

Health Service Provision in a Huichol Community in Mexico: an issue of Intercultural Communication

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Abstract

In Mexico, there is a high incidence of health-related problems among indigenous ethnic groups that are otherwise prevented and have a low impact in non-indigenous rural communities. The Mexican Ministry of Health acknowledges that this problem may be in part due to the fact that the vision of the indigenous patient regarding health issues has been omitted from official programmes. In this paper we show that although understanding cultural aspects is crucial in the development of a culturally-sensitive view of health care service provision, it is also of paramount importance to observe aspects concerning intercultural communication issues, such as differences in expectations regarding interaction patterns. The case of the Huichols, an indigenous ethnic group in Mexico, is presented.

Key words: intercultural communication, healthcare provision, Huichol

Introduction

Mexico is blessed with riches of many kinds. One of these is its ethnic diversity, and related to this an impressive array of languages. It is not widely appreciated that despite repeated attempts by a succession of centralising governments to homogenise society there are 67 officially recognised indigenous ethnic groups and that the number of spoken languages far exceeds that figure. According to the most recent national census (INEGI 2005), 6.7 % of the population in Mexico speak an indigenous language. By law, the languages spoken by these people are accorded the status of *national languages*, but in reality their use for official purposes is extremely limited.

The disparity between what is written in law and what occurs in reality can be seen when one looks at the operation of the health services. We find that the provision of the health services is limited and constrained by cultural and language boundaries. Consequently, one observes there is a high incidence of health-related problems among indigenous ethnic groups that are otherwise prevented and have a low impact in non-indigenous rural communities. These include infectious diseases of various kinds, cancer, high-risk child-delivery, poisoning caused by scorpion bites, the incorrect use of herbicides and pesticides, illnesses that stem from poor sanitation as well as a high level of preventable malnutrition.

The Mexican Ministry of Health acknowledges that such high incidence of preventable health problems and the low impact of current health programmes may be in part due to the fact that the vision (*Weltanschauung*) of the indigenous patient regarding health, disease, life and death has been omitted from official programmes and what we can call a western vision has been substituted and imposed. In their national plan of development for the period 2001 – 2006, for the first time, the Ministry of Health promotes an intercultural program of health which is expected to promote the pertinent changes both in the structure and operational mechanisms of the different entities involved in offering health services to indigenous and multicultural societies in the country. Some of the recommendations offered in this document to health service providers are:

- Find information about the characteristics of the target population regarding language, traditions, target population's vision of health and disease, and the way they deal with them.
- Learn a few words and expressions in the target population's language.

- Seek the assistance of interpreters.

We believe that understanding the vision of the indigenous ethnic groups regarding health and disease is an important step towards an intercultural health system; however, an area that has been neglected, perhaps involuntarily, is that of communication in intercultural settings, that is, intercultural communication. In this article we present an analysis of intercultural aspects of the consultation that occurs between health care providers (both in rural communities and in an urban hospital) and indigenous patients that arises as a result of our research. We hope to justify the need for further investigation and a re-thinking of how health services are provided.

The Huichol people

Huichol people (although they prefer to be referred to as *wixaritari*, plural of *wixárika*) dwell in the *Sierra Madre Occidental* range, in the Midwest region of Mexico. Their language, *Wixárika*, belongs to the Uto-Azteca language family. Unlike other ethnic groups, Huichol people have been able to maintain a certain level of autonomy. They have been able to adapt themselves to changes that society and the government have introduced because they cherish their own values and explore "with dignity" other cultures (Negrin 2006). Nonetheless, Huichol people, like the rest of indigenous ethnic groups in Mexico, are socioeconomically disadvantaged, have low levels of education, and live in areas where there are great environmental hazards.

