VII

INCONTINENCE AND BIOMEDICINE

Introduction

The purpose of this chapter is to examine the issue of incontinence as discussed by Mitcham (1986), that is, whether it is possible to know the good and not to do the good, by considering the responsible and irresponsible applications of Western biomedical technology among the Puyallup Indians of Washington State since the time of their first recorded direct contact with Western culture in 1798 (Morgan, 1979). In order to accomplish this goal, an expanded model of continence/incontinence will be presented which can be effectively generalized to any context in which the introduction of technology is occurring in a multicultural or multinational culture-contact situation.

Thus, this chapter is concerned with the broader issue of the appropriate way to introduce new technology in cross-cultural contexts. In such situations, the nature of the good with respect to the introduction of technology is not always clear, nor are the motivations of the culture brokers and other participants in culture change. What may benefit one social group may be detrimental to another. This is especially true when the culture-contact situation is dominated by a technologically more powerful culture. The ethnographic information upon which this chapter is based is derived from an ongoing ethnohistorical study of the impact of Western Medicine on the Coast Salish of the Puget Sound basin by the authors of this book.

We are concerned with the way in which the medical practitioners who treated the Puyallup used their developing power. Did they use their technology responsibly by: (1) knowing the end or goal toward which technological activity should be directed, (2) knowing the consequences of technological actions prior to the actual performance of such actions, and (3) acting on the basis of both types of knowledge (Mitcham, 1986)? Or, did they behave irresponsibly by knowing the good and acting in a way as to not do the good, thereby displaying incontinence? In order to answer these questions we must first consider the Puyallup and their situation, and the nature of the good.

Definitions

The Good and "the good"

Consider the conceptual model given in Figure 2. The square represents that logical space which contains the good as conceptualized by Mitcham (1986), let us call this The Good. This represents that action

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

which would result in the best for all social groups; if you wish, the common-universal good.

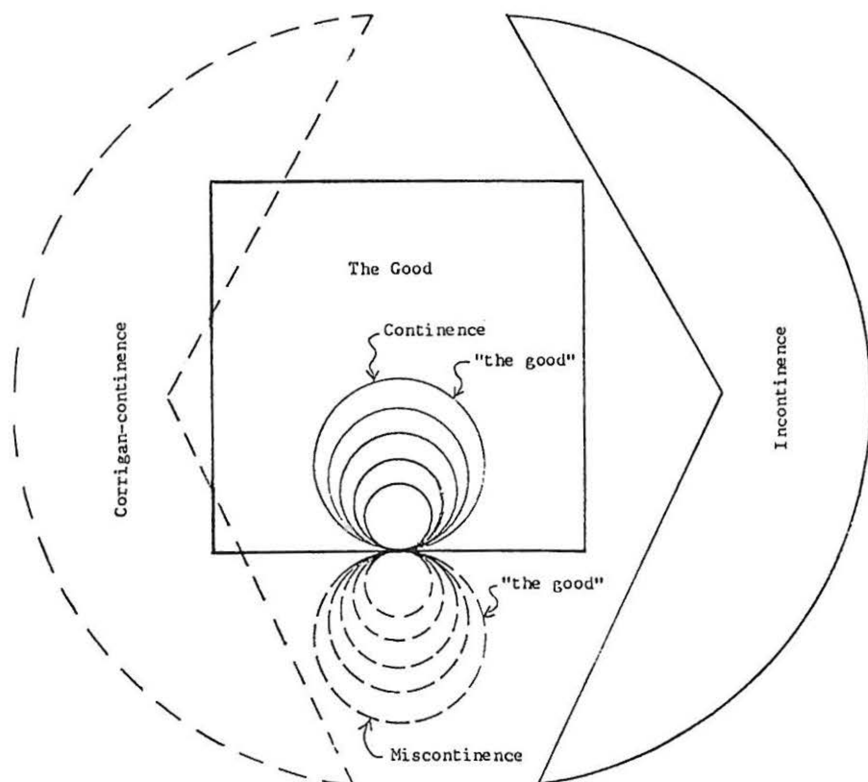

Figure 2

The series of circles within this space and outside of it which touch at one point represent those areas that contain "the good" as perceived by each social group. What may be perceived to be best by one group may be different from that perceived by another. Further, the perceptions of any one of these subgroups may or may not conform to The Good. The solid circles inside of the square represent those situations in which "the good" as defined by each social group corresponds to a subset of The Good. Action within this space represents continence.

