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# MULTIPLE MEDICAL REALITIES

## Patients and Healers in Biomedical, Alternative and Traditional Medicine

Edited by
*Helle Johannessen and Imre Lázár*

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# Self, Soul and Intravenous Infusion

## Medical Pluralism and the Concept of *samay* among the Naporuna in Ecuador*

*Michael Knipper*

Medical practice among the Kichwa-speaking, native population of the lower Napo River in Ecuador, the Naporuna, appears to be a classical situation of contemporary medical pluralism with 'traditional medicine' (or 'ethnomedicine') and 'Western biomedicine' as its main elements. This article is about one specific aspect of the pluralistic medical practice of the Naporuna, which gained increasing importance for the medical anthropological fieldwork I conducted in this region from 1997 to 1999. The question I will focus on is how an indigenous concept, like the Kichwa-notion *samay*, shapes the perception of biomedical devices and services by Naporuna patients and their relatives.

In Kichwa-language dictionaries and related ethnographic writings, *samay* is usually translated as 'breath', 'respiration' or 'rest' (Orr and Wrisley 1965, Mugica 1979, Cordero 1992). Other, more extensive interpretations and my own observations suggest that the notion *samay* refers, at the same time, to a very broad and complex understanding of such diverse issues (from a 'Western' point of view) like 'soul' or 'soul substance', 'life force', 'personhood', the 'inner will' and something akin to the physical 'resistance' of a person (cf. Palacio 1992, Guzmán 1997, Macdonald 1999, Uzendoski 2000). A special relation to the realm of the so-called 'ethnomedical' beliefs, concepts or practices of the Naporuna or their Kichwa-speaking neighbours in adjacent regions of the Amazon is, however, generally not ascribed to this notion: Apart from a few references regarding *samay* in the context of shamanism and healing – for example, as 'the root of shamanic power' (Uzendoski 2000: 73) or as a means to strengthen the 'soul' of an ill or otherwise weak person by giving him *samay* in form of breath over the head (Guzmán 1997: 48, Uzendoski 2000: 89) – ethnographic descriptions of *samay* ascribe little importance to this concept for the Naporuna's treatment and perception of disease. Despite this apparently insignificant relation between *samay* and any kind of health-related beliefs and practices – 'traditional' as well as 'modern' – a more detailed examination of this issue, which was inspired by some particular experiences with the pluralistic medical practice among the Naporuna, was able to disclose the great significance of the beliefs, experiences and practices related to *samay* for the perceptions of both local and biomedical healing practice by the Naporuna. Of crucial importance for this approach was the relation of *samay* with the analytical category 'self', which is understood as the culturally shaped conception of human beings as individual persons.

The analysis of *samay* presented in this paper was primarily stimulated by very pragmatic issues related to healthcare among the Naporuna. During my fieldwork, I worked both as a physician and as a medical anthropologist while conducting a study about the so-called indigenous disease category *mal aire* ('evil wind' or 'evil air', cf. Knipper 2003). As a result, this article also shows the insights to be gained if one combines various theoretical perspectives towards disease, health and healing – including critical approaches towards biomedicine and essentialist conceptualisations of issues like 'disease' or 'medicine' – with the pragmatic and therapeutic attitude of a health worker. As all the data and interpretations presented below are influenced by the double role I played among the Naporuna, they have to be preceded by some remarks on the particular fieldwork conditions and a reflection upon its main methodological consequences.



## Fieldwork conditions and methodological remarks

I conducted my fieldwork in the region of the lower Napo River (see map, Figure 9.1) for a period of about twenty months between 1997 and 1999. While I was attending to patients, either alone or with indigenous community health workers in the small health posts of one of the Naporuna settlements along the river, I became an active part of the therapeutic pluralism in the region.

Communication took place mainly in Spanish and some in Kichwa. In these situations, the company of key informants and research assistants among the community health workers proved to be very helpful. They not only were able to provide me with detailed translations of Kichwa statements but also commented on and contradicted my interpretations and provisional conclusions.