According to the 2005 census report, there are 35 724 speakers of *Wixárika*, which represents the 0.59 % of the indigenous population in Mexico (6 011 202 speakers of an indigenous language). Fewer and fewer communities are exclusively monolingual *Wixárika* speakers. In fact, only 11.4 % (4 070 speakers) of the Huichol population is *Wixárika* monolingual, although the level of bilingualism varies, with a strong tendency for younger people to be more fluent speakers of Spanish, even at the expense of *Wixárika*. Most indigenous communities in Mexico have a functional specialization of their L1 and Spanish. Spanish is used in the so-called higher functions such as 'national' government issues, 'national' health care system, the media and education. Interestingly, the use of *Wixárika* is not only confined to the home and other personal domains of interaction between community members; it is also used in higher functions such as 'traditional' government issues, the performance of rituals including those related to health service provision via traditional healers or *mara'akate* (plural of *mara'akame*, Huichol shaman).

The Huichol vision of health and disease.

Rather than concentrating on health and disease, the Huichol conception of the world is concerned with what they describe as a state of balance. For the Huichol people, one is in a state of balance when the self and the family are in a state of grace with their ancestors who are best defined as the equivalent of deities in other cultures. How can this state of balance be altered or destroyed? From conversations with Huichol people over the past three years we have been able to identify at least three causes of 'imbalance' or disease.

Firstly, there is the belief that if one or a member of one's family does not follow what they call '*el costumbre*' (traditional sacred customs and rituals), the ancestors will be offended and will inflict a punishment (see also Furst 1972; Otis in press; Villaseñor et al 2006). The following testimony of a Huichol school teacher is a good example of this belief:

"... Some years ago I became very sick. I was in a community that is far way from my hometown. I visited one doctor and then another and nobody was able to tell me what my problem was. So I decided to visit the local *mara'akame* and he told me that my problem was because I failed to complete '*yuimakwaxa*' (a ritual in which every Huichol child must participate in October during their first five years of their lives). I was not aware of that and went back to my hometown and asked my father if that was true. He said it was true, so I went back to the *mara'akame* and he said that I had to comply with the ritual. My parents had to sit with me. I was then 23, and two of my children also participated in the '*yuimakwaxa*' ceremony. After that I started feeling much better..."

According to the Huichols a second cause of disease is more related with social issues and takes the form of so-called witchcraft. An evil spell is cast by someone who at one point attempted to become a *mará'akame*, but somehow in the process failed: being a *mará'akame* involves a long process of training provided by experienced *mará'akate* and the development of very specialized healing and skills that include interpretation of dreams, seeing beyond the present etc., whereas those who fail but nevertheless seek to practice witchcraft do not require such advanced skills (Otis in press; see also Villaseñor et al 2006). People who want revenge or who are envious of another member of the community seek the service of a failed *mará'akame* and this is how even when someone complies with 'el *costumbre*' some people get sick. This has nothing to do with breaking the sacred tradition. The following account was given by a Huichol housewife:

"... Right after I got married I started feeling very weak. I did not have the strength to go to work, to do housework, or even to stand up. I went to the *mará'akame* and he told me that my problem was caused by witchcraft. He was able to tell me the name of the fake *mará'akame* who had cast the spell and the person who had ordered it. Then I remembered that years ago that man, the one who ordered the evil spell, had asked me to go live with him and I rejected him. The *mará'akame* told me the exact place where the spell had been cast, a hidden corner in a mountain, and I had to go there and place an offering..."

A third cause of disease is supposedly a consequence of accidental contact with a physical entity; in other words, being at the wrong place at the wrong time. Sometimes animals (although some people believe that those animals are, indeed, *mará'akate* who have the ability to become animals) fight among each other. It is not a physical fight; it is a fight of energy which is visualized as 'arrows' by Huichols. Sometimes people walk into an area where a fight is being held and are hit by one of these arrows. The illness, in this case, does not usually manifest itself immediately. It can be weeks or even months before they become manifest, but the *mará'akame* is always able to track back the origin of the disease. In this case healing takes place in the form of a '*limpia*' (cleansing) and the *mará'akame* sucks the evil out of the body of the sick person (usually in the form of a seed or a small object). The patient is asked to bury the sucked out object in the place where the disease was acquired. Similarly, plants and trees are thought to have the power of making people sick. Huichols identify these trees and try to avoid touching them, but if by accident they touch them, they have to perform certain rituals to recover their health. The following is an account of a young Huichol university student:

