

SOCIAL SUPPORT AND DECISION-MAKING: THE INUIT IN THE BIOMEDICAL SYSTEM

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INTRODUCTION

Many observers writing about the social impacts of biomedical care in the north seem to consider that the Inuit (which they sometimes refer to as "passive," "hypochondriacs," or "deprived") have practically no more alternatives left to face illness than to call upon biomedical practitioners (DeLapp and Ward 1981: 69; Honigmann and Honigmann 1953: 47; Labbe 1981: 73; Lantis 1959: 54; Milan 1974: 28). This view is shared by authors with various academic backgrounds, even if they focus on different areas of the Arctic (each having its own specific history) or describe distinct time periods.

In the scientific literature, micro- and mesosocial aspects of intercultural misunderstanding about health care in the north are often set aside and assigned macrosocial ideological values. The northern expansion of the biomedical system is usually interpreted either as a benediction in a context of inadequate socio-sanitary conditions, or as a colonial intrusion of the dominant Eurocanadian technobureaucracy into Inuit social organization.¹

However, resistance to Eurocanadian medical care permeates Arctic history. For example, such an issue was brought up when federal and provincial administrators were bargaining the jurisdiction of health in Northern Quebec in the 1960s: some Inuit boycotted provincial services, whereas others embraced these new services in reaction to those offered by the federal government. An identical situation occurred when doctors started having a significant presence in the north; they sometimes represented a

welcomed innovation, but more often than not they were shunned or rejected since people preferred the type of contract they had grown accustomed to with nurses (Dufour 1983).

However, the scientific literature also suggests that the biomedical model is not always unilaterally accepted. All over the Arctic, be it 30 years ago or today, in cases where the Inuit use biomedical services, it is also mentioned that they have not placed all their faith in them and still rely on alternatives; some authors suggest that there must exist a conjunction of differing medical knowledge systems that are either parallel or syncretic.²

Finally, and more bluntly, some scientists state that if the Inuit extensively resort to biomedical care, it is simply because there are many services available (Bouchard 1980; Boudreau *et al.* 1980).

It thus seems strange to note that researchers having already worked in the north and having some insight into the dynamics of northern communities agree on the one hand that there is a persistence of medical concepts and strategies differing from those of the biomedical system, while on the other hand they present these populations as extremely dependent upon Eurocanadian care. The analyses thus present an apparent contradiction.

This paper tries to elucidate data on the possible paradox between dependency and alternative resorts by first presenting a hierarchical organization of explanatory levels. The idea is to see how the problem may be understood from the macrosocial (geopolitics of health), the mesosocial (community dynamics) and the microsocial levels (personal and family histories). The discussion then concentrates on the illustration of these considerations by centering on a specific problem related to the use of health services by the Inuit, namely medical evacuations and southern hospitalizations. The paper concludes with a discussion of the role of ethnicity as regards the insertion of Inuit in the biomedical organization.

MACRO-, MESO- AND MICROSOCIAL DISTINCTIONS

At the macrosocial level, political and economic claims have become an area in which Native populations are gradually commanding a more efficient discussion of legislative and executive authority (Duhaime 1988). However, they have been up to now structurally ignored in relation to the biomedical system (O'Neil 1986). In fact, it seems that the medical interpreters, the few community health agents (Cordes 1985; Duffy 1988) and the rare Native auxiliary nurses are practically the only northern representatives officially at the margin of the biomedical clinic. Other forms of official representation (such as health committees) are usually advisory bodies without any effective power. However, recent developments in the north, for example the nomination of Inuit directors at the hospital in Povungnituk and the Regional Council of Health and Social Services in Kuujjuaq, are indicative of a wind of change, although the real scope of these has yet to be analyzed. As O'Neil and Sarsfield (1985) have stated, self-determination still remains another bureaucratic myth.

Research done by Kaufert *et al.* (1985) in Manitoba hospitals has shown how Native medical interpreters are caught in the midst of political and ideological transactions between Native communities, patients and biomedical administrators or practitioners. The project found that medical interpreters cumulate a large number of roles not accounted for or officially considered by their employers. The conclusions of this research are particularly illustrative of a model of community mediation at the mesosocial level in the north. For example, Blake (1978), while describing "negotiating collectivities," illustrates how a network of actors (be they professionals or not) builds itself around the patients to plead or mediate for them. O'Neil (1981) has also demonstrated how certain institutions not directly concerned with health issues are activated in conflictual situations in order to seek adequate care for members of the community.

