indicating that the problems the Mapuche face are not just economic. Robles (1993) found that the health disparities Mapuche children suffer are not statistically attributable to poverty alone. And others have identified pervasive ethnic discrimination (Mellor et al. 2009), state-sponsored violence, and violations of human rights (Kristensen 2010; Moloney 2010)^{vii} as negatively impacting on the health of the Mapuche.

Figure 2.4: Political graffiti in Temuco: ‘No More Violence Against Women’ has been modified to read ‘No More Violence Against the Mapuche’



The Chilean state has long pursued indigenous policy measures designed to alleviate poverty and facilitate the assimilation of the Mapuche into the larger Chilean economy, but these paired aims have met with only limited success. Most Mapuche children today attend Chilean public schools, develop native proficiency in Spanish, and may belong to a Catholic or Protestant church, but the Mapuche continue to consider themselves a culturally, economically, spiritually, and socially distinct group that presents an anomaly to the fiction of the ethnically, culturally homogeneous Chilean nation.

2.6 The Politics of *Medicina Intercultural*

In parallel to trends across Latin America, a discourse of multi-culturalism and ethnic recognition became popular in Chile beginning in the 1990s (Aylwin 1998; Bachelet 2007; Richards 2010). Legislation was promoted and implemented authorizing the incorporation of indigenous linguistic and cultural resources in educational curriculum and medical services in

areas where there were dense concentrations of indigenous people. Programs that grew out of these political initiatives were referred to as *intercultural* ‘cross-cultural’ and, despite early enthusiasm for their promise, they have received a great deal of criticism for such problems as lack of financial support, poor implementation, and reductive interpretations of indigenous cultural practices.

In the field of health services, the *Servicio de Salud Araucanía Sur* (Southern Araucanía Health Service SSAS) regional health ministry promoted and implemented changes that were framed as part of an effort to provide culturally consonant medical care under the rubric of *medicina intercultural* ‘cross-cultural medicine’ (Alarcón 2004; Park 2006). Cross-cultural medical programs have seen growing popularity around Latin America (O’Neil et al 2005; PAHO 2002) and have taken many different shapes. But, in Chile, as Alarcón and her colleagues (2004) have noted, there is little agreement between practitioners and service users concerning what *medicina intercultural* programs should include and how they should operate. Chilean health care policy under the *medicina intercultural* model has largely focused on making biomedical health care services more amenable to indigenous patients, for example with the provision of interpreters and bilingual signage in Spanish and Mapudungun. In the city of Nueva Imperial, the regional health service built a Mapuche healing center adjacent to the local Western hospital. While this was the furthest reaching of all the government sponsored *medicina intercultural* innovations, the program has been criticized by some Mapuche leaders who argue that the design and implementation of the program lacked Mapuche input (Park 2006).

Figure 2.5: *Mapuche Ñi Lawentuwün* healing center at the Nueva Imperial public hospital



Two main concerns drive the governmental implementation of cross-cultural medicine in Chile. The first aim is to improve the health status of the Mapuche population, which displays perduring health inequalities. The second is related to political promises that were made in the Nueva Imperial Accord between Mapuche leadership and the *Concertación* parties at the time of the return to democracy. The political promise involved pursuing a broad political agenda of multiculturalism. Given these twin aims, it is not surprising that the cross-cultural programs promulgated by the Chilean government do not explicitly promote the use of ethnomedical therapies for indigenous citizens.

In ideological contrast to governmental initiatives, many Mapuche community leaders support an interpretation of *medicina intercultural* that would involve a paradigm shift in health care whereby Mapuche medicine would be recognized as on a par with Western medicine (Servicio de Salud Araucanía Sur 2002). Entrepreneurs and community organizers in Makewe specifically, have undertaken their own initiatives to promote Mapuche medicine, including

through the commodification of Mapuche herbal remedies and their sale as homeopathic products and the delivery of Mapuche healing in Western-style medical offices that attract both medical tourists and clients interested in natural curative methods. These initiatives are discussed in greater detail below.

2.7 Primary Care Medicine

Biomedical care is available to the poorest sectors of Chilean society for free in government funded primary care centers (PCC) that are distributed geographically with relation to relative population density. At these PCCs, biomedical practitioners treat patients and refer them, as needed, for specialized care in centralized urban facilities.

2.8 Mapuche Medicine

Mapuche medicine is unregulated but generally tolerated by the state apparatus in Chile (O'Neil et al 2005). The most well-known Mapuche healers are *machi* shamans (Bacigalupo 1994, 2007), though there are numerous Mapuche healing specialists including *gütamchefe* bonesetters, *püñünelchefe* midwives, and *lawentuchefe* 'herbal healers'.

Historically, Mapuche healers attended patients in their homes on the rural reservations, which are now referred to as *comunidades indígenas*. Ritual healing ceremonies, when necessary, are carried out in patients' homes with the participation of extended family and close friends. Illness and healing are treated as processes that involve physical, social, and spiritual elements, collapsing modernist boundaries between religion and medicine. However, in recent years, a number of Mapuche healers have sought to expand the availability of Mapuche healing to a wider population and have emphasized the medical over the spiritual qualities of their practice in order to do so. These healers have been key actors in innovative ventures to establish Mapuche healing centers in several of Chile's urban centers.

Despite these efforts by Mapuche healers and entrepreneurs to establish that Mapuche medicine is effective and not incompatible with mainstream biomedicine, and notwithstanding government health agencies' public discourse on *medicina intercultural*, Mapuche healing continues to be practiced under perduring stigma. Many of the Western medical practitioners I interviewed for this project had a low opinion of the efficacy of Mapuche medicine, and several expressed serious critiques about Mapuche healers and healing practices. One even suggested that healers were more likely to exacerbate than ameliorate children's health problems. This sort of stigma and discrimination is documented by many others (Alarcón et al. 2004; Bacigalupo 1994, 2007; Boccara & Seguel-Boccara 1999; Ibacache 1997; Izquierdo 1995; O'Neil et al. 2005; Robles 1993).

2.9 Wellness, Illness, and Mapuche Sickness Distinctions

Notions of well-being for the Mapuche are based on tropes of harmony and balance in the nested natural and supernatural ecologies of an individual, his family, and his *lof* 'ritual community'. In this cosmological view, balance is achieved between alternating and countervailing forces that operate at all levels of the universe. Transgressions against *ad mapu*, the corpus of Mapuche norms of behavior, upset the harmony within and across interpersonal, natural, and supernatural relational spheres and manifest in ill health and other misfortunes (Ibacache et al. 2002; Quidel 2001). Under this etiological logic, there is a certain degree of collective responsibility whenever illnesses occur because problems are interpreted as socially related across the affected individual's kin and community (Degarrod 1989).

Kutran 'illnesses' can be classified in several ways. According to Grebe (1975), Mapuche classify illnesses by their causes and symptoms. Causes can be natural or supernatural, and symptoms are classified by their intensity, duration, and location in the body. However, as other

ethnographers have pointed out (Bacigalupo 2001; Citarella et al. 2000), the distinctions that are made in cases of real illness are both more complicated and more complex than Grebe's taxonomy would suggest. Knowledge about illness categories and causes differs across individuals and families, and in any given case of illness, one kind of distinction may be invoked while another may not. Citarella and colleagues (2000) provide an excellent discussion of the main distinctions and ideas on which Mapuche lay people and healers draw when recounting particular sickness episodes or providing an ethnoclassification of ailments for researchers. The following paragraphs summarize some of these scholars' chief findings, to the extent that they coincided with accounts I heard from families and healers in Makewe.

One gross division that can be made is between *mapuche kutran* and *wingka kutran*, illnesses that belong to the mapuche and the non-indigenous spheres, respectively. Decisions to seek help in one healing system or another are sometimes made in reference to this distinction according to a logic that attributes curative efficacy to the system where a particular illness ostensibly belongs. Diseases introduced by European contact, for example, are classic examples of *wingka kutran*, while supernatural illnesses are quintessential *mapuche kutran*. At the same time, many illnesses cross the *mapuche-wingka* boundary. For example, tuberculosis requires biomedical treatment to cure the physiological elements of the ailment, but treatment with a *machi* may be sought to treat the origin of the problem, which is related to violations of cultural norms. Simple mapuche illnesses that become medically complicated may also cross into biomedical categories and require attention from physicians. Such is the case of *chafu* (a respiratory ailment) that can deteriorate into pneumonia. According to some, even the most conventional *wingka kutran* may have psychosocial causes that require treatment in the Mapuche ethnomedical system.

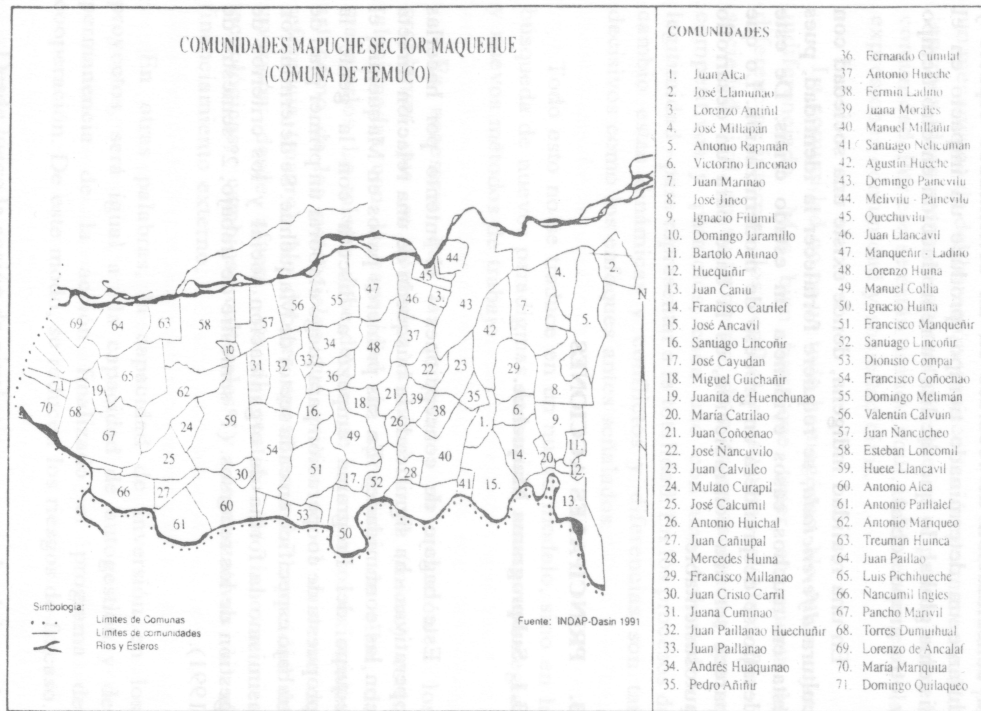
Illnesses can also be differentiated according to whether their cause is natural or supernatural. This kind of distinction is neither exactly opposed nor directly correlative with the categories of *wingka* and *mapuche* illness. Rather, *re kutran* are ‘pure illness’ or ‘simply illness’ and do not involve supernatural forces. These sorts of illness result from such things as temperature changes or tabooed food combinations. *Chafó* is also a prime example of *re kutran* and is treatable at home with commonplace therapeutic resources, including medicinal herbs and over-the-counter medications. In contrast, illnesses with a supernatural origin are inflicted by spirits or deities who belong respectively to the world above the earth, *wenu mapu*, where benign spirits reside, or the world below, *minche mapu*, which is inhabited by mischievous and malignant spirits. *Wenu kutran*, which proceed from the upper world, include (1) *machi kutran*, which signals an individual’s vocation to become a *machi*, (2) *kastigo kutran* which are punitive of persons who fail to fulfill ritual obligations, and (3) *koniün*, which results when a pregnant woman transgresses norms by coming into contact with suffering animals or a dying person. *Weda kutran* include both illnesses caused by witchcraft (*kalku kutran*) and *wekufe kutran*, illnesses that are caused by spirits who either act independently or are ‘sent’ by a human agent with the intention of causing harm.

2.10 Makewe

Makewe is a rural area of rolling hills that covers about 200 square kilometers. Situated immediately southwest of the regional capital city of Temuco, Makewe is bordered on the North by the Cautín River and on the South by the Quepe River. Makewe is constituted for the most part of multiple, contiguous Mapuche indigenous communities, many of which continue to be referred to by the name of the *longko* ‘headperson’ to whom the respective land title was granted during the settlement period at the turn of the century. The majority of the families in Makewe

are direct descendants of the families who were registered to these original reservation communities.

Figure 2.6: Comunidades Indigenas of Makewe



Programa Interinstitucional Maquehue

Conservative estimates indicate that over 80% of families in Makewe identify as Mapuche (Chureo 2001). Though Makewe covers a large area, there is no town of Makewe *per se*. While most towns in Chile are built in the Spanish tradition with a central plaza and church, the geography of Makewe is distinctly Mapuche (Isla n.d.). Made up of many contiguous *comunidades* that spatially map onto the boundaries of titled *reducciones*, the countryside of Makewe is a patchwork of fields and woods. Family homes dot the landscape, often at great distances from each other, sometimes clustered where extended families have built separate homes for grown and married children in close proximity to their parents. Children attend one of many public and subsidized elementary schools that are located throughout the rural area. And

youth who attend high school generally do so in Temuco, either as residential boarders or by commuting daily on the rural bus system. Local residents of Makewe travel by bus to the city of Temuco for purchase of necessary supplies and to access public services. There are many small evangelical and Catholic churches in the area, including an Anglican mission church that has been staffed continuously for over 100 years (Menard & Pavez 2007). A number of traditional and popular healers practice in the area, some with affiliations to the *Asociación Indígena por la Salud Makewe-Pelale* (Chureo 2001).

Figure 2.7: Young research participant and the ethnographer's son at play in a fallow field



Figure 2.8: Anglican Mission Church to which *Hospital Makewe* formerly belonged



Figure 2.9: Children playing near a gate



Figure 2.10: A classroom building on site at one of the public primary schools in Makewe



Population pressure and environmental degradation have made subsistence farming an ever more difficult strategy to sustain in Makewe. Clark (2004) has noted that a substantial percentage of Mapuche families in a partially overlapping area with Makewe experience cyclical food insecurity that is worst during the late Winter and early Spring, when financial outlays must be made for planting. During this period, harvests from the previous year are often depleted. In the face of these difficulties, rural to urban out-migration from Makewe has been substantial, though many Mapuche from the area return to settle and raise families on their natal reservations after several years or even decades working elsewhere, making Makewe an example of what Bengoa (1996), drawing on Aguirre Beltrán (1967), has referred to as an “area of refuge” of the Mapuche diaspora (see also Marimán 1994).

In general, at least one adult member of every extended family in Makewe spends part or all of the year working for wages. Wage work includes agricultural labor on one of the few large farms in the area, jobs in Temuco (e.g. taxi driving, construction, and childcare), or outside the region. Migrant Mapuche men working in the capital city of Santiago most often work in bread-baking or construction. Others choose to travel to the central and northern valleys, where they work as seasonal laborers in the fruit and wine industries. Migrant Mapuche women most often work as live-in domestic servants, though others work in agricultural jobs together with male family members. A growing number of Makewe youth are pursuing higher education and working as practicing professionals. Overall, most families in Makewe depend on remittances from family members working throughout Chile to maintain their households.

2.11 The Primary Care Center at *Hospital Makewe*

Free medical care is available to residents of Makewe at the *Hospital Makewe*, which includes a fully functional primary care center (PCC) and a basic hospital. The medical center was originally founded by Anglican missionaries, who provided first aid and, for several decades, an in-patient tuberculosis sanatorium. In the 1990s, a fight for ownership of the health center began after the Anglican Mission in Chile announced its intention to close the medical center due to lack of funds. Sustained and carefully orchestrated community organizing by local Mapuche leaders led to the eventual acquisition of the hospital and clinic in 1999 by the *Asociación Indígena por la Salud, Makewe-Pelale* (Indigenous Association for Health, Makewe-Pelale), a local organization that was founded expressly for the purpose of taking over management of the medical center. Since that time, the regional government agency of the *Servicio de Salud Araucanía Sur* (South Araucanía Health Service SSAS) has subsidized the budget for the medical center, and the Indigenous Association has managed it.

Figure 2.11: Sign at the Hospital Makewe featuring images of a Western physician and a *Machi*. The sign reads ‘Indigenous Association for Health 1927 Maquehue Hospital’



An early and symbolic action by the Indigenous Association upon acquisition of the hospital was to build a *ruka* (traditional Mapuche building) on site and to make it available for community meetings. This construction was financed with external funds that were generated by the Association through a combination of grant-writing and entrepreneurial activities. In 2006-2007, a new, fully equipped primary care clinic was built on site to replace the outdated wooden building from the era of the Anglican Mission. In 2009, the Indigenous Association was in conversation with representatives of the SSAS to plan for the replacement of the aging hospital building with new construction.

Figure 2.12: Ruka at the Hospital Makewe during the roof re-thatching project



Figure 2.13: The new construction Primary Care Clinic at Hospital Makewe



**Figure 2.14: Original primary care building with hospital in the background.
Photo courtesy of Hanna Garth.**



Figure 2.15: Boxes of medications in the on-site dispensary at the primary care center



The Makewe medical center provides a full range of biomedical primary care services while at the same time promoting and supporting the use of Mapuche medicine by patients. The line of laboratory-processed herbal tinctures that are sold in the city at the *Farmacia Mapuche* are available to patients at the primary care center in the on-site dispensary. Many of the staff at the primary care center are local residents, including the on-site social worker and the Indigenous Association patient liaison. However, the staff physicians, who included three general practitioners, a dentist, and two kinesiologists, were not Mapuche and did not speak Mapudungun. Literature on the Makewe Hospital and Clinic (Ibacache et al. 2001; O'Neil et al. 2005) indicates that in the recent past staff physicians received in-service training about Mapuche cosmology and medicine, had basic competence in Mapudungun, and attended patients together with a Mapudungun-speaking staff member when necessary. However, by the time data were collected for this project, because of physician turnover and budgetary limitations, this was no longer the case.

The Makewe Hospital and Clinic has been highlighted in numerous publications as a flagship intercultural medicine program (Ibacache 1997; Ibacache et al. 2001; O'Neil 2005; PAHO 2003, 2007; Park 2006). The administration of the Makewe medical center frames the expertise of Mapuche healers as comparable to that of biomedical physicians and sees Mapuche medicine as a vital element of a larger political agenda for Mapuche self-determination. The administrative board of the medical center endorses Mapuche healing and maintains positive relations with several local healers, including *machi* Nora, who presides over the annual *We Tripantu* 'new year' ceremony on-site. Patients who express the desire to see a Mapuche traditional healer are provided transportation to do so by medical center staff as a way of ensuring the availability of traditional medicine to residents. The decision *not* to have traditional

healers practicing on site at the Makewe medical center was made out of respect for the preferences of the local *lonko*, who ascribes to the norm that Mapuche healing is appropriately conducted at healers' homes. Valorization of the role of the machi and other traditional Mapuche healers is ideologically linked by the administration to Mapuche cultural continuity. And *medicina intercultural* in this setting is conceived as part of a larger objective of Mapuche self-governance.

2.12 Field Research in Temuco

In complement to the data that were gathered in Makewe, research data were also collected in Temuco at a Mapuche pharmacy and a small Mapuche healing center. The pharmacy was founded and staffed almost exclusively by Mapuche people from the Makewe district. The healing center was jointly owned by several young people from Makewe who were also involved in the pharmacy. The healers who practiced at the healing center were from several rural districts around the Araucanía.

Figure 2.16: View of downtown Temuco taken from the *Torre Caupolicán* building



2.13 The Mapuche Healing Center (MHC) in Temuco

In order to appeal to a broad clientele, the Mapuche Healing Center in Temuco and others like it are intentionally stylized to present Mapuche healing as modernized and medical and to downplay the magico-religious aspects of Mapuche healing practice. At the same time, some elements in the space and practice are employed to signal Mapuche ethnic authenticity and traditionality. The center is located in an urban office building, and the space is organized like a small Western medical practice, complete with a waiting room, reception desk, and two private rooms where healers conduct consultations with their clients. Each consultation room is

equipped with a desk across which patients and healers face one another. All of these elements echo those found in private Western medical practices across the city. In contrast to Western doctor offices however, the Mapuche Healing Center is decorated with iconic elements of Mapuche music and dress. In the waiting room, a *kultrun* drum hangs in a corner, and a hand-woven poncho of the sort worn by rural Mapuche men hangs on a wall. While the receptionist and co-owner dresses in Western style clothes and jewelry, the healers come to work dressed in the types of clothes, scarves, and jewelry that are readily recognized by Chileans and Mapuche alike as the trappings of *machi*. Spanish is the default language in the healing center, though healers reciprocate in Mapudungun when clients initiate a code switch. Despite the clear differences that this institutional setting imposed, the healers with whom I worked at the healing center insisted that their practice there was “the same” as when they received patients in their rural homes in the indigenous communities where they lived.

Figure 2.17: Consultation Room in the Mapuche Healing Center in Temuco



The Mapuche Healing Center operates as an independent, fee-for-service business. The healers included practitioners of various healing specialties. During the data collection period, there were three practitioners who attended patients regularly at the MHC. The first was a male machi, and the second was a female *lawentuchefe* ‘herbal healer’. Both of these healers participated as focal practitioners in the study. A third practitioner at the healing center did not practice a traditional healing role. Rather, he was a university-trained chemist with extensive knowledge of Mapuche herbal remedies. In addition to working at the healing center, this practitioner was also a staff member at the local Mapuche pharmacy. A fourth practitioner, a bonesetter, received patients at the healing center very occasionally on an appointment-only basis.

Figure 2.18: A healer attending a patient at the Mapuche Healing Center



Mapuche healing services can be expensive compared to Western services because they are not covered by the private or public health insurance systems that operate in Chile. As a result, patients who consult a healer must pay for the consultations and remedies “out-of-pocket,” often on a strictly cash basis. In 2009, practitioners at the Mapuche Healing Center charged between \$10 and \$16 US for a consultation. Their herbal remedies and talismanic *contras* cost between \$5 and \$10 US each, and healers generally prescribed multiple remedies for a single patient. Given that these traditional remedies were understood to work more slowly than pharmaceuticals, requiring weeks or months for an effective cure, patients could expect to spend substantial sums over time in the pursuit of wellness under a Mapuche healer’s care.

2.14 Seeking Care from Physicians and Healers

Despite the relative costliness of treatment with indigenous medicine and persistent stigma that is associated with Mapuche healing, many well-respected Mapuche healers continue to receive patients and make a humble living with their practices. This is in part because Mapuche healers are perceived as powerful agents in the assessment and treatment of complicated illnesses as well as illnesses of supernatural origin. The responses I received in interviews at the Mapuche Healing Center indicate that most clients had already sought treatment for their ailments with biomedical practitioners. Among these clients, some reported perplexing sets of symptoms that a variety of physicians had been unable to diagnose satisfactorily. Others reported suffering from chronic conditions for which physicians had advised them there was no definitive cure. These latter clients hoped to gain relief from their symptoms with the use of herbal remedies. These same clients often reported dissatisfaction with pharmaceutical treatments that had proved ineffective or had caused intolerable side effects. A second motive that clients reported for visiting a Mapuche healer was the suspicion that they or their children

were suffering from a popular or supernatural illness that was not recognized in mainstream biomedicine and for which Western doctors would have no cure. These findings suggest that Mapuche healing offered a promising healing modality for people who, for one reason or another, had concluded they could not get the relief they sought from Western medicine.

Parents in Makewe rarely took their children for treatment with Mapuche ethnomedical healers. Although there were a few infant ailments, *empacho* (which manifested as a digestive problem) and *ojo* ‘evil eye’, that required the skills of popular healers, it was far less common for families to determine that a child needed to see the likes of a *machi* or *lawentuchefe*. Most symptoms could be taken care of at home, parents reported, for example with acetaminophen or herbal remedies. When these means were not successful, parents took children to the primary care center and expected to receive medications that would address the problem in short order or, in more complicated cases, to get a referral to a specialist in the city. It was only in cases when children’s symptoms became serious and physicians at the primary care center or the emergency room in Temuco failed to provide an explanation, or when prescribed medications failed to improve children’s conditions, that parents sought help with ethnomedical or popular healers. In these instances, parents feared that children might not recover. An example of such a case comes from the Epu focal family, which faced an alarming illness less than a year before I met them. Their story illustrates the general pattern of recourse that families in Makewe took when children came down with perplexing or serious symptoms.

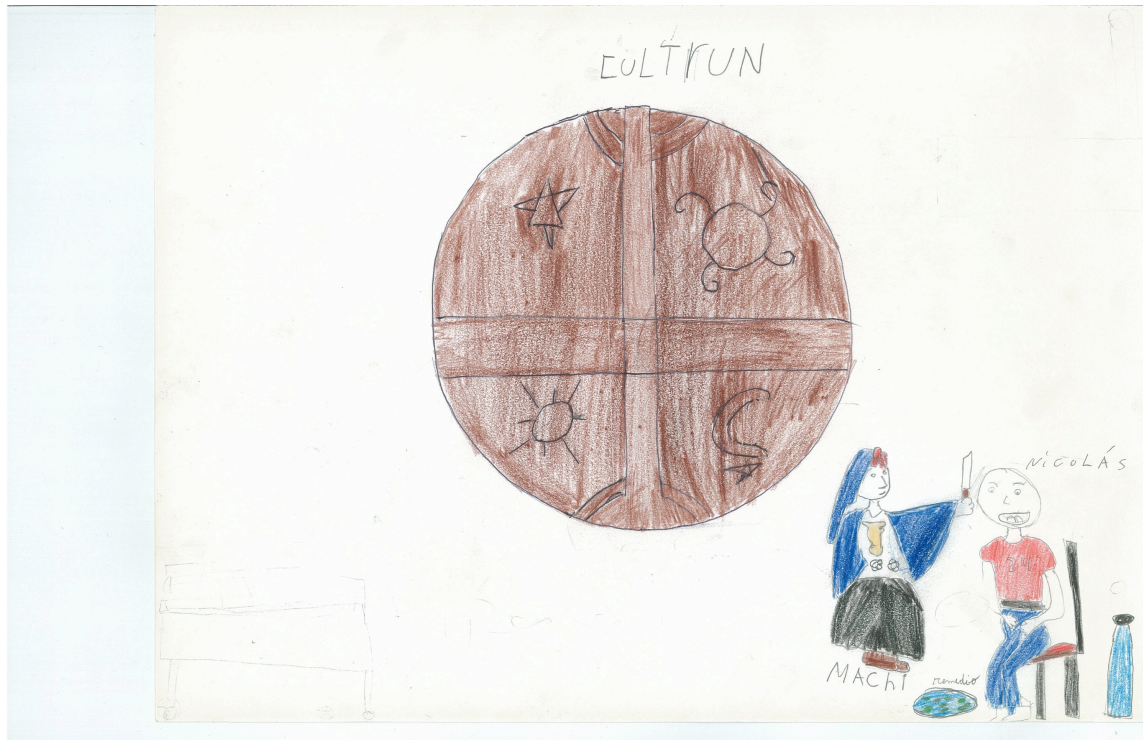
On several different occasions, Inéz told me about the frightening illness her son had suffered the year before. When I asked Gonzalo and his younger sister, Sofia (6 y.o.), to draw a picture of a time when they had gotten sick and to tell me the story of what happened, Gonzalo chose to tell me about the same episode about which his mother had also spoken. According to

Inéz, Gonzalo had suddenly come down with severe symptoms one day at home. Lying prostrate on the couch, her son had vomited blood out of his mouth and nose and was “*ardiendo igual como si uno está al lado del fogón*” ‘burning up just as if one were next to the [wood burning] stove’. Worried by her son’s severe symptoms, the family had taken him to the emergency room in the regional hospital in Temuco. There, the family was told that the boy was suffering from “*un resfrio fuerte*” ‘a bad cold’ and needed only rest and care at home. Unsatisfied with this answer, Inéz remembers growing even more concerned when Gonzalo’s illness worsened. She remembered him being “*flaco, seco, no se mejoraba. Vomitaba todo*” ‘thin, dry, he didn’t get better. He threw up everything.’ In light of his worsening condition, the family decided to consult a machi who lived nearby. The machi gave Inéz a bottle of herbal infusion for 3,000 pesos (~ \$6 US) and warned her to give it to him immediately. Without immediate care, the machi told them, the boy would not be with them in a week’s time. The remedy had a purgative effect, and later, Inéz returned to the machi to ask her to come to the family home to attend Gonzalo. In preparation for the machi’s arrival, Inéz and her husband asked for payment money (~ \$40 US) from their extended family and prepared meat and wine to receive the machi in the customary fashion.

The machi came to the house, “*hizo remedio al Gonzalo*” ‘made remedy for Gonzalo’, and reassured his parents that he would get better. She predicted that he would be eating the following day. The next day, Inéz prepared *cazuela* soup and, when Gonzalo accepted the machi’s invitation to sit next to her at the table for lunch, the boy was well enough to do so. Later in the afternoon, when Gonzalo told his mother he was hungry, Inéz knew that her son would fully recover, thanks to the machi’s treatment. Gonzalo’s drawing of the episode features the face of a large *kultrun* drum in the center of the page. The *kultrun* is a ritual object that is closely

associated with machis' shamanic practice. In the corner of the picture, Gonzalo drew himself, seated on a chair. Next to him, the machi is depicted holding a knife above Gonzalo's head. Next to the two figures, Gonzalo drew a bottle of *aguardiente* alcohol and a basket of medicinal plants, both elements used in Mapuche healing ceremonies.

Figure 2.19: Gonzalo's depiction of the ceremony that cured him of a dangerous illness



When I asked what had caused Gonzalo's sickness, Inéz reported that the machi had diagnosed two problems, *konün* and *mal*. The first is the result of a transgression; Inéz had attended a wake or funeral when she was pregnant with Gonzalo, who was affected by the lingering last breath of the deceased. More recently, Gonzalo had been the victim of witchcraft that was directed at the family. He unwittingly accepted poisoned food from a neighbor who was envious of the family's success with a small homefront store. The combination of these historical

events in Inéz and Gonzalo's lives had brought about the apparently sudden eruption of illness that, if untreated, could have taken the boy's life.

The story of Gonzalo's illness and the course of events that were involved in his healing illustrate a common pattern that parents in Makewe reported whereby their first assessments of children's ailments presumed a best case scenario of ordinary, uncomplicated illness. Parents kept children home from school, kept them warm and indoors, and treated them with a variety of home remedies. In general the next stage of health care involved a visit to the primary care center, where families received attention and pharmaceuticals without charge. Finally, recourse to ethnomedical healers was taken when children's illnesses proved unresponsive to other treatments. Ultimately, families retrospective assessments about a child's illness hinged on their perceptions about which variety of medicine had restored the child's health.