The dotted circles outside of the square represent those cases in which "the good" does not correspond to a subset of The Good. Each social group potentially occupies one circle inside and one circle outside of the square.

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

The size of the circle represents the comparative power of the social group or institution to initiate social action, the larger the space the greater the potential. One way to map these spheres of power is to let the smallest circles represent the Puyallup Indians, the next larger circles the Indian agency representatives who interacted with the Puyallup, the next set of circles the non-Indian community of the city of Tacoma which desired to assimilate the Puyallup, the next the local entrepreneurs who desired Puyallup land, the next the national entrepreneurs who desired and financed Tacoma ("The City of Destiny") as the Pacific Terminus of the Northern Pacific Railroad. Another way to model the existing power structure is to let the smallest circles represent the internal Puyallup Indian medical system, the next larger circles the government imposed Western medical providers, the next larger circles the local Indian agency governmental system, the next the national Indian agency administration, the next the successively larger political organizational structures. The first interpretation accounts for political and economic factors. The second, while not ignoring these factors, focuses more on medical systems. Any particular application of this model will depend on the point of view of the researcher and the analytical detail desired. Clearly, five identifiable levels are an arbitrary choice on our part.

Miscontinence, Incontinence and Corrigan Continence

Adherence to "the good" by true believers whether they be biomedical practitioners or capitalists (both heavily ingrained in Social Darwinism during the latter nineteenth and early twentieth centuries) brought many negative consequences for the Puyallup. We maintain that action in accordance with "the good" that does not conform to The Good is neither continence nor incontinence but *miscontinence*. Miscontinence is represented by the dotted circles outside the square in Figure 2. People who display miscontinence do not purposely hurt others for their own benefit, but, due to their blind allegiance to a particular self-serving world view they hurt others while benefiting themselves or their social group nevertheless. Forms of this phenomenon include biomedical, capitalistic, religious, or engineering miscontinence.

The ideological system which would have sensitized outsiders to the needs of the Puyallup, cultural relativism, made little impact on the consciousness and behavior of Western practitioners and entrepreneurs even though the geographer and philologist with the first American expedition to the southern Puget Sound in 1841, headed by Charles Wilkes, were Charles Pickering and Horatio Hale, two of the first cultural relativists.[1] Pickering wrote the *Races of Man* (1848). Hale, who wrote *Ethnography and Philology* (1846), criticized the anthropologist Lewis Henry Morgan for his Social-Darwinistic views as expressed in *Ancient Society* (1877), and encouraged the young Franz Boas, a founder of relativistic cultural anthropology, to conduct fieldwork on the Northwest coast. The additional

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

power that would have been given to the Puyallup by the wide-spread acceptance of relativistic thinking may explain why it did not become popular. Social Darwinism rationalized exploitation; relativism did not.

The ominous looking Pac-Man type symbol to the right in Figure 2 represents *incontinence*, those who know The Good but do not do The Good, whether through action or inaction. The reverse Pac-Man figure to the left of Figure 2 represents a phenomenon we call *Corrigan continence* after Douglas (Wrong Way) Corrigan who gained notoriety in 1938 when he intended to fly from New York to California but landed in Dublin, Ireland 28 hours later by mistake. Corrigan continence refers to those individuals who deliberately engage in incontinence but do some Good accidentally.

The real world is more complicated than the model we offer. The actions of some individuals are not based on a consideration of either good or bad. The effects of their action can be real nevertheless. We call the positive and negative effects *serendipital continence* and *involuntary incontinence* respectively. Some people do not focus on good or bad but are simply caught in the current of their peer group and their times. Further, some actions may not have an observable relationship to social entities with which one is concerned. Yet, the eventual effects of such actions might be called *fate* or *bad luck* by those who experience their impacts.

We have not illustrated the above four situations on our model. But, they could be conceptualized as third dimensional forces which simply impact the two dimensional representation given here.

Finally, it should be clear that the behavior of an individual is not necessarily consistent over time. Thus, a given person will most likely display more than one of the above behaviors depending on their actions in any given situation.