Arctic communities, just as elsewhere, offer a range of therapeutic alternatives. For example, illness is sometimes treated individually either by traditional and imported medicines (Avataq

1984; Thérien 1980), or by culturally-defined first-aid techniques (Avataq 1984; DeLapp and Ward 1981; Lucier *et al.* 1971; Milan 1974; Murphy 1987). Care may also be accounted for by families, various other persons offering social support or socially recognized Native specialists whether formally trained or not (Avataq 1984; Blake 1978; DeLapp and Ward 1981; Dixon and Kirchner 1982; Dufour 1988a; Milan 1974). While these various resources have been sporadically and unevenly described in the Arctic, there nevertheless seems to be a certain consistency from east to west.

Numerous questions are yet unexplored, for example the reason for a renewed interest in traditional ethnopharmacology or illness-solving methods among the Inuit. This concern is also metaphorically revived in various religiously inspired healing sessions. In fact, it seems that the north is witnessing a redefinition of the forms and a reactualization of the contents of certain ideological structures previously thought to have disappeared. These meta-medical activities are characterized by a collectivization of resources oriented towards an enhancement of healing potential.

Wenzel (1981) suggests that Inuit communities encourage a continuous integration between the healthy and the ill, in a value system shared by all members. Blake (1978) sees there a lever permitting the community to regulate its members along socially approved behaviours. Both these observations illustrate how an illness (just as sickness or disease) can activate social networks in which the patients cannot be fully dissociated from their obligations and responsibilities.

The support networks mobilized around the patients contribute to the activities necessary for the diagnosis and treatment of illness. These networks mediate or plead in favour of the patient, sometimes contribute to the therapy, define preventive or normative conducts for the patient, and help decide if inclusion in or exclusion from daily community life is appropriate. In short, it seems clear that biomedical interventions may be preceded or followed by other therapeutic processes, the

orientation and the choice of which depend as much on the patients as they do on their access to communal help networks.

Concerning the microsocial level, McElroy (1977) has noted a great variety and flexibility of adaptive styles cutting across socio-economic categories in the north. Differences can be noted, for example, between men and women, or between young and aged. Some clues indicate that these distinctions can also be found in their health-seeking strategies. Unfortunately, very little data have yet been compiled on this question.

Another area of interest concerns the rise of regional ruling classes (Simard 1982) and the new relations they weave with Eurocanadian resources. It can be presumed that these elites may be better prepared to discuss or react to the biomedical care they receive. It is also possible that their support groups and health-seeking strategies differ greatly from those of people having few contacts with Eurocanadians. This was observed recently in southern Quebec when the members of an influential Inuit family protested directly to the general-director of a large hospital so that one of their sick family members could receive what they considered more adequate nursing care.

A certain number of factors related to personal or family history influence the relations patients have with practitioners of the biomedical system or with the other resources available. Among these are: education, linguistic competency, possibility of social mobility, control over capital, type of employment, and the degree of family structuration. Emphasis put on family life in the socio-sanitary organization may thus be misleading if distinctions are not made among the variables that also affect and characterize the effective power of different enlarged families in community and interpersonal dynamics. In fact, the complexity of the microsocial level presents itself as determinant in the ideological regulation of the social system.

At the macrosocial level, marginalization (i.e. exclusion and non-control over resources) has been abundantly described; at the mesosocial level, various curative strategies have been sporadically illustrated; and at the microsocial level, the

constraints and the regulation of Inuit health have been little examined. It then seems that the paradoxical involvement of the Inuit in the northern medical system originates from a reduction in the levels of analysis. A re-examination of the hierarchy of observation levels shows that there is no real contradiction, only a complex situation obscured by the fact that, while examining a specific problem, it is virtually impossible to completely isolate the different levels of analysis since they are usually interrelated, if not dependent on each other.

REACTING TO MEDICAL EVACUATIONS

The literature concerning the medical evacuation of Inuit patients to urban centers is generally less qualified than the one concerning the integration of Inuit into the biomedical system. What can usually be read is a disproportionate and melodramatic compendium of problems.