The area of my study was the region between the provincial capital, Coca, and the Peruvian border at Nuevo Rocafuerte. The river provided the sole route of communication and transportation in the area. The distance between

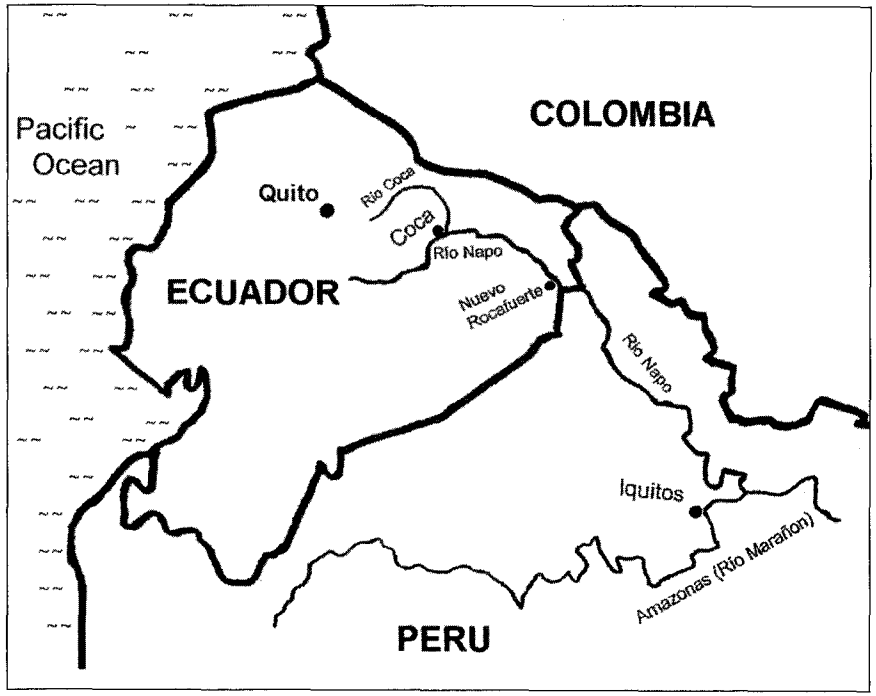


**Figure 9.1** *Map showing fieldwork site: The region of the Lower Napo River, Ecuador*

Coca and Nuevo Rocafuerte is about 300km. In Coca and Nuevo Rocafuerte there are some hospitals, but the quality of attendance especially in the public hospital of the provincial capital is poor, and the private clinics are expensive. Occasional biomedical services are provided by the Ecuadorian army and oil companies, but the most reliable health service is supplied by the community health workers, nurses and physicians of a primary healthcare programme, which is carried out by the diocese of Aguarico and the Federation of the Naporuna Communities (FCUNA).

Regarding the methodological consequences of my engagement within the therapeutic pluralism of this region, I will mention here three basic points:[1] First, I got in touch with the patients and their families at a time when the disease outcome remained uncertain, when the interpretation of the case was still being negotiated and important decisions had to be made. In this moment, any specific disease condition appears very different from the retrospective view developed in an interview and from when the patient is already cured or deceased.

As a second point, in this moment of acute, threatening disease and subsequent actions, the biological aspects of the affliction – the ailments, the symptoms, the materially tangible signs – play a dominant role and can not be



ignored. They definitely do not neutralise or extinguish other aspects, such as the social or the search for meaning. The physical and the social are not mutually exclusive categories: every bodily expression as well as the perception of material signs are culturally shaped. But the overwhelming presence of pain, blood and concrete suffering helps to avoid a merely 'aseptic' and predominantly theoretic perspective upon disease, healthcare and medical pluralism, where sickness appears to be a mainly socially or culturally defined issue and medical pluralism to be a problem of primarily theoretical and academic interest.

Third, I was able to observe the way people actually used my medical service in the everyday practice, how they explained to me, for example, their complaints, desires and priorities. In regard to the topic of medical pluralism, I could appreciate from a really well situated observation point the specific contexts in which people came to consult me as a physician (most of the time as the only physician on trips lasting one to two days) and in which they did not consult me. On several occasions, when I was present – in a household or at a public meeting, for example – and someone fell ill, no one asked me to help. And several times I was indeed asked to help, but not as a physician able to supply antibiotics, antimalarials, aspirin, other pills or a little surgery, but in a 'traditional' way: I was asked to blow tobacco smoke upon the ill person or to fan strong-smelling leaves over the patient in a group of about five or six persons, producing a wind that was supposed to cure. In these situations, I had the impression that for the Naporuna it was evident that biomedical aid was not necessary and that what was going on had nothing to do with my knowledge and experience as a physician. They were able to do me the great favour of perceiving me as a 'normal' person and not exclusively as a physician. I was happy and impressed. The 'biomedical doctor' did not disturb, and people did what they thought had to be done for the patient, independent of my presence. But I, from a methodological point of view, enjoyed the particular opportunity to observe how the people acted in situations when the two main elements of medical pluralism – local methods and biomedicine – were present and equally available. In other situations, the same people with often 'identical' problems (from my point of view: coincidence of symptoms, etc.) came to consult me, woke me up urgently at night or asked me to come to their homes to look after a patient. I remember even some cases, where I was initially asked to help by shaking leaves, and some hours or days later to provide biomedical medicines.