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

Historic Examples

Continence

Dr. William Fraser Tolmie, the first representative of Western medicine to reside in the southern Puget Sound, beginning in 1833, enlisted the help of local Indians to search for herbal cures to problematic diseases. One of his motivations was to find a local cure for "the intermittents" a fever pandemic among the coastal Indians now known as malaria (Morgan, 1979, p. 34). It is probable that he used the bark of the dogwood tree since Gunther (1973, p. 42) cites the successful use of dogwood bark, as a replacement for quinine, in the curing of malaria in Indian children in the Oregon country as early as 1833. Tolmie also attempted to prevent the spread of smallpox among local Indians through immunization. These acts are characteristic of a man who played an important role during the contact period and consequently became well respected and befriended by the Indian people.

Edwin Eells, while Indian Agent at the nearby Skokomish Reservation, prior to becoming Indian Agent at the Puyallup Consolidated Agency, once followed the contemporary practice of incorporating traditional healing into his health care referral system. Eells permitted in 1871 the "ministrations" of an "old Indian Doctor ... who offered his services" when "confronted with Indian illness for which the agency doctor had 'no suitable remedies'" (Castile, 1982, p. 168).

Dr. Tim Byers, the first Indian Community clinic physician hired by the Puyallup under the "self-determination" act attempted to make the clinic more sensitive to Puyallup history and culture in 1976. Dr. Byers is the only physician hired by the Puyallup since that time that we know of who has researched and written medical material concerning the Puyallup situation in the attempt to improve health care delivery. Additionally, during the first armed but peaceful occupation of the old Cushman Hospital site by the Puyallup people, Dr. Byers crossed the police lines carrying his little black bag in order to deliver medical care and medications to the protestors whose actions were eventually upheld by a federal court decision (Byers, 1979).

<u>Miscontinence</u>

Miscontinence is the most noticeably common category on the historical record for several reasons. First, multiple interest groups and cultural systems produce by their very nature diverse world views and consequently differential definitions of "the good" which often do not result in The Good. Second, purely continent behavior is often not considered worthy of the historical record due to the lack of conflict produced by people doing their normal jobs well. Third, incontinent behavior was most commonly hidden by the perpetrators or deleted from the public record.

The first example of miscontinence to be discussed represents a widespread phenomena in any rapidly changing scientific-technological medical system. Knowledge perceived to be correct at any given time often has insidious side effects or a limited lack of efficacy when viewed from a later period. Dr. Price treated allied Indians in 1872 for syphilis in the following way (Payne, 1872, p. 2l0): "He first prepared the system and then gives them freely the *Liquor Arsenici et Hydragyri Iodidi.* This seems to have a very happy effect." He used it in "hundreds of cases" since "A large proportion of the tribe (and we learn that the same is true with all,) are suffering with the worst and most loathsome forms of syphilitic disease." Another source cites for the same group (Eells, 1903, p. 148): "...there are fifty-two families, and in twenty of these there is not a child. A few of them never had any, but most of them had some, and several had five to thirteen, but they are all dead." Payne (1872, p. 210) also says "...a large majority of the half-breed girls die from emansio-mensium and its consequences. They are full of life and vigor until the age of puberty; then gradually pine away and die. Some never menstruate, while others have a slight flow, and then disease of the lungs, and low forms of fever supervene, causing the

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

systemic waste to be much greater than the supply, and great emaciation and death is the result."

We believe, based on preliminary investigation, that Dr. Price was causing some of these effects with his syphilis treatment. Eliason et. al. as late as 1943 reported that individuals received the following mercury-iodide treatment for syphilis for at least two and one half years and thereafter at intervals (p. 406): the solution was given orally or by rubbing into lesions until a slight soreness of the gums appeared, a sign of mercury poisoning, and then the dose was reduced by about half until the symptoms disappeared. The authors report that patients should be carefully watched for signs of mercurial poisoning: soreness of the gums and increased saliva, metallic taste in the mouth, teeth loosening, the breath is fetid, and diarrhea. The poisonous effects of the nonsalvarsan arsenic added to this type of mixture by Dr. Price undoubtedly increased the toxic effects of the latter treatment. To complicate the situation, a reliable diagnosis for syphilis was not available until the Wasserman Test was developed in 1906 (Jensen, 1943). One can but wonder how many tribal people were misdiagnosed and poisoned needlessly.

A second example of miscontinence attributable to Western medical practitioners from the early post contact years to the present was the discrediting of Puyallup shamans and traditional practitioners generally. Some of this material was discussed earlier. The important point is that medical practitioners were functioning under their perception of the "good" while destroying a holistic medical system that has recently been recognized as an effective support system for the maintenance of mental, physical and spiritual health.