Everything seems to go wrong for Inuit having to travel down south; food is terrible or just not what is needed to get well (Blake 1978); loneliness is almost too much to bear (Freeman 1978; Harper 1986; Herbert 1984; Hughes 1957; Wenzel 1981); patients' stress about their families' well-being is appalling (Blake 1978; Choque 1985; Freeman 1978); hospitals are intellectually and culturally hermetic institutions (Honigmann and Honigmann 1965); communication problems are unavoidable (CSN and FAS 1986; Herbert 1984; Projet Nord 1984); relations with the medical staff are difficult (Blake 1978; Freeman 1978); "particular beliefs" are not respected (Herbert 1984); emphasis on cleanliness is felt as an unwarranted aggression (Blake 1978); and certain medical interventions received in the south have been judged as being unacceptable or as provoking socially disruptive effects (Duhaime 1983; Flanders 1986; Thérien 1980).

With this perspective in mind, between 1985 and 1987 the author undertook research in order to elucidate the perceptions and activities of Inuit patients receiving health care in six Quebec City hospitals. During this period, 130 different Inuit patients were met from one to three times, for periods averaging one and

a half hours. The main methodological sources referred to were Corin's (1984) strategic analysis of social support networks and Sigman's (1987, 1986) interactionist investigations of communication in nursing homes. The author used participant observation, and structured and open-ended interviews while working with Patient Services,³ to identify the system of coping strategies the patients used to resolve the problems they encountered. Other people met in the course of the research included the medical staff concerned (interpreters, nurses and doctors), Eurocanadian patients sharing rooms with the Inuit, airline passengers and stewards, and boarding house families.

The objective of the research was oriented towards an interactionist perspective of the relation between the patients and other actors providing them support of any kind, rather than to prepare a list of problems. Put in a more general way, the idea was to find out if the Inuit really lived their medical evacuations as if they were in a state of perpetual shock, which more or less corresponds to the picture drawn by various observers. As the research progressed, reality presented a rather less categorical verdict.

If the scientific literature tends to trace a rather dismal picture of the situation, the current folklore circulating about the Inuit patients' travels down south also transmits the same paradigms, as is evident in some of the following observations: an airline agent commented on the high travel prices and the economic burden the Inuit were to all Canadians; nurses unfamiliar with the Inuit sometimes insisted on unwarranted bathing or cleaning of the patient upon admission in the hospital for fear of fleas; a doctor working in the north was sure that Inuit patients down south were receiving unnecessary tranquilizers (which, in fact, proved false); people believed that the patients were practically parachuted alone into town, without their knowing what was going to happen next; a northern hospital official was told that a patient had been convinced down south not to abort, contrary to what she had already decided up north. In this latter case, the official wrote a complaint denouncing this meddling into

private matters, but when it was proven that this episode did not really happen, he had to write a letter of apology. However, as is often the case, the rumour is still circulating, thus reproducing false information. In another case, a patient insisted on going back to the airport by herself, without being accompanied by an escort as usual. The story came back from the north that this patient had been abandoned and had to painstakingly find her way to the plane through the concrete jungle.

Whereas many of the problems evoked are based on contextual reality, most tend to draw upon an image presenting the Inuit as a monolithic block; microsocial determinants and macrosocial imperatives are telescoped or mixed and nearly all patients are shown as having the exact same reactions. What happens to one patient soon becomes the fate of all, at least from an outsider's point of view. Further, the mesosocial level is eliminated from these comments: help networks and families are presumed to be too far away to have any effect on the patient's southern transit.

It is obvious that problems do exist; patients leaving the north on quick call sometimes do not have enough clothing on them, do not have any money, have not found a babysitter or wonder how their families can provide for themselves. However, most patients usually have time to prepare their departure, and the trip down south is often lived as an extension of northern life rather than a rupture. It is even difficult sometimes for them to feel away from the north: for example, some women are harassed by their husbands calling them in the hospital and insulting them because they think they are having too much of a good time down south.

Observations also showed that the Inuit were actually doing many more things in town than just getting medical treatment and, more often than not, they combined these with economic, religious or social activities: they bought for themselves or for others all sorts of goods hard to find up north (such as books, alcohol or mechanical parts); purchased items that were less expensive in the south than in the Arctic; occasionally sold furs,

jewelry, clothing or sculptures; or combined medical appointments with board meetings in urban head offices or with political meetings.

Proselytism was often associated with their stay as, for example, when they gave bibles to the interpreters or evangelical speeches to the nurses or other patients. At least one patient is known to have brought his wife along with him so they could have some vacations in the south while he followed his medical appointments. Others went to see movies or sporting activities, and some also met other Inuit that they had long wished to see but that circumstances or distances between villages prevented. Reciprocal relations and a spatial extension of community life were often evident in these activities, following patterns related to those described by Nowak (1987).