Gonzalo's story also illustrates how families received and evaluated competing assessments about the origin, nature, and meaning of children's illnesses, as well as about the time frame in which illnesses developed. In this instance, a professional at the emergency room had assessed Gonzalo's symptoms as an acute viral infection for which there was not a pharmaceutical treatment. This explanatory model involved a course of illness that was brief and self-containing. In contrast, the machi's explanation of the illness involved a serious, complex problem with the potential for a tragic conclusion. The roots of the problem lay in the historical past of the family and community. As I will argue in Chapters 5 and 6, the temporal frames that these two accounts exemplify are closely related to the organization of the activities in which diagnostic assessments are made by medical professionals and Mapuche healers, respectively, and have important implications for the social relations between these practitioners and the families who seek their help.

2.14 Focal Research Participants

2.14.1 Focal Families in Makewe

Four focal families from Makewe participated in the longitudinal portion of the study. The most pressing concerns in the lives of these Mapuche families involved finding ways to eke out a living and provide for growing children under difficult circumstances that included the unpredictable expenses and complications of children falling sick or sustaining injuries. A significant part of the difficulties these parents regularly faced in providing for their families had to do with the paucity of land that was available to them and the scarcity of financial resources they had to farm it effectively. Each of the four focal families with whom I worked relied on a different constellation of resources and strategies to provide for their families' needs. All of the families kept small gardens and a handful of farm animals. Most planted or sharecropped enough wheat to ensure the family would have flour to make the staple *pan amasado* bread throughout the year. And at least one adult member of each family worked sporadically in wage-paying jobs, either locally, in Temuco, or in the capital. More detailed information about each of these families is included in Appendix A.

2.14.2 Focal Practitioners

The practices of five healing and medical practitioners are highlighted in the pages that follow. And while the differences in their ideological stances and medical practices is elaborated in detail, one thing they had in common was a sincere interest in helping their patients and clients to cope with illness and improve their well-being. Each of the focal healers and physicians dedicated long hours in the exercise of their respective professions and were recognized as competent practitioners of their craft. Examples from consultations with all of the practitioners except the *machi* are included in the dissertation. Perhaps because *machi* Esteban was best

known for his expertise concerning women's ailments, he generally received few children patients. Over the course of data collection with the *machi*, no families with children chose to participate in the study. The 11 consultations that were recorded with the *machi* were all concerning the health of adult individuals. While these kinds of consultations are not within the purview of the dissertation, the recordings familiarized me with the practice of this second Mapuche practitioner. This familiarity alerted me to which features of *peloton* performance are crucial to the genre and which are more idiosyncratic. My interview and conversations with *machi* Sebastian were also critical to my understanding of Mapuche healing practices.

Machi Esteban had worked in association with the staff at the Mapuche Pharmacy in Temuco for years and was a well-established practitioner who was known for his openness to finding ways to make Mapuche medicine and healing accessible to non-Mapuche people. He attended patients in a number of settings, including the Mapuche Healing Center in Temuco and a similar establishment in one of the main tourist towns in the region. He also attended patients in his rural home, where he was able to conduct more extensive healing ceremonies and keep the seriously ill under his close care for extended periods of time when necessary. *Machi* Esteban was considered particularly knowledgeable about ailments that were particular to women. He assessed clients preferentially with the practice of *willentun*, the evaluation of urine from a sick person.

Lawentuchefe Lorena, a person knowledgeable about herbal remedies, clarified to her patients that she was not a *machi*. As such, she did not address cases of witchcraft, referring them instead to her *machi* colleagues. Lorena had not been apprenticed into her practice however. Similar to many Mapuche healers (Citarella et al. 2000), she had received knowledge about healing in dreams and exhibited from an early age the ability to perceive patients' ailments. The

lawentuchefe attended patients in her rural home as well as in the Mapuche Healing Center, and during the research year she had recently begun attending patients in the outdoor market of a smaller town in the region. *Lawentuchefe* Lorena preferred to diagnose her patients by examining the radial pulse. She was considered especially knowledgeable about *re kutran* ‘natural’ or ‘pure’ illnesses, including *empacho*, a digestive ailment, and *pasmo*, which affects the face.

Doctor Felicia was the chief clinician at the *Hospital Makewe* during the research period. A soft-spoken Ecuadorian, Doctor Felicia had worked in the public medical system prior to taking her position at the subsidized *Hospital Makewe*, where her clinical obligations to make rounds in the hospital and attend acute and chronic patients in the primary care center seemed to occupy almost all her time. Consultations with Doctor Felicia had an unhurried quality to them, and the doctor sometimes recruited children patients’ “help,” for example in calculating how many days they had left of an antibiotic regimen. Doctor Felicia respected the cross-cultural medicine mission of the *Hospital Makewe* by participating in the various meetings and ritual celebrations that were held on-site. During *We Tripantu* ‘new year’, for example, Doctor Felicia was the only staff physician who--rather than observing from a distance--danced as part of the ritual congregation around the *rewe* ‘altar’. And though Doctor Felicia did not prescribe Mapuche herbal remedies in any of the consultations that were videorecorded for the study, another clinician reported that of all the physicians at *Hospital Makewe*, she was the most likely to recommend the herbal tinctures that were prepared by the Mapuche Pharmacy and available in the primary care dispensary.

In 2008, Doctor Tomás attended patients at the *Hospital Makewe*, but by 2009 he had moved to another job. The spouse of Doctor Felicia, Doctor Tomás was less involved in the overall operation of the medical center. In his consultations with children patients, Doctor Tomás

often provided recommendations to parents concerning the care of children, rather than providing just pharmaceutical prescriptions. He explained for example how to make home-crafted vaporizations for children suffering respiratory symptoms, and he urged children to keep well-bundled from the cold.

Doctor Emilia was the youngest physician working at the *Hospital Makewe* in 2009. As such, she was allocated a consultation room that was located in the old hospital building, rather than the new primary care building. She also attended the bulk of the pediatric acute care patients, which leads to her over-representation among the cases presented in this study. A Chilean who had grown up in Temuco, Doctor Emilia was the most ‘local’ of the clinicians featured in the dissertation. She worked not only at *Hospital Makewe* but also a public medical center in another town in the region, requiring that she often leave the primary care center immediately after she concluded seeing patients. Her clinical style emphasized providing medical information to parental caregivers, for example throughout the Winter months, when parents often expressed concerns that their children might have H1N1 flu, she explained the clinical requisites pertaining to H1N1 diagnosis in order to allay parents’ fears.

Notes to Chapter Two

^{vi} See Gundermann et al. 2005 for a discussion of the ethnic self-attribution questions that appeared on the 1992 and 2002 censuses, respectively, and the effects the alternate wording had on the number of people who were subsequently counted as indigenous.

^{vii} In contrast to the direction of inequality that most studies on Mapuche health have found, Vicente and colleagues (2005) found that Mapuche respondents demonstrated lower rates of psychiatric disorders than their non-Mapuche peers in a study that used the Composite International Diagnostic Interview (CIDI) to survey a small sample of Mapuche and non-Mapuche Chileans in the Cautín region. In particular, the study found that generalized anxiety disorder, simple phobia, and drug dependence rates were lower among the Mapuche than the non-Mapuche respondents.

Chapter Three

PRIMARY TELLERS AND THE EPISTEMICS OF SYMPTOMS

3.1 Introduction

This chapter presents close analysis of the interaction that occurs at the beginning of consultations for children's illnesses with Lorena, a *lawentuchefe* 'herbal healer' who worked at the Mapuche Healing Center. Research specifically looking at the openings of medical consultations suggests that participants orient to two primary tasks: identifying the patient and identifying the health problem that requires attention. At the outset of medical consultations, participants are concerned with establishing the general parameters of the health problem that needs to be addressed by the practitioner. In order to do this, the participants in the consultation must designate a *primary teller* (Ochs & Capps 2001) who will be responsible for describing the illness. The allotment of the interactional role of primary teller is revealing because it presupposes that the selected participant possesses both knowledge about the patient's illness trajectory and the communicative competence to provide a coherent illness account. These presuppositions endow the selected individual with a certain degree of epistemic authority at the same time that they project that she may be held accountable by the other participants for accurately portraying the ailment. In addition, the discursive and embodied resources that are deployed in the selection of a primary teller foreshadow the evidentiary grounds of the illness account itself.

This chapter examines how patients are identified and how a 'primary teller' is selected to provide an account of the illness at the outset of consultations at the Mapuche Healing Center. The analytical focus on these two tasks serves as a means for identifying how rights and responsibilities to *know about* and *report on* children's illnesses are established among patients,

familial caregivers, and Mapuche healers. Analysis of the illness accounts that follow on the designation of a primary teller in these consultations will be presented in Chapter Five. The presentation of several cases of the first minute or so in this medical setting provides evidence of what constitutes typical practice for identifying patients and selecting primary tellers in this setting.

The analysis of these cases reveals cultural and ideological assumptions about (1) the source and quality of legitimate knowledge about illness experience, (2) how this knowledge is distinctively accessed by variably positioned social actors, (3) who has the requisite communicative competence to provide an adequately detailed and conventionally formatted account of illness. I elaborate in the chapter discussion how the interactional rights and responsibilities that are established with the designation of a primary teller reflect an underlying *epistemology of illness* on which the medical paradigm is founded. Thus, the establishment of speaking responsibilities at the outset of consultations orients patients and their familial caregivers not only with respect to how participation is organized in the consultation but also with respect to the epistemic and epistemological assumptions that are at play. Finally, the chapter demonstrates that the pragmatic and embodied resources that are employed in the earliest moments of these encounters sets the tenor of the consultation and has important implications for the practitioner-patient relationship in Mapuche healing.

3.2 Launching Illness Accounts in Mapuche Healing

The description of health problems in Mapuche healing consultations is primarily the responsibility of the healer. As a rule, healers do not elicit symptom accounts from their clients. Rather, they use a combination of sensory and imaginative resources to identify the problems that are disrupting their patients' lives. This is accomplished through the inspection of what I

refer to as *vital objects*. These objects, which “contain[] the essence, image, or bodily humors” (Bacigalupo 2007:21) of the patient can be used not only as diagnostic resources but also as media through which witchcraft can be worked. Typical vital objects include urine, clothing, and national identification cards. *Lawentuchefe Lorena* preferred to make her assessments through direct contact with patients’ bodies. She palpated the radial pulse of adults and older youth or the abdomen of younger children. When an ailing person was not in attendance, this healer diagnosed using a photograph. Upon inspection of the vital object, healers verbalize dysphoric sensations the person ostensibly experiences and problems that are operating in the person’s body and life. The action of holding the vital object is maintained throughout the *pelotun*, and the visible saliency of this posture is a crucial manner in which the epistemic authority of the healer’s pronouncements is established.

Figure 3.1: *Machi* Esteban inspects the urine sample of an adult patient



Figure 3.2: *Lawentuchefe* Lorena holds the forearm of a patient to palpate her radial pulse



Figure 3.3: *Lawentuchefe* Lorena palpates the abdomen of a very young patient



Figure 3.4: *Lawentuchefe* Lorena assesses a patient's health using a photograph



In Mapuche healing consultations, following a greeting sequence and the identification of the patient, healers explain the kind of vital object with which they work. Depending on what is identified, clients pass the healer the object or they move into a position from which the healer can physically examine a part of their body. This sequence of actions literally and figuratively puts the patient's body, or some proxy of the body, into the hands of the healer. It sets up a situation in which the healer is recognizably positioned to inspect the body or its proxy, attending to it with her own senses, a somatic mode of attention (Csordas 2002) that focuses on manifestations of the illness that can be perceived sensorially and empathically by the healer. Clients' behavior at this juncture provides evidence in support of this interpretation of the healer's actions. Once the healer has taken the relevant part of the body or the vital object into her hands, clients routinely refrain from speaking, allowing for a gap of several seconds of silence to open up while the healer holds and inspects the pulse, urine sample, or clothing. It is

this sequence of actions, from the identification of the patient through the examination of the vital object, that is examined in detail below.

While it falls outside the analytic scope of this chapter to examine the pronouncements that healers make about children's health, a brief explanation of how they are produced is helpful to contextualize the data presented below. In general, it is the healer who takes the initiative to break the silence that opens up while she examines the vital object. Continuing to hold the object of inspection, the healer commences with a lengthy pronouncement in which she describes multiple aspects of the patient's illness experience. What is important to note is that the healer's direct, embodied access to the vital object, which is sustained throughout the pronouncement, functions to establish the origin and authority of the knowledge she claims about the patient's subjective experience illness. At the same time that this embodied posture helps construe the healer's pronouncement as authoritative, the first hand knowledge that patients have regarding their own subjective experience of their bodies constitutes a measure of accountability for the healer's claims. Patients commonly express varying degrees of agreement or confirmation regarding the specifics of what healers posit about their illness experience during the course of the healer's long turns until a diagnosis is reached and recommendations for treatment begin.

3.2 Beginning Consultations at the Mapuche Healing Center

At the Mapuche Healing Center, healers received patients in one of two consultation rooms and kept track of their own patients in personal notebooks to which the administrative staff and other healers did not have access. This measure of privacy allowed healers to develop and personalize their therapeutic relationships with clients over time. In the waiting room, one of the several co-owners of the center received patients and took care of most financial matters, including charging clients for appointments and selling vials of herbal tinctures produced by the

local Mapuche pharmacy. This receptionist *cum* owner also scheduled patients to see healers, often providing recommendations to newcomers concerning which practitioner would be best suited to the client's healing preferences. This division of labor allowed healers to operate on a fairly independent basis. It also ensured a strict confidentiality between practitioners and their patients, one that was effectively more comprehensive than that enjoyed by patients in more bureaucratized medical settings.

Most importantly, the organization of the healing center was such that healers received each new client in the consultation room without any prior knowledge about who the individual was or why she had come for a consultation. This contextual factor shaped how interaction was organized at the beginning of consultations, as will be apparent in the presentation of cases below.

Following greetings, which were generally conducted while the client entered the room and sat down at the desk where the healer was seated, healers inquired who the sick individual was. This inquiry was necessary in some cases because patients arrived in the company of family members. In other instances, clients arrived seeking help for a person who was not present. Because Mapuche healers exercise skills for diagnosing patients *in absentia*, it was frequently the case that a client would come for a consultation on behalf of an ailing loved one who could not (or would not) attend on his own behalf. Once the patient or *kutran* 'sick person' was identified, the healer could move on to the matter of identifying the problem that needed attention.

In the following sections, I present the opening moments of several Mapuche healing consultations. These representative examples from the data corpus represent the range of ways in which *pelotun* for children patients were launched. An analysis of the talk and other embodied

behaviors that characterized these first exchanges illustrates the key importance they had in framing and projecting the appropriate forms of participation in the activity as well as how the participants would define the basic shape of the patient's illness to launch the diagnostic process.

3.3 Beginning Fernando's Consultation

The first example, excerpted from a consultation for a 15 year old youth named Fernando, illustrates a typical opening for a consultation with *lawentuchefe* Lorena. The healer speaks directly to her young patient to coordinate their actions to carry out the *pelotun*. Fernando was accompanied by his father and by his mother, the latter of whom had been a patient of Lorena's for over a year.

Example 3.1

- 01 Healer Quién es que viene a verse?
Who is it that comes to be seen?
- 02 Mother Él. Señora.
Him. Madam.
- 03 Healer Ya. A ver hijo, deme su pulso (.) (-iste)
Okay. Let's see son, give me your pulse (.) ()
- 04 mi chiquillo.
my little one.
- 05 ((2.5))
- 06 Healer Y usted está bien. ((addressed to mother))
And you are well.
- 07 Mother Si. Si bien.
Yes. Yes well.
- 08 Healer Que bueno.
That's good.
- 09 ((11.0))
- 10 Healer .hh Estamos (.) con un problema
.hh *We are (.) with a problem*
- 11 de (.) depresión.
of (.) depression.

Fernando's consultation with Healer Lorena begins with a brief exchange that clarifies which of the three people in attendance is the patient. Fernando's mother indicates that her son is the patient (line 2), which allows the healer to direct her subsequent instructions to the youth himself. Lorena's response begins with *ya*, a word that in contexts such as this works analogously to English 'okay' as a "sequence closing third" (Schegloff 2007) that also can function to signal the transition to a new activity (Beach 1995; Heritage & Clayman 2010). Lorena then asks Fernando to extend his arm so that she can feel his pulse "Give me your pulse" (line 3). She makes this request in a kindly fashion, combining formal (respect) marking on the verb *deme* 'give me' with affectionate address terms *hijo* 'son' (line 3) and *mi chiquillo* 'my little one' (line 4).

As the healer and her patient get into position, the healer asks Fernando's mother, "And you are well?" (line 6), a polite question that recognizes the established relationship the two of them have as patient and healer. Following this exchange, 11 seconds of silence (line 9) open up before Lorena begins her description of Fernando's ailments (lines 10-11).

Overall, Fernando's case illustrates the typical tasks that are accomplished in the first moments of Mapuche healing consultations. The healer ascertains who the patient is, she indicates what she needs in order to make her pronouncement and, before beginning the *pelotun*, she spends several seconds in focused attention on her physical contact with the body of her patient. Patients and parents generally collaborate to open up this period of silence by refraining from speaking once the healer is in position, presumably with the wrist of her patient in her hands^{viii}. For the duration of the silence, the healer is recognizably engaged in a particular somatic mode of attention (Csordas 2002) the aim of which is the perception of the patient's

07 Father Un- un hijo que tenemos alla. sta enfermo.
A- a son we have there. He's sick.

08 Healer Ah. No le trajeron una foto nada (de nada).
Oh. You didn't bring a photo at all (or anything).

09 Mother Eh m- una foto, tendria que- pero
Uh m- a photo, it would have to- but

10 Healer Si tienen una foto recien-
If you have a recent photo-

11 Mother Ah pero recien no.
Oh but [it's] not recent.

12 Healer Ah- a ver traigame la foto. Puede ()
Oh- let's see bring me the photo. It's possible ()

13 Si puedo captar, () mejor
if I can grasp, () better

14 Mother No sabemos nosotros (.). Eh primera vez que vinimos.
We didn't know. It's the first time that we come.

15 Father Mapuche inchein Ñaña. Inchein mapuche ñaña.
Mapuche we are madam. We are mapuche madam.

16 Healer Inche () orin [(pek-) chachay.
I () urine () sir.

17 Father [Ah.

18 Healer Re validan tañi kimun
I practice only according to my knowledge.

19 Mother Fey llemay.
This is right.

20 Healer Re pulso entun o foto.
I discern ((lit. take out)) by pulse or photo only.

21 Father Entonces el viernes lo traemos.
So Friday we will bring him.

22 Healer Si.
Yes.

23 Father El otro viernes.
Next Friday.

24 ((several seconds while mother gets photo))

25 Mother Ese' él. ((passing photo to healer))
That's him.

26 Healer Este es- la edad de este chico?
This is- the age of this little one?

27 Mother Doce años.
Twelve years.

28 Healer Doce años.
Twelve years.

29 Mother Si.
Yes.

30 Healer Pero de que- en que tiempo la tomo? Mah
But at what- at what time did you take it? More

31
o menos?
or less?

32 Mother Eh. Eh. ((phone rings in Mother's purse)) Va'
Um. Um. ((phone rings in Mother's purse)) It's

33
ser el año ya.
Going to be a year ago now.

34
((several seconds of silence))

35 Mother No se si podrá servir. No traje ni el
I don't know if it will do. I didn't bring the

36
carnet siquiera
I.D. card even.

37
*((Several seconds while healer holds and looks at
photo and Mother looks for phone in her purse))*

38 Healer Este chiquitito pero- ha sido enfermizo.
This little one but- [he] has been sickly.

Daniel's mother's first turn "I come to bring urine but they told me that you do not see with urine" (line 1) indicates her familiarity with *willentun*, the common Mapuche diagnostic technique that relies on a urine sample, at the same time that it makes the healer aware of the practical problem that her clients have brought the wrong sort of vital object to the consultation. Yet it is not only Daniel's mother's reference to urine as a diagnostic resource that indicates her

familiarity with Mapuche healing. Her unusual use of the Spanish verb *ve* ‘see’ in “You do not *see* in urine” indexes her knowledge more subtly. In this instance, ‘see’ functions as a synonym of ‘diagnose’, a usage that is due to a semantic loan from the Mapudungun verb *pelotu-* ‘to see clearly’. As indicated above, *pelotun* is the vernacular term used to refer to Mapuche healers’ diagnostic process. Thus, Marta’s reference to the healer ‘seeing’ in urine marks her speech style in Spanish as one that is influenced by Mapudungun. Converging with her client’s style, the healer repeats the same ‘see’ in describing her own diagnostic practice, “I *see* in pulse” (line 3).

Over the next several turns, in which the parties negotiate the alternative of conducting the *pelotun* using a photo of Daniel, the parents’ speech is rife with indexes of Mapuche identity and the parents’ familiarity with Mapuche healing practices. Lorena responds in a very solidary manner, reciprocating their positive affective stance toward Mapuche healing and language. These gestures on the part of Daniel’s parents and the healer toward shared cultural meanings constitute important early steps in what grew to be an extended therapeutic relationship. This family continued to consult with Healer Lorena and to purchase herbal remedies and talismans from her on a regular basis throughout the remainder of the time that data were collected at the healing center (about three months).

Once Lorena and Marta had established that Lorena would use a photo of Daniel that his mother was carrying, Ernesto switched to Mapudungun to tell Lorena that he and his wife were Mapuche (line 15). The healer responded, also in Mapudungun, with a more elaborated explanation of her diagnostic process (lines 16, 18), explaining that she did not diagnose with urine but according to her knowledge “*tañi kimün*,” where the term *kimün* ‘knowledge, wisdom’ invoked not merely the learned knowledge healers gain from tutelage under senior practitioners but also the healing know-how that has been bestowed on them supernaturally in dreams,

mediated by the healing *püllü* ‘spirit’ they have inherited from ancestral healers. Marta responded with “*fey llemay*” (line 19), an idiomatic Mapudungun expression that is used to affirm the assertion of an interlocutor. And Lorena went on to explain that she only diagnosed using a patient’s pulse or photograph (line 20). At this point, Ernesto switched back to Spanish to confirm that following the present consultation, he and his wife would bring their son for a consultation on the subsequent Friday.

When Marta had produced the photo, Lorena inquired about the patient’s age and the recency of the photo with which she would conduct her *pelotun*. Marta replied that her son was twelve years old and indicated that the photo was nearly a year old. She then went on to silence a cellular phone that was ringing in her purse at the same time that the healer moved into position, looking down at the photograph, which she held on the desk with fingertips of both hands. In the style of an aside, Marta mused out loud that perhaps the photograph was too dated to be of use (line 35) and lamented not having brought her son’s national identification card (lines 35-36), an object that is used by some Mapuche healers as a diagnostic resource. The healer did not acknowledge her client’s last utterance, allowing it to pass and several seconds of silence to open up as she continued to hold and look at the photo of Daniel (line 37) prior to beginning her pronouncement on his health (line 38).

In this example, efforts were made to find a way of conducting the *pelotun* even in the absence of the ‘ideal’ vital object, the patient’s body. It is notable that at no moment in their efforts to carry the diagnostic process forward did the healer or parents refer to or discuss the parents’ knowledge about the son’s ailment, information that their lived experience of caring for him certainly afforded them. This to say that in this as well as in the prior case, while the parents had clear reasons for bringing their children to the healer, they did not treat their knowledge of

the illness trajectory as relevant to the initial task of establishing the parameters of the child's illness.

3.5 Beginning Daniel's First Visit

A third example demonstrates how Healer Lorena oriented Daniel to participate in the *pelotun* on the first occasion that he visited her. On this day, Daniel was accompanied only by his mother, who had administered the healer's recommended herbal remedies to her son following the initial consultation she and her husband had made the prior week.

Example 3.3



- 01 Healer ((reaches out with open hands toward patient))
M:ya. A ver su mani:to,
Okay PREP see.INF POSS-3S-FORMAL hand.DIM
Okay. Let's see your little hand,
- 02 Acérquese p' acá:,
Move-close.FORMAL-IMPERATIVE-REFL PREP here
Come closer here,
- 03 Patient ((moves closer to desk; rests both wrists on desk))
Cualquiera?
Whichever [hand]?
- 04 Healer Cualquiera. No, pa- la: derecha.
Whichever. No, pa- ART right
Whichever. No, pa[ss]- the right [hand].



05 Patient ((patient extends right wrist to healer's hands))

06 Healer Es- e::so.
Tha- that
Tha- That['s it].

07 ((rubs thumbs across patient's wrist four times))
Va::moh a conversar (mi) chiquillo.
Go.PRESENT-1P PREP converse.INF my little-boy.DIM
We're going to converse my boy.

08 (1.2)

09 Healer ((settles thumbs on patient's wrist))
Co:mo-
How
[about] how-

10 ((healer slightly repositions thumbs three times))
(7.0)



11 Healer ((shifts gaze to mother))
Pütoengey lawen tufá.
Drink.PASSIVE herbal-remedy then

Remedy was taken then.

12 Mother **((nods slightly))**

13 Healer Nieymi no cierto?
Have.PAST-2S [tag question]
You got it, right?

14 Mother Si.
Yes.

15 Healer **((shifts gaze back to patient))**
(3.0)

16 Mother Chumül llepen (n/t)ati.
Recently AFFIRMATIVE.get.1S PRO
I did get it recently.



17 Healer **((nods and places two fingers on patient's pulse))**
(7.3)

18 Healer Tení asco a la
Have.INDICATIVE-INFORMAL-2S revulsion PREP ART
You have revulsion toward

19 comi:da,
food,

Opening the activity, Healer Lorena asked Daniel to extend his arm saying, “Let’s see your little hand. Come closer here.” (lines 1-2). Her simultaneous gesture of reaching toward the youth with her palms open (frame grab in line 1) as she said this clarified for him that she was requesting that he move his body into a position from which she could take his forearm in her hands. To make this initial request, the healer drew on some of the same pragmatic resources that

she used in asking the same of Fernando (Example 3.1). She used formal morphological marking on the verb *acérquese* ‘move closer’ and the respective formal possessive form *su* ‘your’. In the same utterance, she applied a diminutive affix *-ito* to the noun *mano*, producing a softened form ‘little hand’. This combination of respectful and diminutive forms conveyed an affective stance that was simultaneously gentle and polite. The tenor of the activity was established in part by these pragmatic contextualization cues as well as the healer’s embodied actions that brought her into closer proximity and contact with her patient: leaning toward the patient, extending her arms toward him, and opening her hands to receive his forearm (frame grab line 1).

Once Daniel had moved closer to the desk and extended his wrist into the healer’s receptive hands (lines 3-6), Lorena further clarified the nature of the activity for her patient saying, “We’re going to converse my boy” (line 7). The healer’s characterization of *pelotun* as a ‘conversation’ was technically an inaccurate one. The genre differs from ordinary conversation in several ways, perhaps most importantly in the asymmetrical participation pattern that it requires. Once the diagnostic pronouncement of the *pelotun* commenced, the healer would exercise substantial privilege in maintaining the floor. Patients’ and parents’ normative participation is limited to confirmations, disconfirmations, or expansions on the healer’s propositions. These prescriptive forms of participation that characterize *pelotun* differ from the norms of ordinary conversation, where there are no prescriptions for turn-allocation and participants’ actions are not proscribed by their institutional roles (Heritage 2004; Schegloff 2007).

However, while *pelotun* differs substantially from ordinary conversation, the healer’s characterization of it as such may have served an orienting purpose for Daniel. The description of this specialized diagnostic genre as a quotidian speech activity of conversing invited Daniel to

interpret the activity as ‘like’ ordinary conversation and invoked schemas of the same, suggesting the parameters of felicitous participation that would be at play. A conversational schema casts patients as conversational partners with healers, a role that is locally enacted in accord with Grice’s (1989) cooperative principle. Thus patients (and parents) are cued that participation should further the progressivity of the diagnostic conversation and that talk between them and the healer would be construable as “mak[ing a] contribution such as it is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which [they] are engaged” (26). In other words, the invocation of a conversational schema supplied an interpretive frame for the activity, one that both presupposed and entailed that patients, parents, and healers would collaborate cooperatively in the co-construction of an illness description, which is the relevant “accepted purpose or direction” of the activity at hand. This sort of collaborative participation increases the likelihood that the illness descriptions that emerge in *pelotun* will be viewed as cooperatively reached, the ostensible convergence of insights among the parties.

After the healer had provided her young patient with the pithy explanation of *pelotun* as conversation, she allowed more than a second of silence to open up before quietly saying the single word *como* ‘how’. She abandoned the utterance, leaving it grammatically incomplete. The incomplete utterance reiterated that the healer was involved in an ongoing turn, making a transition to a next speaker irrelevant, even over several subsequent seconds during which the healer refrained from speaking.

The healer and her clients allowed a lengthy silence of seven seconds to open up (line 10) while the healer was conspicuously engaged in positioning and repositioning her thumbs on Daniel’s wrist, likely to establish the best position for feeling his pulse. Lorena slightly

repositioned her thumbs three times, allowing them to rest momentarily between each shift, feeling for whether the position was adequate.

Resting momentarily in her search for position on Daniel's wrist, the healer spoke again, this time addressing Daniel's mother. The shift in addressee was signaled by both a code-switch to Mapudungun and the healer's glancing up from Daniel's wrist to meet Marta's gaze (line 11). But the indicative form of the healer's utterance, "Remedy was taken then" left slightly ambiguous whether the assertion required a response.

Marta responded with a weak confirmation in the form of a small nod (perhaps responding to the ambiguity of whether the utterance required a response. In light of the mother's equivocal response, the healer pursued a more secure confirmation by reframing her assertion as "You got it right?," a more explicit request for information, in the form of a statement + interrogative tag (Heritage & Clayman 2010). Marta then provided an immediate and clear confirmation *si* 'yes', at which point the healer refocused her gaze on her patient's wrist, returning to the task of finding Daniel's pulse. Though the healer had visibly reoriented her attention back to her patient at this point, Marta interjected that it was only *chumül* 'recently' (line 16) that she acquired the remedy, a remark that clarified that the youth had only been taking the healer's prescribed *lawen* for a short period of time. The healer acknowledged this caveat from Daniel's mother with a silent nod but without taking her gaze from her patient, displaying her now committed attention to the task of assessing his pulse and formulating her pronouncement.