The most instructive and fruitful situations of my research have been those where I worked together with one of the 'indigenous healers', the *yachak*.[2] In such moments of combined treatment, I began to ask myself the questions which brought my attention to the notion of *samay*: How do people perceive my biomedical treatments? Why do they ask me for help and what do they expect? Their enigmatic decisions to ask or not, to explain their complaints or not, the words some patients used to describe their problems and expectations in my consultation office ('do you have injections?') and many other

observations, made me think of the way they perceive biomedicine – a kind of perception, that did not coincide with mine. But what was the difference?

One of the key experiences that helped me develop a meaningful answer to this question was one of these 'bi-cultural' healing sessions. It was the story of the little girl Maria.[3] Apart from some hints in regard to the questions related to *samay* and the indigenous perception of healing, this case study also provides a vivid insight into the living conditions and the practical side of medical pluralism in the region.

## Maria

I first remember meeting Maria, as she sat in her godparents' home, where I came to look in on her ill cousin. She was a five-year-old girl and lived with her parents about half an hour walking distance from where we lived in this Naporuna community. While her cousin was suffering from abdominal pain, Maria appeared to be well; thus I did not pay her any special attention. Like on other occasions when I was called to see a patient in a household, a *yachak* had also been sent for. While I examined the boy and talked to the old and experienced *yachak* Don Valentín, I saw Maria sitting in a corner of the house in front of Rodrigo, a relatively young *yachak* and apprentice of the former, who was slowly blowing tobacco smoke upon her head.

One day later, Maria and her parents came to my office. She was astonishingly pale and weak. I became a little bit nervous because my therapeutic possibilities were limited. But the family felt unable to undertake a trip to the hospital, which is about 150 kilometres down the river. I treated her with antiparasitic drugs and advised her parents immediately to take the girl to the hospital aboard any one of the commercial boats that travelled down the river every day. Only a few hours later, they again called and asked for my assistance, saying that Maria's condition was urgent. She was bleeding heavily from her gut and had fallen unconscious. At such a late hour on a dark, rainy afternoon in the Amazon, it was not possible to reach the hospital. So I sat half a day and a whole night together with Don Valentín at the girl's bedside. At the insistence of Maria's family, I put her on an intravenous infusion with a physiologically inadequate 10 per cent sugar solution, which I considered useless. I had no other infusion available because I had spent the last 'Ringer' solution on a patient bleeding from a considerable cut on his back a few days before. As the sugar solution slowly dripped into the vein of the barely respiring Maria, Don Valentín took his *aya waska* and began to sing the whole night long, quietly, softly but continuously. From time to time he interrupted his singing, illuminated the sugar-solution bottle with his electric torch and asked me: 'Does it go, Miguel?' Then, he went on singing and blowing tobacco smoke upon the girl. In this way, we spent the whole night.

In the early hours of the next morning, we managed to prepare a boat, to get gasoline and to take the trip to the hospital in Nuevo Rocafuerte. We arrived



in the evening and the little girl survived with the help of oxygen, blood from her mother and drugs against the tropical malaria she had contracted and the intestinal parasites, which had penetrated her gut. The infusion I had given her during the night, from the physiological point of view, could not have had any major effect. And the 'unspecific' pharmacological effect, identified generally in a more or less disparaging way as the 'placeboeffect', may have been important but cannot explain sufficiently the impact of the intravenous infusion in this concrete situation. The significance of this chemically defined and industrially produced object of Western hospital-based medicine lies far beyond the realm of physiological knowledge and biomedical beliefs.

What is really interesting here is the meaning of the infusion for the Naporuna involved in Maria's disease history; for her parents, the relatives and friends present in the house as well as the *yachak*, the same people who had to convince me, the Western physician, to put the child on an infusion, which I myself considered as lamentably useless. The indigenous concepts relevant in this situation can further explain why people asked for both Don Valentín and me to help, and what they expected from our therapeutic efforts. Evidently, they did not distinguish between 'spirits' and 'soul loss' as regards Don Valentín and 'sugar solutions' and 'fluid replacement' while thinking about my biomedical efforts.