As Louis-Jacques Dorais (pers. comm.) put it, the first thing that comes to mind is that these transits to urban centers are quite similar to the old visits to trading posts where people also did much more than just trade. It is also interesting to note that Inuit patients who could move around would often leave the hospital during the day, if they did not have any medical treatments coming up, and visit shopping centers.

Once the patients are in town, they must adjust themselves to the new situations they encounter. Reactions vary from the reactualization of northern activities to the adoption of new behavioral schemes. For example, patients that must stay a long time in the south will often follow the succession of northern activities and will become nostalgic when the hunting or fishing season is about to start. Manual activities (such as knitting and sewing) are important occupations and help alleviate stress, occupy time, justify visits to shopping centers to procure missing material, or help establish contacts with other patients through a shared interest.

Patients usually create a private space so they can continue some of their normal activities or isolate themselves from an imposed public environment. The hospital room, even if shared with others, constitutes a sphere where personal involvement is

evident. The bible placed near or under the pillow, various personal items and the television serve as territorial markers.⁴ Public spaces in the hospital are rarely visited and contacts with Eurocanadian patients are limited to those sharing the room. Social and professional visits from the medical interpreters also occur only in the patients' rooms.

This retreat to a personal space bears likeness to what Goffman (1972) calls "secondary adaptations," and provides the Inuit with the possibility to distance themselves from other patients or from the medical personnel. The patients also insist on keeping a part of their personal belongings on themselves when they are in hospital. Underwear, socks, or *alirtiit* contribute to their comfort and palliate the aggressive aspect of the institution's statutory accessibility to the body.

However, recreating a private space is not feasible for everybody. The problem is particularly evident for women who have just had a baby, and this for at least three reasons. First, it is difficult for the women to experience in solitude an event that holds such symbolic and social significance. Second, the women are not sick but they have less mobility than many other patients and have to restrict their movements to a limited area. Third, it is almost impossible for Inuit patients having babies to recreate a private space when they share rooms with Eurocanadian women who practically transform the room into an extension of their own domestic sphere: one Inuk had very little space to move around since the Eurocanadian woman with whom she was sharing her room had dispersed the gifts she had received all over the room (chocolates on the table, clothing on the shelves, and teddy bears on the window sill) and acted as a quite occupied hostess when she entertained her numerous kin. The Inuk was confronted with a microsocial environment to which she could not identify, and projected her isolation in her yearning to talk with other Inuit, a macrosocial identification and distancing mechanism.

Other types of adaptations are also evident down south. For example, youths often stop smoking while in town because they do not appreciate the adult Eurocanadians' comments: they thus

adjust themselves, in this case, to southern moral codes. Occasionally, changes include quite profound transformations in the patient's behaviour: one man drank a great deal everytime he was in town, whereas he never touched a drop up north. Each time the medical interpreters would tell this story to other Inuit, people would never believe them. The new diet is a welcomed change for some, but a big problem for others. However, most grievances concern the fact that little venison is available, and when it is, it is limited to caribou with little or no fish.

Changes can also be noted in clothing or general attitudes. For example, patients often arrived in the south with their nicest clothing, one even put on her high heels for the occasion; those that were not used to dining out quickly learned the etiquette in restaurants; many also asked permission to smoke in certain places such as cars or living rooms (which were considered "public" when in boarding houses). All these changes, even if apparently unimportant, show that the Inuit adjust themselves discretely to southern rules.

It is also typical for patients in the hospital to be late when the time to leave approaches, as opposed to patients that are in boarding houses and only need a split second to get ready. This is probably due to a shift in the ordering of time in the hospital. Whereas the restructuring of the patient's rhythm of life could be seen as an additional aggression of the biomedical system, it usually seems to be quite the opposite and proceeds from an adaptive structuring by the patients to rethink the passing of night and day in the hospital, to reorganize their lives in order to alleviate the stress of hospitalization.

The patients usually have to "warm in" to the system, and they have to gradually make the necessary adjustments just as they have to gradually "cool out" when they are ready to go back north. An efficient way to accomplish this north/south transition is by the creation of habits, by establishing a routine. Thus, patients usually prefer going to hospitals or boarding houses they have already seen: they limit the unexpected and know where to find the stores they visit, are less afraid to get lost and can find

their way around a part of the city. Habits are reassuring and they also prefer meeting nurses, interpreters or drivers they already know. Quite often, and to make sure that they have a certain control over the organization of their stay, the patients call down south and reserve a place in the boarding house where they want to stay. Sometimes they will even prepare months in advance, a long time before Patient Services even know they will be having a medical appointment down south. They also frequently express the wish to meet the physician with whom they are familiar: one woman had made a hat for "her" doctor and was planning to make him a pair of gloves for her next visit.