Consider the following dramatically absurd illustrations of "good" medical theory: Dr. Payne reports that low levels of electricity resulting from the sparsity of thunder and lightening were undoubtedly the explanation for "... the frequent occurrence of rheumatic forms of neuralgia and nervous diseases generally" (Payne, 1872, p. 209). Later in his presentation to the Clark County Medical Society, Payne describes the deadly effects of the interbreeding of races: "... but all careful observers are fully satisfied that this mixture of races results in an unhealthy and short-lived offspring" (Payne, 1872, p. 210). Major Charles E. Woodruff, A.M., "a learned surgeon of the army," describes how the "... excess of sunshine is injurious to the blond or Teutonic races and ultimately, without fail, leads to their extinction..." with the exception of the Pacific Northwest where the people are "... absurdly healthy... They should thank God that they are protected from his sunshine" (Radebaugh, 1913, p. 93-94):

> [S]unlight is stimulating, but in excess, it causes mental, nervous and finally organic troubles. It is a curious commentary on our ignorance of climatology that the people of Tacoma, Seattle and all this region, attribute their exuberant health, small sick rate and small death rate, to all

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

> sorts of causes except the right one - protection from sunshine (Radebaugh, 1913, p. 94).

Additionally, we have not been able to identify one Western medical practitioner who was either specifically trained in mental health or was employed as a specialist to offer mental health therapy until Tribal pressure initiated such efforts in the early 1970's. Yet, the role of the only other practitioners who could provide such services were being steadily eroded by Western authorities.

The rate of emotional illness among the Puyallup during this time is unknown. However, given the rapid culture change that they were experiencing, emotional disorders surely existed. For example, 8% of the 4,599 cases treated by the three physicians on the main Sound (Tulalip, Puyallup and Skokomish Agencies) between 1883 and 1885 were "nervous diseases of which headache was the most common." (Eells, 1887, p. 274). No cases of "mental illness" were reported. However, an extremely high percentage of cases involved what we now call somatic complaints. Also, St. John (1914, p. 14) stated that in the year following the 1905 Heff decision of the United States Supreme Court which opened up the sale of liquor to Indians, there was a striking increase in the amount of drunkenness, crime and death on the Puyallup Reservation which "spelled almost absolute ruin and prostration for the Puyallup Indians."

Sadly, many of the Puyallup thoroughly respected and held affection for the physicians who were displaying miscontinence. For example, a Tribal leader describes the feelings of some Puyallups toward Dr. Spinning, the first physician to remain any length of time on the Reservation (Sicade, 1927, p. 3):

> The good doctor lived up the Stuck Valley, but rode down nearly every day and visited the Indians from place to place looking for the sick. The changing of our way of living to the white's was very fatal and Dr. Spinning did much to serve the young.[2] No other Doctor had done such noble conscientious work, going out in all kinds of weather and nothing but trails to follow and sometimes make his own trails, fording streams, and often a-foot, always hailing with that cheery voice.

A third example of miscontinence displayed by Western practitioners was the perpetuation and reinforcement of negative attitudes among local Indians regarding the Indian hospital. Many of the Puyallup avoided seeking Western medical care because of the stigma attached to the facility. For example, preliminary interviews with former patients and Indian staff of the Cushman Indian Hospital conducted by the authors of this paper indicate that the Hospital was feared and avoided because it was believed to be the place where people went to die. The existence of

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

tuberculosis wards, the delaying of seeking Western practitioners until sickness became serious, the "yanking" of children off the streets to perform tonsillectomies, and the practice of hauling dead bodies from the Hospital to kin (even to other reservations) in the open back of pickup trucks undoubtedly added to the negative perception of the facility. Older people told us that relatives used to cry over people who went to work there. This perception was also expressed to the first physician (Dr. Byers) to work for the "self-determination" Indian Community Clinic.

> The hospital was a source of pride for the Puyallup Tribe. Nonetheless, distrust for "white" medicine still remained under the surface. One woman told me, with obvious bitterness, that "the ones who went to the hospital died, but the ones who stayed home lived." (Byers, 1979, p. 23)

Part of the aversion to the hospital was due to providers' insensitivity to the persisting traditional Puget Sound area Indian belief that the spirits of the dead linger near friends and family to take their loved ones across with them so the spirit of the dead will not be lonely. People report the uneasy feeling of the presence of their dead relatives, sometimes in physically observable forms such as owls. They at times express the need for a traditional-spiritual cleansing ceremony to assist the dead on their way. This phenomenon seems not to be restricted to family members. Current Tribal employees still avoid certain areas of the old Cushman hospital because they believe the spirits of the dead are still "alive" there.