Possibly, during these extended moments at the bedside of the little girl, no one thought reflexively at all about these issues because they had other, more urgent preoccupations: Maria's life was in danger. Upon first observation, it is evident that the major motivation to combine both 'traditional' and 'Western' medicine was the urgent character of the problem and the uncertainty of its causes. Furthermore, both options were available: Valentín and I were present and respected by the people. But apart from the mere acknowledgement of the compatibility between different medical conceptions and therapeutic options as a matter of fact and of little concern for contemporary research (Miles and Leatherman 2003: 9), it remains interesting and relevant to look for positive statements to the question of *how* the integration of strange medical devices and practices succeed and *what* the relevant cultural patterns and perceptions are. The significance of the intravenous infusion in the situation described above had to do, in particular, with *samay* and the Naporuna's perception of body, self, soul and personality. Sugar solutions, blood pressure or renal circulation, in contrast, were as insignificant as clear-cut 'ethnomedical' beliefs with their narrow focus on local 'disease categories' and the supposed 'indigenous' elements of medical pluralism.

## *Samay*

The following approximation of the indigenous concept of *samay* is based on translations and explanations found in Kichwa-language dictionaries and in ethnographic literature about Amazon Kichwa-speaking populations and,

secondarily, other linguistic groups of this region. The search was focused especially on topics related to the perception of 'self', 'personhood' and allied topics. It was interesting to note that even among the heterogeneous Kichwa-speaking peoples, these concepts are not necessarily denominated with the same expression.[4] By the way, it was not intended to develop a complete and ultimate bibliography of this issue among indigenous groups in the Amazon. A third type of data are, finally, my personal observations during fieldwork.

According to relevant dictionaries of the Ecuadorian Kichwa language, the translation of *samay* generally consists in the notions 'breath' or 'respiration' (Orr and Wrisley 1965: 76, Mugica 1979: 106, Cordero 1992: 102) and 'rest' (Mugica 1979: 106, Cordero 1992: 102). The verb *samana*, accordingly, is translated as 'to breathe' and 'to rest'.

In various ethnographic studies, in contrast, the meaning of *samay* appears to be much more complex. The suggestions of Whitten (1985), Palacio (1992), Guzmán (1997) and the extensive work of Uzendoski (2000) coincided to a great extent with my own observations and proved to be especially useful for my interpretations.[5] Suggestions from other regions came principally from the very instructive contributions of Conclin and Morgan (1996), McCallum (1996) and Pollock (1996) to the ethnography of indigenous conceptions related to 'self', 'soul', 'personhood' and 'illness' among different native groups in the Amazon.

In synopsis, the different aspects of *samay*, which must be seen as linked and interwoven, can be described as follows:

In parts, *samay* coincides with the traditional Western and Christian notions of 'soul', though it must be differentiated from a concept expressed by the Kichwa word *aya*, which frequently becomes directly translated to the Spanish word *alma*. In contrast to *samay*, *aya* refers mainly to the soul of the deceased (cf. Mugica 1979: 83, Palacio 1992: 15–19, Uzendoski 2000: 75). To go further, it may be useful to describe *samay* as a kind of 'soul substance' (Uzendoski 2000: 71, 76) materially tangible in the 'breath' of a person and representing what is known in multiple cultural contexts all over the world as 'vital energy' or 'vital force' (Whitten 1985: 108). The 'inner power' of an individual person to live, to act and to realise his work belongs to the realm of *samay* (Guzmán 1997: 46), as well as a person's 'spiritual' and 'physical' resistance against any kind of disturbance (if one decides to introduce this problematic, but sometimes useful, dichotomy between the 'spiritual' and the 'physical' into analysis). It correlates to biomedically definable diseases as well as to the fright, for example, which follows the encounter with a spirit in the forest, or a condition like *mal aire* (Uzendoski 2000: 78).

Another aspect of *samay* comprises what can be described as 'personhood', the individual character, abilities and qualities of a human being (cf. Guzmán 1997: 46). The 'will' of a person, his ability to 'understand' and to 'comprehend' are part of this broad concept.