Some youngsters have trouble adapting to the south and separation from their family is quite difficult. However, others would prefer staying much longer when they have finished their treatments. They have made friends and would like to live down south where life seems easy, and for good reason since they do not have to go to school, they receive gifts from everybody and have their own rooms. The children that are afraid to leave home are usually "briefed" by their families and friends on the things they can do in town. In one case, a young boy's friends made telephone calls to people they knew in Quebec to make sure that he would be visited and taken around town when he would be there.

However, it is necessary to add that it is easier to appreciate their stay in the south when they are not very sick. Also, those that have family problems are inclined to look elsewhere than at home for solutions. One person explained that her mother had been hospitalized many years in the south during the tuberculosis epidemics in the 1950s, and whenever she would argue with her husband she would say: "I should have said no when the doctor asked me if I wanted to go back north." It is also interesting to note that many patients must also readapt to northern life when they go back home, even if they were not gone a long time. As one put it: ". . . when I come to Quebec or Montreal, I have to take some time to get used to (being) here, and then I can do all sorts of things. But when I go back

(up) north I have to get used to it all over again because it looks like there's nothing to do. Going back is like . . . like (being in) a cage."

One of the immediate effects of southern hospitalization is the separation of the patient from his social support network, which Jacobson (1987: 44) has roughly defined as the system of social relations through which various health-enhancing elements are mobilized. However, various processes in the south reactivate ties with northern social support networks and/or compensate their normal activities. For example, the support network's activities are extended by the resort to help, offered by or asked of, people not normally associated with the patient. Thus, the first thing the patients usually do when they arrive in an urban center is to ask if there are other Inuit in town; they want to know how many, where and who they are. Strong bonds are then built between some patients: they offer each other moral support, counseling or financial help; visit each other and sometimes translate between patients and Eurocanadians; often meet to go shopping together and help the handicapped to move around.

The Inuit also receive support from Eurocanadian patients: linguistic problems are usually resolved with body movements and sometimes by Eurocanadian patients acting as French/English translators; one Eurocanadian patient would advocate for an Inuk woman that was sharing her room everytime she had the impression the medical staff was not being cooperative enough.

Spontaneous and contextual help is often offered from other southerners unknown to the patients. For example, travelers in the airport or taxi drivers in town have helped Inuit patients that seemed lost. In the airport, security measures are sometimes less strict for the Inuit patients, and pilots will occasionally have a plane wait for a patient that arrives late. Neighbors of boarding houses pitch in to help the patients either by giving them clothes, by showing them around town or by keeping them company when the housewife has to leave. The patients also get moral, physical or financial help from the boarding house families or the medical staff that organizes their stay.

These various options tend to install a communal mesosocial help network around the patients. It must be noted, however, that this network is forever changing, situationally defined, and subject to the same interpersonal and socio-economic variables that determine the patients' access to various support groups. One particular macrosocial variable is determinant in this case: that of ethnic affiliation. Many non-Inuit patients thought the Inuit patients seemed "pitiful;" they would extrapolate this from their quiet, reserved attitude.

On the other hand, the patients' usual social support networks are also activated by a south/north communication network pivoting around the patient. The medical staff often contact northern nursing stations, from which information may be transmitted to the families; nurses regularly send news of long term patients by radio through CBC's northern service in Montreal and the communities generally listen in on the patient's health and when he/she should be going back home. This service contributes to the mass-mediatization of health at the mesosocial level, thus adding a dimension to the microsocial discussion of the health status of patients that are outside the northern communities.

These services towards the north are usually counterbalanced by an informal communication network directed towards the patients: they often telephone their families, write letters or send parcels. Contacts between north and south are also established by "messenger-patients" that carry news, parcels or letters of families or patients with them. These "messengers" link families and patients, but also various members of the northern communities with Inuit working down south.