After Marta's remark regarding how long Daniel had been taking *lawen* and before Lorena commenced with her account of Daniel's health problems, the healer engaged in a visibly salient performance of assessing Daniel's pulse. This began when Lorena removed her right

thumb from the youth's wrist in order to place her index and middle fingers in the place where she had located his pulse. At this repositioning of the healer's hands, both Daniel and his mother shifted their gaze to where the healer had positioned her hand on his wrist. The three participants remained in this configuration of bodies and gaze for more than seven seconds. During this time of bodily and verbal stillness, the physical contact between the patient and healer was particularly prominent. The cessation of other activities afforded an interpretation of the physical contact as eventful in itself. It was an event that was designed to make the healer's focalized somatic attention construable as an assessment of the patient's health via channels that were purposefully opaque to everyone except her.

3.6 Conclusion

Analysis of these several examples from *lawentuchefe* Lorena's practice reveals several facets of the epistemological framework that underpins this ethnomedical system as well as the ways in which it is evoked and reinforced early in the consultation itself. First, the evidentiary grounds of the healer's legitimate knowledge are established through the identification of a particular vital object toward which the healer directs her focused somatic attention in a visually salient performance of direct assessment. Second, the performance of this assessment projects the healer as the primary teller of the child patient's illness. A verbal account is projected as the appropriate 'next action' to follow on the healer's multisensorial assessment of the diagnostic object. It is notable that at this early stage of consultations, talk about the child's illness from patients and parents is conspicuously absent; such talk is rendered sequentially inappropriate as participants orient to the principle task of coordinating their embodied actions such that the patient's body (or some proxy thereof) can be made accessible to the healer. Finally, the tenor of the practitioner-client relationship is established (at least provisionally) in the ways that

participants address and make requests of one another in the process of establishing the vital object. I detail each of these analytical points separately as follows.

The clients' proffering of a vital object and the healer's salient performance of focused attention toward this object constitutes the healer's physical contact with the patient's body as the origin of her legitimate knowledge and thus the evidentiary grounds of her forthcoming pronouncement about the child's illness. The healer's privileged epistemic access to the child's bodily states is made visually appreciable to everyone present in three ways: the production of a gap in talk, the coincidence of the participants' mutual gaze on the site of physical contact, and (for patients and the *lawentuchefe*) the tactile sensation of sustained skin-to-skin contact.

The projection of the healer as the primary teller of an imminent illness account on which the diagnostic process will be grounded has implications for clients' participation as well. Patients' and parents' ostensible experiential knowledge about the child's illness, grounded in their familiarity with the symptoms and signs of the illness prior to the consultation, is interactionally subordinated vis-à-vis the healer's immediate, direct access to information about the patient's body. In this way, patients' and parents' epistemic access to the illness is rendered less germane than that of the healer. Furthermore, the deferral of parents' or patients' talk about the child's condition to a sequential position in the interaction that is associated with secondary epistemic access (Heritage and Raymond 2005) reinforces the subordination of patients' or parents' epistemic access to children's illnesses. Even when parents or patients are called on to speak about an illness during a consultation, their talk occurs meaningfully 'after' the healer's initial descriptions. This consequential positioning is a direct result of the constellation and sequencing of kinesic actions at the beginning of the consultation (i.e. producing a vital object, positioning bodies, and the healer's examination), all of which privilege non-linguistic acts and

relegate talk to an ancillary rather than constitutive role (Hasan 1999) in the activity. Parents' and patients' talk about the illness in the first moments of the consultation is thus rendered premature, irrelevant to the task at hand.

Finally, several elements of the early talk and actions in Mapuche healing consultations set the stage for a practitioner-patient relationship that is essentially empathic, amicable, and personal. When child patients are present, the healer addresses them directly to launch the diagnostic process. The healer's initial talk with child patients is both considerate (conveyed through the use of grammaticalized respect forms) and gentle (conveyed through the use of diminutive grammatical affixes). The aim of the talk is to solicit the child's cooperation in the forthcoming activity of the healer's assessment by requesting that the child coordinate his own body in concert with the healer to make it possible for her to hold a part of his body (e.g. the forearm) for an extended period of time. The cooperation that is requested from children, therefore, involves their bringing themselves into closer proximity and more prolonged physical contact with the healer than most quotidian interaction between children and non-kin adults regularly requires in this sociocultural setting.

Even in the case of very young patients, Healer Lorena spoke directly to children at the outset of consultations. In a case that I will discuss in Chapter 5, Healer Lorena used a baby-talk register to address a three year old patient named Pancho. She told the boy that she wanted to move close to him and to place her hand on his "tummy" (her standard practice for assessing infants and small children). In this way, she solicited Pancho's compliance in the form of his tolerating her movement alongside him and her placing a hand on his abdomen. The healer's selection of her child patients (regardless of their age) as her primary addressees at the beginning of the diagnostic process constitutes a very personal overture she makes toward the children that

is often successful at precluding the sort of parental mediation that characterizes much of children's interactions with adults in medical settings (Clemente 2005, 2009; Clemente et al. 2008; Stivers 2001; Stivers & Majid 2007). Healer Lorena's behavior at the outset of consultations with children affords a very immediate interpersonal connection between healer and patient that she further deepens with the physical contact that she sustained between them for the duration of the *pelotun*.

Overall, the key achievements of this earliest activity in Mapuche healing consultations are three: (1) the privileging of the healer's epistemic access concerning children's ailments and the subordination of ordinary first-hand knowledge that patients and parents ostensibly have about the illness trajectory, (2) the establishment of an empathic, inter-corporeal grounding for the definition of the child's health problems, and (3) the projection of the healer as the primary speaker (teller) of the illness account that will form the basis for diagnosis. Finally, the initial activity of these consultations has a tenor that is kindly, cooperative, and intimate, qualities that help project the eventual diagnosis as something cooperatively reached, even while the healer dominates the primary teller role in the description of the child's illness, and clients' speaking opportunities are restricted.

Note to Chapter Three

^{viii} This consultation was audio rather than video recorded.

Chapter Four

THE SELECTION OF PRIMARY TELLERS IN PRIMARY CARE

4.1 Introduction

This chapter presents a parallel to the last with an analysis of the beginnings of acute care consultations at the Hospital Makewe primary care center. As in the last chapter, this chapter shows how a primary teller is selected to describe a child patient's illness for the purposes of diagnosis. An analysis of several examples illustrates several important accomplishments of the interaction at this early stage in the appointment. First, parents' selection as primary tellers is a recognition of the legitimate knowledge that they have of children's ailments as a result of their care for them. But their selection also makes them accountable for providing adequate accounts of this care, exposing them to the evaluation of clinicians. Finally, clinicians' conspicuous attention to medical charts in this setting reinforces their bureaucratic role as representatives of the official medical system.

4.2 Presenting Concerns in Primary Care Medicine

The interactional organization of acute primary care consultations has been studied extensively by medical sociologists (e.g. Byrne and Long 1989; Robinson 2003), who have established a nomenclature with which to refer to the phases and interactional tasks that constitute the activity. The first clinical task in primary care consultations involves the accounting by the patient (or caregiver) of a *presenting concern* for which the visit is being made (Heritage & Robinson 2006a, 2006b; Ijäs-Kallio et al. 2010; Robinson 2006; Robinson & Heritage 2005; Ruusuvuori 2000, 2005; Stivers 2002). The establishment of this presenting concern, also referred to as a *chief complaint*, is the objective of the *reason for the visit* phase of consultations. This phase, which launches the diagnostic process, occurs early in consultations,

preceded only by an *opening* phase, in which participants carry out such preliminary actions as greeting one another and identifying the patient prior to their “getting down to business” (Robinson 1998).

The ‘reason for the visit’ phase consists minimally of two moves; in conversation analytic terms it can be comprised of a single adjacency pair (Schegloff 2007). First is an elicitation of the problem by the physician. Second is the response by the patient or caregiver describing the problem. The activity is complete when the physician re-takes the floor and initiates a transition into *history-taking* or *physical examination* (Boyd & Heritage 2006; Heath 2006). One reason why this phase-transitional move is important to the establishment of the patient problem is because it implicitly accepts the illness account as adequate and the symptoms identified in it as legitimate (Heritage 2009; Heritage & Robinson 2006a).

The account that is provided in response to the physician’s solicitation question at the beginning of a consultation is of particular importance. In this sequential position, patients (or their caregivers) have the opportunity to formulate a description of the relevant health problem in their own words. Typically, this is the only instance in the medical interview where patients and their companions are provided a 'slot' for framing the health problem as they choose (Heritage & Robinson 2006a). Once the complaint has been established in this phase, patients and their companions are largely restricted to answering questions that the physician puts to them, questions that, nonetheless, are responsive to the way in which the problem was originally presented (Boyd and Heritage 2006; Heritage 2010). For this reason, the framing of the ailment at the beginning of a consultation is extremely consequential for the trajectory of the diagnostic process.

Research into the grammatical forms that are used in medical interviews to solicit a chief complaint reveals that physicians orient to and design their questions differently with respect to at least two variables: the kind of consultation that is underway and the amount of information that is available to them about the patient's complaint. First, solicitation questions may differ in their format depending on whether the physician is encountering a patient who has come for an initial visit concerning a new (i.e. acute) health problem, for a follow-up visit, or for a routine visit (e.g. regarding a chronic health condition) (Heath 1981; Robinson 2006). At the same time, the range of questions that physicians use reveals the range of epistemic statuses that the physician can inhabit and the epistemic stance that he can display in the moment and act of asking. Studies of these questions indicate that physicians often avail themselves of information recorded in medical charts by staff members prior to consultations and therefore begin their interactions with patients with some legitimate prior knowledge about the reason for the visit.

Physicians may choose to display their knowledge about a patient's reason for the visit by designing their solicitation questions as requests for confirmation that make explicit reference to specific symptoms or complaints, for example, "I understand you're having some sinus problems" (Heritage and Robinson 2006b:94). These questions, which deploy declarative syntax, convey that the physician has some knowledge about what is wrong with the patient. This question design can be contrasted against cases in which physicians deploy interrogative grammar to ask open-ended "general inquiry" questions such as "What can I do for you today?" With these latter kinds of questions, physicians convey an unknowing epistemic stance about the patient's problem. Heritage and colleagues (Heritage 2010, 2012; Heritage & Clayman 2010; Heritage & Raymond in press) have depicted the relativity of such epistemic status differentials as a gradient that can range from flat, when interlocutors have relatively equal access to the

matter at hand, to shallow, when one party knows more than the other, to deep, when one party is knowledgeable and the other is not.

Research in the U.S. (Heritage & Robinson 2006b) found that the format that physicians used most frequently to solicit presenting concerns was the open-ended, general inquiry question. General inquiry solicitation questions shape patient responses in important ways, “(a) their design invites the immediate presentation of patients’ medical business; (b) they are ‘general’ in that they formulate an agnostic stance about the precise nature of patients’ medical business [i.e. what kind of visit they are making: acute, follow-up, or routine]; and hence, (c) they allow patients to present their concerns in their own terms” (92). In sum, analysis of general inquiry questions suggests that they provide patients with the greatest possible degree of latitude in how they formulate the problem for which they have come to the doctor. However, even in cases where physicians use a question form that restricts the form of the patient’s answer, patients may take liberties in their responses to provide the sort of illness account that suits their own purposes, even when this answer does not conform to the agenda of the physician’s original question, suggesting that patients orient at least as much to the general aims of the institutional task of problem presentation as they do to the particular form of the question with which it is launched (Ruusuvuori 2000).

A final observation is relevant concerning why the syntactical form of physicians’ questions matters to the larger issue of social relations between them and patient families. Raymond (2010) has pointed out that interrogative grammatical form constitutes a particular social relation among interlocutors. Interrogatives project that speaker and addressee are asymmetrically knowledgeable and that the addressee has the obligation to provide the information that is being requested. Specifically, “the use of interrogative syntax formally or

officially confers rights on a selected recipient (to provide the authoritative answer) and obliges that person to respond^{ix} (93). Thus, physicians' general inquiry solicitation questions simultaneously endow patients with authority concerning the health problem that has occasioned the visit, and they make them accountable for describing it.

There are several things all complaint-solicitation questions have in common, regardless of their grammatical form. I follow Heritage's breakdown concerning physicians' questions in general (Heritage 2010) to elucidate these commonalities. First, solicitation questions set up a *topical agenda*: they project that the properties of a specific, current health problem are the appropriate propositional content for the question response. They also set an *action agenda*: they project that the addressee should provide an account in response. Third, they embody *presuppositions*. These presuppositions are multiple and, given the institutional context in which these questions are posed, include that the patient has a medical problem that has occasioned the visit, that the patient is seeking professional medical assistance, that the doctor needs to know the reason for the visit, that the patient is capable of communicating the problem to the physician, and that the physician has the right to know what the problem is.

4.3 Beginning Consultations at Makewe PCC

At the Makewe primary care center, each physician has her own consultation room. Doctors call patients one at a time into the consultation room where they are working, gradually working through a stack of medical charts that an administrative staff member delivers at the beginning of each shift. When they are summoned, patients and their caregivers enter the consultation room and seat themselves across a desk, opposite the physician. Physicians first confirm the identity of their patients then solicit from the patient's caregiver (and occasionally from older child patients themselves) a verbal account of the health complaint that has

occasioned the visit. Physicians generally do this with an open ended question that inquires into what has happened to the child or why the parent has brought the child for consultation.

Physicians' questions acknowledge that parents are knowledgeable about what has happened to their child at the same time that they hold parents accountable for this knowledge and for producing an acceptably coherent and complete account of the illness trajectory with which to move the diagnostic process forward. The organizing principle of the diagnostic process in this medical setting, therefore, is that clients identify the health problem, and the entire diagnostic process is *complaint-driven*.

While the organization of the opening phases of pediatric consultations at the Makewe clinic endowed parents with a certain domain of epistemic privilege (i.e. what has happened in the illness trajectory prior to the clinical encounter), the authority of what parents claimed in their accounts about children's health problems was contingent on physicians' confirmations of relevant signs of illness during the physical examination later in the consultation. This eventual fact-checking notwithstanding, physicians opening questions and parents' subsequent illness accounts were routinely treated as good faith efforts on the part of both parties to respectively provide and procure appropriate medical care when children were suffering (see Chapter Seven for extended analysis of a case when these presumptions did not hold).

In the following sections, I present several examples of how physicians at the rural primary care facility launched the reason for the visit phase and, where data were available, how they opened their consultations with pediatric patients and their companion caregivers. Analysis of these cases illuminates several important presuppositions of pediatric care in this setting. It also demonstrates the ways that physicians' questions projected the terms of the epistemological framework that governed their practice, alerting their clients to the relevant rights and

responsibilities for participation to which they would be held accountable.

4.4 Beginning Samuel Carlos' Consultation

Example 4.1 is from an acute consultation for Samuel Carlos (5 y.o.), who was diagnosed with pneumonia. The excerpt provides a canonical example of how physicians at the primary care center launched the reason for the visit phase of acute pediatric consultations.

Example 4.1

01 DOCTOR Ya. El Samuel entonces. (.) Cuente no mas. Qué
Okay. [ART] Samuel then. (.) Just tell. What's
02 le pasa a su bebe.
happening to your baby.

In example 4.1, Doctor Emilia began her talk with Mariano's mother by saying 'Ya' (line 01), which marked off the transition from the immediately prior activity (Beach 1995), in which the researcher exited the room after turning on the camera, to the current matter of the consultation. Next the physician identified the patient by first name, "*El Samuel entonces*" '[DEFINITE ARTICLE] Samuel then' (line 01). The use of the gendered definite articles *el* or *la* before proper names is a common form of third person reference in colloquial Chilean Spanish (Oroz 1966; Dixon 2011^x). This particular usage in reference to pediatric patients was pervasive at the Makewe primary care clinic. The inclusion of the definite pronoun functioned in part to clarify that a physician was not addressing the patient but orienting to him as the business at hand, the focus of the forthcoming activity.

Physician's initial reference to child patients in the third person is best understood in light of the bureaucratic organization of the local institution. Physicians worked through a stack of patient charts that was given to them at the beginning of the workday by an administrative staff

member. Affixed to each of the charts was a small number indicating the order of attention. Thus, by stating each patient's name at the outset of the medical interview, prior to inquiring about the reason for the visit, physicians accomplished two important actions. First, they formally launched the clinical activity by identifying the sick person to be attended. Second, they ensured that the embodied and the bureaucratic subjects (Robinson 1998) to whom they were oriented were the same person. This is to say that physicians ascertained whether the child who had entered the consultation room was in fact the patient whose chart was 'up' in the queue. By reading the patient's name aloud from the medical chart, physicians made relevant a confirmation or disconfirmation of identity by the patient's adult caregiver.

It was only after this preliminary step of establishing the patient's identity that Doctor Emilia used a polite directive and a question to solicit an explanation of what was ailing the boy, "*Cuenta no mas. Qué le pasa a su bebé.*" 'Just tell. What is happening to your baby.' (lines 1-2). First, by instructing her addressee to 'just tell', the physician made clear the appropriate form of a response: a verbal account. In the physician's question, the reference to 'your baby' unambiguously selected the mother rather than the child to provide the requisite account. This next-speaker selection, along with the present tense of the verb *pasa* 'happens' projected what should be included in the mother's description. As the observer of her child's illness, the mother should provide a description of the observable signs of illness that she had witnessed in her caretaking tasks. Her description should center around those signs that she esteems relevant to the child's present state, those signs that are manifest currently or that were present in the very recent past.

At the same time, the open-ended form of the physician's question, "What is happening to your baby?" conveys an epistemic stance in which the physician is claiming to have no

knowledge about the patient's symptoms. Given the protocol at the health center, physicians indeed, had almost no information about children's health conditions prior to their face-to-face interaction with patient families in the consultation room. Because of the spartan budget of the government subsidy for the clinic, the intake process for primary care patients was absolutely minimal. Most often, the only information that was obtained from pediatric patients prior to their meeting with a doctor was their temperature. Apart from noting a child's temperature, staff did not solicit medical information or make entries into medical charts for doctors' reference. This meant that at the beginning of consultations, physicians knew virtually nothing about why a particular child was presenting on any given occasion. Thus, physicians' elicitation of a chief complaint from patients' caregivers located them at one end of a steep epistemic gradient between them and their interlocutors (Heritage & Clayman 2010). The question, 'What is happening to your baby?' cast the patient's caregiver as both knowledgeable about the child's condition and accountable for producing the sort of illness account that would allow the diagnostic process to move forward.

4.5 Beginning Yordan's Consultation

In an excerpt from a consultation for Yordan, who was in eighth grade, there is a slight variation on the physician's solicitation of the primary complaint. In this case, the doctor selected the patient rather than his caregiver to respond.

01 Doc Ya. El Yordan. Qué le pasó a usted?
 Okay. [ART] Yordan. What happened to you?

As in the previous example, the doctor's *ya* 'okay' marked the transition into the complaint phase and was followed by the physician's identification of the patient, 'El Yordan'. Next, Doctor Emilia addressed the open-ended question, 'What happened to you' to the patient rather than his mother. The phrasing of the physician's solicitation question in this case differs

significantly from the prior example only in its selection of the next speaker. The physician's choice of second person reference selects the patient as her primary addressee, signaling that, in her judgment, this youth possesses the requisite communicative competence to produce an adequate account of his own illness experience.

It is notable that in addressing Yordan, Dr. Emilia used the respectful form *usted* rather than the unmarked form of address by an adult to a child in Chilean Spanish, the informal *tu* (Torrejón 1991). This pragmatic use of the respectful address form echoes the Mapuche healer's use of the same in addressing some of her young patients. By asking the youth to verbalize his own subjective experience of ailment, Dr. Emilia construed the young patient as competent in two ways. First, he was treated as legitimately knowledgeable about his own illness experience, and second, he was treated as accountable for producing the sort of illness account that was appropriate to the institutional activity in which he was involved as a patient. This allocation of accountability presupposed his communicative competence to do so.

4.6 Beginning Eustacio's Consultation

The opening of a pediatric consultation with another physician at the primary care center demonstrates the degree to which the solicitation of a primary complaint was systematic across practitioners as well as illustrating a few differences in style that existed across physicians in how they launched this phase of the consultation. Excerpt 4.2 is from a consultation for Eustacio (1 year 3 months old), who was brought by his father to see Doctor Tomás for upper respiratory and digestive symptoms.

Example 4.2



- 01 Doctor ((reading from top patient chart in a stack))
Ya. Manqueman Eustacio por favor.
Okay Last.name First.name please
Okay. Manqueman Eustacio please.



- 02 ((Takes top chart in his hands and opens it))
(8.0)



03 Father ((Enters room with baby. Doctor looks toward them))
Permisito.
Permission-DIM
Excuse me./May I?



04 Doctor ((returns gaze to child's open chart on the desk))
Buenos dias.
Good-PL day-PL
Good morning.

05 Father Buenos dias doctor.
Good-PL day-PL doctor
Good morning doctor.

06 Doctor El niño <Manqueman Eustacio>.
The boy last-name first-name
The boy is Manqueman Eustacio?

07 Father Si.
Yes.



08 Doctor ((gestures toward seat on opposite side of desk))
Entonces (). Traelo par' aca.
Then ? Bring-3S.IMPERATIVE-DIR PREP here
Then (). Bring him over here.

09 Sientese.
sit-3S.IMPERATIVE
Take a seat.



10 ((Father crosses from door to desk with child.
Doctor returns gaze to chart))
(3.6)

11 ((Father sits across desk from doctor))
(1.0)



12 Doctor ((writing in patient chart))
 Cuenteme. Qué se- qué le suceda
 Tell-IND What REFL what IND happen-3S.PRESENT
 Tell me. What- what is happening to

13 a la guaguita. Por qué vi[ene].
 the baby-DIM Why come-2S.PRESENT
 the baby. Why have you come?

14 Father [Eh que:-
 It's that-



15 Doctor ((Looks up from chart toward father))
 Father Doctor, sta con: un fuerte
 Doctor be-3S.PRESENT with a strong
 Um. Doctor, he's got a bad

16 (de-) tiene rehfrio.
 ? have-3S-PRESENT cold
 () *he has a cold.*

Following the physician's summons of the patient (line 1), this consultation began when one year old Eustacio was carried into the consultation room by his father (line 3), who announced their entry with a polite utterance, '*permisito*' 'Excuse me', which was marked as particularly deferential by the diminutive affix '-ito'. After glancing at the patient and his father when they entered the room, the physician returned his gaze to the patient's chart as he issued a greeting (line 4). The father reciprocated the greeting, "Good morning doctor" (line 5) but remained standing near the door, refraining from approaching the desk where the physician was seated. At the father's hesitation, the physician solicited confirmation that the small child the father had brought into the room was, indeed, the patient whom the doctor had just called. The doctor again read the patient's name from the chart (line 6), maintaining the bureaucratic ordering of surname followed by first name. Once the father confirmed that this was the boy he was carrying, "Yes" (line 7), the doctor instructed him to approach and sit down, gesturing to a chair on the opposite side of the desk (lines 8-9). Once the father was seated, the doctor proceeded to inquire into the patient's health problem, at the same time that he began writing in the patient's chart. Thus, it was without looking at the patient or his father that the doctor launched the primary complaint phase saying, "Tell me. What- what is happening to the baby. Why have you come?" (lines 12-13). It was not until Eustacio's father began his response "It's that-" (line 14) that Doctor Tomás stopped writing and looked up from the chart toward the patient and his father (line 15). At the conclusion of the excerpt, having secured the doctor's gaze, the father launched his account of the boy's illness "Doctor he's got a bad- he has a cold" (lines 15-16).

The beginning of this consultation reveals more than the previous excerpts about how doctors, parents, and patients at the primary care center negotiated the initial moments of consultations when they got themselves into position to begin the medical interview. As Robinson (1998) has argued, this getting “down to business” that happens in the first moments of primary care consultations requires careful coordination among the participants as they 1) attend to one another’s involvement in tasks such as shutting the door, taking a seat, or reviewing a medical chart and 2) assess one another’s readiness to begin talk about the patient’s health problem.

For the most part, Doctor Tomás oriented to the same interactional and bureaucratic tasks that Doctor Andrea did in the first moments of her consultations (Excerpts 4-5). As discussed above, one key task involves confirming the patient’s identity, a bureaucratic task that ensures that the order of attention in the clinic follows protocol and that information gleaned from and entered into medical charts corresponds to the appropriate individual. The systematicity with which this step was carried out across consultations in the data corpus also speaks to the central importance of medical charts in this setting. As mediating objects in the clinical environment, medical charts contained (ideally if not actually) comprehensive documentation of a child’s medical history, including the dates of all of their consultations at the center, the diagnoses that had been applied on these occasions, and the pharmaceutical and other therapeutic prescriptions that had been dispensed. The status of children’s medical charts as recursively updated archival documents that were circulated exclusively among medical personnel made them an integral part of the document-oriented epistemological regime that characterized this institution more generally. Charts presupposed and facilitated the medicalization of children’s illness experiences as diagnoses of pathological phenomena, privileging the professional knowledge of medical

practitioners and effacing the subjective quality of patients' symptoms and the lifeworld (Mishler 1984) concerns that the illnesses entailed for families.

4.7 Beginning Maria Natalia's Consultation

An example from a consultation with a third physician at the primary care center illustrates how parents oriented to and actively participated in the task of confirming patients' identities at the beginning of consultations. In this case, which is excerpted from a consultation for a nine year-old girl's ear pain, the physician's identification of the patient occasioned a brief repair before the primary complaint could be announced. At the beginning of the recording, the patient and her grandmother were already seated, and Doctor Felicia was flipping through the charts that were stacked in front of her on the desk. Reaching the chart for the current patient, Doctor Felicia addressed the patient's grandmother to inquire about the reason for the girl's visit.

Example 4.3

01 Doctor Ya. ((opens chart)) Cuénteme.
Okay. Tell-2S-Formal-IND.
Okay. Tell me.



02 ((looking at patient chart))
Por qué me trae María.
Why IND bring-2S-Formal First.name
Why do you bring me María.

03 G'mother Ya. La Natalia,
Okay ART First.name
Okay. The Natalia

04 Doctor La Natalia.
ART First.name
The Natalia.



05 Doctor **((looks up from chart toward g'mother))**
G'mother Eh tiene problema del oído.
have-3S problem PREP ear
Um she has an ear problem.

In this case, Doctor Felicia launched the diagnostic process at the same time that she was still visibly oriented to her patient's medical chart (lines 1-2). Referring to the patient as María, the doctor asked the girl's grandmother, "Why do you bring me María" (line 2). Before answering the doctor's query, the grandmother initiated a repair by referring to the girl by her middle name, "Natalia" (line 3), which was the name the girl used on a regular basis. The physician acceded to the grandmother's proffered correction by repeating "La Natalia" (line 4), but did not look up at the patient and her caregiver until the girl's grandmother began describing the girl's ailment "Um she has an ear problem" (line 5).

4.7 Conclusion

As the four cases presented above demonstrate, there was remarkable consistency in how physicians at the Makewe primary care center opened pediatric acute care consultations. The first matter of business involved confirming the identity of the patient against his or her medical chart. Following this task, physicians solicited accounts from their young patients' caregivers, and sometimes from older youths themselves, regarding the reason for the medical consultation.

In soliciting a primary complaint, physicians in this setting almost always used open-ended questions, reflecting a narrower range of practice than has been found elsewhere (Heritage & Robinson 2006b). The pervasiveness of this question design was related to the institutional protocols at the center, which entailed that physicians began consultations with no information available to them about the details of their patients' ailments. The open-ended question format with which virtually all pediatric first-visit consultations at the primary care center began conveyed a substantial amount of information to patients and caregivers, orienting them to the respective rights and responsibilities that were being allotted to them and to the other participants with respect to the task-at-hand of establishing a health problem for diagnosis. The following paragraphs elaborate the significance of these findings.

At the outset of consultations, prior to addressing health problems, physicians had to locate patients within the bureaucratic field. This involved the matching of what Robinson (1998) has referred to as the "patient embodied," the patient in person, to the "patient inscribed" or the "patient in bureaucracy," the patient's medical chart. At the Makewe Center, the lamination of embodied and bureaucratic patients is a fundamental (and non-negotiable) part of the professional relationship between practitioners and patients because the clinic, as a government-funded institution, constitutes part of Chilean state bureaucracy. As the only established medical center in this densely indigenous area, the Makewe primary care center is one of the key sites where local Mapuche interact with state bureaucracy and receive public services. Patient-citizens who avail themselves of these medical resources concurrently submit themselves to scrutiny regarding their health-related behaviors^{xi}. And this has consequences for the doctor-patient relationship that characterizes this setting. Doctors here act not only as members of a healing profession but also as bureaucratic officers mediating relations between

the state and its indigenous citizens.

Physicians' consistent orientation to bureaucratic protocols, especially the use of medical charts, served as a recurrent reminder that physicians were beholden not only to the oaths they took upon accepting the mantle of medical practice but also to the state apparatuses within which they ministered professional care and acted as gate-keepers who were responsible for allocating scarce resources^{xii}. Thus, while physicians' ostensible primary responsibility was the provision of medical care, they were simultaneously involved, in a very intimate way, in the documentation (*ergo* surveillance) of patient's medical(ized) lives. Patients' charts had a social life that existed largely outside patients' and their parents' direct control or full understanding. Whenever patients relayed illness accounts, physicians annotated their charts, recontextualizing the verbal accounts 'for the record' and, presumably, translating the clients' speech into medical jargon. In this way, doctors accumulated a historical record of patients' past visits to the center, the health matters that had been addressed, and the therapeutic actions that had been prescribed. Physicians' attention to these cumulative texts during the very early stages of consultations signaled their centrality as a key artifact mediating the doctor-patient relationship at the same time that it projected charts as evidentiary sources that could be used by physicians to confirm or deny patients' accounts about their own medical histories^{xiii}.

Once a patient's identity had been established, physicians turned to the task of soliciting caregivers' or patients' chief complaints. The occurrence of this phase at the beginning of consultations cast the diagnostic process as one that was both complaint-driven and organized around the goal of gathering information. As Mattingly (2010) has pointed out, one of the most dominant tropes for understanding the biomedical diagnostic process is that of the detective who searches for clues that will reveal the true nature of an underlying condition.