In addition to the various semantic and conceptual dimensions of *samay* described until now, both Guzmán (1997: 46–48) and Uzendoski (2000: 73–78) describe two further and especially important observations, which coincide with the observations of Conklin and Morgan (1996), McCallum (1996) and Pollock (1996) that relate to 'soul' and 'personhood' in other ethnic groups of the Amazon: they point out that *samay* is not a constant quality of the human being, but that it changes over time and can increase and decrease depending on the actual situation. Further, *samay* circulates among people: it can be transmitted among humans and non-humans and can be increased or reduced by the action of third parties, mainly by *yachaks*, spirits of the forest, mountains or rivers, or by the souls (*aya*) of ancestors. The *aya* are supposed to walk – for example after their funeral – through the forest or near the households. These two aspects, the dynamic and communicative qualities of *samay*, proved to be very instructive in relation to my own observations in the medical field.



I will conclude my description of *samay* with some examples, which I hope can link together the different aspects of *samay* mentioned above.

The most common and frequently described situation of 'filling up' *samay* is the preparation of a young individual to become a *yachak*. Here, the transmission of *samay* takes place when an old and powerful *yachak* blows his breath upon the head of the other person; thus the young receives the *samay* of the old so that he or she may one day become a *yachak* too. A further source of an especially powerful kind of *samay* for any *yachak* are the different 'spiritual beings' known by the Naporuna by the notion *supay*. The more or less voluntary encounter with a *supay* in the forest, for example, can result in the transmission of *samay* of extraordinary power and quality and can prompt the initiation of a career as *yachak* for a person who previously had not aspired this.

Another occasion of 'filling up' *samay* is directly after birth. When a child is born, it lives (it is breathing, moving, eating, crying, etc.) but it is weak and vulnerable. It is helpless, with little vital power and easily falls ill. Consequently, a newborn baby is supposed to have little and really weak *samay*. It is well known among the Naporuna that the first year of life is the most dangerous. For this reason, old people and sometimes a *yachak* blow upon the head of a newborn child. The breath in this situation is also called *samay*. Nowadays, this custom is losing importance and people associate 'blowing' upon a baby with the transmission of specialised *samay*, i.e., to prepare it to become *yachak*.

During the further life cycle of a person, when a child grows up and becomes an adult, personal *samay* is supposed to increase. The individual gains power, resistance and the ability to realise his or her life in a more and more autonomous way. Working, having a family and living in harmony with kith and kin are of overwhelming importance in becoming a 'person'. All this, as my informants told me, correlates to having a strong and resistant *samay*. But when disease befalls a person, *samay* decreases. He or she cannot work, cannot fulfil the obligations of reciprocity, social activities are interrupted or decrease and he or she is in danger of dying. Consequently, it

is necessary to fill him up with new *samay*, with power and resistance. And so, every curative action of a *yachak*, when confronted by a serious or threatening illness consists of or is accompanied by the transmission of *samay*. No threatening disease is treated without blowing upon the ill person's head.

Normally, this responsibility falls upon a *yachak*. But if no one is available, any person with 'strong' *samay* can do so. And much like the breath of a *yachak*, blown upon the head of an ill or otherwise weak person, the liquid of the infusion bottle, which slowly dripped into Maria's vein and the coloured pills called 'vitamin compound tablets' or 'ferrous sulphate and folic acid dragees', prescribed by the physician for mothers feeling weak and tired, are understood to be a 'modern' kind of *samay*. And this indigenous perception is 'proven', when, for example, the intravenous infusion of an adequate solution strengthens a weak person, who from the biomedical point of view has suffered from dehydration. Similar situations are given day by day when young mothers or (generally as a consequence of intestinal parasites) anaemic children recover a few days after taking iron pills.

The actions and corresponding material objects introduced by the physician hold (or gain) indigenous meaning, which makes them 'useful' in a more than purely material or pragmatic way. People neither stop thinking when they are confronted with formerly unknown or strange methods of treating disease, nor do they passively adopt the biomedical theories and beliefs behind these objects and practices. And although Western biomedicine does not accept ideas like 'vital power', 'life force', *samay* or the Chinese *qi* as relevant for its theoretical models (cf. Kleinman 1995: 36), this by no means excludes patients (and even some practitioners) from considering this dimension when dealing with biomedical devices, services, institutions and staff.