Families also telephone nurses to advocate or plead on behalf of the patient for better medical care, services or support; a woman kept calling the nurses because she felt her child was not getting adequate care; another person having accidentally injured two children regularly telephoned them to hear how they were and to know if they needed anything. Thus, be it by long distance contacts, by visits from other patients or by the medical

personnel, the Inuit in town usually knew what was happening up north and information about the people in town circulated along numerous paths.

The model is, of course, ideal since a certain number of factors determine the composition of the support groups upon which the patients could count. Gravity of the illness was important, since quite unexpectedly, when people were very sick, they had a tendency to see less people; age was also determinant, as the elderly received more visits; length of the stay was significant, since Inuit being longer in town got to know more people; ability to transact with Eurocanadians was quite important, for those that were less shy or familiar with them would open up more quickly; linguistic competency was sometimes important, since those speaking English could learn more things or speak to more people, although those that spoke only Inuktitut (particularly the elderly) were quite expressive and could communicate easily; personality was also a decisive factor, as the degree of support received was affected by the friendly or forbidding attitudes of the patient (as well as of the medical personnel and the other Inuit); the number of Inuit in town was seen as significant, since the contacts between Inuit patients were multiplied and active when they were many; sex was determinant, because women were usually more inclined to create stronger bonds between themselves than were men; finally, patients that were known to suffer from social stigma in the north (for example alcoholics) were sometimes shunned in the south by other patients.

Apparently, it seems that the patients' southern transits constitute the crystallization of a set of social relations aimed at facilitating their stay. When problems are encountered they are confronted alone or with the help of various people.

Medical staff, interpreters, and boarding house personnel were asked who they thought most helped the patients during their stay. Indicative of their social commitment, these various actors suggested that it was probably one or the other among them that was most important in the organization. Families and other Inuit patients were rarely seen to contribute in any

significant manner. However, when the same question was asked to the patients, they very often answered it was the doctor. If they were asked again who, apart from the doctor, had helped a great deal, they had difficulties in seeing any sense to the question. Of course, they had appreciated visits by the nurses or the interpreters, but they also complained that the latter did not visit them enough, that the former did not take them shopping, that nobody had offered to show them around town, and so on.

The patients rarely accredited the mediation or advocacy activities these actors were doing to insure the Inuit had better medical care or services. The patients were down south to get cured, and that was of utmost importance. They adapted to all sorts of little aggressions, but the search for well-being was omnipresent.

DECISION-MAKING AND DOUBLE-STRATEGIES

Patients do confront some problems, but reactions to these vary greatly from one person to the other. They are also rarely alone to cope with predicaments and call upon various resources to maximize their socio-cultural adjustment to southern evacuations.

Social problems usually highlighted in the literature are not necessarily what the Inuit patients identify as most important. In fact, the distinction is a major one since the Inuit do complain about nutrition, clothing or visits; these are considered an area where they do have an effective resolution power and a right to change the situation. However, it must be noted that these questions are usually considered minor by the Inuit.

This brings us to a methodological issue, since when asking the patients directly if they had any problems, the usual reply would either be "no" or some answer about the quality of food, odours, store hours, etc. In fact, these replies would probably be elicited from anybody hospitalized, just about anywhere. Thus, extrapolating any symbolic or cultural importance in these matters seemed a little exaggerated. This was also the opinion of some

patients who suggested that some Inuit would always be complaining with little justification.

On the other hand, questioning in the dubitative mode (e.g. "naluvunga inna tukisimangat . . ." = "I wonder if that person understands . . .") would often elicit a different kind of comment, usually related to the type of contact the Inuit had with the people they encountered. People would then open up more freely to talk about the medical problems of other Inuit. What then became evident was that the patients evaluate the medical care they receive: they are sometimes angry when they go back north and feel they did not get all the answers they expected; they are frustrated to come back many times for the same treatment and feel the care is inadequate; they get upset when they think interpreters have trouble communicating with the doctors; they dislike some medical interventions; and they sometimes consider the medical personnel to be confused, namely when they receive "orthodox" medical advice from the doctor and contradictory "alternative" advice from the nurses (in one case the doctor suggested that the patient get a lump removed from her breast, whereas the nurse insistently told her that it was an unnecessary medical intervention).

Problems associated with medical care were usually discussed with a more limited audience. Nevertheless, other Inuit patients, boarding house personnel, interpreters and nurses from Patient Services were common interlocutors. While these networks essentially centered around the circulation of information to facilitate the decision-making process, rather than the resolution of the problems, it was evident that the patients reacted to the problems encountered and very rarely felt completely overwhelmed by them. When this did happen, for example, when a patient had to decide about a risky operation, the decision-making group was extended by the patient deciding to go back north to discuss the question with family members.