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

Incontinence

The first example of those who knew The Good but did not do The Good, whether through action or inaction, is the inaction of individuals responsible for delivering the Treaty guaranteed physician and medical support system to the Puyallup Reservation. Although the Treaty was signed in 1854, the first physician to "remain any great length of time in the service" was Dr. Spinning in 1862 or 1863 (Shackleford, 1918). The Indian agent in 1859 stated that he had not been able to secure a doctor at the salary provided even though he had been searching for nine months. At least three kinds of individuals were guilty of this inaction: physicians who would not perform their sworn duties at the given salary level, Indian Service inaction regarding the Treaty obligation, and the inaction of federal representatives responsible for the funding of Indian Service physicians. Even after Dr. Spinning was secured, the other two provision levels failed to provide adequate medical support (Shackleford, 1918, p. 59): "Though the need for a hospital was constantly urged, none was built for many years, and that one was for the school children. The doctor's medicine was shipped to him quarterly from the east; and he frequently complained of the supply not being large enough." As late as 1876:

> An epidemic of itch and measles swept the school and some died and many of us lay rotting with no care of any sort -- not even fed. But for a timely arrival of our parents, the school might have closed for want of scholars. Once in a while someone would show up and look at our tongues and would quietly go away with no comment (Sicade, 1927, p. 4).

A second illustration of incontinence involves the systematic closure of the Cushman Hospital and the subsequent "transfer" of responsibility for local Indian health care to the Indian Health Service Contract Care system and/or local providers. Due to the inability of the Interior Department's health system to deliver health care and the federal government policy of "termination," Cushman Indian Hospital's general wards were closed in 1954 leaving only the tuberculosis wards.

> In line with the change of policy in the administration of Indian affairs it had been decided to let the individual Indian assume more of the responsibilities and privileges of full citizenship. In April 1954 by directive from the area office, all Indians not living on tax-free land would be ineligible for hospitalization.[3] Tuberculosis patients were not included in the new ruling, but it was confirmed that all other general hospital cases would be cared for by the local county and state facilities in their area. (History of Cushman Indian Hospital, 1956, p. 6; also see National Lawyers Guild, 1973, p. 80)

As noted earlier, even the tuberculosis wards of the Cushman Hospital were closed under Indian protest in 1959.[4]

The system that was to have replaced the Cushman facility paid "little attention" to unique cultural and medical needs of the Indian community (National Lawyers Guild, 1973, p. 80). In fact, the abrogation of responsibility by the federal government and the unwillingness by the State of Washington to accept the responsibility resulted in shoddy to nonexistent care:

> [I]t is patently obvious that the case of the elderly Indian woman residing in Pierce County who was taken to a local hospital in an ambulance and upon her arrival at the hospital, was neither admitted or attended to in any manner, should have never occurred. As she lay dying on the portable gurney, the question seemed to be that since she was Indian, she should be treated by the Indian Health Service and not by the local hospital. The pondering of this

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

> question took some five hours. The Indian woman was then rushed to the nearby county hospital where she died some twenty minutes later (LaCourse, 1970, p. 23-24).

See also Dr. Byers' reference to inadequate to non-existent prenatal care for Indian women during this period noted earlier. We realize that it is extremely difficult to define The Good (Moore, 1903); however, if these examples do not reflect incontinence, then we conclude that incontinence does not exist.

A third example of incontinence is the failure to fund the Contract Care system at a sufficient level to meet the needs of a population with a life expectancy approximately eighteen years shorter than the members of their surrounding non-Indian community. We fail to see how the guaranteed Treaty right to "...a physician...who shall furnish medicine and advice to the sick...with costs to be defrayed by the United States..." (Medicine Creek Treaty, 1854, Article 10) places a limitation on the number of sick to receive care, the extent or seriousness of the illnesses to be treated, or the ultimate costs of the interventions.