The form of the questions physicians used to solicit the chief complaint conveyed an epistemic stance in which they claimed no knowledge concerning the nature of the illness for which medical attention was being sought. This form and the stance it represented was consequential because it established what Heritage and Clayman (2010) have referred to as a steep epistemic gradient among the participants. At the opposite end of the gradient from physicians was the addressee of the question (i.e. the caregiver or patient), who was construed as inherently and legitimately knowledgeable about the relevant health problem. This epistemic gradient between physician and addressee at the moment the solicitation question was asked projected a corresponding set of participatory rights and responsibilities for the identification of the health problem. As the first-pair part of a question-answer adjacency pair, the solicitation question obliged the primary addressee to provide a verbal account of the health problem with which the diagnostic process could proceed. The caregiver or patient was thus recruited into a primary teller role for the purposes of identifying the child's primary health problem. This designation also projected that the teller could be and would be held accountable for accurately conveying sufficient and appropriate information about the illness trajectory to the physician.

It is important to qualify that while the epistemic gradient presupposed by the solicitation question was clear on the point of the physician's unknowledgeable status and the addressee's knowledgeable status, it left ambiguous what epistemic status was accorded to the third participant. In order to more fully understand the epistemic ecology (Goodwin 2011) that obtained among the three participants at this moment in these clinical encounters it is necessary to recall the epistemic distinctions that are codified in biomedical theory. As the subject-experiencer of symptoms, a child patient in this setting was presumably accorded legitimate epistemic access to knowledge about the subjectively perceptible qualities of her illness (i.e. the

symptoms). In a complementary fashion, parents (or grandparents) exercised legitimate knowledge concerning the noticeable illness signs that had manifested since the onset of the illness, signs that would have been appreciable during their physical care for the sick child.

Yet this explanation about the division of epistemic access across child patients and their kin caregivers does not account for why physicians addressed caregivers most often and child patients only rarely in their solicitation of a chief complaint, nor why physicians addressed one rather than the other on any given occasion. In order to understand this interactional decision, another presupposition embodied in the question can be considered. Not only did physicians' solicitation questions presuppose that the addressee had pertinent and legitimate knowledge about the child's health problem, they also presupposed that the addressee exercised the requisite communicative competence (Hymes 2001) for producing a felicitous illness account.

Adequate illness accounts in this setting needed to include specific information regarding the quality, locus, and duration of problems in the child patient's body. It can be assumed that representing such issues requires not only grammatical competence but also familiarity with and the ability to produce felicitous descriptions that would conform to genre expectations for illness accounts, including pragmatic features and appropriate vocabulary for referring to parts of the body and bodily processes in addition to genre-appropriate time references (see Chapter 7 for a discussion of the norms that governed how the timing of illness was conveyed in presenting concerns). In a study of pediatric consultations that were conducted in Los Angeles, CA, Stivers (2012) found that children's age and the form of physicians' questions both correlated with the likelihood that children would respond to questions in medical interviews. Specifically, the study found that as children grew, they became progressively more likely to answer physicians' inquiries. In addition, children of all ages were more likely to answer yes/no interrogatives than

wh- questions. These findings suggest that children's competence in medical interaction, as in other activities, develops over time and that certain forms of participation, such as the reporting of a medical problem in answer to a physician's *wh-* variety question, "*Qué te pasa*" "What's happening to you," may be more difficult than other communicative tasks. It may be the case that physicians anticipate children's difficulties in presenting concerns and respond by selecting adults most often to fulfill this task in the diagnostic process.

Notes to Chapter Four

^{ix} This particular quotation is taken from Raymond's discussion, specifically, of yes/no interrogative questions, but the assertion cited also holds true for other kinds of interrogatives, including those used by physicians to solicit patients' presenting concerns.

^x Dixon 2011 cites three sources that attest to definite article + first name usage in Chilean colloquial Spanish: Oroz 1966; RAE 1973; Fernandez 1999 (incorrectly listed as Leborans & José 1999). Dixon's study involved acceptability measures of the definite article + first name form among residents of Santiago, Chile's capital and largest urban metropolis. Among Dixon's findings was a low rating of the acceptability among all social classes and age groups for what were referred to as "formal situations." Acceptability judgments were based on invented scenarios. One invented scenario involved talk by a physician. For this case, research subjects were asked to rate the acceptability of usage based on a prompt that read, "*Es normal que un doctor al referirse a una paciente en el hospital, diga 'la Juana' en vez de 'Juana'*" "It is normal that a doctor, in referring to a patient in the hospital, say 'la Juana' instead of 'Juana'." Across the three invented scenarios of the study, all of which involved talk in work-related settings, the majority of participants considered use of the definite article with proper name inappropriate. A greater percentage of high SES participants judged the form inappropriate than did low SES participants. Due to the design of the study, I would argue that Dixon's findings are not likely to predict whether Chilean Spanish speakers might use the form nor whether they might find the form acceptable in case of authentic production, such as those documented in this paper. What Dixon's study more likely demonstrates is that most of his Chilean participants knew that this common colloquial form was unacceptable according to prescriptive Spanish grammar and chose to reply to research questions in ways that indexed this knowledge.

^{xi} My interpretation of physicians' orientation to medical charts diverges from Robinson's account, which refrains from interpreting doctor-patient interaction in terms of a larger political economy in order to focus instead on the proximate influences that affect conduct in the openings of medical interviews.

^{xii} It is also notable, though outside the scope of this paper to discuss, that as bureaucratic officers, physicians are also involved in the rationing of limited medical resources (e.g. pharmaceuticals), a process that affects the therapeutic recommendations they make and the prescriptions they dispense in the latter phases of consultations.

^{xiii} Carr (2010) documents how client charts circulated across service agencies on which drug-dependent women depended for basic resources. While these charts played a central role in whether women were extended or refused services, the women themselves had little control over the representations that were entextualized in them. In my own data corpus from the Makewe center, there are cases of medical practitioners referencing information in patient charts to contradict parents' claims about their children. There is a case in my data set in which a health worker questions the sincerity of a mother's assertion that her infant has been eating very little by appealing to the fact that the patient's weight gain has not flagged since an earlier appointment. This example illustrates how information in medical charts carried the potential for undermining parents' and patients' epistemic privilege or authority concerning experiences that occurred outside the clinical setting.

Chapter Five

GENERIC REGIMENTATION OF TELLERSHIP

5.1 Introduction

Once a week *lawentuchefe* Lorena receives as many as a dozen Mapuche and non-Mapuche clients for consultation at the Mapuche Healing Center in Temuco. A handful of these patients are children. As was introduced earlier, in *peloton*, skilled Mapuche healers describe a sick person's symptoms to him without needing to elicit his health history or concerns. The ability to perform *peloton* diagnosis is considered a *don*, a Spanish word meaning 'supernatural gift'. Practically, this diagnostic genre establishes the set of problems around which a healing consultation will revolve. Ideologically, the genre provides a "conventionalized orienting framework" (Bauman 2004) that both presupposes and reifies participants in the locally meaningful subject positions of *lawentuchefe* 'healer', *kutran* 'sick person', and *ngen kutran* 'keeper of the sick person'. The interactional achievement of these practical and ideological outcomes, however, is jeopardized when clients visiting the healer lack familiarity with the *peloton* genre and participate in unconventional ways.

While Chapter 3 demonstrated how a teller is selected in *peloton*, this chapter explores the generic regimentation (Bauman 2004) of tellership (Ochs & Capps 2001) and epistemic authority as they played out over the course of *peloton* pronouncements. Analysis of transcript excerpts from videorecordings of Healer Lorena's consultations with two children patients provides evidence supporting two arguments. First, I further the argument that *peloton* affords an empathic account of illness that is characterized by healers' display of extraordinary knowledge about the subjective, lived quality of symptomatic experience. The constitution of this extraordinary account or "reality" (Schutz 1945) of a client's illness is facilitated by the

embodied practices, formal properties, and participation norms of the genre, specifically the sustained physical contact, poetics, and sequential ordering of tellership. Second, the demonstration of empathic insight into illness experience, because it relies on healers' control over tellership, can become difficult when they consult for children's health problems the first time. New clients, unfamiliar with *pelotun*, may orient to the consultation as if it were a primary care medical interview, and they try to reproduce the interactional format that characterizes pediatric consultations. Their unconventional participation opens an intertextual gap (Briggs & Bauman 1992) that threatens the extraordinary illness accounts that the genre is designed to afford. Healers are thus faced with a dilemma of generic regimentation and face management: how to craft a successful *pelotun* text in concert with naïve interlocutors. The data presented below demonstrate how *lawentuchefe* Lorena managed the generic regimentation of tellership rights in just such a problematic consultation and considers the implications such negotiations have for the legitimation of Mapuche medical authority and the ontology of diagnoses in the context of asymmetrical medical plurality that exists in the Araucanía.

5.2 Generic Regimentation, Medical Storytelling, and the Crafting of Illness Realities

Research on verbal art has demonstrated that performers and audience members orient to generic norms as grounds for both recognizing and evaluating performances. The ability of participants to judge a particular performance as an instantiation of a particular genre hinges on their past experience with other performances of the same. Thus successful intertextuality relies not only on continuities in formal features across texts and ideological orientations across audiences but also on participants' competence in what Bauman (2004) has referred to as the "conventionalized orienting framework" (3) of a genre. Yet while the continuity of a genre depends on multiple continuities and competencies, it can also involve change across

performances and historical time. Because awareness of generic norms and commitments to the various language ideologies that underpin them are likely to be unevenly distributed across participants, it is predictable that discrepancies in expectations for performances and evaluations of their acceptability will emerge (Kroskrity 2009).

One of the ways in which discrepancies become apparent is in acts of generic regimentation (Bauman 2004), when participants seek to minimize the intertextual gap between a present performance and the generic precedents of prior performances. Participants may utilize any number of resources to militate against generic innovation. Tactics can range from explicit metacommunicative commentary, for example explaining the appropriate circumstances for the telling of a story, to such implicit moves as declining to perform under circumstances that are deemed inappropriate (Hymes 1981). At the same time, acts of generic innovation can serve very different aims, from the creation of new, hybrid genres to the conservation of an existing genre in modified form when a sociocultural pressure such as language shift eliminates the kinds of language socialization opportunities that are needed to sustain a critical mass of competent performers (Falconi n.d.; Kroskrity 2009).

Alfred Schutz's (1945) essay "On Multiple Realities," offers a useful heuristic for considering what medical storytelling genres, with their conventionalized orienting frameworks, may afford for patient families who are looking to make sense of children's illnesses. Schutz, building on Husserl's work, posited that there is a particular style of experience^{xiv} proper to each state through which we pass in the course of ordinary life. The primary of these states is everyday wakefulness, a state characterized by the natural standpoint or attitude ('*natürliche Einstellung*' Husserl 1962:91) and into which we gear our actions. Schutz compared everyday wakefulness to the world of dreams and the world of scientific theorizing. He argued that we

endow each of these realities or *finite provinces of meaning* with a particular “accent of reality” (553) that holds true and makes sense within its own confines but which “would appear as merely fictitious, inconsistent and incompatible” (553) if scrutinized from the perspective of another finite province of meaning. Applied to medical paradigms, this notion of finite provinces of meaning may be a good model for interpreting how each medical ontological system, and the genres proper to it, offers wellness seekers (Harvey 2008) a unique way to make meaning of the felt experience of ailment, with ‘meaning’ understood as “an interpretation of a past experience looked at from the present Now with a reflective attitude” (Schutz 1945:535). I expand on the applicability of Schutz’s model to Mapuche healing in the description of *pelotun*, below.

5.3 The Healer’s *Don* and the Empathic Epistemics of *Pelotun*

The ideology of the healer’s *don* has been attested by contemporary ethnographers working with Mapuche healers and patients in both rural and urban areas. Bacigalupo (2007) quotes a *machi* who made this comparison, “When I treat a patient I follow everything—his life curriculum, we could say—what she is like, why he is ill. All of those things *machi* know...*Machi* don’t ask you: ‘How are you? What hurts?’ But if you go to the doctor, you have to say ‘It hurts me here’, and then the doctor draws a conclusion” (191). In this statement, the *machi* compares his own experience as a person possessed of the healer’s *don* to the practices of physicians, who do not possess it. He notes that, as a Mapuche healer, he simply *knows* important information about his patients’ lives, and this allows him to diagnose and treat them. In contrast, physicians lack comparable insight. The *machi* frames biomedical patients as unfortunately obliged to tell their doctors what ails them and, reciprocally, physicians as dependent on patients’ first-hand reports to come to any diagnostic conclusions about their patients’ health. The *machi*’s comment is an indictment of Western physicians’ standard

elicitation routines and the corresponding designation of illness story tellership to patients. He implies that this key interactional format in Western medicine undesirable but necessary because physicians lack the supernatural gift of illness perception.

Similar judgments about physicians are reported by Izquierdo (1995), who conducted interviews with Mapuche patients at a public primary care center in the capital city of Santiago. Participants in Izquierdo's study considered general practitioners' probing questions about symptoms to be a sign of their ineptitude at recognizing illness. As Izquierdo notes, for the Mapuche "a good healer asks few questions" (49). The findings from Bacigalupo's and Izquierdo's studies point to a disjunct in ideology between Mapuche and biomedicine that illuminates the epistemic framework that characterizes Mapuche healing.

Three relevant social roles are assumed in Mapuche healing consultations. The sick role is referred to as *kutran*, a polysemous Mapudungun word that means 'sickness' as well as 'sick person'. *Kutran* are considered to inhabit a diminished state of personhood, which requires their care by a *ngen kutran* 'keeper of the sick person'. *Ngen kutran* are responsible for direct care of their charges as well as for acquiring medications, seeking recourse with medical practitioners, and often for speaking on behalf of *kutran*. When children become ill, mothers generally take on the role of *ngen kutran*. Healers can make pronouncements on the health of a *kutran* even in the absence of the sick person herself, which means that many consultations are conducted between just a healer and a *ngen kutran*.

The authority of healers' pronouncements is predicated on the notion that healers share epistemic access to patients' subjective experience of illness with patients themselves. This particular distribution of epistemic access implies a form of sociality that contrasts sharply with the epistemic assumptions of ordinary conversation, where interlocutors orient to the exclusive

epistemic rights of individuals over matters concerning their own biographical past (Goffman 1983; Sacks 1984). And it is with respect to this extraordinary form of sociality that Schutz's (1945) essay is useful. For Schutz, every finite province of meaning (e.g. a medical paradigm) is characterized by a particular style of experience that contributes to the reality it affords. Among the basic characteristics of a specific mode of experience are a particular experience of the self and a particular form of sociality. The practice of *pelotun* in Mapuche medicine invokes an extraordinary sociality in which self-other relations are transformed. General assumptions about a patient's privileged awareness of his own past and his bodily experience are disrupted by the extraordinary experience of being told by an Other what the illness experience has been like. When patients are children, their parents are also treated as knowledgeable parties who may know better than children themselves what is ailing them. These assumptions about participants' knowledge, together with the interactional format of the consultation, invoke a self that does not retain exclusive epistemic rights over its own experience and a social relationship in which a supernaturally gifted 'Other' sees into, and therefore knows about, subjective experience. This presumed overlap in knowledge generates empathically charged illness representations that are viewed as having converged from the valid perceptions of all parties.

5.4 The Style of *Pelotun*

In this section several generic features of *pelotun* are identified in the first part of Healer Lorena's pronouncement for Daniel (12 y.o), whose case was introduced in Chapter 3. The consultation from which this example is taken is Lorena's second pronouncement on Daniel's health, on the occasion when Daniel first attended and was accompanied by his mother. The excerpt begins where analysis left off in chapter 3.

As was shown in detail in Chapter 3, Healer Lorena initiated the orientation phase of the consultation by asking Daniel to extend his right arm toward her across the desk that was between them. The healer took the youth's forearm in both hands and located his radial pulse with her fingers. They remained in this position of physical contact throughout the *pelotun*, allowing both parties to attend not only to visually and audibly available cues but also tactile sensations that provided an additional channel for perceiving and interpreting each others' actions.

Sustaining Daniel's wrist in both hands, Lorena commenced a long description of multiple health problems and discomforts the youth purportedly felt. Her talk was punctuated by Daniel's periodic acknowledgements and confirmations as well as his mother's quiet listening. Through her telling, Lorena established the propositional grounds on which the health discussion would move forward and on which diagnoses would be predicated. At the same time, Daniel and his mother ratified Lorena's version of Daniel's illness trajectory by refraining from making modifications to the account as it was produced. In this way, the establishment of Lorena's epistemic authority over Daniel's illness experience was a joint accomplishment of all three participants.

A close analysis of the first part of the pronouncement, in which Healer Lorena identified three symptoms and sought Daniel's immediate confirmation, serves to illustrate several elements of the generic style.

Example 5.1

1. Healer Tení asco a la com↑i:da,
 have-2SG.PRS disgust PREP the food
 You feel disgusted by food,

2. te marea la cabe↑:za,
REFL dizzy-3SG.PRS the head
your head dizzies you,
3. andai deca↑i:do,
go-2SG.PRS dispirited
you go around dispirited,
4. te dan esah cosah?
OBJ give-3PL.PRS those things
Do those things happen to you?
5. Patient Si.
 Yes.

The pronouncement began with Lorena’s description of a triad of sensations the patient purportedly experienced. The grammatical resources Lorena used to describe Daniel’s symptoms provided important signposts to her interlocutors about the insight she was claiming about the boy’s bodily experience. Lorena stated that Daniel felt disgusted by food, that his head was dizzy, and that he went around dispirited (lines 1-3). The present tense indicative verbal form in the first three clauses frames Daniel’s disgust, dizziness, and dispiritedness as temporally continuative and uncontroversial. The unmitigated phrasing presupposes Lorena’s knowledge more by omission than commission; the assertions are unmarked by any qualifications regarding the healer’s certainty, which implicitly treats such a qualification as unnecessary. Indeed there were no hedges or other epistemic qualifiers (e.g. evidential verbs) in Lorena’s entire *pelotun* for Daniel.

The first three symptoms Lorena identified are noteworthy as well. As subjectively experienced, somatic phenomena that are not accompanied by outward physical signs, the three symptoms of disgust, dizziness, and dispiritedness are Type-1 knowables (Pomerantz 1980), matters over which Daniel would normally maintain exclusive epistemic privilege.

Because the symptoms that Lorena identified early in the *pelotun* constituted information that properly ‘belonged’ to Daniel as part of his subject-actor experience of his own body, it required a certain amount of interactional labor on the healer’s part to constitute them as phenomena over which she, too, had epistemic authority. In addition to the grammar, the sequential positioning of her assertions was crucial. Lorena’s introduction of the symptoms into the unfolding talk constituted “first position assessments” (Heritage & Raymond 2005), which, by virtue of their position in a dialogue, “index a tacit claim to epistemic primacy” (22) with respect to their referents. Healers’ production of their assessments in first position is extremely important yet, as will be shown below, it is a generic feature of *pelotun* that can be difficult to achieve.

The stylized performance of *pelotun* also contributes to the privileged epistemic stance the healer adopts with respect to the young patient’s symptoms. As can be seen in the representation of the talk on the transcript, Lorena’s delivery was paced and performed as if in verse, with stretched vowels occurring on the penultimate syllable of each assertion. The verbal delivery of each symptom-descriptive clause ended with a rise in intonation (represented by an arrow ↑) on the stressed, clause-final word, indicating that it was part of an ongoing utterance that was not yet complete. This intonational pattern facilitates long turns at talk in which healers are able to posit multiple symptoms. Together, these qualities of stress, pace, and intonation mark a shift in style (Hymes 1981) away from the healer’s normal conversational speech and into a *pelotun* style. The style shift accomplishes a break from the talk of the orientation phase and marks the symptom assessments as proper to the *pelotun* and, as such, evaluable within the parameters of the genre. The healer’s performance of this speech style also helps consolidate her

authority by indirectly indexing (Ochs 1992) her competence in healing via a display of her competence in this healer-exclusive speech genre.

Having posited an initial triad of symptoms, Lorena elicited a confirmation from Daniel that he, indeed, felt “those things”, and the youth supplied a confirmation, enabling the two of them to interactionally converge on a common initial assessment of several symptoms. Following the multiple ways that Lorena had indexed her epistemic authority concerning Daniel’s symptoms (lines 1-3), her solicitation of a confirmation (line 4) requires some interpretation. One hypothesis would be to treat the question “Do those things happen to you?” (line 4) as operating like a tag question that downgrades the speaker’s epistemic stance, “index[ing] a putatively secondary access to a referent relative to the coparticipant” (Heritage & Raymond 2005:20). However, two considerations militate against this interpretation. First, the contextualization of the healer’s claims as occurring concurrently with her holding his wrist and feeling his pulse, I would argue, is a case of what Heritage and Raymond refer to as a state in which “copresent parties assess[] a commonly available state of affairs” (2005: footnote 7). In this case, the healer has direct access to the relevant “state of affairs” (i.e. Daniel’s symptoms) as a result of her physical contact with the patient’s body. At the same time, Daniel enjoys the access of a subject-actor. In cases where participants share common access to information, Heritage and Raymond note that a “[declarative + tag question] format” (ibid.) can index equal epistemic access on the part of both parties by “downgrad[ing] the putatively primary rights to assess the referent that might attach to having gone first” (ibid.). Under this interpretation, Lorena’s solicitation of confirmation from Daniel is an act of recognition that indexes Daniel’s status as a subject-actor, signaling his parity of epistemic access with hers, which has just been established in her first set of three claims (lines 1-3).

But this first interpretation may not be entirely satisfactory, as questions such as the one posed to Daniel in line 4, “Do those things happen to you?” are uncommon in this genre. Healer Lorena and her *machi* colleague at the Mapuche Healing Center very rarely addressed explicit questions to their clients inquiring whether aspects of their pronouncements were accurate or not. Rather, the healers deployed the more implicit interactional resource of opening up carefully timed silences or “gaps” in their listing of symptoms as a way to signal to their interlocutors that an acknowledgement or confirmation was relevant. This was a highly successful strategy, as clients frequently supplied acknowledgements, confirmations, or signs of disalignment in these slots, helping healers to tailor their *pelotun* from moment to moment in response to their patients’ observable behavior. Thus, Lorena’s use of an explicit question in Daniel’s *pelotun* diverges from generic convention.

An alternative interpretation of Lorena’s question is that it was deployed as a means of language socialization. As Stivers (2011) notes, questions can be effective socializing devices in pediatric medical settings, signaling to children the sorts of information for which they are accountable. Lorena’s question displays just this sort of function. At 12 years old, Daniel, though not an adult, was old enough to be held accountable for knowing about his own illness experience. By asking Daniel to confirm that he indeed felt the sensations Lorena had described, she scaffolded the young patient’s participation in the speech event and demonstrated to him the appropriate participatory talk that is attached to the sick role of *kutran*.

As evidenced by Daniel’s straightforward confirmation (line 5) of the first three symptoms Lorena mentioned, the first part of this *pelotun* came off without any interactional hitches. The rest of the *pelotun* proceeded in a similar fashion, though Daniel refrained from explicitly confirming or acknowledging some of the additional symptoms that Lorena posited.

What is remarkable about the accomplishment of this *pelotun* was its strong allocation to the healer of tellership rights and epistemic authority concerning the subjective, somatic experience of her patient. Lorena's *pelotun* about Daniel's illness experience indexed her extraordinary knowledge of B-events, those aspects of biographical experience that are treated in ordinary conversation as properly known to the interlocutor but not the speaker (Labov and Fanshel 1977). By indexing her equal epistemic rights to make assessments about Daniel's symptoms, Lorena thus invited her patient to adopt a stance toward his own bodily experience in which he was not the sole arbiter.

This distribution of knowledge involves a special sort of empathic sociality. The healer and her patient mutually oriented to the healer's identification of a set of bodily experiences of ailment: disgust, dizziness, and dispiritedness, that under normal circumstances would be unknowable to anyone apart from the suffering person. By appropriating epistemic access to these experiences, Lorena was able to render them as interactionally verified signs of illness for which a diagnosis could be established and a therapeutic plan developed. Not unlike the members of Sansom's (1982) mobs, whose retrospective illness stories could only be told by their caregivers, patients of Mapuche healers, like Daniel, have to depend on the illness stories that their healers produce in *pelotun*. When ephemeral symptoms such as dizziness, which in Western medicine might be treated as unverifiable or purely subjective, are named by the healer and ratified by the patient, they are endowed with an accent of socially validated reality.

Revisiting Schutz's definition of meaning as "an interpretation of a past experience looked at from the present Now with a reflective attitude" (535), we can see how *pelotun* is essentially a meaning-making activity in which the inchoate experience of illness is endowed with an accent of socially validated reality by its ordering as a text. Thus, while *pelotun* denies

the primary teller role to *kutran*, the genre also functions to “make real” those aspects of illness experience such as dizziness that in Western medicine might be treated as untestable, merely subjective or, in a worst case scenario, figments of a child patient’s imagination.

5.5 Contested Tellership in Pancho’s Consultation

I now turn to the *pelotun* from Pancho’s consultation, which illustrates a case in which Lorena’s epistemic privilege and tellership rights over her patient’s illness story were challenged by a client’s unorthodox participation, triggering efforts on the part of the healer to minimize the resulting intertextual gap. Pancho (4 y.o.) was a non-Mapuche Chilean boy from Temuco. Pancho’s mother, Soledad, like many other first time clients visiting Lorena, faced the dilemma of how to make manifest her health concerns about her son when Lorena did not elicit this information. Unfamiliar with the *pelotun* genre, Soledad had to rely on the schemas for medical interaction that she had developed from participation in pediatric medical consultations.

As was discussed in the previous chapters, the basic interactional format of Western pediatric primary care conforms to the epistemological ideologies observed by Pomerantz (1980) and Labov and Fanshel (1977) whereby participants refrain from displaying an authoritative stance toward events and phenomena that lie outside their first-hand purview. Patients are granted primary epistemic privilege over their own illness experience^{xv} and, in cases where patients have not yet developed the communicative competence to be held accountable for producing accounts of their illness experience, their parents or caregivers are held accountable for knowledge they have gained about their children’s illness trajectories by virtue of their involvement in the children’s care.

These epistemological ideologies are reified in the standard phase organization (Byrne and Long 1989) of acute care medicine, which, as noted above, includes an early interactional

‘slot’ in which medical professionals solicit from patients or their caregivers an account of the reason for the visit (Robinson 2006). Having always sought medical care for her son with Western physicians prior to her visit to Healer Lorena, Soledad oriented to the consultation with the healer as if it were a pediatric interview and produced a lengthy account of her son’s ailment for Lorena’s benefit. Lorena resisted simply ratifying the illness account Soledad offered because it would have made her own pronouncement irrelevant. As a result, the two women soon found themselves competing for tellership rights about Pancho’s illness. Lorena utilized a variety of semiotic tactics to downplay her client’s telling and forward her own. The result was a performance of the *pelotun* genre that differed significantly from generic precedents and in which the display of the healer’s extraordinary insight into Pancho’s illness experience was only tenuously achieved.

The first excerpt from Pancho’s consultation begins when *lawentuchefe* Lorena moves to formally begin her *pelotun*. Prior to this, Soledad had instructed her son to ask the “grandma’s” [*lawentuchefe* Lorena’s] name. The healer had responded that her name was Lorena, and Soledad told her son “*Vamoh preguntar la abuelita que eh que te pasa.*” “We are going to ask the grandma what it is that’s happening to you.” Lorena was settling some of her belongings on the floor immediately before the excerpt began.

Example 5.2



- 1 Healer ((raises head to meet the gaze of the patient))
Ya. Le- (.) Le veo su guatita?
Okay. [Should] I see your- your tummy?
- 2 Mother S:i.
Yes.



- 3 Healer Permiso. A ver la guatita.
Excuse me. Let's see the tummy.
- 4 Yo no hago nada.
I don't do anything.

From the outset of Pancho's consultation, Lorena organized her talk and movements to forefend against an illness account from Pancho's mother. First, the healer addressed her young patient directly (line 1) to propose her typical diagnostic activity for small children, palpating the

abdomen. She lifted her gaze from her personal belongings on the floor to Pancho saying, “[Should] I see your- your tummy?”^{xvi} (line 1). Pancho met Lorena’s gaze, and Soledad responded on behalf of the boy with a very tentative “yes” (line 2). Lorena continued to orient her movements and talk to the boy, moving alongside him and lifting his sweatshirt to put her hand on his abdomen, recasting her proposed action, “Let’s see the tummy” (line 3) and assuring Pancho that she would not do anything harmful, “I don’t do anything” (line 4).

As Lorena got into position, Soledad began speaking, volunteering an account of her son’s illness.

Example 5.3



- 5 Mother Bronqui:ti los bro:nquios.
 Bronchitis, the bronchials,
- 6 Todo eso tiene.
 he has all that.
- 7 Healer La güatita.
 The tummy.



8 Mother ***((opens buttons on boy's sweater))***
Abrimos aqui hijo?
Shall we open up here son?

9 Healer *Alli no mah.*
There that's all.

10 *Alli no mas señora.*
There. That's all madam.

11 Mother *Alli no mas?*
There that's all?



12 Healer *Eh que veo la guatita. La guatita veo (yo).*
It's that I see the tummy. The tummy I see.

Once Lorena was positioned with her hand on her young patient's abdomen, she typically would have launched into her pronouncement on the boy's ailments. But before she was prepared to speak, and despite her clear orientation to Pancho, Soledad interjected, announcing the health problem that had occasioned the visit, "Bronchitis, the bronchials, he has all that" (line 5). Immediately following her announcement that Pancho had bronchial problems, the mother moved to unzip her son's sweater at the neck saying, "[Shall] we open up here son?" (line 8) in an attempt to provide Lorena with access to the boy's chest, which the mother had just identified as the part of the body that was the seat of her concern.

What is notable about Pancho's mother's interjection at this juncture is that it reflects the sort of content and timing that are appropriate for a parent reporting the reason for a visit to a Western physician. Soledad was aware of the responsibility that caregivers have in pediatric medicine to provide a verbal account of the relevant health concern that has occasioned a medical visit. This sequence of sub-activities in the diagnostic process of acute care is predicated on the epistemic framework, noted above, wherein physicians are assumed to inhabit an unknowing stance about their patients' symptoms (Heritage and Clayman 2010). Patients and parents essentially bring physicians up to date with the production of a reason for the visit. And, in primary care, it is only after caregivers have given this description that clinicians move to make a physical examination.

Given this schema, Soledad may have interpreted Lorena's move to examine her son's abdomen as premature because the healer had not yet heard what was ailing the child. In the absence of the solicitation of an account for the reason for the visit (lines 1-4), Soledad interjected an explanation of what was wrong with her son for the healer's benefit (lines 5-6; cf. Ruusuvuori 2005). In response to this recognizable action of 'accounting for the visit' that

Pancho’s mother was attempting to pull off, Lorena pushed back. She refrained from verbally responding to the mother’s pithy illness account at all, and she declined the mother’s offer to uncover her son’s chest saying, “There that’s all. There that’s all, señora” (lines 9-10). When the mother responded in surprise (line 11), Lorena provided an account of her diagnostic technique that served to mitigate the face threat of her refusal with an account for her actions that framed them as part of her standard examination procedure, “It’s that I see the tummy. The tummy I see” (line 12).