The patients, the interpreters, and the staff organizing the medical evacuations are usually aware of the roles they have to play in the system, and of what is expected of them.

Furthermore, if most medical actors have to advocate or mediate at one time or the other, the patients also assume these roles. The question then does not concern the efficiency of the resources available to the patients, but rather the fact that they are called upon by the patients to participate in an informal social support network.

In fact, everybody seems aware of the difficulties usually associated with intercultural care, however they have to bear or minimize them to continue delivering services. The same goes for the patients who often wish to go down south but do not want to be staying too long. Medical evacuations to urban centers are thus characterized by double-strategies since all actions, and all decisions are but necessary compromises, rather than solutions.

What is more important is the fact that if the Inuit were not used to maximizing their resources, if they did not usually activate community networks in problematic situations, and if they did not understand administrative complexities, then all the good intentions, all the personal involvement of the medical staff would probably be useless. To paraphrase Serres (1985), one might say that the Inuit have learned to live in a continuous relationship with interruptions, they are familiar with them, and they are themselves acclimatized. If the Inuit were not at least partially immunized to various Eurocanadian aggressions, then the transit to the south would be the equivalent of a real suicide.

To illustrate the capacity of adjustment and the occasional deployment of coping strategies of the patients is in no way an inversion of the paradigm suggesting that the Inuit are victims of the biomedical system. Problems of social iatrogenesis have been extensively and quite accurately described already, so the objective here is rather to show how the Inuit make use of different resources down south, just as they do up north. One of the obvious problems with this approach is the possibility that the adjustments presented herein could eventually be understood as "voluntarist," which is certainly not the case. It is necessary to repeat once more that problems do exist, but they are part of the poisons with which the Inuit learned to live in order to survive.

Thus, it might have been interesting to include in this article some detailed case studies to better illustrate secondary gains associated with the use of medical services, expand on the creation of personal space, or explain the cultural bargaining of health care. However, the Inuit patients do not adapt along a prepared plan, they do not have any organic way of confronting new situations and, just as everybody, they react here and there without always controlling the end results. None of the experiences of the patients could explain adequately the wide range of possibilities and personalities that determine the direction and the degree to which the Inuit accommodate to health care in urban settings; this is why a more general, albeit short, mode of presentation is preferred in this article.

The patients want changes, and they have the right to ask for them. However, the question discussed here is that the scientific literature, when concentrating on problems only rather than on the way people get around them, practically states that the Inuit are socially lobotomized. Clearly, this is not the case, since they understand how the biomedical system functions and have learned to short-circuit it sometimes; for example when women play on their conception date to save time because they do not want to deliver down south, or when some people harass the northern medical personnel with an ambiguous illness because they want to go down south.

If the Inuit or Eurocanadian scholars and politicians discuss the relations between the Inuit and the biomedical system, there is no logical reason to transpose problems from the macrosocial level to the microsocial level. The question of the marginalization of the Inuit at the macrosocial level is one thing, and it may be debated, however at the microsocial and mesosocial levels people are discussing the conditions necessary to obtain adequate care, which is their ultimate concern. Each level has its own logic and rules; strategies for the macrosocial, but tactics for the microsocial.

It is necessary to recall that major problems are isolated cases. However, when they do occur, the use of the argument of

ethnicity tends to be abusive, since Inuit are reacting to and confronting the problems just as anybody, anywhere.

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NOTES

¹Arqaluk Lyngé, Minister of Social Affairs in Greenland, poetically translated this encounter as: "You import illnesses, and give us a hospital" (Stenbaek 1985: 10).

²(Cf. Avataq 1984: iii; Blake 1978: 15; DeLapp and Ward 1981: 70; Descent 1986: 25; Dixon and Kirchner 1982: 120; Dufour 1988b; Fortune 1987: 20; Labbé 1987: 75-76; Lantis 1959: 4, 50; Lucier *et al.* 1971: 252; Milan 1974: 29, 32; Murphy 1987: 52; Wenzel 1981: 13).

³Patient Services is an organization designed to escort the patients in Quebec City, set their medical appointments, assure translation services and arrange boarding facilities.

⁴The expression is from John O'Neil (pers. comm.) who also notes that "the ability to create personal space in a crowded environment (i.e., snowhouse, tent, or frame house) is very much a part of their culture."

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