"... there are trees that you don't touch. People in communities know it. For example, there is this one that we call "*Techuchan*". If you walk by it and touch it, five or ten minutes later, or perhaps half an hour later you get a rash and the only way you can get rid of them is making ash tamales. You hang them in the tree and stone the tree. And believe it or not, the rash will disappear. Many people who are not indigenous do it, even if they don't fully believe in these things, and it also works for them..."

Contrary to the idea that Huichols accept disease and even death with submission, under the argument that there is a feeling that one gets what one deserves (see e.g. Villaseñor et al 2006), our data shows that they cling to the hope of life. Having a state of balance is not an individual endeavor, but a social one. The whole family and the whole community work together and perform the rituals they are told to perform to help the ones whose state of balance has been altered.

Given the explanations to the reasons they get ill, getting well depends not so much on pills but by making amendments to the offended ancestor. Treatment is more associated with the performance of rituals and prayers, offerings, abstinence, fasting, pilgrims to sacred places, animal sacrifices, among others. It should be noted, however, that the Huichols distinguish between native and 'western' disease (Vázquez 1992; Casillas 1996). The cases described above are part of what they consider native disease, hence the preference to visit a *mará'akame* for help. The visits to the physicians are more associated with either the so called western disease or with accidents, such as a broken arm or a scorpion bite. Even for the 'western' disease, if after a while they do not see evident progress, they go to the *mará'akame*.

Understanding the Huichol vision of health and disease is crucial in the development of a culturally-sensitive view of health care service provision. However, it is also of paramount importance to observe aspects concerning intercultural communication issues, such as differences in expectations regarding

interaction patterns. The following section explores an aspect of interpersonal communication between non-indigenous healthcare providers and Huichol patients.

The issue of intercultural communication

Recent research (e.g. Johnson et al 2004; Cooper and Roter 2003) indicates that patient beliefs, values, preferences, behaviour and expectations in relation to health services (including involvement in medical decisions, adherence to treatment, partnership with physicians, and satisfaction) differ by race, ethnicity, class, language, and levels of literacy. Research also shows that what the health care provider does, says, or does not do or does not say about medical decisions in general are influenced by his or her perception of the patient and this perception depends to a great extent on the race, ethnicity, class, language and the degree of literacy of the patient (Smedley et al. 2003).

Part of our research carried out with the Huichol people was intended to explore differences in interpersonal aspects of healthcare between non-indigenous healthcare providers and Huichol patients. What follows is an account of what we observed and collected from interviews of health care providers (physicians and nurses) and Huichol patients both at a rural clinic in a Huichol community where the prevalent language is Wixárika and the minority language is Spanish and at an urban hospital that provides service to the indigenous community in the area, where the official language is Spanish and the minority language is Wixárika. In total, we interviewed 20 health care providers: 7 physicians and 10 nurses in an urban hospital and 2 Spanish-speaker physicians and 1 bilingual Huichol-Spanish nurse in a clinic in rural indigenous community. We also interviewed 20 patients in multiple occasions: 10 in an urban hospital and 10 in a rural indigenous community (only one Huichol monolingual). Interviews were carried out in an informal setting. Appendix 1 shows the semi-structured questionnaire used for the interviews. The questionnaires were used only as a baseline for the researcher, but each interview took a different path depending on the circumstances of the interviewees. Except for the Huichol monolingual patient, the interviews were conducted in Spanish. The help of a bilingual Huichol-Spanish relative of the patient was used to interview the monolingual Huichol patient.