Following this initial jostling for the floor, the remainder of the *pelotun* can be parsed into two sections. In the first (Example 5.4), Lorena was engaged in examining Pancho’s abdomen.

Example 5.4

13 Healer Alli. Echadito [para atrah.
There. leaned back.



14 Mother [Echate par’atras.
Lean back.

15 Healer E::so alli.
Tha::t’s it there.

16 Mire que bien que me (dio) tan bien,
Look how well he (gave) me so well,

17 Patient ((coughs))

18 Healer O:y pobrecito. tiene los bronquios bie::n [obstruidos.
O:y. *Poor thing. He has his bronchials re::ally obstructed.*

19 Mother [Si.
Yes.



20 Que sabe de marzo que estamoh
You know it's been since March that we are

21 con los bronquio los bronquio los bronquio y:
with the bronchials the bronchials the bronchials a:nd

22 le pasa una sema:na, le [vuelve .hh
a week passes, it returns to him, .hh

23 Healer Mm. (1.0)

24 Lo mas () sta con un empacho este mocosito.
The most- () with an empacho this little one.

25 Mother Pobrecito.
Poor little thing.

26 Lo encontraron ale:rgico.
They found him (to be) allergic,

27 Healer Si.
Yes.

28 Mother Asi que toma remedio para l'ale:rgia.
So he takes medicine for the allergies.

29 Healer .hhhh ()

30 Mother .hh Sta co- en la noche se congestio[:na.
He's like- at night he gets cong[ested,

31 Healer Si.

Yes.

- 32 Mother No duerme bie:n,
He doesn't sleep well,
- 33 Se despie:rta y=ahora mah encima la-
He wakens, and now to top it off
- 34 Healer Mm. Pobre.
Mm. Poor thing.
- 35 Mother Le duele la güatita.
His tummy hurts.
- 36 Y ha baja:do de peso.
And he's lost weight.



- 37 Sta palidito. Mira.
He's palid, look.
- 38 Patient ((coughs))

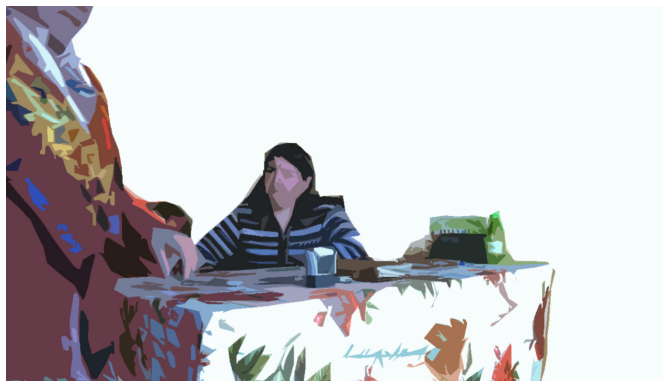
In this excerpt, though Lorena was conspicuously involved in examining the abdomen of her patient, she was unable to achieve a period of silence during which she could concentrate solely on this intercorporeal contact with her patient. This was because Soledad pursued her telling of the story of Pancho's protracted health problems at length. As Soledad spoke, Lorena responded to her story with backchannel acknowledgements (lines 23, 27, 31, 34) that are characteristic of polite listening in everyday conversation (Schegloff 1982), but she selectively disattended the mother's talk by moving her gaze back and forth to look at her patient. In addition, the healer

refrained from asking Soledad the sorts of clarification questions that Western physicians pose in pursuit of a medical history (Boyd & Heritage 2006). With this style of response, Lorena treated her client's story as small talk that was ancillary rather than contributory to the diagnostic activity in which she was engaged.

The last section of the *pelotun* (Excerpt 5.5) began when Lorena had completed her examination of Pancho's abdomen, marked by her 'okay' (line 39). The healer then moved away from Pancho and returned to her chair across the desk from her clients to launch her version of Pancho's illness in a format that conformed more closely to typical *pelotun* pronouncements.

Example 5.5

- 39 Healer Ya.
Okay.
- 40 Mother Y esos bronquios otra vez () volver.
And those bronchials again () to come back.



- 41 Healer Tiene empacho tambien señora.
He has empacho too madam.
- 42 Mother Ya:,
Oka:y,
- 43 Healer Tiene dos cosas.
He has two things.



- 51 Healer No bota la secreci[on bien,
(He) doesn't throw/spit the secretion well,
- 52 Mother [No.
- 53 Healer Esta como pegandose [(dentro)
It's like- sticking inside,
- 54 Mother [Claro.
Right.
- 55 Healer Como pasando un poquito al asma.
Like passing a little to asthma.
- 56 Mother Ya.
Okay.

Once she was seated again, Lorena was able to maintain the floor at length. She provided an account of her patient's illness that incorporated her client's chief concern of bronchial problems into a larger complex of health issues that she identified. In lines 44 and 46-47, Lorena framed Pancho's bronchial problem (Soledad's concern) as auxiliary by tacking it on third, after two problems that she claimed were primary, a cold and a digestive ailment, "He has two things. He has a stuck cold, and the- the *empacho*. And the bronchials quite tight." (lines 44, 46-47). Lorena then elaborated on Pancho's bronchial symptoms in ways that indexed her authoritative knowledge vis-à-vis Pancho's illness experience, "[He] doesn't decongest well, [he] doesn't expel the secretions well, it's like sticking inside" (lines 49, 51, 53). Lorena ended her *pelotun* in line 55 with the diagnostic claim that Pancho appeared to be developing asthma.

Throughout this last section of the *pelotun*, Soledad acknowledged and signaled agreement with the problems Lorena described, suggesting that the two were aligning on a common assessment of the boy's illness. In this respect, the *pelotun* was successful in producing a diagnostic text that displayed a convergence of the participants' perspectives. However, at the same time, the *pelotun* was only marginally successful in the display and performance of the healer's *don*. Because the sorts of respiratory symptoms Lorena described were typical of Western categories of respiratory distress in general, it is likely that Pancho's mother mistook Lorena's description of Pancho's *subjective, lived* experience of symptoms (lines 49, 51, 53) for a claim about the symptomatology of colds or of asthma. It is important to point out that the construal of Lorena's account as "merely" an explanation about the symptomatology of respiratory illnesses in general would fail as a demonstration of the sort of extraordinary epistemic privilege and empathic social connection with the patient that the healer was striving to display.

Overall, a considerable intertextual gap occurred in the performance of Lorena's *pelotun* for Pancho illness. Most importantly, the sequential positioning of Lorena's claims were displaced from the important position of first mention to a position following the generically inappropriate illness account that Pancho's mother interjected, rendering Lorena's display of extraordinary knowledge less recognizable as such. As a result, Lorena managed only a tenuous establishment of her epistemic authority regarding her young patient's symptom experience.

At the same time, Pancho's mother, acting according to participation schemas she had developed from participating in consultations with Western physicians, managed to leverage her own concerns about her son's health into *lawentuchefe* Lorena's *pelotun* by orienting to a perceived right and responsibility to describe Pancho's illness. While Lorena ultimately

incorporated her client's concerns into her *pelotun*, she also sought ways to interactionally foreground her own story of Pancho's ailment and downplay Soledad's. Her generic regimentation can be interpreted as an effort to safeguard her authoritative knowledge as a Mapuche healer possessed of the *don* of illness perception with a minimum of face threat to her interlocutor, on whom she depends for her living.

5.6 Conclusion

Because Mapuche healers' authority rests in part on their success at *pelotun*, they have a vested interest in perpetuating the traditional norms for tellership and the epistemic framework proper to this medical storytelling genre. As can be seen in the short excerpt from Lorena's *pelotun* on Daniel's health problems, Mapuche healers are often able to claim primary knowledge about their patients' symptoms by producing symptom accounts in 'first' positions (see Sidnell & Enfield 2012 for a discussion of epistemic privilege in first and second position assessments cross-linguistically). One important accomplishment of such traditionally formatted pronouncements is the reinforcement of the ideology of the healer's *don*. Another important accomplishment is the establishment of an empathic connection between the healer and her patient, which affords a particular kind of illness 'reality' in which the subjective experience of ailment comes to be treated as fundamentally shared rather than (merely) verbally communicated.

For healers who receive patients who have had little exposure to Mapuche healing practices, establishing an empathic connection, maintaining the floor, and asserting extraordinary knowledge about illness experience can become difficult. This difficulty arises because new clients are likely to draw on their familiarity with the discursive norms of Western pediatric medicine, which include an interactional obligation for parents and patients to produce a story of

illness that serves to set up the diagnostic process. In these cases, healers are faced with the challenge of formulating an illness story about the child that both addresses the concerns of their clients and ensures that the ultimate portrait of the child's ailment is more than just a repetition of these concerns, that they tell their clients something novel and essentially of the healer's fashioning. In order to do this, Lorena chooses implicit rather than explicit interactional tactics. In her consultation for Pancho, Lorena explained her diagnostic procedure when it became necessary, she oriented to Soledad's volunteered story as small talk, and she embedded Soledad's health concern in a more complex account of the boy's health than the mother had provided.

For Lorena, modifying her *pelotun* pronouncements to fit the expectations of non-Mapuche clients is of utmost importance in her practice at the Mapuche Healing Center because she depends on these kinds of clients for her livelihood. The strategic choice to work in an urban healing center on the one hand has insured her a somewhat steady stream of work, but it also means that she receives many clients who are unfamiliar with the particularities of Mapuche medical practices and their attendant ideologies. It therefore behooves Lorena to produce *pelotun* in such a way that they are recognizable to her clients as authoritative, but she cannot assume that they ascribe to (or are aware of) the ideology of the healer's *don*.

With a repertoire of semiotic resources available to her for shaping her *pelotun* from moment to moment in response to her clients' participation, Lorena is able to tailor her particular performances to suit the genre competence of an increasingly uninitiated clientele. In this way, she is not unlike the *pééyu'u* storytellers in the Village of Tewa about whom Kroskrity (2009) writes. These storytellers modify the code of their performance to accommodate to Tewa youth who would otherwise not understand or learn the community's traditional stories. In both cases,

performers efforts help ensure the continuity of a valued genre at the same time that they instantiate innovations that break with what is seen to be ‘traditional’. It appears that modifications such as these may be a necessary compromise for performers who are committed to traditional practices and conscientious of the restrictions posed by their contemporary social milieu.

Notes for Chapter Five

^{xiv} I have chosen to substitute the term ‘style of experience’ in lieu of Schutz’s original “cognitive style” (533) in order to avoid connoting the ideas that the term ‘cognition’ entails today.

^{xvi} Because of the coincidence of second and third person indirect object pronouns and possessive adjectives in Spanish, the addressee of this utterance is grammatically ambiguous. It could be interpreted as either addressed to Pancho’s mother, “Should I see his tummy?” or Pancho, “Should I see your[formal] tummy?” However, the lexical choice of the vernacular term *güatita* ‘tummy’ in combination with Lorena’s reciprocated gaze with Pancho, as well as her production of the utterance with a high pitch, suggest that the primary addressee is the young patient, not his caregiver. My informal questioning of several native Chilean Spanish speakers suggests that the use of formal address forms with children is a common affiliative strategy that is deployed by adults to solicit children’s cooperation in performing requested actions or behaviors.

Chapter Six

THE PERSUASION OF *PELOTUN* ILLNESS ACCOUNTS

6.1 Introduction

As was introduced in Chapter 5, *pelotun* are designed to provide clients with novel interpretations of their illnesses. As part of an activity that is aimed at defining and addressing ill health, these illness accounts may be a good example of what Garro (2003) described as “socially and structurally grounded processes through which individuals learn about, orient towards, and traffic in interpretive plausibilities” (7). The ideal outcome of the genre is an account of illness that is authored by the healer but ratified by the patient, one in which all the parties perceive that they have achieved a convergence of their personal knowledge, the sort of story that is told “with” another (Ochs & Capps 2001). This chapter builds on the observations of the last and presents additional data to show how *pelotun* accounts are designed to provide portrayals of the illness experience that are both provocative and plausible for patients and caregivers.

Ethnographer Ana Mariela Bacigalupo, who has written extensively about *machi* practice, observes that these healers frame illness in ways that are comprehensible to their clients, that their diagnoses express and reproduce the Mapuche system of medical knowledge, and that these affirmations of Mapuche cosmology reaffirm Mapuche ethnic identity. In an article on these topics (Bacigalupo 2001), she notes that “Machis satisfy the expectations of those around them and explain illnesses in terms that are comprehensible and meaningful for each patient” (94 translation is mine). But I argue that this description of healers’ speech falls short in its description of what healers’ pronouncements accomplish. In the following sections, I present evidence showing that healers’ *pelotun* pronouncements aim not just to *explain* but to

persuade clients of a particular, personally meaningful interpretation of illness. Importantly, felicitous performances of *pelotun* persuade clients not of propositional knowledge about sickness but of embodied self-knowledge concerning their own subjective experience of illness. This achievement is facilitated by a number of key features in the textual and interactional design of the genre. In the sections that follow, I first introduce the sorts of expectations that clients' have for their interactions with healers. After this, I identify the key resources that healers use to express the timing of illness. And finally, I discuss how these features promote clients' appropriation of healers' claims and support healers' felicitous demonstration of their empathic knowledge.

6.2 The Desire for Insight about Problems

Clients who sought the assistance of healers at the Mapuche Healing Center were often concerned not only with receiving effective remedies for their ailments but also receiving meaningful interpretations of what was wrong with them. This interest in gaining insight about illness from specialists is not limited to health seekers who consult with ethnomedical healers. People suffering diverse ailments often seek clearer understandings of their problems from practitioners who range from diviners (e.g. Evans-Pritchard 1937; Foster 1941; Turner 1975) to psychotherapists to physicians. However, what distinguishes a *pelotun* pronouncement from most other diagnostic genres is the kind of knowledge that it provides. *Pelotun* pronouncements offer clients insight not only concerning etiological agents or physiological processes, but also regarding the experiential qualities of illness, the nature of the symptoms that are involved, and how these relate to invisible bodily processes.

6.2.1 The Value of Illness Interpretations

Comments that clients at the Mapuche Healing Center made to me in the context of conversations in the waiting room and in my semi-structured interviews with them before or after their consultations indicate that many were indeed concerned to receive novel interpretations about their problems. Their comments indicate that they believed healers would be able to perceive problems that physicians had been unable to identify and treat. For example, one woman, Flora, who came to see *lawentuchefe* Lorena because she was suffering from symptoms that had been diagnosed by physicians as allergies told me, “*Ya estoy en otro tratamiento pero quiero ver otra cosa para ver si tengo otros problemas. Si se que tengo otra cosa*” “I’m already in another treatment but I want to see something else to see if I have other problems. It’s that I know I have something else.” Flora’s concern with getting a second opinion about her ailment was related to her own perception of residual symptoms (Maynard and Frankel 2006) that her doctor had not addressed adequately. Flora insisted that she knew she had something more than allergies and hoped that Healer Lorena would be able to account for and treat this nagging problem.

On other occasions, clients were concerned to understand the character of their problems within the Mapuche distinction between natural and supernatural afflictions. Anxiety was especially acute when clients suspected they were the victims of witchcraft. Angela, who suffered from chronic health problems, had been in *machi* Esteban’s care for several months. She regularly travelled almost two hours with her husband for her appointments with the *machi*. When I asked Angela her primary reason for seeking help with the *machi*, the following exchange occurred.

Example 6.1

- 01 RESEARCHER Okay y ustedes vieron el machi porque
Okay and you saw the machi because
- 02 pasó algo puntual o-
something specific happened or-
- 03 CLIENT Es que yo pensaba que era enfermedad mala.
It's that I thought it was bad [witchcraft] illness.
- 04 RESEARCHER Ah. Al principio vino para ver si era así.
Oh. At the beginning you came to see if it was thus.
- 05 CLIENT Era enfermedad natural.
It was natural illness.

In Angela's case, the persistence of her health problems led her to suspect that they might not be 'merely' natural disease. It was this worry that led Angela to consult with a Mapuche healer, despite the fact that she had received diagnoses from her physicians and was following a treatment regimen for hypertension and high cholesterol. Angela was thankful for the machi's herbal preparations, which she asserted were alleviating her symptoms. In addition, she was grateful that the machi had been able to ascertain that she was not the victim of *enfermedad mala* 'bad illness' (line 3), a euphemism for witchcraft.

A third case reinforces that clients often sought the insights of Mapuche healers because they suspected that "no problem" diagnoses from their doctors had missed some underlying issue. These clients trusted that healers would be able to perceive things that medical technologies and physical exams had not. Helena had recently undergone an endometrial biopsy at a local medical clinic. In her conversation with me before her first consultation with *machi* Esteban, she related that she was unconvinced by her doctor's assessment of the biopsy results and decided to consult with a healer despite her physician's insistence that she was in good reproductive health. When I asked her what she expected or hoped the machi could do for her, she replied, "*Mm que si tengo algo complica'o él me lo va a decir y me va a dar remedios. O si*

no es complicado él también me va a aclarar mis dudas” “Um that if I have something complicated he is going to tell me and he’s going to give me remedies. Or if it’s not complicated he is also going to clarify my doubts.”

The comments presented above point to clients’ interests in receiving the sorts of interpretations about illness that physicians, who focused on diagnosing physiological problems, could not provide. Clients’ descriptions of their reasons for visiting the Mapuche Healing Center indicated that they trusted that healers had perceptive insights about illness that would open up new interpretive understandings for them. Some clients specifically hoped that healers would either rule out or confirm certain worst-case scenarios about which they were worried.

6.2.2 The Cultural Injunction to Have *Fe*

A widespread cultural injunction in the Araucanía calls on the suffering to have *fe* ‘faith’ in the healing practitioners from whom they seek help. Indeed, the efficacy of treatments is sometimes posed as dependent on patients’ faith in their power and in the healers who dispense them. Bacigalupo (2001) describes this ideology as follows, “*Lo que importa es la fe que tienen los pacientes en la machi y en el método de curación utilizado para que sus terapias sean efectivas*” “What matters for therapies to be effective is patients’ faith in the machi and in the curing method that is used” (94). Izquierdo reports as well on this ideology, saying that for her informants, “the idea of *fe* implies that if one prays or simply wishes for a desired outcome, the probability of success is increased” (54). This cultural ideology is evident in the ways that clients at the Healing Center portrayed their own stance and the stance of others toward Mapuche medicine. For example, Barbara, a new client, explained that she had heard about the Mapuche Healing Center from a woman she met in the waiting room of the regional hospital. The woman described to Barbara how the *lawentuchefe* had cured her grandson and told Barbara, “*Tenga fe.*

Vaya allá. Pida hablar con ella” “Have faith. Go there. Ask to talk to her.” Invoking the same notion, Helena professed her faith in Mapuche healing when I asked her how she found the Mapuche Healing Center, “*Yo como tengo tanta fe me acordé de la farmacia Mapuche y allí me dieron un folleto donde decía lo del machi*” “I, since I have so much faith, I remembered the Mapuche pharmacy, and there they gave me a flyer where it said about the *machi*.” The ideology of faith even came up in my interview with Soledad, the mother of three year old Pancho, who had not visited a Mapuche healer before. In answer to my question why she had brought her son to see *lawentuchefe* Lorena, Soledad told me, “*Porque creo harto en la medicina natural*” ‘Because I believe a lot in natural medicine’. In this case, even though Soledad was unfamiliar with Mapuche ethnomedical practice, she approached her son’s consultation with the appropriate, culturally sanctioned attitude of trusting faith.

The preceding examples, in which clients professed to have faith in Mapuche medicine or natural medicine more generally, demonstrate that clients at the Mapuche Healing Center often approached healers with a disposition of trust that both reflected and reproduced the local healing ideology that frames efficacy as dependent on the attitude of the person seeking care. In fact, research into placebo effects (Shea 1991) suggests that this sort of faithful disposition does indeed contribute to the effectiveness of curative treatments. As Shea notes, “There has always been a recognition, extending as far back as Hippocrates and Galen (Shapiro 1960), that ‘faith’, ‘the imagination’, or ‘the placebo effect’ has an influence on somatic events” (253). And such effects are likely to have been mutually reinforcing in Mapuche healing such that clients’ faith in healers was in turn strengthened by their experiences of improvement under healers’ care.

6.3 Normative Features of *Pelotun* Accounts

In this section I present several key textual and interactional features of *pelotun* and describe how these elements amplify or facilitate the persuasiveness of the genre. These features contribute to healers' effective demonstration of their empathic-perceptive gift and make it easier for clients to accept healers' accounts. The first several excerpts are taken from the *pelotun* pronouncement that Healer Lorena provided concerning Fernando's health. To contextualize Lorena's claims, I begin with a brief description of Fernando's case.

6.3.1 Fernando's Illness and Ximena's Faith

A tall, quiet youth who wore glasses, Fernando saw *lawentuchefe* Lorena in the company of both of his parents. Regarding why they had come to see the healer from their home in the distant town of Curacautín, Fernando's mother, Ximena, first told me "*Porque él tiene malestares y lo hemos llevado a diferentes partes. Exámenes acá en Temuco, en Santiago. Y resulta que no le encuentran nada. Y lo otro que por lo mismo del sobre peso*" "Because he has discomforts and we have taken him to different places. Exams here in Temuco, in Santiago. And what happens is they don't find anything [wrong] with him. And the other thing is for the same [issue of] overweight." Over the course of our interview, Ximena elaborated more about the family's search for treatment for her son. She explained that Fernando tolerated very few foods and that he suffered with severe abdominal pain that was so persistent it kept him from studying. In fact, the youth had lost the academic year on account of his health problems.

Ximena noted that she had been a patient of Lorena's herself and, based on her successful experience, she decided to bring her son.

Asi como ella supo lo que tenía yo, depresión, yo quiero que ella- para mi hijo lo mismo, tenga una mejoría. Él ha tomado tantos medicamentos que ya no le hace efecto. Espero

que aquí le encontremos algo. Vengo con la seguridad que va a ser así.

Just like she knew what I had, depression, I want her- for my son the same, to have an improvement. He has taken so many medications that they don't have any effect on him anymore. I hope that here we find something. I come with the security that it is going to be thus.

Ximena's explanation of what she hoped for her son reflects similar concerns and dispositions to those reported by other clients. She notes that Lorena "knew" what was ailing her and that she wants the same for her son, an improvement. Using a somewhat disfluent comparison, Ximena references Lorena's perceptive-diagnostic and therapeutic abilities, her capacity to know and her capacity to bring about an improvement in her patient's condition. At the same time, Ximena expresses a disposition of "security" that an improvement will be forthcoming, signaling her faith in the healer's abilities. In the consultation that followed my conversation with Fernando, his mother, and his father, Lorena provided the family with a lengthy account of Fernando's ailment in which she detailed multiple problems that she perceived to be afflicting Fernando and interrupting his normal life (See appendix for transcript of the entire *pelotun* account).

6.3.2 Numerous Claims and the Temporality of Listening

Two of the most significant characteristics of *pelotun* illness accounts are their duration and a super abundance of claims. The pronouncement on Fernando's health unfolded over a total time of three minutes and three seconds and included 49 separate clauses in which assertions were made by the healer. To understand why this density of claims contributes to the persuasiveness of the *pelotun*, it is helpful to think of the performance as a temporal object of the participants' perception. Fernando and his parents each came to the consultation with their own understanding of what Fernando's health problems entailed. However, it was not their

prerogative to communicate these issues for the purposes of publicly establishing the problem that Lorena would treat. Instead, each of them participated in the *pelotun* activity in the role of recipient or addressee of Lorena's pronouncement.

For each of the participants in the activity, the *pelotun* was, as it unfolded, an intentional and temporal object in the phenomenological sense that it was what they turned their attention toward, and its grasping as a whole required the experience of hearing it as it unfolded in its entirety. Considering this listening experience in light of Husserl's (1991) notions of protention and retention, we can imagine each participant's listening as involving both the anticipation of what the healer might say next and the fading perception of things the healer had already said, such that the series of discrete claims (like notes in a song) were perceived as a fleeting but complex whole description of Fernando's distress. Imaginably, both during and following their listening to the *pelotun*, each of the participants was engaged in comparing the claims Lorena made against his or her own knowledge about what had happened in the course of Fernando's illness.

With 49 separate claims being made over the temporal span of just three minutes, the number of issues identified in the *pelotun* account challenges the limits of short term memory. And, like the memory of a song heard for the first time, the participants' memory of the *pelotun* would be imprecise. At the conclusion of lengthy *pelotun* pronouncements in which dozens of symptoms and issues are mentioned, participants likely recall only some of the specific claims that are made, perhaps those that resonate most with their own prior understanding of the problem as well as any major points on which they differ. Importantly, following *pelotun* pronouncements, many clients, Fernando and his parents included, seek interactional opportunities to describe their own knowledge about the problem. This subsequent talk in which

clients express their own accounts of the illness may also exert an influence on participants' memory traces (Toland et al. 1991) of the original *pelotun* such that subsequent instances of recollection of the *pelotun* may be more similar to their own accounts than the actual *pelotun* (as a textual artifact) was at the time of performance.

6.3.3 Linguistic Resources for the Representation of Timing in Illness

The manner in which healers represent the timing of illness experience is central to their successful performance of *pelotun*. At the most general level, healers present illness as the kind of experience that is of long duration, though its symptoms manifest sporadically and unexpectedly over time. In addition, they portray the roots of illness as deeply embedded in the life history of their patients. The most important linguistic resources that healers have at their disposal for conveying illness in these ways are verb tense and temporal adverbial phrases. This section presents examples of how these linguistic resources are deployed in the claims that healers make.

The most pervasive grammatical resource that healers use to express the timing of illness is verb tense. With every clause, healers are able to subtly communicate something about the timing and duration of illness phenomena through their choice of tense. And, as a rule, claims about symptoms are made using the present tense. This framing construes symptoms and problems as ongoing and perduring, having begun in the past and projecting into the future. The following excerpt is from the beginning of *lawentuchefe* Lorena's pronouncement regarding Fernando's condition. In it, she identifies numerous problems in quick succession. The pervasive use of the simple present tense is evidenced in this sequence of claims. The main verb in each clause is underlined for ease of identification.

Example 6.2

- 11 HEALER Estamos con un problema de depresion.
We are with a depression problem.
- 12 y mas, tiene ansiedad.
And more, he has anxiety.
- 13 (2.0)
- 14 .hh y los sistemas nerviosos estan un poco alterados.
and the nervous systems are a little disturbed.
- 15 MOTHER alterados.
disturbed.
- 16 HEALER .hhh y mas se le inflaman un poco las manos, los pies.
.hhh and more the hands, the feet swell up on him a little,
- 17 amanece un poco hinchado **de repente** la cara,
*He wakes up a little swollen **at times** in the face,*
- 18 los rinyones no funcionan muy bien.
the kidneys don't work very well
- 19 hay como retencion de liquido.
there is like retention of fluid.

Lorena's first observations about Fernando's condition identify depression, anxiety, a problem in Fernando's nervous system, inflammation in his hands, feet, and face, poor functioning kidneys, and liquid retention. In the fashion of a list, Lorena posits a diverse set of symptoms and problems that are vastly different with respect to their locus in the body, the danger they potentially pose to Fernando's health, and even the degree to which Fernando would be likely to have sensorial awareness of them. Yet at the level of textual organization, Lorena maintains consistency in her choice of verbal tense. Across these first seven discrete assertions, the verb in each clause (underlined in the transcript) is in the indicative present tense.

The meaning that the present tense conveys about each of the purported problems, however, is not identical. While the temporal space that is signaled by the present indicative

tense in Spanish always extends away from a present moment of *ahora* ‘now’ to include expanses of both the past and the future, Hernández (1984) observes that there are several distinct meanings that can be conveyed by the present indicative. Among these are the *actual* and the *habitual*, where “the actual present...opens its domain toward the past and future, partially. It marks an action that is developing” (332) and the habitual present “notes a repetition of actions or processes” within which “the internal temporal extension can be variable and depends on the meaning of the verb” (ibid.) This polysemous quality of the indicative present tense is what allows Lorena to convey different kinds of duration (ongoing and iterative) while maintaining the grammatical consistency of verb tense across multiple clauses. Through the deployment of the simple present tense, Lorena characterizes some of Fernando’s afflictions, depression and anxiety in particular, as perduring over time and others, specifically the swelling of hands, feet, and face, as reoccurring periodically.

The sense of iteration or periodicity that is conveyed with the habitual meaning of the present tense is underlined by the healer’s use of the temporal adverbial phrase *de repente* ‘all of a sudden’ (line 17) which, in this context, is best understood idiomatically as ‘sometimes’. In similar fashion, later in the *pelotun*, Lorena announced, “*tambien a veces, como que le baja la presion*” ‘and also at times, like his blood pressure drops’ (line 44). The phrase *a veces* ‘at times’ has the similar function of underscoring the sense of a problem that repeatedly but unpredictably disrupts the patient’s life. Together, the resources of the indicative present and temporal adverbial phrases that convey iteration function to express the timing of Fernando’s symptoms in the most general and non-specific way possible.

The reason why this non-specificity of timing is desirable is related to the ideological conceptualization of *pelotun* as an instance in which a healer demonstrates her empathic

knowledge of her patient's physical and emotional states. The measure of a healer's success in performing this empathic knowledge is a client's assessment of the *pelotun* as an accurate representation of the illness experience. For example, when I asked Carmen, an elderly patient of machi Esteban why she had sought the machi's help, she told me "*Por enfermedad. Me duelen mucho los huesos y los tendones, las varices. Y don Esteban me dijo todo.*" "Because of illness. My bones hurt a lot and the tendons, the varicose veins. And don Esteban told me everything." With her observation that the machi had "told her everything," this patient affirmed her evaluation that the healer had accurately perceived and described what was ailing her. This sort of evaluation reflects the ideal type of account to which healers aspire, one that inspires a patient to conclude that the healer "told them everything" about their ailment. Given this ideal, it behooves healers to produce accounts that are both provocative and plausible. These qualities heighten the likelihood that a client will be able to relate to the pronouncement and recognize in it an interpretation that jives with her own knowledge about what is wrong. One of the most important ways that healers can make their accounts plausible is by using language that will be subjectively meaningful to clients. And one of the key ideational realms about which they can do this is time.