## Conclusions

On several occasions, the interpretation of *samay*, as described above, proved to be useful to my work as a physician among the Naporuna. Recognising *samay* as a highly flexible indigenous category of perception, which comprises such apparently disparate issues like 'breath', 'respiration', 'soul', 'personhood' and 'vital force', considerably improved my ability to communicate in the quotidian cooperation with patients, their relatives and *yachak*. It provided me with a suitable explanation for the, at a superficial glance, surprising and apparently 'irrational' way the Naporuna employ biomedical devices and services – a problem physicians, medical anthropologists and other strangers also have to face in regions other than the Amazon.

With this outcome, the major goal of my study was achieved: The health related decisions and the behaviour of Naporuna patients and practitioners no longer appeared to be as striking and astonishing as they did initially. I was able to understand patients' complaints better than before and to explain them my own opinions and interpretations in respect to a concrete disease or health problem in a more appropriate way.



Through my active involvement in the health-seeking process, with nearly daily contacts with patients and different kinds of 'local healers', the apparently clear-cut boundaries between different 'medical systems' lost all of their seductive power. In the real life of patients as well as practitioners, this distinction is of so little importance that it can be neglected without problems.[6] Dependant upon the aims of each study, it may or may not be useful to acknowledge the theoretical models and categories about medical pluralism, which have been developed to approach the structural and political aspects of this ubiquitous phenomenon. The application of analytic categories like 'medical system' or 'practitioner systems' for example, which proved to be helpful and instructive in some occasions, can be misleading and confusing in others. And even the analytic tool called 'explanatory model', which I used widely in the first months of my fieldwork, turned out to be too unspecific. The usual methodological devices to elicit an indigenous Explanatory Model (as, for example, the questions proposed by Kleinman 1980: 106), proved to be too narrow to grasp meaning and to develop appropriate interpretations in the face of the observations I made (and the answers I got) at the Napo River.

To understand the disease-related concepts and behaviours of the Naporuna, it was necessary to relate them to a non-medical concept (*samay*) and to overcome the nearly instinctively made distinction between 'local' and 'Western' medicine. It was astonishing that all those aspects of the indigenous culture, which proved to be relevant in the course of this study, by no means fit into any kind of ('ethno-') medical categories and even lost this character if it had been assumed before. *Samay,* for example, is not an ethnomedical notion and any attempt to develop such an interpretation would result in a crude medicalisation of indigenous terms. Even notions like *mal aire* or the well-known *susto,* widely recognised as 'ethnomedical' notions of Latin America, could not be considered in a predominantly 'medical' way (cf. Knipper 2003). Among the Naporuna, these terms refer to a much broader set of experiences, knowledge and practice than those related to disease and health. In daily life, they are not used to describe mutually exclusive categories for the interpretation and denomination of health problems, and the related concepts have just as little importance for the choice (or rejection) of a special kind of treatment. As a consequence, there remained little support for any 'medically' biased classification of these notions.

Looking back to the beginning of my work with the Naporuna, the thought of ever relating such strange things like 'self', 'soul' and 'intravenous infusions' at that time seemed entirely absurd. But my attempt to understand what people did with, and thought of, my simple (and mainly biologically defined) work as a physician, brought me to this point. I must stress the impact of the methodology as an important determinant of the surprising outcome of my study. Far beyond the theoretical considerations mentioned above, which although very important, easily got out of sight during daily

fieldwork, the inductive character of my approach was responsible, to a considerable extent, for my results: I used the different techniques of gathering and analysing data with the explicit aim of eliciting comprehensible 'local' domains of meaning, knowledge and practice. With time (which is a very important factor!) and as a consequence of the repeated and critical reconsiderations of my contradictory and disconnected findings, insights into the importance of the notion *samay* arose during my field observations. The analytic category 'self', finally, did the same among the repertoire of my own intellectual devices.

## Notes

* I thank the editors of this volume, Helle Johannessen and Imre Lázár, as well as Volker Roelcke and Sahand Boorboor, for their very useful comments on earlier versions of this paper.