Contract Care has been severely cut back in recent years. In *all* cases, patients must seek the aid of Public Assistance to pay for referrals to private providers or for specialty care before Contract Care support is possible. For the last several years Contract Care dollars have been in "Priority One" which means that Contract Care is only available for life threatening conditions. Further, either patients or providers must apply through proper channels within 24 hours of care or 72 hours on weekends. To further exacerbate the situation the system calls for "prior authorization" for service. To make matters worse, the limited amount of Contract Care funds are appropriated and assigned to geographic areas allowing a few major illnesses to exhaust available funds prior to the next budget period leaving many without any form of care.

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

Corrigan Continence

Our limited research has thus far revealed no examples of Corrigan continence among true medical personnel. However, we will relate two examples of non-medically specialized individuals or entities who conspired to take all they could from the Puyallup but whose activities resulted in some Good accidentally. James Wickersham, a prominent Tacoma attorney in the 1890's, was in the forefront of the struggle to "swallow up" the Puyallup Reservation which was in the way of the adjacent city of Tacoma Land speculators:

> The Northern Pacific Railroad, the city council - indeed, the whole business and political community of Tacoma - were determined to free the Puyallup lands, and they ultimately succeeded so well that only few acres now

> remain....Wickersham's apparently noble interest in freeing the Indians from the supervision and control of the agents takes on a different aspect when we recognize that the primary freedom sought was the freedom to sell their lands (Castile, 1982, p. 66).

St. John states that the only thing that the Puyallup Tribe did not lose was their citizenship, "which has been largely responsible for their present condition" (1914, p. 17).

However, Wickersham accomplished some Good by freeing the Shaker Church from the Indian agent's supervision and by organizing their Church legally in 1892. As we noted earlier the Shaker Church aided in the survival of traditional religious and healing practices which persist to this day. "His defense of the Shakers was no simple act of justice, for he was deeply involved in opening the Indians' land to white developers" (Castile, 1982, p. 66).

A second example of Corrigan continence was the persistent action by representatives of Washington State to maintain control of the old Cushman facility after it had been improperly transferred to the State by the federal government. The State attempted to forcibly retain control of the complex in the face of persuasive Tribal arguments, eventually sustained by a federal court, after the facility was occupied by Puyallup representatives in 1976 and 1980. The tribe wanted the facility to be returned to them for use as a school, hospital, and for an elders program (Puyallup Indians, 1976). Even after the federal court decision, chagrined state employees left the facility in a ransacked state of disarray.[5] The keys to the facility were transferred to the Tribe unlabelled in two fifty gallon drums. All of the windows on one of the floors of the main building were stripped of their brass fixtures. The valves for the steam heating system were randomly adjusted to make operation nearly impossible. Blueprints and engineering drawings of the complex were unavailable. Further, the state had formerly ripped out the hospital equipment of the facility during its remodelling period. They had installed an elaborate system of alarms and locks turning the last Indian hospital in the Northwest into a juvenile jail and rehabilitation facility. It is perhaps ironic that the federal government reimbursed the state for their "improvements."

Nonetheless, some Good resulted for the Puyallup Tribal community. The conflict served to publicize their plight. The State's actions reinforced the Puyallup revitalization movement, the beginnings of which had already been manifested in the ongoing fishing rights struggle (American Friends Service Committee, 1975; United States Commission on Civil Rights, 1981) and catalyzed pan-Indian support for the developing urban health facility. The State of Washington's stalwart resistance amplified the antagonism and cohesion of an overlooked people transforming them into a true social force. In 1974 only about 45 American Indians or Alaska natives in Pierce County were eligible for federally supported

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

health care. Since the opening of the Indian Community Clinic by the Puyallup in 1976, over 10,000 Indian and Alaska Native people have received primary medical care and referrals, when appropriate, to specialized treatment.

Serendipital Continence

Individuals who brought the potato to the Pacific Northwest probably did not think about it in terms of its potential Good for the Indian people. Nevertheless, Smith (1940b, p. 228) noted that local Indians lacked carbohydrates in an otherwise excellent, high-protein diet. One historian records the positive potato fetish of "henpecked" Steilacoom John:

> In truth he was a much henpecked person. His klootchman ridiculed and reviled him, especially when whites were within hearing distance. Mrs. Steilacoom despised with savage refinement the whites and all their ways. She urged her spouse to take up arms and drive the intruders out. She did not share with her husband his gratitude to the Caucasians for bringing potatoes to this country. The chief on the other hand, believed that this fact alone compensated for whatever offenses the whites might commit against the country. For he loved potatoes. (Hunt, 1911, p. 40)