Healers use the available linguistic resources in Spanish to describe time in terms of subjective experience. By sustaining a frame of lived time in their talk about patients' ailments, healers avoid making falsifiable claims about the historicity of any given symptom and simultaneously index an ostensibly shared frame of reference about the timing of illness events. The following excerpt is the segment of Lorena's pronouncement that addressed the timing of Fernando's ailment most explicitly.

Example 6.3

- 37 HEALER Se siente bastante complicado durante estos
He feels quite complicated during these
- 38 tiempos mas ultimoh.
latest times.
- 39 Que ahora estamos hablando de los tiempos
Now we are talking about the times
- 40 mas cercanos de ahora.
closest to now.
- 41 El viene enfermandose mucho tiempo, pero,
He has been getting sick for a long time, but,
- 42 ahora siente todo estos problemas.
now he feels all these problems.

One of the most striking features of this segment is the indeterminacy of the temporal deixis.

Lorena's phrasing of "these latest times," "the times closest to now," and "a long time" are all extremely vague references that are unanchored to any particular moment in the past or the present. These deictic references are without conventional boundaries except for their fixed point of reference to *ahora* 'now', a stretch of time in which Lorena, Fernando, and his parents are together sharing the experience of the *pelotun* pronouncement. This shared experience of a 'now' contributes to the perception that they share a frame of reference about the past and the timing of the illness, even though Lorena's descriptions about this past are extremely vague.

About the way Fernando's ailment has manifested over time, Lorena set up an important contrast. Beginning with the observation that Fernando "feels quite complicated during these latest times" (lines 37-38) Lorena establishes a recent timeframe in which Fernando has been aware of symptoms. She emphasizes the shallowness of this window of time by reiterating, "Now we are talking about the times closest to now" (lines 39-40). Then she contrasts Fernando's recent awareness against a deeper timeframe in which his illness has been developing

imperceptibly, “He has been getting sick for a long time” (line 41). What both of these timeframes have in common is their lack of specificity. Lorena’s phrasing leaves open to the interpretation of her hearers exactly how much time “these latest times” might reference or exactly how long ago Fernando’s sickness began. As a result, Fernando and each of his parents would be able to interpret the duration of the problem however best fit his or her own recollection about how long Fernando had been suffering or how recently his symptoms had emerged. Given the indeterminacy of illness experience in general, there may be intuitive appeal in this sort of description that shies away from describing illness as a tidy phenomenon with a clearly identifiable beginning or ending.

6.3.4 Repetition, Parallelism, and the Participation of Clients in *Pelotun*

Two additional textual characteristics of *pelotun* contribute importantly to their eventual construal as accounts in which the knowledge of healers and clients converge. These are repetition and parallel grammatical structure. On the one hand, healers use repetition and parallel structure to organize the discrete claims they make about symptoms. Over the course of several clauses, a healer will describe an aspect of sickness several times in slightly modified ways. This series of clauses often involves partial or complete repetitions of words and phrases. Other modifications include similes, synonyms, and parallelism that elaborate the claim. During these extended descriptive segments, clients often contribute to the emergent description with verbal responses of their own. Their usually brief turns frequently include partial repetitions of the healer’s speech and tend to affirm the assertions she makes. Given this participation from clients, healers are able to tailor their emergent descriptions to emphasize those issues that clients convey from moment to moment are important to them. The following excerpt illustrates how these features of repetition and parallelism contribute to the characterization of a symptom in

ways that reflect both the healer's and her client's contributions.

Example 6.4

- 20 HEALER *y se siente cansado,
and he feels tired,*
- 21 *se siente como que ha caminado mucho.
he feels like he has walked a lot.*
- 22 MOTHER *mucho.
A lot.*
- 23 HEALER *maltrata'o.
worn out.*
- 24 MOTHER *maltrata'o.
worn out.*

In this excerpt, Lorena elaborates on Fernando's experience of tiredness. She begins with the simple statement that the youth "feels tired" (line 20) and then elaborates in a second clause by giving an evocative description of the tiredness as "like" the fatigue from having walked a lot (line 21). She begins this second clause with a repetition of the phrase "he feels," which links it to the first clause and emphasizes the sensorial quality of Fernando's fatigue. In response, Ximena echoes the final word of Lorena's phrase, *mucho* "a lot" (line 22). And, given this affirmative response from Ximena, Lorena elaborates even further on the quality of Fernando's tiredness with the word *maltratado*, which translates literally as 'mistreated' but is used idiomatically in the region to express the sensation of being worn out from work or other physical exertion. Again, Ximena repeats Lorena's descriptor, even stylistically converging with Lorena's pronunciation with the dropped intervocalic stop in the final syllable of the word, *maltrata'o*. Through her repetitions, Ximena actively contributes to the construction of tiredness as a salient symptom of Fernando's illness and, in doing so, lends authority to the claim that Lorena is making about her son.

Immediately after this sequence in which Ximena actively participated, Lorena launched into a description of another, tangentially related symptom of sleeping poorly. Over the course of this claim, Lorena again used repetition and elaboration through several clauses. This time, however, Ximena refrained from actively acknowledging or affirming the claims through several places when it would have been relevant for her to do so.

Example 6.5

25 HEALER .hh tambien no está durmiendo bien.
 .hh also he is not sleeping well.

26 ahora ultimo no está durmiendo bien.
 now lately he is not sleeping well.

27 Casi decir que no duerme bie- no duerme.
 Almost to say he doesn't sleep we- he doesn't sleep.

28 Duerme por capito.
 He sleeps in spurts.

29 MOM Si.
 Yes.

30 HEALER se asusta, .hh siente dolor, se ahoga,
 he startles, .hh feels pain, feels short of breath,

In this part of the pronouncement, Lorena proposes that Fernando sleeps poorly. Over three clauses she uses slight modifications to repeat this symptom (lines 25-27). When none of these phrasings is met with a verbal response from her clients, Lorena modifies her claim even further to say that Fernando “sleeps in spurts” (line 28). Finally, Ximena responds to this assertion with a clear affirmation, “yes” (line 29). And it is upon receiving this affirmation that Lorena moves to posit a different kind of symptom, returning in line 30 to the kind of rapid-fire symptom list with which she began the pronouncement. What is important to note here is that when clients do not respond to a posited symptom, the healer has several resources at her disposal to solicit an affirmative response or at least an acknowledgement. Here, she slightly revised her claim

multiple times until Ximena supplied an acknowledgement. This kind of pursuit is valuable to Lorena as a way to secure clients' verbal and public acknowledgement of the claims she makes. Over the course of an entire pronouncement, these sorts of acknowledgements from the client cement Lorena's felicitous performance of empathic insight into the patient's multiple problems and give the overall impression that the pronouncement reflected the opinions of her clients as well.

6.3.5 The Sedimentation of Evidence across Multiple *Pelotun*

Another important way that *lawentuchefe* Lorena was able to persuade clients of certain interpretations of their illnesses was a gradual approach of building up a particular view of an ailment over multiple visits. In this section, I trace the development of a particular symptom, *memoria* 'memory', and the diagnosis of *trafentun* to which it was related over multiple consultations. The presentation of excerpts from several sequential consultations demonstrates the persuasive power of consistently framing illness in a particular way. The presentation of this data also demonstrates the effectiveness with which *lawentuchefe* Lorena attended to the concerns or hypotheses that her clients proffered and wove them into her own descriptions of patients' ailments such that they were ultimately construable as discoveries that she had made through empathic insight. The case in point involves Lorena's diagnosis of Daniel with *trafentun*, a supernatural Mapuche illness, and traces the ways that Daniel and his parents variably oriented to this diagnostic possibility from the beginning of Daniel's care and over three months during which he was under *lawentuchefe* Lorena's care.

It was a rainy Spring day when Marta and her husband, Ernesto first traveled to consult with *lawentuchefe* Lorena. It required a series of three buses to bring them from their home in the rural foothills of the Araucanian Andes, where they farmed under the shadow of one of Chile's

most active volcanoes. The family generated income from Ernesto's seasonal labor and the sale of Marta's garden produce. They made the trip to consult with Lorena because Daniel had been suffering from "strange" symptoms for about six months. In their interview with me before they met Healer Lorena, Marta explained that Daniel experienced sharp pain in his side that a Western doctor had suggested might be "*el principio de vesícula*" 'the beginning of gall bladder' (a vernacular term associated with the biomedical ailment of gall stones), but nothing had been detected with lab tests. In addition, an episode had occurred where Daniel had suddenly run out of the family home "like a crazy person" and fainted at around 10 o'clock one morning. Following this occurrence, the boy continued to have pains and would sometimes speak in ways that, according to Marta, were not natural.

Marta reported that following on this episode, the family had consulted with a *machi*, who had divined that Daniel "*se topó con algun espíritu malo que andaba suelto. Y él, como era un niño, está muy indefenso. Entonces lo atacó por su lado.*" '[Daniel] encountered some bad spirit that was loose. And he[Daniel], because he was a boy, is very defenseless. So it[the spirit] attacked him[Daniel] on his side'. Marta's account, which is framed as a report of another healer's *pelotun*, describes an incident that in some ways parallels that of Machi Nora, who became sick after angering a *ngen* keeper spirit. In Daniel's case, the etiologically significant event was a chance encounter with a *wekufe* 'malevolent spirit' that was able to successfully attack him because children are constitutionally vulnerable. The event was a *trafentun*, sometimes referred to as *topantun* (Citarella et al. 2000; Oyarce 1989). Both terms literally mean 'an encounter', the former formed with the Mapudungun verbal root *traf-* and the latter derived from the Spanish verb *toparse* 'to run into' or 'to meet by chance'. Notably, the terms are polysemous, referring both to the triggering event and the illness resulting from it. Though

symptoms and signs of *wekufe kutran* can vary, Citarella and colleagues (2000) note that sufferers may experience, in addition to *trafentun* encounters, *perimontun* ‘visions’, *pewma* ‘dreams’, and *ñiwiñ* ‘disorientation or confusion’. While Marta did not note any of these latter problems in her conversation with me, they emerged as important over the course of Daniel’s treatment with *lawentuchefe* Lorena.

Immediately following the interview in which Marta recounted her own and the machi’s illness accounts to me, she and her husband had their first consultation with *lawentuchefe* Lorena. Lorena described a complex set of discomforts that she attributed to several different problems. Finally, moving both to close the *pelotun* and to solicit feedback from her clients, Lorena said to Ernesto, “*Eso le encuentro yo en este momento. No se si eso lo que siente su niño, chachay*” ‘That is what I find in this moment. I don’t know if that is what your boy feels, sir’. She closed with the Mapudungun address term *chachay*, emphasizing her client’s shared self-identification as Mapuche. Marta and Ernesto confirmed in Mapudungun that Lorena’s account was, indeed, accurate. But later, while the healer annotated the details of Daniel’s case in her notebook, Ernesto posed a question to her, “*Ngelay trafentun entonces*” ‘There isn’t trafentun then?’ Lorena affirmed that yes, Daniel had *trafentun* and that she had coincidentally brought an herbal remedy that was appropriate for its cure. Shortly after, Ernesto posed another candidate diagnosis in an almost parallel grammatical form, “*Vesícula ngelay entonces?*” ‘There isn’t gall bladder then?’ In response to this suggestion, Lorena hesitated, admitting the possibility and saying that she would have to see when they brought the boy for a consultation in person.

Given that Marta had mentioned both of these candidate explanatory models, *trafentun* and *vesicula*, in the ethnographic interview that preceded the consultation and that she indicated that they were the diagnoses that had been suggested by two previous medical practitioners with

whom Marta and Ernesto had consulted, Ernesto's questions to Lorena can be interpreted as an effort to solicit a second opinion that would either corroborate or cast doubt on one or both of these plausible diagnoses that had been proffered by other medical practitioners. Over the course of subsequent consultations with Lorena, the possibility that Daniel was suffering from *trafentun* was transformed from a tentative hypothesis that Ernesto proffered into an authoritative diagnosis for which Healer Lorena was able to claim authorship in the iterative redefinition of the youth's state over the course of the healing process.

When Daniel came for his first consultation with *lawentuchefe* Lorena, among numerous other symptoms, Lorena posited that Daniel suffered from memory problems and that he found it difficult to concentrate.

Example 6.6

51	HEALER	Y tambien, <i>And also,</i>
52		(1.5)
53		La memoria. De repente te afecta. <i>Memory. On occasion it affects you.</i>
54		(1.0)
55		Como que te cuesta concentrarte. <i>Like it's hard for you to concentrate.</i>
56		(0.6)
57		Ultimamente. <i>Recently.</i>
58	Patient	((nods slightly))
59	Healer	Y a veces, te duele el pecho tambien. <i>And sometimes, your chest hurts too.</i>

On this occasion, when *lawentuchefe* Lorena first suggested to Daniel that he was suffering from memory and concentration problems, the youth provided little uptake. He

withheld any sign of alignment through two gaps in the talk when it would have been appropriate to respond (lines 4 and 6) and signaled only a weak acknowledgement with a slight nod (line 8) at the third such transition-relevance place (Schegloff 2007). Though Daniel did not display strong concurrence with these posited symptoms at the time, it was significant that Lorena had introduced them and Marta had heard them identified. At a subsequent consultation, Lorena reiterated to Marta that Daniel's memory was affected by the illnesses he was suffering and, aligning with this assessment, Marta recounted that Daniel had recently misplaced the family's cellular phone, an occurrence that the healer framed as congruent with the youth's general state of agitation.

On a later date, the issue of Daniel's impaired memory emerged again and was more difficult for him to refute.

Example 6.7



- 39 HEALER ((looks up from patient's wrist to mother))
Tambien teni:a ciertamente un trafentun.
Also he certainly had a trafentun.
- 40 MOTHER ((nods))
- 41 HEALER Y eso le ha ido mal.
And that has gone badly for him.
- 42 MOTHER Myah.
Okay.



43 HEALER ((leans toward and shifts gaze to patient))
A veces s- sintiai mie:do.
Sometimes [you] f- feel fear.

44 PATIENT ((nods))

45 HEALER A veces como que se te olvida.
Sometimes [it's] like you forget.



46 PATIENT Si.
Yes.

47 HEALER Y de repe:nte, le pasa asi. Pero
And on occasion, it happens to him thus. But

48 ((shakes head at 'no es seguido'))
ahora, no es seguido. De repente todavia te senti
It's not frequent. On occasion still you feel

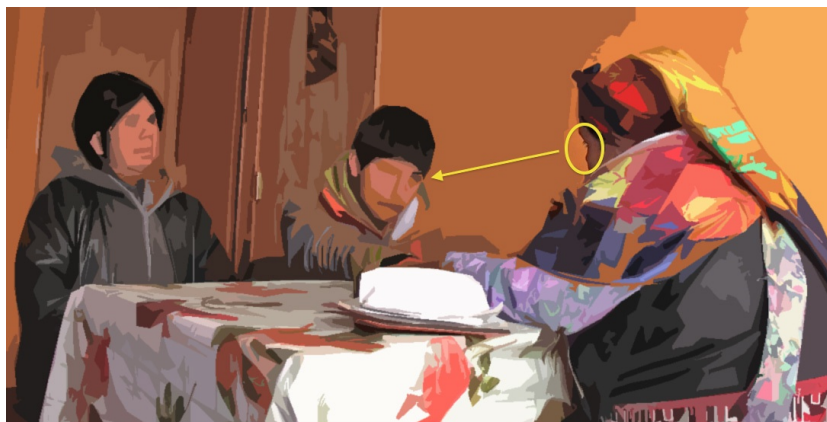
49 miedo.
afraid.

50 MOTHER Si. S'asusta harto.
Yes. He gets afraid a lot.

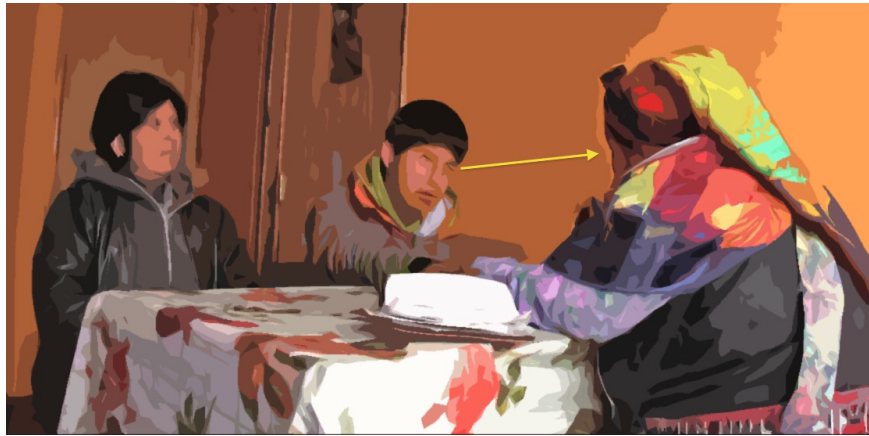
In this sequence, Lorena, Marta, and Daniel all contributed to a portrayal of Daniel as forgetful and fearful. First, before mentioning the relevant symptoms, the healer introduced the diagnosis itself, addressing Marta, “Also he certainly had a *trafentun*” (line 1). This identification of the supernatural illness category that had come up at the first appointment, six weeks earlier, framed Lorena’s subsequent description of memory and fear symptoms as related to and, in fact, evidence for the diagnosis. Her framing of the symptoms as occurring “*a veces*” and “*de repente*” followed her standard for describing illness in terms of lived time such that her interlocutors could interpret the recurrence of the symptoms independently.

Shortly after this exchange, Daniel explicitly denied having had a particular illness experience that Lorena identified (Example 6.8). The healer asserted that in a dream, Daniel was offered and ate food. In response to this assertion, Daniel issued an unmitigated rejection. This direct differentiation of healer and patient accounts led to an exchange in which Lorena defended her assertion and bolstered her claim that Daniel was, indeed, suffering from *trafentun*.

Example 6.8



- 61 HEALER ((shifts gaze from mother to patient))
 Ha tenido sueño(h) (). Te dan comida. Comí
 You’ve had dream(s) (). They give you food. You eat
- 62 comida en el sueño.
 food in the dream.
- 63 (0.5)



64 PATIENT

No.

65 HEALER

No te ha(h) dado cuenta_
You haven't realized_

66 PATIENT

No. ((shakes head))



67 PATIENT
 HEALER

((looking away))

((looks down toward patient's wrist))

Aqui sale que (asustado) que (por) que
Here [it] comes out (afraid) that (because)

68

te dan comida (.) comida asi (.) (como) normal (.)
they give you food (.) food like (.) (like) normal (.)

69

en tus sueños.
in your dreams.

70

(1.0)



71 PATIENT ((Still looking away))

'Seh
Yeah

72 HEALER

Si. No debeh acordarte. () asi memoria hijo.
Yes. You must not remember. () that's memory, son.

73

(Sonyai asi) Comi comida asi: (.) como
(You dream like) You eat food like (.) like

74

normal. Como que: (.) eh- esta(ba) asi en
normal. Like as if (.) uh- you were in



75

la vida directa. (En/eh) un sueño.
direct life. (In/It's) a dream.

In this exchange, Lorena asserts that Daniel has dreamed about accepting food from someone. Following on her assertion that he was suffering from *trafentun*, it is possible to interpret this dream sequence as the etiologically significant instance of *trafentun* encounter itself. Mapuche cosmology holds that oneiric events, though they are experienced by the *am* 'soul' of a person rather than the whole person, are real experiences and a common site of encounter and

communication between human beings and supernatural forces, both malignant and benign (Degarro 1989).

When Daniel pressed back against Lorena's assertion by denying that such a dream had taken place (lines 4, 6), Lorena challenged her patient's epistemic privilege over this particular autobiographical knowledge. Lorena's assertions at this juncture that Daniel was unaware of the dream (line 5) or that he was unable to remember it (line 12) gained explanatory strength and authority from anaphoric reference to earlier mentions of Daniel's lack of concentration and his forgetfulness both in this consultation and in previous *pelotun* for him. These multiple, repeated renderings of Daniel as forgetful over the course of several consultations had built up a sedimentation of evidence such that the healer was now able to treat his forgetfulness as an indisputable fact.

At the same time that Daniel's talk was treated as unreliable, he was framed as communicating in another, unintentional but more reliable, way through his pulse. Lorena indexed the authoritativeness of her account of the youth's dream by drawing attention to the source of her knowledge in Daniel's body, glancing down at his wrist in her hands as she said "*aquí sale que*" 'here [it] comes out', a vernacular phrasing in Chilean Spanish that is used synonymously to "*aquí dice que*" 'here it says' as an unmarked way to preface the reading aloud of a written text. The analogy in this case was that Lorena was reading the true story of an oneiric *trafentun* encounter straight from her patient's body.

This last sequence demonstrates how authoritative knowledge in the Mapuche medical context extends beyond knowledge of illness processes and into illness experience itself. Daniel's epistemic privilege as the first-hand 'knower' of his own dream experience was challenged. It was Daniel's very ability to recollect and to know his own experience of an

etiologically consequential event that was brought into doubt by the healer, who claimed to have more accurate knowledge of the experience in question than did the patient himself. In the end, the diagnosis of a traditional, supernatural illness in Daniel's case was afforded by the truncation of his opportunities for telling his own illness experience and by the healer's repeated insistence on a symptom over time. Ultimately, Daniel was denied the prerogative to assert the validity of his own biographical memory by the healer's assertion of an authoritative "reading" of his body.

6.4 Conclusion

This chapter has demonstrated multiple key features of *pelotun* pronouncements that facilitate their persuasiveness. Through the presentation and analysis of multiple excerpts from pronouncements that Healer Lorena provided for patients Fernando and Daniel, I have attempted to show that the *pelotun* genre is designed to demonstrate healers' empathic gift of perception and to create rich portrayals of illness experience that clients can embrace as valuable and true. Factors that support the tenability of healers' pronouncements include a widespread cultural imperative for clients to have a disposition of *fe* or belief in the practitioners with whom they seek help. Patients orient to the obligation they have to have faith in the healer's ability to perceive and treat their ailments. In addition, clients professed their interest in receiving a novel interpretation of illness from the healer that would differ from the explanations they have received from Western doctors. Several interactional and textual features of the *pelotun* genre contribute to the plausibility and provocativeness of healers' illness accounts. These features are: a high density of assertions made in a short period of time, the representation of illness processes in terms of lived time, repetition, parallel structure, and the incremental modification of healers' claims from moment to moment in response to clients' actions during the *pelotun*, and the reiteration of symptoms or diagnoses over sequential consultations, which provides for a certain

sedimentation of a claim such that it becomes difficult to deny. In sum, both the design and the cultural context of *pelotun* pronouncements contribute to the construction of illness accounts that are construable as comprehensive and accurate portraits of a patient's health that the healer has intuited and that the clients have not had to describe.

Chapter Seven

TIME DISCIPLINE AND PRESENTING CONCERNS IN PRIMARY CARE

7.1 Introduction

Late one morning in July, Señora Juana arrived to join two of her sons in the Makewe PCC waiting room after receiving shots in the adjacent building to alleviate the chronic pain she suffered in her hands. I had given Señora Juana a lift earlier in the week when I saw her walking under a heavy drizzle, and she recognized me right away. While she and her sons waited to be called by the doctor, Señora Juana chatted with me, sharing that years of knitting and laundering clothes to earn money had left her with crippling arthritic pain in her hands. The pain made it extremely difficult for her to keep up with the needs of her household. She lamented that she could no longer knead bread or wash dishes and had to oblige her youngest son, Yordan, to do these chores, which in Makewe were regarded as women's work. Perhaps Yordan would have preferred to be working with his father and older brother, Camilo, I thought to myself. Before his mother had arrived in the waiting room, Camilo had been boasting that he was quitting high school in order to work. When I asked what work he would do, he told me he was already working *en el campo* 'in the countryside' with his father. The two of them were building a house, but with the recent rains they hadn't been able to make much progress.

Later that morning, after Señora Juana, Yordan, and Camilo had seen the doctor and set off for home, Doctor Emilia sought me out. Clearly exasperated, she told me that Señora Juana's sons had not attended school in weeks. The elder had not attended since sometime in April. Calling the family's complaints of gastroenteritis and the mother's joint pain, "no excuse" for missing so much school, Doctor Emilia told me she had refused to provide the customary *certificado médico* that would be needed to excuse their absences. Knowing that I visited some

of the families who came for care at the PCC, Doctor Emilia implored me to press Señora Juana to send her sons to school. She went on, opining that these youth should minimally be able to finish high school, even if it be in a vocational program. She concluded with a loaded observation, “*Si no completan su educacion, ¿que futuro les espera? ¡Trabajar en el campo no mas!*” (If they don’t complete their education, what future awaits them? Nothing but work in the countryside!).

This case in which Señora Juana and her sons became the object of Doctor Emilia’s disapprobation illuminates one of the most pernicious ethnic stereotypes that circulates in the Araucanía, that of the Mapuche as backward and uncommitted to the Enlightenment ideals of education and self-improvement. This and other stereotypes about the rural Mapuche are part of an unacknowledged backdrop to the interactions between Mapuche families and the *wingka* (non-indigenous) physicians who treat them at the Makewe PCC. In this particular case, Camilo’s leaving school was viewed differently by Camilo and by Doctor Emilia. They both referred to his future of *trabajo en el campo* ‘work in the countryside’ but attached to it very different values. For Camilo, beginning *trabajo en el campo* was a positive step in his life. He referred to his leaving high school with pride. The transition signaled his movement from the world of children to the world of men. And the fact that the work he would be doing was with his father reflected positively on his commitment to the livelihood of his family. For Doctor Emilia, by contrast, formal education constituted the only chance that rural Mapuche children had of escaping poverty. But in Makewe, concerns to this effect are not so simple. Here, where rurality is emblematically tied to indigeneity (McFall 1998), when people express concern that Mapuche children find a way out of the *campo*, their comments are also construable as mandates for their cultural assimilation into Chilean society and their participation in the market economy.

In a study that identified stereotypes about the Mapuche in the speech of non-indigenous residents of Temuco, Merino and her colleagues (2009) found that the most widespread prejudice was a perception that the Mapuche had “failed to progress” as a culture and, as a result, that they were holding back the progress of Chile. The dominance of this particular stereotype is not surprising. Stuchlik (1974) observes that beginning in the 1960s, the dominant image of the Mapuche was that of “*salvajes gentiles, a los que falta solo la educación*” ‘gentle savages in need only of education’. And the roots of this stereotype have been traced back as early as the era of forced settlement on the *reducciones*, when the Chilean state disseminated the image of the “uncivilized and uneducated Indian” (Merino and Quilaqueo 2003) as part of a campaign to resettle the southern territories with European and *criollo* agriculturalists. While the 1960s perception of the Mapuche as constitutionally gentle has given way to one that portrays them as prone to violence (Merino et al. 2009), the notion that the Mapuche are uneducated and that this is the reason for their continued poverty and marginalization has proved very durable. In light of these enduring ideas about the Mapuche, it is also not surprising that Doctor Emilia told to me in an interview at the end of the research period that she considered her primary responsibility to her patients to be one of education. Most of the time, pervasive Chilean stereotypes about the Mapuche recede into the background as families and doctors attend to the pressing work of caring for sick children at the Makewe PCC. But occasionally they erupt into the foreground when conflicts about children’s care arise.

This chapter explores one facet of children’s medical care for which parents were accountable at the primary care center, the timeliness of acute care visits, and develops the argument that this issue was closely tied to a larger cultural imperative for the Mapuche to develop the kind of time discipline that is associated with industrial capitalism. I document how

parents and clinicians alike oriented to the importance of giving detailed information about the timing of illness in the course of presenting concerns at the beginning of acute consultations. Multiple examples illustrate that the generic norm for representing time in this setting is in terms of calendric units: days, weeks, months. I argue that this kind of time reckoning in parents' descriptions of their children's illnesses afforded clinicians the necessary information for monitoring the amount of time that had elapsed between the beginning of an illness and the medical appointment. This monitoring was tied to normative expectations regarding what was an appropriate window of time to bring sick children to the doctor. The latter part of the chapter addresses what occurred when the timing of children's appointments exceeded these (usually unspoken) institutional norms. The last example of the chapter is from Yordan's consultation with Doctor Emilia. The analysis of the problem presentation from this consultation demonstrates the social consequences that resulted when Señora Juana represented the duration of Yordan's symptoms and the timing of his medical appointment in ways that diverged from normative expectations in this setting. At the conclusion of the chapter, I discuss the interactional conflict that ensued and consider how conflicts of this sort reinforce negative stereotypes about the Mapuche. I suggest that the issue of calendar time discipline in children's medical appointments exemplifies the kind of work discipline that E. P. Thompson described as a change ushered in by the Industrial Revolution in London.

7.2 Acute Care and the Onus of Timely Doctor Visits

Primary care medical services in Makewe, and in Chile more generally, are designed to be the first resort of the sick in cases that are not medical emergencies. This model of primary care is organized as the most basic "level of community-based medical services" (Stoeckle 2009) where patients have their "first contact" with medical practitioners. This institutional model is

consequential for the expectations that physicians have for the kinds of problems patients and their caregivers will present during appointments. Most of the complaints physicians address involve quotidian health problems that have recently become manifest, viral and bacterial infections being the most common. The medical treatments physicians routinely dispense in these cases include over the counter medications, including acetaminophen and antihistamines, and antibiotics. These therapeutic measures presume an episodic model of illness, where symptoms emerge and are resolved within a short period of time. Heritage and Robinson (2006a) have described these sorts of medical problems as “routine acute” cases and describe them as “most often mild, self-limiting, and of short duration” (76). At the Makewe medical center, cases that do not conform to this general pattern include patients who arrive with serious injuries or an advanced stage of disease. These patients are taken by ambulance to the regional hospital. Patients dealing with chronic illnesses are scheduled predictably on two afternoons in the week. This means that doctors at the medical center can reasonably expect that patients entering their consultation room during most of the work week are presenting a new health problem that has emerged very recently.

When children in Makewe become sick, their parents are faced with decisions concerning how to care for them at home as well the responsibility of assessing if and when they should take their children to the medical center to see a doctor. This decision is what Halkowski (2006) has referred to as “the patient’s problem.” Patients or their parents are expected to know not only *what signs of illness* merit a visit to the doctor but *how soon* they require professional medical assistance. These assessments also involve balancing the two main obligations that Parsons (1951) ascribed to the sick role: trying to get well and seeking appropriate medical assistance. In light of these obligations, patients often explain their illnesses to physicians in ways that make a

case for the doctorability of their problems (Heritage and Robinson 2006). In other words, they organize their illness accounts so as to demonstrate that their symptoms warrant medical attention. Patients may allude to home care measures they have taken or may narrate the trajectory of an illness in ways that show that they are sufficiently but not excessively attentive to their bodies. Patients may find ways to convey to practitioners that they have come to see the doctor in a timely fashion. This is especially crucial for parents during pediatric visits because children cannot seek medical care alone and rely on their adult caregivers to do so on their behalf.