In addition, the researchers were present in 15 medical consultations at the urban hospital. No recording was allowed during those observations. It should be noted that methodologically speaking, direct observations may not be completely reliable, since we feel that every time we were present during consultation the physician tended to conduct an extremely extensive interview of the patient and to make sure to carry out a thorough check up. Nonetheless some interesting insights emerged. The interviews, on the other hand, provided us with some interesting data.

Specifically, we wanted to find out whether there were patterns in the way the Huichol people communicate with the health care provider and among each other. At first sight, from the observations of the interaction between physicians and patients during consultation one can conclude that, in general, the Huichol patients are very shy and quiet: they hardly respond to the physician's questions and when they do, they give monosyllabic responses. In interviews, health care providers agreed to this stereotype and, indeed, go further suggesting that, in their view, Huichol patients may be impolite and even uncooperative. In practice, physicians seem to act with this stereotype in mind. They often address their patients with short, sometimes non-grammatical utterances, pronounced extremely slowly and loudly. There is a prevalence of yes-no questions; thus for example, instead of asking what the symptoms are, they offer a range of possibilities for the patient to say *yes* or *no*. The following is the translation of a sample conversation that took place in Spanish between a physician (Ph), a native speaker of Spanish and his patient (Pa), a native speaker of Huichol:

Ph: ... What seems to be the matter?

Pa: <no response from patient, Ph waits for around a minute; meanwhile he starts checking up the patient>

Ph: You – understand – Spanish? (Do you understand Spanish?)

Pa: <pause of around 30 seconds> Yes

Ph: You – speak – Spanish? (Can you speak Spanish?)

Pa: <pause of around 10 seconds this time> Yes

Ph: Why – you – here? Why – you – come? (Why are you here? Why did you come?)

Pa: <pause of around 30 seconds> I feel bad

Ph: Exactly what do you have?

Pa: <no verbal response, patience touches her stomach>

Ph: <Ph touches the patient's stomach and asks> Does it hurt?

The interview continues with the physician eliciting from the patient the specific symptoms basically using yes-no questions. From observation of other similar encounters between a physician and a Huichol patient, one can conclude that they seem to have a regular pattern of activities, as depicted in diagram 1 below.

Diagram 1: Structure of a consultation between a non-indigenous physician and a Huichol patient.

Stage 1	Physician asks questions regarding the problem Patient answers those questions
Stage 2	Physician checks up patient Interaction may take place (Ph asks questions - Patient responds)
Stage 3	Physician reaches a diagnostic and prescribes treatment Patient may make further questions, ask for clarification, etc.

One evident assumption that seems to be made by the physician in the interaction above is that the patient does not fully understand Spanish, hence the need for syntactic and lexical regulation, and perhaps a justification for the monosyllabic responses of the patient. A less evident assumption is that both the physician and the patient share an understanding of the characteristics of this genre and that they are proceeding along similar lines of interpretation; that the patient fails to proceed as expected may be seen by the physician either as limitations in linguistic competence or as an act of impoliteness – reluctance to cooperate (see e.g. Hyland 2002).

Regarding the first assumption, does the patient feel that he or she lacks the ability to communicate symptoms to a provider who understands their meaning? We had the opportunity to visit this patient whose conversation is shown above several times over the following two weeks because she stayed at the hospital for over two weeks and we talked about different topics. During the third visit we ended up talking about her health problem and surprisingly, with no elicitation, she spoke about her symptoms. The possibility of displaying a quiet behaviour during consultation because of lack of lexical resources in Spanish had to be discarded.

As for the second assumption, Gumperz (1982) points out that speakers proceed along similar lines of interpretation only to the extent that cultural background is shared. How much is shared regarding expectations of this kind of encounters between the two participants? It might be worth taking a look at what happens during consultation between a Huichol patient and a *Mara'akame* (Huichol Shaman). The following is the description that summarizes what happens during a consultation with the *mara'akame*. Consultations are generally carried out in *Wixárika*, but more and more *mara'akate* speak Spanish and consultations may also take place in Spanish.