1. For a similar view on the specific 'bias' of anthropological research conducted by physicians, cf. Bolton 1995.
2. The Kichwa notion *yachak* is derived from the word *yachana,* which can be translated as 'to know'. The *yachak* are 'those who know' and their competence extends to a wide range of problems, from attending ill people to explaining disease, misfortune, etc. They achieved this via their connection to, and influence upon, the beings of the non-visible world, which is made possible, among other things, by the consumption of the drug called *aya waska.*
3. All the individual names are changed.
4. And sometimes it remains open, if the notion *samay* actually does not exist or is unknown among the particular Kichwa-speaking Indians described in some ethnographic studies, or if it was simply neglected in the course of the related investigation. This is the case, for example, in the early work of Whitten (1976) as well as in the books of Iglesias (1989) and Kohn (1992).
5. To a minor extent my research coincides with the writings of Whitten (1976), Hudelson (1987), Iglesias (1989) and Muratorio (1998).
6. In my experience, the only group of local actors which really pay attendance to this classification, are those 'traditional healers' engaged in the development of a professionally organised 'traditional indigenous medicine'.

## References

Bolton, J. 1995. 'Medical Practice and Anthropological Bias', *Social Science & Medicine* 40(12): 1655–1661.

Conklin, B.A. and L.M. Morgan. 1996. 'Babies, Bodies, and the Production of Personhood in North America and a Native Amazonian Society', *Ethos* 24(4): 657–694.

Cordero, L. 1992 [1895]. *Diccionario Quichua-Castellano y Castellano-Quichua.* Quito: Corporación Editora Nacional.

Guzmán, M. 1997. *Para que la yuca beba nuestra sangre. Trabajo, género y parentesco en una comunidad quichua de la Amazonia Ecuatoriana.* Quito: Ed. Abya-Yala / CEDIME.



Hudelson, J.E. 1987. *La cultura quichua en transición. Su expansión y desarrollo en el Alto Amazonas.* Guayaquil / Quito: Museo Antropológico del Banco Central del Ecuador / Abya-Yala.

Iglesias, G. 1989. *Sacha Jambi. El uso de las plantas en la medicina tradicional de los Quichuas del Napo.* Quito: Ediciones Abya-Yala.

Kleinman, A. 1980. *Patients and Healers in the Context of Culture. An Exploration of the Borderland between Anthropology, Medicine and Psychiatry.* Berkeley: University of California Press.

——1995. *Writing at the Margin: Discourses between Anthropology and Medicine.* Berkeley: University of California Press.

Knipper, M. 2003. *Krankheit, Kultur und medizinische Praxis. Eine medizinethnologische Untersuchung zu* 'mal aire' *im Amazonastiefland von Ecuador.* Münster: Lit (Spanish version will be available in summer / fall 2005 in Quito, Ecuador: Ediciones Abya Yala / CICAME).

Kohn, E.O. 1992. *La cultura médica de los Runas de la región amazónica ecuatoriana.* Quito: Ediciones Abya-Yala.

Macdonald, T. Jr. 1999. *Ethnicity and Culture amidst New 'Neighbors'. The Runa of Ecuador's Amazon Region.* Boston: Allyn and Bacon.

McCallum, C. 1996. 'The Body that Knows: From Cashinahua Epistemology to a Medical Anthropology of Lowland South America', *Medical Anthropology Quarterly* 10(3): 347–372.

Miles, A. and T. Leatherman. 2003. 'Perspectives on Medical Anthropology in the Andes', in J.D. Koss-Chioino, T. Leatherman and C. Greenway (eds) *Medical Pluralism in the Andes.* London and New York: Routledge, 3–15.

Mugica, C. 1979. *Aprenda el Quichua. Gramática y vocabularios.* Pompeya (Ecuador): Ediciones CICAME.

Muratorio, B. 1998. *Rucuyaya Alonso y la historia social y económica del Alto Napo 1850–1950.* (2. ed.) Quito: Ediciones Abya-Yala.

Orr, C. and B. Wrisley. 1965. *Vocabulario Quichua del Oriente del Ecuador.* Quito: ILV (= Serie de vocabularios indígenas 11).

Palacio, J.L. 1992. *Muerte y Vida en el Río Napo.* Pompeya (Ecuador): Ediciones CICAME.

Pollock, D. 1996. 'Personhood and Illness among the Kulina', *Medical Anthropology Quarterly* 10(3): 319–341.

Uzendoski, M.A. 2000. 'The Articulation of Value among the Napo Runa of the Upper Ecuadorian Amazon'. Unpublished Ph.D. Thesis, University of Virginia.

Whitten, N.E. 1976. *Sacha Runa. Ethnicity and Adaptation of Ecuadorian Jungle Quichua.* Urbana: University of Illinois Press.

Whitten, N.E. 1985. *Sicuanga Runa. The Other Side of Development in Amazonian Ecuador.* Urbana: University of Illinois Press.