The presentation of data that follows demonstrates how this obligation to seek medical attention in a timely fashion shapes the ways that parents and pediatric patients report illnesses to doctors at the Makewe primary care center. An analysis of multiple complaints reveals that parents, patients, and practitioners alike oriented to an expectation that sick children be brought to the medical center very quickly after symptoms appeared, usually within the space of a few days. Parents and patients accounted for the recency of children's symptoms when presenting their concerns by indicating the timing of the onset of symptoms in terms of calendric time. This standard for time measurement contrasts with the orientation in Mapuche healing to lived time. The affordance of framing children's illnesses in terms of calendar time is an objective measurement of the duration of children's illnesses.

7.3 Calendar Time and Felicitous Complaints

When doctors solicited the reason for acute visits, parents typically responded with accounts that were very concise. They indicated a specific moment in time when signs of the child's illness first became apparent, and the number of problems they identified were generally few. Most of the health problems that were presented had emerged a very short time before the

appointment. Some accounts referenced the timing of the symptoms using deictic temporal adverbs. The following excerpt illustrates this kind of time framing.

Example 7.1

- 01 DOCTOR Ya. El Samuel entonces. (.) Cuente no mas. Qué
Okay. [ART] Samuel then. (.) Just tell me. What's
- 02 le pasa a su bebe.
happening to your baby.
- 03 → MOTHER El Carlos, esta con una tos:, eh ayer del- del
[ART] Carlos is with a cough, um yesterday from- from
- 04 jardin volvio asi como decai:do.
preschool he returned like unanimated.
- 05 DOCTOR Ya.
Okay.
- 06 MOTHER Y en la noche estuvo con mucha: mucha tos: [y
And at night he had a lot- a lot of cough [and
- 07 DOCTOR [Ya.
[Okay.
- 08 Pero la tos sequii:ta? o tos como con desgarrro.
But dry[DIM] cough? Or cough like with phlegm.

In this case from Samuel Carlos' (5 y.o.) consultation, the patient's mother, Antonia, used the temporal deictic *ayer* 'yesterday' to anchor the first sign of her son's illness in the very recent past. About these kinds of deictics (e.g. tomorrow, yesterday), Hernández notes that they correspond to the conventional measure of the solar cycle and are reckoned with respect not to *ahora* 'now' but *hoy* 'today'. When they are used, deictics of this variety convey an orientation to chronological rather than lived time. Thus by describing Carlos' symptoms as having begun yesterday and become worse in the night, Antonia provided the doctor with an objective, socially interpretable timeline with which to understand how the symptoms had progressed.

In the following example, another mother began her account by indicating the amount of time that had elapsed since her 3-year-old daughter fell ill.

Example 7.2

- 09 DOCTOR La Barbara entonces. [Cuentame que
The Barbara then. Tell me what
- 10 MOTHER [Si.
Yes.
- 11 DOCTOR le pasa a su chiquitita?
is happening to your little one?
- 12 → MOTHER Es que hace tres- como tres dias, esta con- con
It's that for three- like three days, she's with- with
- 13 harta tos. Una tos seca. Y dice que aqui
a lot of cough A dry cough and she says that here
- 14 le duele.
hurts her.
- 15 DOCTOR Le duele la gargantita. Fiebre ha tenido
Her throat hurts. Has she had fever
- 16 en la casa o no?
at home or not?

In this case, Barbara's mother prefaced her account of Barbara's cough and sore throat by specifying, "for three- like three days." This phrase, which also reckons in terms of days, indicated to the doctor exactly how long Barbara had been sick prior to her appointment.

A third example illustrates how parents sometimes referenced a day of the week to the same effect of indicating the duration of an illness in terms of days. This excerpt is taken from a consultation for a 12 y.o. girl that occurred on a Friday morning.

Example 7.3

- 05 DOCTOR Ya. >Y que le pasó a la Magdalena.< Cue:nteme.=
Okay. And what happened to [ART] Magdalena. Tell me.=
- 06 → MOTHER =La Magdalena esta resfria'a. O se'que: el: dia:m-
=The Magdalena has a cold. That is tha:t the: da:y W-
- 07 → mie:rcoles en la noche?
We:dnesday night?

- 08 DOCTOR Ya,
Okay,
- 09 MOTHER Eh le dolia la cabe::za: (.) estaba con ha:rta to:h
Uh her head hurt (.) she had a lot of cough
- 10 le dolia el pe:cho.
her chest hurt.
- 11 DOCTOR Mya. Fiebre ha teni'o? o no,
Okay. Has she had a fever or not?

In this case, Magdalena's mother began her account with a candidate diagnosis (Stivers 2002) "Magdalena has a cold," which she immediately clarified with the time reference "the day w-Wednesday night?" (lines 6-7) and then a list of three symptoms that provided evidence for why she believed her daughter had a cold. The physician responded to this list of symptoms as a move to close the problem presentation, marking receipt of the mother's account '*Mya*' and then inquiring whether the girl had had a fever (line 11). Again in this case, the mother indicated very early in the account the precise day when her daughter's illness became manifest. In this instance, however, she made a reference to the name of the day of the week. This calendric reference functions similarly to phrases like "for three days" in the sense that it provides the doctor with an objectively verifiable measure of how many days of illness have elapsed. Both reckon in terms of projecting back in time from the shared orientation of 'today'.

All of the parents in the sequences presented above demonstrated a certain savvy with regard to normative expectations for the explanation of ailments in acute primary care appointments. They presented their concerns about their children in ways that framed symptoms with an objective, socially interpretable timeframe. The intervals they indicated between the onset of symptoms and the day of the appointment were all appropriate for the expectations of acute pediatric care and, as such, went unquestioned by the physicians. The sorts of temporal deictic references parents used ensured that clinicians would understand exactly when children's

illnesses had become noticeable. The following example is from an acute appointment for Oscar (7 y.o.), who was diagnosed with an ear infection. When Oscar’s mother, Amanda, initially neglected to indicate the timing of the onset of her son’s complaint, she quickly self-corrected to add this information at the end of her account, treating this as information that needed to be included.

Example 7.4

01 DOCTOR Ya. Entonces, el Oscar. Cuénteme no mas
Okay. Then, the Oscar. Just tell me

02 que le pasa a su chiqui[tito].
What’s happening to your little one.

03 MOTHER [Sabe que en la noche-
You know at night-

04 → que anda con dolor de oido. O sea anoche empezo.
he’s with ear pain. That is last night it started.

05 DOCTOR Ya?
Okay?

06 MOTHER Y:::-
A:::nd-

07 DOCTOR Y habia 'stado con fie:bre. alguna cosa no no?
And had he been with fever, something or not?

When Oscar’s mother, Amanda, described her son’s ear pain, she initially did so using the adverbial phrase “at night” (line 3) and the present tense in “he’s with ear pain” (line 4). While this account conveys a clearly doctorable problem, it also fails to indicate when the symptoms of the illness began. Orienting to the obligation to provide this information, Amanda used the idiomatic Chilean phrase *o sea* ‘that is’ to preface the information that her son’s ear pain had begun the prior night (line 4). In response, the doctor provided a minimal acknowledgement “ya?” (line 5) that provided Amanda an opportunity to elaborate in greater detail, but when Amanda failed to introduce more information (line 6), the doctor reclaimed the floor to begin

information gathering. The doctor's standard question about fever at this point treated Amanda's explanation as sufficient.

At the Makewe primary care center, there was no protocol ensuring that patients saw the same physician from one visit to the next. Thus, when parents brought children for follow-up appointments, the onus was on them to clarify that this was the nature of the visit to the doctor. They generally conveyed this information immediately following physicians' solicitation of the reason for the visit. The accounts parents and patients provided at the beginning of follow-up visits reveal that they accounted for the time frame since the initial appointment, rather than from the onset of symptoms. The following excerpt exemplifies this time orientation. In this consultation, the physician addressed Ruth (11 y.o.) to ask what brought her to the doctor.

Example 7.5

- 01 DOCTOR Que te pasó Ruth. Cuéntame no mas.
What happened to you Ruth. Just tell me.
- 02 → PATIENT (No eh) que el- el lunes vine a con-
(No it's) that on- on Monday I came for an app-
- 03 a medico? y me ('ncontraron) bronquiti.
to the doctor? And they (found) I had bronchitis.
- 04 DOCTOR Ah te di- ya. Esa vez viste la doctora Milan?
Oh they sa- okay. That time you saw Doctora Milan?

In this case the patient, Ruth, provided an account of her illness to the doctor herself, though she was in the company of her father, Samuel. What is notable is that Ruth refrained from mentioning anything about her symptoms, choosing instead to identify the diagnosis she had been given and the day when she had come to the PCC for the first time. In this way, she immediately communicated to the doctor that she was there for a follow-up visit, citing that she had come on Monday and been diagnosed with bronchitis. Notably, in this minimal account of the reason for her visit, Ruth took care to identify how long it had been since she saw the first

doctor.

The following example is from a consultation for Sofia, a six year old who was struggling with pain in her leg and a limp that had emerged following a sprained ankle and an operation. The complicated nature of Sofia's medical history with respect to her current problems of pain and gait posed a recurring dilemma for her mother, Inez, who had to repeatedly explain to different doctors the convoluted trajectory of the girl's problems. On one occasion, Inez shared with me that she herself did not have a clear understanding of what was wrong with her daughter because she had received conflicting and piecemeal information from the multiple generalists and specialists who had treated her daughter since the original accident when she sprained her ankle. On the occasion of the consultation from which the following excerpt is taken, Inez needed to ask the doctor to order a pair of children's crutches for Sofia. Earlier in the day, the staff kinesiologist at the PCC had recommended that she do so.

Example 7.6

01 DOCTOR La Sofia. Cuenteme no mas. que le pasa a
The Sofia. Just tell me. What's happening to

02 su chiquitita.
your little one.

03 → MOTHER Ella- la operaron en el mes de- de
She- they operated on her in the month of- of

04 → Enero.
January.

05 DOCTOR Ya.
Okay.

06 MOTHER Le-
To her-

07 DOCTOR Y los papelitos de-
And the papers from-

08 MOTHER Si. Incluso la traje a kinesiologa,
Yes. Also I brought her to [the] kinesiologist,

In this case where there was a complicated medical history that preceded Sofia's current problem, Inez chose to immediately inform the physician that her daughter had had an operation. Without indicating the reason for the procedure, Inez told the doctor only that it had occurred in January. Given that the present consultation was taking place in July, it is possible to interpret Inez's reference to the month (but not the date) of Sofia's operation, as a way of conveying to the doctor that the health problem at hand was one of long duration. In this case, Inez chose to emphasize the long duration of her daughter's health problems over all other relevant information that the doctor was eventually going to need in order to authorize a set of crutches for Sofia. Notably, in conveying that her daughter was facing a long-standing medical problem, the wording Inez chose "in the month of- of January" (line 3) aligned to the local institutional expectation that medical events be framed in terms of calendar time.

The examples presented thus far demonstrate that on the whole, Mapuche parents in this area have appropriated ways of talking about the timing of symptoms and sickness that fit Chilean medical models of routine acute illnesses. On the whole, parents bringing children to the Makewe primary care center were largely successful in describing the timing of childhood ailments in ways that were intelligible to clinicians. And on most occasions, clinicians diagnosed children's symptoms without many interactional hitches, identifying such common problems as bad colds, bronchitis, or pneumonia. In these cases, families were provisioned with appropriate medications, and patients were either sent home or hospitalized, as appropriate, to recuperate before returning to school. However, there were occasional cases that did not fit this pattern.

The remainder of the chapter presents evidence showing that on the rare occasions when parents delayed bringing children beyond the normative expectation of a few days, substantial interactional work was required for them to avoid appearing insufficiently attentive to their

children's well-being. The assessment of consultations as timely or untimely was afforded by the practice of describing the onset of symptoms in terms of calendar time. And because parents framed their children's illnesses as unfolding in terms of this objective time measure, clinicians were able to assess with precision exactly how long parents had waited to seek medical services. Parents and clinicians alike oriented to parents' responsibility for timely care and, in cases where parents had delayed their children's medical care, they treated the timing of the appointment as potentially problematic.

An excerpt from an appointment for Pamela (10 y.o.) illustrates how the timeliness of doctor visits sometimes arose in conversations between doctors and parents. On this occasion, Pamela was recovering from an ear infection and came to the primary care center for a follow-up appointment after a weekend visit to the emergency room in Temuco. Earlier in the appointment, Camila, Pamela's mother, confirmed for Doctor Teresa that blood had come from Pamela's ear. When Doctor Teresa began her physical examination by looking into Pamela's ear, she quietly exclaimed in a sympathetic voice, "*A:::y pobrecita*" 'Oh::: poor thing'. When she concluded her examination and was returning to her desk, Camila launched into an elaborate narrative in which she accounted for why she and her husband had delayed taking their daughter for medical care in the first place. The following excerpt is of Camila's volunteered account.

Example 7.8

45 MOTHER De primero lo habia manejado no mas. Porque mi marido
 At first I had just managed it. Because my husband

46 fue a preguntar a su mama? Que- lo habia dicho que
 went to ask his mom? That- she had told him that

47 su hermano menor tambien le habia pasado lo mismo
 the same thing had happened to his younger brother

48 antes. Asi que habiamos quedado con eso (y mi marido
 before. So we had stuck with that (and my husband

49 seguia insistiendo) que asi le pasaba a los niños
kept insisting) that it happened thus to children

50 antes. Lo- gente mas antigua. Y entonces yo
before. The- people from the old times. And then I

51 le dije- despues al final (marido no). Estaba
told him- afterward at the end (husband). I was

52 enfe::rma yo igual po' con fiebre. y to'via 'stoy asi.
si:::ck too with fever. And I am still.

53 DOCTOR Mm.

54 MOTHER Y tambien saqué hora para eso. Y entonces
And I got an appointment for that too. And then

55 le dije: pucha (.) Bueno vai a llevarla
I said to him shoot (.) Well are you going to take her

56 o no le dije yo porque entonces yo voy a contratar
or not I said to him because then I'm going to hire

57 auto para poder llevarla la niña. Y allí
a car to be able to take the girl. And there

58 se encontró apurado el. Fue a buscar
he felt pressured. He went to look for

59 su hermano. Entonces (yo la voy a) llevar
his brother. Then (I'm going to) take her

60 entonces dijo. Oy que la niña estaba
then he said. Ay it's that the girl was doing

61 mal po.
really poorly.

Following on Pamela's physical examination, in which the doctor voiced sympathy for the state the girl was in, Camila produced this involved story that described her and her husband's reason for delaying taking their daughter to see a doctor. Camila began by stating that early on, she just "managed" the illness, conveying in vague terms that she cared for her daughter at home. The reason she gave for doing so was that her mother-in-law had informed them that *lo mismo* "the same" (a reference to blood coming from the ear) happened to children in the past, to "*lo- gente mas antigua*" "The- people from the old times" (line 50). This reference to the old times indexes

an historical era when there was less regular contact between Mapuche and Chileans, the period before Western illnesses arrived and before Western medicine was available. This historical framing of the symptom implicitly categorizes the health problem as *mapuche kutran* ‘mapuche illness’ rather than *wingka kutran* ‘foreigner illness’. And as such, the presumption was that the problem should not require *wingka lawen* ‘foreigner medicine’ (i.e. Western medicine) for a cure. Camila indicated that this was the reasoning the family followed at first, delaying their eventual visit to the emergency room. Notably, Camila framed herself as the parent who ultimately took seek medical care for her daughter. She described herself, reasoning through a fog of fever, pressing her husband to take their daughter to the doctor and threatening to spend money on a taxi if he wouldn’t find a way to take her himself.

Camila’s exculpatory narrative about the family’s delay in taking an obviously sick child to see a doctor identifies two reasons for the decision. First, Camila explained a reasoning process from which she distanced herself personally, attributing it to her mother-in-law and husband. She referenced, albeit somewhat obliquely, Mapuche medical knowledge that differentiates between indigenous and Western ailments and the related logic that holds that each kind of illness requires treatment in the respective medical system or, at least, that illnesses that existed prior to contact should not require Western medicine to be resolved. Second, Camila indicated another, pragmatic obstacle to their seeking medical care, that of the difficulty of travel from their home to a medical facility. In describing how she leveraged a doctor visit for her daughter, Camila referred to the need for them to “*contratar auto*” ‘hire a car’ (lines 56-57) in order to get to a medical center. For a family of meager means, this would be no small expenditure. Indeed, I learned first-hand just how complicated doctor’s visits were for Camila’s family when I visited them at their home a week after this doctor appointment. In order to find

Camila's family's home, a staff member from the PCC had to accompany me and provide directions. The roads I took to reach the family's home were icy and extremely muddy, and the drive took more than half an hour. I learned later that travel for families in this area of Makewe was routinely difficult because virtually no bus routes passed within walking distance.

In the consultation on this day, Doctor Teresa did not directly address the timing of Pamela's medical treatment with Camila. As can be seen in the transcript above, she provided only minimal verbal acknowledgement to Camila midway through the story (line 53). But for the most part, Doctor Teresa did not orient to the story or the timing of Pamela's medical care as a matter of discussion. In fact, while Camila was telling the story, the doctor was occupied in filling out paperwork related to Pamela's case. And at the conclusion of Camila's narrative, Doctor Teresa did not provide a verbal response. Seven seconds of silence opened up before Camila spoke again, asking the doctor a question that was unrelated to the issue of Pamela's delayed medical care. Though Doctor Teresa did not orient to the timing of Pamela's first doctor visit as a problematic issue, or even one that merited discussion, Camila clearly did orient to the timing of her daughter's first consultation as potentially problematic by volunteering an explanation that was designed to exonerate herself from the appearance of being inadequately attentive to her daughter's medical needs. The section that follows presents a final case in which the clinician, rather than the patient's parent, treated the timing of a child's appointment as problematic.

7.4 A Problematic Account

The following consultation demonstrates a breakdown in communication where a mother failed to cast her son's illness in an acceptable way to the physician. When the mother and the boy jointly failed to produce a symptom account that conformed to the temporal and

symptomatic expectations for a doctorable illness episode, forward progress in the interaction stalled over several turns of talk.

Example 7.9

01 DOCTOR Ya. El Yordan. Que le paso a usted?
Okay. [ART] Yordan. What happened to you?



02 MOTHER Empezó con dolor de esto:mago,
It started with stomachache,

03 DOCTOR Ya:?
Okay?



04 MOTHER °Y que dijeron° ((addressed to Yordan))
And what did they say ()



05 DOCTOR Hace cuantos dias mas o menos q'estas con
Since how many days ago more or less are you with
06 dolor de güatita.
a stomachache.



07 PATIENT Eh: dos semanas.
Um two weeks.
08 DOCTOR Hace dos se[^]manas. Haz estado con vo:mitos(.)diarre:a,
Since two weeks [ago]. Have you had vomiting, diarrhea
09 con algo, o no.
something, or not.

In this case, Doctor Emilia elicited a problem presentation directly from Yordan, but it was Señora Juana who initially responded^{xvii}. However, after mentioning a first symptom of '*dolor de estomago*', Señora Juana's account began to founder when she could not remember some relevant information and turned to her son to ask *sotto voce*, "and what did they say"^{xviii} (Line 4). Before Yordan could answer, Doctor Emilia came in to explicitly solicit information about the

timing of the stomachache, "*Hace cuantos dias mas o menos q'estas con dolor de güatita*" "Since how many days ago more or less are you with a stomachache" (line 5). With this question, the doctor conveyed to Señora Juana and Yordan their obligation to describe the timing of symptoms. Notably, Doctor Emilia chose to immediately ask about the timing of the stomachache, rather than asking, for example, what other symptoms had appeared, even though Señora Juana's phrasing "It started with stomachache" clearly projected that there were subsequent symptoms. In response to the doctor's question, Yordan answered "Um: two weeks" (line 7); the hesitation marker at the beginning of his answer and his glance toward his mother suggests that he may have known this time frame was potentially problematic. And, in response, the doctor's stressed repetition of the phrase, "dos se[^]manas" and her follow up question, "have you had vomiting (.) diarrhea something, or not." (lines 8-9) imply that a stomachache of two weeks is not a doctorable problem in itself. This move can also be understood as an effort to make sense of Señora Juana's initial claim that the ailment *began* with stomachache, which entailed that some other issues followed.

As the conversation about Yordan's stomachache progressed, the fact that Yordan had missed quite a bit of school emerged. With this admission, the two week time lapse between the beginning of Yordan's stomachache and the present consultation became sanctionably problematic.

Example 7.10

08	DOCTOR	<i>Hace dos semanah. Haz estado con vo:mitos (.) diarre:a Since two weeks [ago]. Have you had vomiting diarrhea</i>
09		<i>con algo, o no. With something, or not.</i>
10	PATIENT	<i>Si. Yes.</i>

- 11 MOTHER [Con di-
[With di-
- 12 DOCTOR [Cualquier cosa.
[Anything.
- 13 MOTHER con diarrea estuvo. Y ya- y
He was with diarrhea. And okay- and



- 14 yo no le he mandado a- no lo mande a
I haven't sent him to- I didn't send him to
- 15 clase porque estuvo con:-
class because [he] was with-



- 16 DOCTOR Pero (para) la semana pasada [o esta semana.
But (for) last week [or this week.
- 17 MOTHER [La semana pasada.
[The last week.



- 18 DOCTOR De la semana pasa:da que no va a cla:se.
Since last week he's not going to class.
- 19 MOTHER ((nods)) De la semana pasada.
Since last week.
- 20 DOCTOR Y porque no lo trajo antes al control.
And why didn't you bring him before to check-up.
- 21 (1.0)
- 22 MOTHER Porque yo pensé que era un dolorcito de güatita
Because I thought it was a little tummy ache
- 23 así no mas que tenía.
that's all that he had.

Although Señora Juana's response to the doctor's follow-up question about additional symptoms identified a medically valid symptom 'diarrhea' (lines 11, 13) that would warrant medical care, her subsequent mention that she had kept her son out of school (lines 14-15) derailed the progress of the medical history again. Before Señora Juana was able to finish stating why she had kept her son from class, Doctor Emilia looked up from writing in Yordan's chart to meet Yordan's gaze and ask for clarification whether Yordan had been out of school during only the present week or also the previous week. The importance of this distinction was emphasized by both the shift in Doctor Emilia's gaze and the design of her question as an interruption. And when Señora Juana confirmed that Yordan had been absent from school since the previous week, Doctor Emilia emphatically expressed that this was inappropriate with a drastic shift in her

bodily posture and a modified repetition of what Señora Juana had said. From an upright position, Doctor Emilia swiftly leaned forward, shifting her weight to her forearm on the desk and turning her face to lock gaze with Señora Juana. She repeated back to her patient's mother, "Since last week he's not going to class" (line 18). Treating this as a request for confirmation, Señora Juana nodded and repeated, "since last week" (line 19). Doctor Emilia's next question, "And why didn't you bring him before to check-up." (line 20) directly addressed this lapse of time and treated it as too long to wait before bringing a sick child to see a doctor. The full second pause that elapsed before Señora Juana produced a response further underlines how far off course this medical history was getting. When she finally answered Doctor Emilia's critique, Señora Juana explained that she initially underestimated the gravity of her son's illness, "*Porque yo pensé que era un dolorcito de güatita así no mas que tenía*" 'Because I thought it was a little tummy ache that's all that he had' (lines 22-23). With this excuse, Señora Juana gave what might have been a reasonable account for why she had not come earlier to the medical center, but she simultaneously undermined the reasonableness of her son's prolonged absence for school. And this latter issue evolved over the rest of the consultation.

Following this exchange, Doctor Emilia explained to Señora Juana that waiting two weeks was too long to bring a child to see a doctor. Then, in the excerpt that follows, she returned to the matter of Yordan's absence from school.

Example 7.11

- 37 DOCTOR *Y en que curso estás?*
 What grade are you in?
- 38 PATIENT *Octavo.*
 Eighth.
- 39 DOCTOR *Cuando tienen que estudiar ma:s. Monton de pruebas y*
 When they have to study mo:st. A heap of tests and

40 cosas.
 things.

41 MOTHER Mm

42 DOCTOR Octavo [basico.
 Eighth grade.

43 MOTHER [(Si.)
 [(Yes.)

44 DOCTOR Para enseñanza media.
 For high school.

45 (.2)

46 DOCTOR No lo puede hacer faltar tantas clases señora.
 You can't make him miss so many classes ma'am.

47 (1.0)

48 DOCTOR Ya? No puede ser.
 Okay? That can't be.

49 MOTHER Myah.
 Okay.

In bringing up the matter of Yordan's absence from school again, Doctor Emilia addressed her patient directly, asking what grade he was in (line 37). When Yordan answered that he was in eighth grade (line 38), the doctor responded in a plaintive voice that this was precisely the time when he most needed to attend school because it was the year in which children had "a heap of tests and things" (lines 39-40) in preparation for high school (line 44). The doctor's assertion that eighth grade was a crucial academic juncture was particularly true in Chile, where children compete for spaces in hierarchically differentiated high schools, which consider applicants on the basis of their grade point averages. Having driven home the point that eighth grade is a crucial year for determining children's academic trajectory, Doctor Emilia scolded Señora Juana saying, "You can't make him miss so many classes ma'am" (line 46). The grammatical construction of the turn clearly framed Señora Juana as the responsible party for "making" her son miss school. Doctor Emilia sustained this accusatory stance in her conversation with me later, when she

contended that Señora Juana was not “sending” Yordan and his brother to school, to their detriment.

A final excerpt from late in Yordan’s consultation illustrates the severity of the sanction that a delay in seeking medical care could bring down on parents and the gravity with which unexcused school absences were viewed.

Example 7.12



181 DOCTOR

Y faltaste muchas pruebas o no?
And did you miss many tests or not?



182 PATIENT

Cuatro.
Four.



183 DOCTOR CUA:tro prue:bas.
FOUR tests.

184 (2.0)



185 DOCTOR Mal.
Bad.

186 (1.2)

187 DOCTOR Mu:y mal hecho.
Very badly done.

Late in the consultation, as Doctor Emilia was filling out a form verifying Yordan's medical appointment (but not excusing two weeks of illness), she brought up the issue of Yordan's absences again. She asked him how many tests he had missed (line 181), raising her eyebrows as she glanced momentarily over to where he was seated on the examination table. She had returned her gaze to the form on which she was writing when he answered "Cuatro," 'Four' (line 182).

Then, in a display of incredulity and disapproval, she swung her head up and right to look at Yordan directly as she exclaimed, “CUA:tro prue:bas.” ‘FOU:r te:sts.’ (line 183). The depth of Doctor Emilia’s disapproval was clearest when she returned her gaze back to the task at hand of filling out the form and stated, as if to herself but loud enough to be heard, “Mal. (1.2) Mu:y mal hecho.” ‘Bad (1.2) Very badly done.’ (lines 185-187).

In sum, Yordan’s routine acute medical consultation became a site in which the discipline of regular school attendance arose as an issue. This occurrence was possible because of the generic norm that primary complaints reckon the duration of symptoms and signs of illness in terms of calendric time. The accompanying interactional expectation that parents volunteer this information about their children’s illnesses early and clearly in their problem presentations set the stage for a conflict in Yordan’s case. First, he and his mother failed to identify the timing of the onset of Yordan’s stomachache. Then, when prompted, they located the onset of this symptom two weeks prior to the consultation that was in progress. Because this duration was much longer than is customary, it raised the doctor’s doubts about the adequacy of Señora Juana’s care for her son, the truthfulness of their complaint, and finally the motive for their delay. In the end, Doctor Emilia strongly implied that the delay constituted an instance of malingering. And because of her authority to dispense or withhold a *certificado médico* that would excuse Yordan’s long absence, her estimation that Señora Juana had allowed her son to evade his responsibilities as a student carried a substantial social consequence even beyond the humiliating scolding she dispensed on that day.

7.5 Conclusion

In many ways, the dominant conception of time in the Mapuche *comunidades* of Makewe is task orientation (Thompson 1967). Because most families continue farming as a primary

source of food and income, the rhythm and schedule of household work is governed by the particular requirements of the daily, weekly, seasonally, and annually cyclical tasks in which individuals and families labor. Days are organized around such tasks as feeding animals, collecting firewood, preparing bread, and tending crops and gardens. Weather conditions regularly affect how and when these are carried out. And families' tasks change seasonally as fields need to be either plowed, sowed, fertilized, protected, or harvested. Yet families must also orient to time in ways that are more typical of urban settings. Everyone I met in Makewe knew when the rural bus passed nearest their house and prepared themselves accordingly to meet it when necessary. Individuals who worked or attended school in Temuco structured their lives by this schedule and had to accommodate their farming and household work accordingly.

Though the situation differs in many ways, this reality in contemporary Makewe reflects many of the same issues that Thompson described about the situation that existed in England at the time of the industrial revolution. He portrayed a change from a task-oriented agrarian society to a clock-oriented one, where adults became accustomed to working on a schedule. And he related this shift to the emerging forms of labor exploitation and synchronization that large industry required. Thompson observed that schools became sites where children were adapted to this "new universe of disciplined time" (84) and he contended that the juggernaut of clock time was a crucial element in discourses of development that were aimed at transforming Latin America and other unindustrialized areas of the world. Indeed these two observations are entirely relevant to rural Mapuche today. The disciplining of Mapuche children to regular participation in the Chilean formal education system, and the enforcement of this participation in part at the hands of medical practitioners is fundamentally tied to long-standing imperatives that the Mapuche abandon their cultural practices and assimilate to Chilean society.

As can be seen from the ways that Mapuche parents in Makewe describe their children's medical problems to physicians in routine acute care consultations, the very timing of illness has come into alignment with a calendric metric. Almost without exception, parents have learned to represent illness in felicitous ways, identifying with calendric precision the exact timing of their children's symptoms and signs of ailment. The social affordance of this metric is the monitoring and assessment of parents' medical care decisions by Chilean medical professionals. In their role as bureaucratic officers working in the government-funded medical care system, these physicians are charged with the responsibility not only to fulfill the technical work of medicine but its moral work as well, extending or denying the rights of the sick role to Mapuche children and their parents through assessments of the veracity of their illness accounts and the authenticity of their needs.