After greetings, the patient and/or those who come with him or her will explain to the *mara'akame* what the problem seems to be. We observed that what the patient tends to communicate at this stage are not merely the symptoms, but further information that may

include things the patient did over recent days, where he or she went, what paths he or she took, what houses he or she visited, who he or she ran into and talked to. During this stage the *mara'akame* remains silent; he listens intently and eventually nods with the head.

Once the patient has explained the 'problem' in detail, he or she is then asked to lie down on a flat surface – a bed, a table, the floor – and to remain still. The *mara'akame* proceeds to perform a '*limpia*' ('cleansing' ritual), using a *muwieri* (a sacred feathered stick). Although the '*limpia*' includes the whole body, it concentrates on the part of the body associated with the 'disease'. At this point, and depending on the 'nature' of the disease, the *mara'akame* may remain quiet, intone ritualistic chants, or engage in a 'fight' with those who caused the 'disease'. As part of the ritual, and also depending on the nature the 'disease', the *mara'akame* sucks out the 'evil', which may take the form of a seed, a leave, a stone, or a piece of wood.

After performing the '*limpia*', the *mara'akame* explains to the patient the nature of the problem, showing the sucked out object as evidence and indicates what the patient or his/her relatives must do to complete the healing process. These indications may include taking offerings to specific places, performing a specific ritual, visiting a sacred place, among other things.

The structure (often referred to as *script* or *schema*) of a consultation between a *mara'akame* and a Huichol patient can be depicted as follows:

Diagram 2: Structure of a consultation between a *mara'akame* and a Huichol patient.

Stage 1	Patient explains the problema Mara'akame listens
Stage 2	Mara'akame performs 'limpia' Patient remains quiet
Stage 3	Mara'akame explains nature of the problem and discusses 'treatment' with patien and family Patient and family listen

If one compares the structure of the basic healer-patient interaction (e.g. during consultation) in the two contexts, some similarities may emerge regarding the elements of the macrostructure: they both consist of three basic moves. A closer look, however, will make salient some fundamental differences that have to do with what happens within each move, specifically regarding:

- Verbal dominance
- Content of interaction
- Non-linguistic elements of exchange: silence

Verbal dominance

Even though specific measures of audiotape data concerning healer-patient communication were not carried out, it is still possible to ascertain that verbal dominance is different in the two contexts described above. A comparison can be established between the amount of talk of the physician and the *mara'akame*, and between the amount of talk of the healer (either the physician or the *mara'akame*) and the patient.

Diagram 1 above shows that the Socratic Method can best describe the physician-patient consultation: the physician tends to be more verbally active during the whole process of consultation, mainly with utterances that take the form of questions. Diagram 2, on the other hand, shows that the *mara'akame* speaks only towards the end of the process.

Diagrams 1 and 2 above also show that the opportunities for the patient to speak take place at different times and that the amount of talk also varies from context to context. Whereas in the consultation with the *mara'akame* the patient does all the talking during the first stage (stage 1), there are possibilities for the patient to speak throughout the whole process during the consultation with the physician.

In very general terms, it can be said that the physician does more talking than the patient in a physician-patient consultation and that this is not due to a lack of opportunities on the part of the patient. Why does one find a tendency of the Huichol patient to restrict herself to monosyllabic responses? One possible explanation for the shy behaviour of the patient before the physician may be found in the fact that in principle, interactions in the context of medical consultation are asymmetrical in that the patient is subordinate to the healer (Tannen 1992). For example, the patient addresses the healer by title-last name and the physician addresses the patient by his or her forename. In the case of the *mara'akame*, there is still a level asymmetry imposed by the power and authority of the healer in the community, yet some solidarity may be conveyed because of a reciprocal form of address: both speakers address each other by their forename; of course this solidarity is reinforced by the fact that they share a common culture. Hence, the patient not only does more talking than the *mara'akame* in a *mara'akame*-patient consultation, but communication is more fluent, even in those situations where Spanish is been used.