Involuntary Incontinence

Numerous individuals certainly did not consider that the diseases they had been exposed to would decimate an aboriginal population lacking "herd immunity" to contagions common to Western culture. Smallpox, measles, diphtheria, cholera, and various strains of influenza were often delivered unwittingly to a highly susceptible and unwary pre-contact group. Many of the individuals who made profits on the expansion of railroads did not even pause to consider the fact that the increased ease of transportation would exacerbate this deathly situation. The spread of syphilis and other venereals by single males seeking sexual congress from available and relatively powerless aboriginal females (Morgan, 1960, p. 58) was in many cases unpredictable. Yet, the effects were real.

The entrepreneurs who originally brought "progress and civilization" to the "City of Destiny" (Victor, 1891) probably did not consider that their activities and those which would emerge later from their efforts would turn Commencement Bay into one of the top ten most polluted bodies of water in the United States. The costs of cleaning up the entire Puget Sound are estimated to be $1,000 for every man, woman and child living around the Sound (Testing, 1985). Tacoma residents have been warned that

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

diseased Commencement Bay "bottomfish may endanger public health," (Toxic Waste, 1984).

One of the most publicized examples of air born pollution in the Tacoma area is the American Smelting and Refining Company smelter which had its origins in the Ryan Smelter established in 1888: "... hard by a favorite clam bed of the Puyallup Indians... which produced more smoke than profit..." (Morgan, 1979, p. 262). Local residents have recently been advised that eating produce from family gardens may be injurious to their health. Parents are warned to keep small children from crawling around on the soil. Until it recently closed, the Smelter was the nation's number one arsenic polluter (Toxic Waster, 1984).

Further, the National Oceanic and Atmospheric Administration recently reported that: 1) PCB concentrations in southern Puget Sound harbor seals are among the highest found anywhere in the world, 2) harbor porpoises have virtually disappeared from southern Puget Sound; high levels of PCBs are suspected, 3) high copper and mercury levels in Puget Sound birds were found, 4) birds from the industrialized areas of Puget Sound were found to have some of the highest levels of PCBs found in birds anywhere, 5) concentrations of contaminants in sediments may be a thousand times higher than they are in water, and 6) Tacoma's waste water treatment plant at the mouth of the Puyallup River is the major source of mercury contamination (Chemical Soup, 1984). We believe that *current* polluters are surely aware of their actions, thus, are guilty not of involuntary incontinence, but pure and volunteered incontinence.

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)

Conclusions

Fate and bad luck exist, but they do not dictate human circumstance. Human actions are intricately bound by choice and responsibility. Thus, we have chosen to consider those who: 1) perceived "the good" and have acted in a way consistent with The Good (continence), 2) knew "the good" in their own perceptual sphere but whose actions, which were consistent with their perceptions, did not result in The Good (miscontinence), 3) knew The Good but did not choose to act in a manner consistent with their perceptions (incontinence), 4) consciously choose not to do The Good but whose actions, nonetheless, resulted in some Good (Corrigan continence), 5) failed to consider ethical issues but whose actions resulted in some Good (serendipital continence), and 6) failed to consider ethical issues but whose actions resulted in negative consequences for which they are nonetheless responsible (involuntary incontinence).

Although we have focused on the technology of medicine and health, we believe this paradigm can be effectively generalized to any situation in which technological change is occurring in a multicultural or multinational contact situation. We truly hope that we too have not been guilty of creating a perceived "good" which blinds us from actions which have resulted in behavior inconsistent with The Good. Since human

societies have the potential to limit incontinent behavior, we are more concerned with the human predisposition of individuals - and especially groups - to be blinded by their own preconceptions of "the good," resulting in behavior with inconsistent consequences. How can we assume responsibility for technology if we can not break free of our own personal cultural filters which define "good" in a way that may not be consistent with The Good? We must, as a human community, in order to support our own survival, understand that The Good *can* be defined (contrary to Moore, 1903). The Good can and must be defined by the shadow that is cast by nonrecognition and noncompliance. The question becomes one of our willingness and interest and desire to visualize the shadow before it appears. Though we eagerly await the appearance of those who know The Good and somehow do The Good consistently, we recognize that most of the Saints are dead.

American Indian and Alaska Native Mental Health Research
Copyright: Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)