Given that accounts of illness in Mapuche healing routinely frame illness in terms of lived time, which cannot be falsified because it is subjectively variable, the absolute prevalence of calendar timing in primary care medicine has to be recognized as a substantial achievement in the process of marginalizing indigenous epistemology in favor of a rationalist ideology. Indeed, as Thompson astutely observed, "values stand to be lost as well as gained" (94). In Makewe what stands to be lost is the notion that children's development, learning, and illness occur in lived time, time that unfolds in cycles related to the family and the natural world. What is gained, or perhaps imposed, is a conception of children's illnesses in terms of school time lost.

Note for Chapter Seven

^{xvii} Stivers (2001) found that this kind of pattern was common in pediatric care in the United States. It was not uncommon for parents to answer questions that physicians had addressed to their children. Interestingly, participants often treated these parental responses as unproblematic. There were so few cases in my data of physicians soliciting presenting concerns from children patients that it is not possible to make any generalizations about the relative acceptability of this sort of tellership appropriation in this setting.

^{xviii} Later in the consultation the mother divulges that she had already brought her son to the health center as soon as the stomachache commenced, only to be told that a simple stomachache was not sufficient warrant for an immediate visit to the doctor. The mother's whispered question to her son '*y que dijeron-*' 'what did they say' (line 4) is probably in reference to what they had been told at this earlier visit.

Chapter Eight

CONCLUSIONS

Long referred to as part of *la frontera* ‘the border’, the Araucanía Region continues to be a space of cultural diversity and encounter in Chile. Historically, *la frontera* demarcated the Spanish colonial from the Mapuche territories, though boundary crossing was common. Today, geographic space continues to be largely segregated, with rural areas like Makewe populated mostly by Mapuche families. Yet daily life blends the Mapuche and the Chilean in syncretic ways such that deliberate acts of differentiation are sometimes required to distinguish one from the other.

The realm of healing is one such cultural domain where practitioners and lay people engage in boundary marking. Western physicians eschew therapies that fall outside official medicine and readily cast doubt on the existence of a multitude of ailments that occur with frequency in the Mapuche *comunidades*. For their part, practitioners of Mapuche healing play up the supernatural origins of their medical knowledge and profess to recognize sicknesses that physicians cannot. In the city, entrepreneurial enterprises like the Mapuche Pharmacy and the Mapuche Healing Center represent ambitious efforts by Mapuche leaders, healers, and young adults to promote Mapuche medical resources as efficacious, natural, and compatible with official biomedicine. Their efforts have been rewarded with a steady number of clients who seek the advice of healers when they are dissatisfied with biomedical explanations and therapies. Among these clients there are both urban and rural Mapuche as well as *wingka* ‘non-indigenous’ Chileans.

However, the inter-ethnic exchange that occurs in these intentionally cross-cultural medical settings, while important, stands in juxtaposition to a much broader reality in the region

of marked inequalities, both medical and otherwise, between Mapuche and *wingka* Chileans. Any analysis of medical consultations in this sociocultural setting must take these issues of inequality into account. The rural Mapuche families with whom I worked live realities of endemic poverty and social marginalization even while their options for work, education, and social integration outside the rural *comunidades* were constrained by discrimination. When their children got sick, these families often took recourse to the biomedical services that were available to them for free at Hospital Makewe or the Regional Hospital in Temuco. However, seeking help at these sites was not free of risk. When accessing services in *wingka* spaces or with *wingka* practitioners, Mapuche families are susceptible to judgment, discrimination, and general poor treatment (Alarcón 2004; Izquierdo 1995; Kristensen 2007). In some cases, families determine that the ‘free’ services at these sites are ineffective for recognizing and treating their children’s ailments, and they seek the assistance of Mapuche healers. These decisions are financially costly and therefore not undertaken lightly. This dissertation has investigated how children’s illnesses are accounted for in these separate healing contexts as part of the respective diagnostic activities of primary care and Mapuche healing. The study explored how these activities, in turn, shaped and were shaped by social relations between Mapuche families and different healing and medical practitioners.

At the most basic level, this study examines how two medical discourse genres facilitate the cultural construction of illness realities in the respective institutional spaces where they are used. The dissertation adopts Hanks’ (1987) assertion that “genres consist of orienting frameworks, interpretive procedures, and sets of expectations that are not part of discourse structure, but of the ways actors relate to and use language” (670). According to this view, generic conventions are not fixed but flexible, and felicitous performances are social

achievements. Both speakers and recipients contribute to the construction of a performance and to its evaluation as appropriate, adequate, and acceptable or, alternatively, as incomplete, infelicitous, or problematic. In light of this definition, the study has sought to identify the orienting frameworks, role expectations, and characteristic features of *pelotun pronouncements* and *chief complaints* in the context of their performance. The project aligns with other research on genre that is concerned with how institutional constraints and social relations shape generic function, forms, and meaning. And by analyzing both the institutional contexts and the immediate face-to-face influences on how illnesses are verbally represented, the study has addressed several key issues concerning how illness realities are constituted in Mapuche healing and biomedical primary care in southern Chile. Building from the observation that the speaking rights normally associated with an ordinary epistemics of subjective experience are reordered in children's medical care such that children are rarely selected to report on their own illnesses, the study examines the social relations that are constituted and reinforced in the process of accounting for illness, especially as these are tied to assumptions about the distribution of knowledge concerning illness processes and experiences, communicative competence, and the social and communicative responsibilities that are related to caring for children.

First I presented evidence demonstrating that activities occurring at the beginning of consultations for children's health problems accomplish important work toward organizing social relations among participants in the medical consultation. The earliest actions in consultations establish norms for participation in the diagnostic process for each of the differentially positioned institutional actors who are present: practitioners, patients, and familial caregivers. In establishing these expectations, participants orient to the particular epistemological framework that governs the medical tradition in which they are working. This epistemological framework is

an ideologically organized set of ideas about the evidentiary sources of legitimate knowledge about illness and the distribution of this knowledge across social actors. Third, early talk and coordinated embodied actions in consultations set the tenor of activities and, consequently, lay the groundwork for the sort of practitioner-patient relationship that takes shape over the course of the encounter.

Analysis of the openings of Mapuche healing consultations revealed unique forms of participation, epistemological assumptions, and social relations among healers, children patients, and their parents. Interaction at the outset of these encounters foregrounded and privileged healers' direct access to knowledge about children's illness experiences through a highly stylized performance of attention to either the child's body or some vital object. This performance conferred a direct form of knowledge in the sense that it flowed from healers' first-hand, sensorial assessment or somatic attention to the patient's body or its proxy. Thus, the evidentiary ground of healers' knowledge was construable as embodied and first-hand.

The visibly salient assessment of a vital object projected the healer as the primary teller for a subsequent illness account and the child patient and his familial caregivers as the recipients of these accounts. This distribution of participation roles favored the healer as the primary authority on the illness and restricted speaking opportunities for the other participants in the initial definition of the health problem. The systematic suppression of patient and caregiver talk about children's illnesses at the beginning of consultations disrupted ordinary epistemic assumptions, which grant primary epistemic access to subject-actors concerning such personal matters as somatic experience. However, the proscription against patient and caregiver illness accounts at the outset of healing consultations was accomplished without the invocation of a hierarchical relationship between the healer and her clients. Rather, the overall tenor of the

interactions was empathetic and intimate, projecting a solidary relationship between the healer and her young patients. This intimacy was fostered by the healer's selection of child patients as primary addressees, her use of respectful and diminutive morphology in her talk with them, and her sustained physical contact with these young patients.

Previous research on Mapuche ethnomedical practice has emphasized that Mapuche healers provide their clients with culturally resonant diagnoses, in contrast to biomedical physicians who traffic in terms of physiological disease. The common argument for why clients find Mapuche diagnoses meaningful is that Mapuche cultural models of illness (Garro 1994) tend to externalize illness, locating problems in the social world rather than the interior of the body (Bacigalupo 2007; Kristensen 2007). In fact, this sort of explanation is a common one in the literature on ethnomedical systems. While biomedical explanatory models (Kleinman 1988) emphasize internal mechanisms of disease, many ethnomedical and popular medical systems posit explanations for sickness and other troubles in disordered social relations (e.g. Pollock 1996). In contrast to this focus on interpretive frameworks for illness, my analysis of Mapuche ethnomedical practice suggests that the nature of the social relations between Mapuche healers and their clients is also crucial to the constitution of felicitous interpretations of illness. I have provided evidence supporting a broad argument that healers' direct, empathic knowledge about the lived experience of ailment is both meaningful for clients and ideologically and interactionally salient in interaction.

In Chapter Five, excerpts from two of Healer Lorena's consultations illustrate the difference between canonical or felicitous performance of *pelotun* and a problematic case in which a substantial intertextual gap opened up as the result of a client's unconventional participation. I demonstrate that an important element or contributing factor to the

authoritativeness of healers' pronouncements is the production of claims in first position (Heritage & Raymond 2005; Raymond & Heritage 2006). Healers demonstrate their empathic gift of illness perception, the *healer's don*, in large part by identifying symptoms that patients are suffering without clients having to volunteer information. Thus, the first-positioning of symptom claims is a consequential feature of the *pelotun* genre, one that is typically facilitated by the interactional organization of the activity. However, clients who are unfamiliar with the genre may act on schemas they have developed from participation in primary care medicine, volunteering illness accounts at sequentially inappropriate moments in the consultation. Such infelicitous forms of participation jeopardize the successful demonstration of a healer's empathic insight into the patient's illness experience by displacing her claims to second-position, a position that is associated with non-primary epistemic rights. In this chapter, I discuss how Healer Lorena managed her interaction with one such naïve client such that her *pelotun pronouncement* incorporated the patient's mother's health concerns about her son while also conveying the healer's authoritative epistemic stance vis-à-vis the young child's illness.

The final chapter concerning *pelotun pronouncements*, Chapter Six, advanced the argument that these illness representations not only instantiate an empathic relationship between healers and the sick, they are also designed to have persuasive illocutionary force. The chapter began with the presentation of interview data that demonstrated a local cultural imperative for the sick to have *fe* 'faith' in the healers with whom they sought recourse. This imperative, in turn, is underpinned by a dominant medical ideology in the region that efficacy is dependent on belief. The particular variety of belief that clients at the Mapuche Healing Center referred to was not the sort of propositional belief (e.g. the conviction that something exists) of post-modernity and early anthropological literature but what Good (1994) has identified as an older sense of the

term in which belief denoted a pledge of trust or allegiance. Dovetailing with these local ideologies, research into placebo effects suggests that this kind of belief in a healing system can, in fact, support placebogenic responses that improve the efficacy of therapeutic efforts (Hahn & Kleinman 1983; Moerman 2002; Moerman & Jonas 2002; Shapiro 1960; Shea 1991). The chapter also considers how clients at the Mapuche Healing Center framed their desires about treatment with the healers and finds that many expressed an interest in receiving novel interpretations of their ailments from healers. Finally, the chapter identified multiple textual and performance features of the *pelotun* genre that facilitate the persuasiveness of healers' claims. These features include: a high density of discrete claims during a single pronouncement; the representation of illness in terms of lived time; the combination of repetition, parallelism, and the contributory participation of clients in the constitution of illness accounts; and finally the sedimentation of claims over multiple sequential consultations. Together, these features make for compelling accounts of illness experience that are both provocative and plausible for patients and their caregivers.

The other half of the dissertation examines in detail the production of *primary complaints* at the Hospital Makewe primary care center, where Mapuche families and *wingka* doctors defined and sought resolutions for children's routine acute (Heritage & Robinson 2006a) illnesses. Analysis of the illness accounts that parents produced in this setting suggest that there were strict generic norms surrounding the linguistic representation of children's illnesses to clinicians. The ways that physicians solicited and parents produced illness accounts revealed that far from being opportunities for parents to represent illness as they chose, *primary complaints* were "quintessentially intertextual" (Briggs & Bauman 1992) and exhibited very little in the way of linguistic creativity or narrative innovation. At the same time, parents and clinicians seemed

quite unaware of the generic strictures on these descriptions of illness. The invisibility of these generic norms fostered a situation in which the entextualization (Bauman and Briggs 1990) of children's illness experience was treated by practitioners and patient families as a directly referential process and language was construed as a neutral medium through which illness was simply conveyed. Clinicians orientation to this referentialist ideology (Hill 2008) was visible in their repeated prompts directing parents, "*Cuénteme no más*" 'Just tell me'. This construal of parents' illness accounts as transparent vehicles contributed to the naturalization of the emergent representations of illness (as recent and symptomatically uncomplicated) as authoritative and 'real'.

In Chapter Four, analysis of how children's acute care consultations begin at the primary care center revealed that participation in these encounters was predicated on the assumption that parents were best equipped to be the 'tellers' of an initial illness account. This designation of the primary teller role privileged the legitimate knowledge that adult caregivers gain about children's illness trajectories as a result of their first-hand observation of children in the process of caring for them at home. This speaker selection cast physicians as the primary recipients and children patients as ratified overhearers of illness accounts.

This arrangement of participation revealed assumptions that were at work about the epistemics of illness experience in this primary care setting. Complaint solicitation questions presupposed that physicians had no way of gaining direct knowledge about children's ailments, and therefore had to rely on the verbal accounts of a more knowledgeable party to carry forward their professional activities. In this setting, medical care was fundamentally concern-driven and diagnosis was organized as a process of information-gathering. Simultaneously, the 'passing over' of children as potential tellers suggested that while children may have been understood to

exercise epistemic privilege over the intimate domain of symptom experience, physicians' estimations of children's communicative competence for relating illness narratives were low. This interpretation supports the argument made by Stivers (2010) that children's participation as ratified overhearers or peripheral participants in medical interviews constitutes a crucial opportunity for language socialization into the patient role because the opportunities they are offered to speak on their own behalf are very limited.

Several features of the interaction in the first moments of primary care consultations established a respectful but bureaucratic tenor. This was signaled by the combination of formal morphological marking in the speech of all participants, physicians' sustained orientation to medical charts paired with their gaze patterns toward patients and parents, and the formulaic quality of physicians' questions soliciting reasons for visits. This combination of features projected the pediatric primary care consultation as a kind of service encounter at the same time that it cast physicians in the institutional role of bureaucrats, not merely service providers, and Mapuche children and parents in the institutional roles of citizens and beneficiaries of state aid, not merely patients and caregivers.

One benefit of the lens of genre is that it affords the consideration not only of texts but performance (Hymes 1981). By considering the production of different kinds of illness representations in their context of performance in medical consultations, I have been able to focus on how producers of these texts were accountable to their interlocutors in a variety of ways. In Chapter Seven, I looked closely at how the timing of illness and the timing of medical care was normatively represented in parents accounts. Analysis of multiple accounts revealed a normative orientation to calendar time and a generic preference for framing symptom emergence according to this metric. I argued that this normative orientation to calendric time was associated

with both medical models of illness as episodic and parents' social obligation to seek immediate medical care when children fell ill. At another step of indexical remove, the cultural imperative for children to attend school was implicated in what was deemed as an appropriate lapse of time for seeking medical care. An extended examination of a case in which the time framing in a mother's illness account was treated as problematic by a physician revealed that the violation of the genre norms surrounding the temporal framing of children's illness was indexically related to social proscriptions against malingering as well to insidious ethnic stereotypes about the Mapuche as uneducated and uncommitted to education. This last analytical chapter took up Thompson's observation that the adoption of social time metrics can be associated with forms of time discipline that are required for the exploitation of labor in the post-industrial world. I argue that the generic normativity of representing illness in terms of calendric time in primary care made parents' medical care seeking actions evaluable by clinicians, who acted as gatekeepers in the disciplining of Mapuche children to the time orientation of urban, Chilean life. The imposition of a metric of calendar time on Mapuche children's illnesses is related to historically deep processes through which *wingka* 'non-indigenous' epistemologies have come to predominate, and Mapuche knowledge has lost prestige.

The preceding chapters have documented illness accounting in pediatric primary care and in Mapuche healing practice. My first analytical aim was to identify the particular ideologies and social relations that shaped how children's illnesses were understood in the Araucanía. The second aim, which I consider equally important to the first, was to identify what Mapuche families stood to gain and what they risked when they presented their ill children for diagnosis in Chilean primary care and Mapuche medicine, respectively. To explore these issues, the project focused on two elements that shaped illness accounting in these two settings. On the one hand, I

investigated the epistemics that were particular to each of these medical systems and asked how responsibilities to know about and report on children's ailments were distributed across everyone involved in caring for the children. This was paired with an examination of the normative expectations concerning the history and temporality of illnesses themselves and how these were regimented in verbal accounts of children's medical histories. Mapuche cultural knowledge about sickness processes emphasizes historical depth and the iterative or chronic recurrence of symptoms, while the Chilean model of primary care is designed to address sickness that is historically shallow (i.e. acute) and manifested through a clear and recent onset of symptoms. While these two models of illness can be gleaned from existing literature about the ideational foundations of these medical traditions, this dissertation has made the argument that there are important social consequences attached to these contrastive cultural models of illness.

As a study of illness representations, this project contributes to the study of medical discourse. In addition to focusing on medical authority, which has garnered a great deal of attention, I have also focused on accountability as a matter for inquiry. This choice enables a pragmatic interpretation of medical discursive practices that addresses them primarily as a mode of social *action*, even though the genres in question are ostensibly devoted to *representation*. By examining both the broader cultural context and the more immediate interpersonal and activity contexts of these discourse genres, I have endeavored to identify what is at stake when people represent illness to one another as part of the process of seeking medical care. I contend that, as historically situated practices, *pelotun* and *primary complaints* contribute to the reproduction of Mapuche and *wingka* cultural models of illness, and this cultural construction is entangled with the tandem reproduction of caregiving roles. Thus, in Mapuche healing, where sickness is empathically perceived by healers, the subjective qualities of illness experience are transformed

into social facts, and healers gain intimate knowledge about their patients' problems. By contrast, in Chilean primary care, where parents are obliged to provide strictly regimented accounts of their children's illness, clinicians are positioned to make moral evaluations of parents' care and to enact verbal and material disciplinary measures accordingly.

APPENDIX A: The Focal Families

The Kiñe Family: Parents Antonia and Samuel had three children and made a living primarily with vegetable farming, a back-breaking enterprise in which the two eldest children participated actively. In order to get the best prices possible for their produce, Samuel made regular trips to the market in Temuco using a small truck he and Antonia had purchased with money they saved during years of wage work in Santiago, where their oldest daughter, Ruth, had been born. When times were particularly tight, Samuel worked as a taxi driver in Temuco. The family's children, Ruth 11 y.o., Sara 10 y.o, and Carlos 5 y.o., attended a government subsidized Christian elementary school a few kilometers from their home. Ruth and Sara were proud of their academic achievement and regularly earned highest honors in their respective classes. The family belonged to and regularly participated in one of the many Evangelical Protestant churches in the area.

The Epu Family: The Epu family had the least land of the focal families. They had inherited only enough land to build a house, plant a small garden, and keep a few small fowl. The father in the family, Ramón, worked seasonally as a farm laborer and augmented the family income by digging wells. The mother in this family, Inéz, used some of the income from Ramón's paid work to purchase alcohol, cigarettes, and household goods, which she brought from the city on the municipal bus and resold to neighbors for a marginal profit. Inéz and Ramón had two children, Gonzalo 9 y.o and Sofia 6 y.o. Gonzalo attended one of the larger, public elementary schools in the area. Although Sofia was old enough to attend kindergarten, her parents had not yet sent her to school. They had been unable to send her because Sofia had sustained an injury shortly before the beginning of the school year. And, despite the family's efforts, Sofia's injury failed to heal over the course of many months.

The Kūla Family: This family lived closest to Temuco of all the focal families, which made it feasible for the father in the family, José, to work in construction during part of the year. The mother of the family, Amanda, was originally from central Chile and was not Mapuche. The family kept several pigs, in addition to chickens and geese. They had a sharecropping agreement with members of José's extended family to plant lupine, a cash crop, on a plot of land in a distant area that the family visited infrequently. This arrangement with José's kin (some of whom had moved to the other area) was enabled by a land grant to the *comunidad* that was administered through the governmental body *Corporación Nacional de Desarrollo Indígena* (National Corporation for Indigenous Development CONADI). Amanda and José had three children: Esteban 9 y.o., Oscar 7 y.o., and Anna 5 y.o. The children attended a small, subsidized private school a few kilometers from their home.

The Meli Family: María was the head of household in this family. She lived with her son, Andrés 11 y.o. and María's elderly mother, Eustacia. They lived in the home where María had grown up and were close neighbors with the families of María's brothers. María was the most politically involved of the focal parents in the study, having served as an elected member on the council of the *comunidad* where they lived. The family actively participated in the local Catholic parish, where Andrés was a student in the parish school. In order to earn money, María worked as a seamstress and occasionally at other jobs in Temuco. The family kept a small number of cattle, which allowed them to produce and sell artisan cheese. The cattle also served as an investment that could readily be sold for cash in the case of an emergency.

APPENDIX B – BEGINNING OF FERNANDO’S CONSULTATION

This transcript accounts for the first five minutes of the recording

- 01 HEALER quien es que viene a verse?
Who is it that comes to be seen?
- 02 MOM el señora
He does, ma'am.
- 03 DAD el.
He does.
- 04 HEALER Ya. a ver hijo, deme su pulso.
Okay. Let's see son, give me your pulse.
- 05 () mi chiquillo.
() my boy.
- 06 (1.5)
- 07 HEALER Y usted está bien
And you are well?
- 08 MOM Si. Si.
Yes. Yes.
- 09 HEALER que bueno,
That's good.
- 10 (12.5)
- 11 HEALER estamos con un problema de depresion.
We are with a depression problem.
- 12 y mas, tiene ansiedad.
And more, he has anxiety.
- 13 (2.0)
- 14 .hh y los sistemas nerviosos estan un poco alterados.
and the nervous systems are a little disturbed.
- 15 MOM alterados.
disturbed.

16 HEALER .hhh y mas se le inflaman un poco las manos, los pies.
.hhh and more the hands, the feet got a little swollen,

17
amanece un poco hinchado de repente la cara,
He wakes up a little swollen suddenly [in] the face,

18
los rinyones no funcionan muy bien.
the kidneys don't work very well

19
hay como retencion de liquido.
there is like retention of fluid.

20
y se siente cansado, se siente como
and he feels tired, he feels like

21
que ha caminado mucho.
he has walked a lot.

22 MOM mucho.
A lot.

23 HEALER maltrata'o.
worn out.

24 MOM maltrata'o.
worn out.

25 HEALER .hh tambien no esta durmiendo bien.
.hh also he is not sleeping well.

26
ahora ultimo no esta durmiendo bien.
now lately he is not sleeping well.

27
Casi decir que no duerme bie- no duerme.
Almost to say he doesn't sleep we- he doesn't sleep.

28
Duerme por capito.
He sleeps in spurts.

29 MOM Si.
Yes.

30 HEALER se asusta, .hh siente dolor, se ahoga,
he startles, .hh feels pain, feels short of breath,

31
y, su guatita se le- como que tiene un ardor

and, his tummy has- like he has a burning

32 aqui en su guatita.
Here in his tummy.

33 (0.3)

34 despues toma la espalda.
then it goes to his back.

35 MOM Si.
Yes.

36 HEALER todo eso.
all that.

37 se siente bastante complicao durante estos
he feels quite complicated during

38 tiempos mas ultimoh.
these latest times.

39 que ahora estamos hablando de los tiempos
now we are talking about the times

40 mas cercanos de ahora
closest to now

41 El viene enfermandose mucho tiempo, pero,
He has been getting sick for a long time, but,

42 ahora siente todo estos problemas
now he feels all these problems

43 MOM si
Yes.

44 HEALER .hh y tambien a veces, como que le baja la presion,
.hh and also at times, like his blood pressure drops

45 de repente como que le sube, puh eh,
sometimes like it rises, um uh,

46 como que siente calor,
like he feels heat,

47 De repente siente frio
Suddenly he feels cold

48 MOM Si. Si.
Yes. Yes.

49 HEALER es inestable su: eh: su forma (.) de (.) de pasar el dia.
It's unstable his uh his form of passing the day.

50 (1.0)

51 asi esta.
that's how he's doing.

52 (1.0)

53 este (eh) problema los rinyones
this is a problem of the kidneys

54 problema sistema nervioso,
problem of the nervous system

55 esta la depresion, y la ansiedad.
there's depression, and anxiety.

56 eso tiene el niño.
that's what the boy has.

57 MOM Mm-

58 HEALER es asi m'hijo?
Is it like this my son?

59 (0.5)

60 MOM Y tiene (y)?
And it has (and)

61 HEALER Si. Podemoh tratarlo.
Yes. We can treat it/him.

61 MOM (())

62 HEALER Si. Podemoh tratarlo.
Yes. We can treat it/him.

63 Y el estomago que se le estrinye
his stomach gets constipated

64 Se sirve algo, queda una pelota, queda pesa'o alli.
He eats something, it stays a ball, it stays heavy there.

65 Como que no baja, como que
Like it doesn't go down, like

66 no injiere bien el alimento. eso le esta pasando.
the food doesn't ingest well. that's happening to him.

67 MOM Si.
Yes.

68 HEALER .hhh (.) Dios quiera, tengamos solucion.
God willing, we will have a solution.

69 con los remedios que le voy a dar yo.
With the remedies that I am going to give to him.

70 porque se siente bastante mal este nino.
because this boy feels quite badly

71 .hh y tiene que seguir con tratamiento de- lo que-
and he has to continue with treatment whe-

72 de donde el esta. Ya?
where he is.Okay?

73 MOM Ah: ya.
Oh, okay.

74 HEALER Medico.
Doctor.

75 MOM Con medico.
With the doctor.

76 HEALER Tiene que star con su medico.
He needs to be with his doctor.

77 MOM mm:::

78 DAD (())

79 HEALER Ambos lados, se van (ayudar) este remedio
Both sides, are going to (help) this remedy.

80 Yo no soy capaz sacarlo de lo que el esta,
I am not able to remove him from what he has,

81 Pero los medicos tambien va a ser la otra parte
The doctors also are going to do the other part.

82 MOM Ya.
Okay.

83 HEALER Ya?
Okay?

84 MOM Ya.
Okay.

85 HEALER Eso le quiero decir.
That I want to say to you.

86 MOM Mbueno.
Fine.

87 HEALER eso seria todo su enfermedad que yo stoy encontrando.
That would be all the illness that I am finding.

88 Pero hay mas cosas, pero
But there are more things, but

89 son loh mas especificos que es eso me sta dando
those are the most specific that is coming to me

90 MOM Eso- Esos dolores que el siente- siente muchos dolores
Tho- those pains that he feels- He feels a lot of pain

91 en el lado derecho me decia usted?
on the right side you were saying to me?

92 HEALER Si.
Yes.

93 MOM la espalda?
The back?

94 DAD/PATIENT? (())

95 MOM los pies, (to')
the feet, everything

96 HEALER todo.
Everything

97 MOM Pero como que- sabe que- como que no le creen.
It's like they don't believe him.

98 Le dicen que eh todo sicologico
They tell him that it's all psychological.

99 HEALER No. No es sicologico. Es dolor.
No. It's not psychological. It's pain.

100 pero está la depresion tambien.
but there is the depression also.

101 MOM Mm

102 HEALER sistema nervioso ES enfermedad.
also nervous system, it IS illness.

103 (.6)

104 porque el esta con ese problema.
because he is with that problem.

105 y hay que ayudar hay que sacar, hay que
and it's necessary to help him get it out, necessary

106 hacer hartas cosas.
to do many things.

107 MOM Si porque lo pasamos con el en medico
Yes cuz all the time we spend with him at the doctor's

108 HEALER ()

109 MOM y sabe usted que segun el medico
and you know that according to the doctor

110 HEALER No los medicos no-
No. The doctor doesn't-

111 MOM lo mandaba al siquiatra
he sent him to the psychiatrist

112 HEALER Ya.
Okay.

113 MOM ni siquiera converso con el. (Con es-) le dan eh- esta
He didn't even talk to him. With - they give him um this

114 cosa para dormir. Relajante musculares.
thing for sleeping. Muscle relaxers.

115 HEALER Hmm

116 MOM y no le hasen efectos () donde se- se marea?
and they don't have the effect () where he gets dizzy?

117 Pero no se siente bien con el remedio
But he doesn't feel well with the remedy.

118 HEALER no cada dia se siente mas-
No. Each day he feels more-

119 MOM y con la ansiedad. O sea, y no puede comer verduras,
and with anxiety. That is, and he can't eat vegetables,

120 frutas, porque todo le produce-
fruits, because everything causes-

121 HEALER Lo hincha mucho.
It bloats him a lot.

122 MOM y demasiado dolor
and too much pain

123 Y eso. Y ya () sea practicamente come
And that. And already () that is he practically eats

124 puros tallarines por que lo demas todo le hincha.
only spaghetti because everything else bloats him.

125 Todo hace que se sienta mal.
Everything makes him feel poorly.

126 MOM Tenemos-problemas nosotros porque somos los tres.
We have-problems because it's the three of us.

127 MOM Pero yo como mama lo entiendo. Yo se porque yo tambien
but I as mom I understand. I know because I too

128 estuve enferma.
was sick.

129 HEALER Claro.
Right.

130 MOM pero ahora misma tengo () visita.
But right now I have a () visitor,

131 Igual, o sea,
The same, that is,

132 HEALER ()

133 MOM No es comodo porque el siempre esta enfermo.
It's not comfortable because he is always sick.

134 HEALER Sta enfermo si.
He is sick, yes.

135 MOM Si-
Yes-

136 HEALER Y es enfermedad y esta enfermo. Para mi esta enfermo.
And it is sickness and he is sick. To me he is sick.

137 MOM Esta enfermo.
He's sick.

138 HEALER Claro. No sta bien. (.) 'tonceh-
Right. He's not well. So-

139 MOM Le dicen haz esto. Anda. Camina. (.) (Que te-)
They say to him do this. Go. Walk.

140 HEALER Se cansa.
He gets tired.

141 MOM Se cansa demasiado con los dolores Señora Lorena.
He gets really tired with the pains Mrs. Lorena.

142 Si sta enfermo!

He's sick!

143 HEALER Se cansa. Claro. Se cansa y- y duele.
He gets tired. Right. He gets tired and- and it hurts.

144 MOM claro po si es algo de- Eh- Eh lo- ()
Right. It's something that- ()

145 con el suero, lo inyectan y ya no le hace efecto.
they give him an I.V. and it doesn't work anymore.

146 ya no-
Anymore it doesn't-

147 El dia dieciocho pasamos el dieciocho y
The day of the eighteenth we spent the eighteenth and

148 la noche con suero
that night with an I.V.

149 HEALER en el hospital

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