So far we have portrayed contextual differences in the structure of a healer-patient interaction regarding when and how much talking takes place. Other differences have been identified regarding what is being talked about and how it is being discussed.

Content of interaction

Looking at what is being talked on, and perhaps more importantly, the communicative purpose of the speaker, two points are salient from our observations:

Firstly, in the physician-patient interaction the physician elicits the symptoms and he or she decides what information is relevant and vital: he or she formulates specific questions. This happens regularly during moves 1 and 2 in diagram 1. In the *mara'akame*-patient interaction, on the other hand, the patient is in charge of the interaction during symptoms description and he or she decides what to say, and this occurs during stage 1. The decisions of what to say in relation to what needs to be known in order to arrive at a diagnostic is permeated by our understanding of issues such as what causes a disease or a state of imbalance, and how it is corrected or alleviated. A Huichol perspective assumes that both parties in the interaction (patient and *mara'akame*) share this kind of knowledge, hence the patient is in a position to decide what might be relevant; conversely, in a western perspective, the physician is 'in the know' and the patient is 'in the dark' regarding what is relevant in order to make a diagnostic.

Secondly, stage 3 in both cases is also fundamentally different. In the *mara'akame*-patient interaction the *mara'akame* offers explanations that are in full agreement with the systems of belief of the Huichol patient about health and disease, life and death, balance and imbalance, and gives precise instructions about what needs to be done. It is during this stage that the *mara'akame* explains to the patient and his or her family the nature of the problem, and the patient knows that healing depends on obeying instructions (the equivalent to adherence to treatment). It is important to note that the stereotype of Huichol patients portrayed earlier prevents physicians from establishing communication with the patient that goes beyond checking up and general instructions for treatment. They may question the patient's ability to understand the prescribed management strategy, and they may see no reason for discussing with the patient his or her expectations of care, his or her preferences for or against specific diagnostic or therapeutic procedures. As a consequence adherence to preventive measures and medications may be affected, as suggested by a student doctor who happens to be Huichol, in the following translation of an extract from an interview:

"... in many cases the patient abandons the treatment. He does this because some medications also have side effects: they give you a headache, they give you a stomachache, and the doctors should tell the

patient 'if you take this medication you are going to have these reactions'. So when there is no such communication the patient concludes that the medication is affecting him or her and that is why he or she abandons the treatment..."

Non-linguistic elements of exchange: silence

Much has been written about the small pauses that occur between turns as one speaker gives up the floor and another takes over the right to speak (see e.g. Scollon and Scollon 2001). These pauses play an important role in interpersonal judgments of competence. It has been found that even very small differences in the timing in the interturn pauses can lead speakers in a conversation to develop negative attitudes toward each other (Scollon 1985). Research on the use of silence in conversation indicates that indigenous people tend to use pauses and silences in very special ways (see e.g. Saville-Troike 1992). From a Navajo perspective, for example, silence is a sign of respect and politeness. For the Huichol people, as we have come to see from interactions, a long pause indicates that the person is thinking thoroughly before answering, as a sign of respect and politeness.

In interactions like these types of interviews, such as the medical consultation in a 'western' context, the person in charge is the person who formulates the questions. Usually this person has the control not only of the direction of the interview, but also of the time allowed for silences: the governing rule is his or her own expectations about the appropriate length of silence between question and answer. In our experience talking to many different members of Huichol communities, we know that pauses between turns tend to be significantly longer than pauses between non-indigenous speakers. It follows that in the case of a physician interviewing a Huichol patient, the physician expects a shorter pause than does the Huichol patient; hence he or she tends to move on or repeat before the Huichol patient has had a chance to respond. In consequence, as a faster speaker, the physician ends up doing most of the talking because he or she has come to the conclusion that the patient has either nothing to say or is linguistically incompetent (Scollon and Scollon, 2001).

The interaction between a physician and a Huichol patient can be described as a *hierarchical politeness system*. In such a system, "the participants recognize and respect the social differences that place one in a super-ordinate position and the other in a subordinate position" (Scollon and Scollon 2001:55). This system is described as asymmetrical because the speakers do not use the same politeness strategies in speaking to each other. In the context being described here, the physician would use '*involvement strategies*' in speaking 'down', whereas the Huichol patient would use '*independent strategies*' in speaking 'up'. Longer pauses are associated with *independence politeness strategies* while shorter pauses are associated with *involvement politeness strategies* (Scollon and Scollon 2001: 75). The system described above predicts a difference in the use of pauses by the person in the higher position and the person in the lower position.

Even though intrinsically an interaction between a physician and a patient (not necessarily indigenous) in a western context implies a hierarchical politeness system, the hierarchies are emphasized if the length of pauses of both participants are in principle different; It follows that, because Huichol people tend to use longer pauses, there will be a tendency for the system to develop into a hierarchical system, whether the participants intend that outcome or not. This can be contrasted, in a way, if one looks at the system developed in a *mara'akame* – Huichol patient interaction. The interaction between a *mara'akame* and a Huichol patient fits more readily with what Scollon and Scollon (2001) call *deference politeness system*. There is a shared expectation of length of pauses (i.e. both participants expect long pauses) and the communality of long periods of silence. In other words, they both share an understanding of the characteristics of this genre hence they proceed along similar lines of interpretation. These facts make the system *symmetrical*, but at the same time *distant* because each participant uses independent strategies speaking to the other.

Towards a better understanding of interactions in medical consultations.

In the previous section we have discussed some factors that are present in the interaction between participants with different cultural backgrounds. These factors are thought to influence patient and physician decision-making and the interactions between patients and the health care delivery system, thus contributing to health disparities.

An assumption made throughout this research report is that health care provider – patient effective communication will result in patient satisfaction, adherence to treatment and subsequently, health outcomes. In order to minimize the potential conflicts in communication, an ‘inter-culturally competent’ health care system should be developed. Such a system can be defined as one that acknowledges and incorporates – at all levels – the importance of differences in interaction patterns across cultures. It should be noted, however, that in order to better understand intercultural communication, one should focus on the actions people take in which differences produce sources of conflict in power and in understanding. But social actions in general and communicative acts in particular, are based on tacit, normally unconscious actions. Hence norms governing communication acts and intercultural differences must be made explicit, not only for and in research, but also for and in education and training; in other words, training in intercultural competence for health care providers should promote not only an understanding of the social and cultural influences on patients’ beliefs about health and disease, but also, and above all, aspects concerning intercultural communication issues, such as the described in the above sections. In the light of our analyses of patient-doctor interactions during medical consultations there is a need for more research to be conducted to more fully understand differences in communication patterns between indigenous and non-indigenous speakers in the context of health service provision. We hope this report elicits further discussion.

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Appendix 1. Semi-structured questionnaire used with health-care providers and Huichol patients.

Questionnaire used with health-care providers:

Do you have any special considerations when communicating with indigenous patients?

Have you ever experienced particular communication problems?

Do you think you have to use ‘special’ language when talking to indigenous patients?

Do you think they trust you?

Do you tend to discuss symptoms/treatment issues with your patients?

Questionnaire used with Huichol patients:

Do you come to the hospital for regular check ups?

When do you decide to come to the hospital?

Who do you prefer to visit, the mara’akame or the physician?

Do you think you receive a first class service here?

How do you feel about the service you receive?

Do you find it difficult to communicate with the doctors and nurses?

Who do you feel most comfortable talking to?

Have you ever experienced difficulties in understanding your doctor’s instructions?

Was it because of the language or because of the complexity of the instructions?

Do you generally agree on your doctor’s instructions?

Do you find it difficult to adhere to treatment?

Have you ever abandoned a treatment? Why?

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