This paper examines the effects of federal policies on the health and health care system of the Coquille Indian Tribe. A historical framework is provided within which the nature and magnitude of these effects can be assessed. This paper provides a discussion of the effects of federal termination policy on the health of the Coquille tribe. The health of the Coquille tribe is compared to that of other Indians, and to the Oregon All Races group. The effect of efforts by the Indian Health Service to improve the health of Indian people in the United States is appraised. Efforts of the Coquille Tribe to address the long-standing problem of inadequate health care for its tribal members are documented. Particular attention is given to the achievements of the Coquille Tribal Health Department since 1989, when recognition of the Coquille Tribe’s sovereign status was restored by Congress.

Secondary research employed both archival and library sources. The primary research consisted of compilation of data from unpublished Coquille tribal documents and interviews. The interviews were conducted with staff members of the Coquille Tribal Health Department and with elders of the Coquille tribe old enough to remember the health care systems prior to termination. Additional interviews were conducted with elders from other Oregon tribes and with staff of the Indian Health Service clinic in Salem, Oregon.
The major conclusions are that though the federal government passed its termination laws in 1954, for the Coquille "termination" was actually a process that began in the 1850s and continued on for over one hundred years. Termination for the Coquille only gained "official" recognition by Congress in 1954. The negative health effects upon the Coquille people were due to the actual termination, not the official termination. Since the Coquille tribe gained restoration of its federal recognition it has established a solid base for a health care system for its members. Plans for the growth of this health department and the expansion of the services it offers should, when implemented, provide for the health care needs of the tribe and other Indians in the area.
Impact of Federal Policies on the Health of the Coquille Indians

by

Michael J. McCanna

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APPROVED:

Redacted for Privacy

Major Professor, representing Anthropology

Redacted for Privacy

Associate Professor, representing Public Health

Redacted for Privacy

Associate Professor, representing Anthropology

Redacted for Privacy

Chair of Department of Anthropology

Redacted for Privacy

Dean of Graduate School

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Michael J. McCanna, Author
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Though my name appears on this work, as the author, credit for its completion belongs to all of the people who have helped me get to this point in my life. Among all of these, my family deserves the greatest thanks and appreciation. My family is the greatest asset available to me. They have always believed in me, even when I wasn’t certain I deserved it. I hope this thesis proves your faith in me was, after all, well deserved. Thank you.

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Impact of Federal Policies on the Health of the Coquille Indians

1. Introduction

This paper examines the effects imposed by federal termination policies on the health of the Coquille Indians of Southwestern Oregon. It also explores the effect of these policies upon the delivery of health care to the Coquille people. Evidence will be presented to show that the "termination" process for the Coquille Tribe began one hundred years before the passage of the Termination Acts by Congress in 1954. A historical framework is provided within which the nature and magnitude of these effects can be assessed. The paper will then provide an account of the efforts of the Coquille Tribe to address the long-standing problem of inadequate health care for its tribal members.

Policies imposed upon the Coquille and the other Indians of Southwest Oregon had tremendous health impacts, not only on individuals, but also on their communities and culture. The forced relocation of the Coquille people to reservation sites far north of their traditional grounds accelerated the destruction of their culture. The Termination Acts passed by Congress in 1954, whereby the United States government rescinded its recognition of a number of tribes as sovereign entities, occupy a central place in the recent history of the Coquille Tribe. A review of the impact of this legislation is necessary to an understanding of the health issues at hand.
The Termination Acts were designed to achieve three goals: transfer of the Indian land base into Euro-American ownership and thereby assist in the destruction of indigenous culture and community structure; eliminate the Indian's access to federal economic development, educational, and health benefits; and force the Indians to acculturate into mainstream society. Due to government policies these effects were all inflicted upon the Coquille in the late 1800s. The destructive impact to the culture and community of the Klamath and other Western Oregon Tribes, which resulted from the Termination Acts in 1954, occurred among the Coquille over one hundred years ago.

A clear understanding of the current health care situation of the Coquille cannot be gained apart from a contextual framework that considers who the Coquille were prior to non-Indian incursion into southwestern Oregon and how the subsequent history of that incursion impacted the lifeways and the health of the ancestors of the contemporary Coquille people. Following the arrival of non-Indians to the Northwest in the late 1700s, epidemics raged through the population in waves occurring about once each generation. The decimating effect of these repeated scourges upon the fabric of the culture and the subsequent adoption of various survival mechanisms by the Coquille must be assessed.

The establishment of the Indian Health Service in 1955, one year after termination took effect, began a trend of improvement in the health status of Indian people across the nation. A review of this progress demonstrates the health benefits that were denied to the Coquille people as an "incidental" result of the Termination Acts. Another "incidental" result of termination is that no health records have been kept that specifically address the health status of Coquille. Fortunately, socioeconomic data regarding the Coquille is
available. Socioeconomic indicators have been used to assess health risk in populations. From these data on the Coquille, combined with socioeconomic and health data from other populations I have drawn conclusions relative to the current health of the Coquille.

In 1989 the Coquille Tribe of Indians successfully reestablished recognition of their sovereign tribal status in the eyes of the United States government. Considerable work has been done by the Coquille since 1989 to initiate health care services for their people. In 1991 they established the Coquille Indian Tribe Community Health Department. A review of the process and progress since then gives evidence of how close they are to completion of their 200 year effort to regain the health and community lost to them since the arrival of non-Indians in their land in the late 1700s.
2. Methods

Introduction

The research methods I employed for this thesis included, first, a review of published literature regarding the health status and health care systems of native people, past and present, with a particular focus on the Pacific Northwest; and secondly a search for detailed information on the health status and health services available to the Coquille people. I utilized reports that had been done on the health of the neighboring tribes, of other Indians in Oregon, and of the general population of the surrounding areas. I interviewed Coquille elders, the staff of the Coquille Tribal Health Department, elders from other terminated tribes, and staff of the Indian Health Service Clinic at Chemawa Indian School to determine the degree of similarity between the health circumstances of the Coquille and that of their neighbors.

The resources available are deficient in many ways. To compensate for the deficiencies inherent in each resource, I gathered information on as many health related criteria as possible, such as demographic structure, economic conditions, cultural continuity, community structure, availability of health care resources, and morbidity and mortality data. I pieced this information together with information gathered from personal interviews to develop a picture of the health care situation of the Coquille Tribe.
Literature Review

An initial review of the literature exposed details about the termination process and the events surrounding its passage. Information concerning the health of American Indians, historically and currently, is abundant. Information linking the Termination Acts and the health of those affected, however, is scarce. No information specifically linking health of the Coquille to the termination process was uncovered.

A Master's Thesis written by Alison Taylor Otis (Otis 1981) provided information about the nature and extent of mental health needs among Southwestern Oregon Indians. A document produced by David Lloyd Whited (1979) supplied valuable information regarding health care availability for Indians in Southwestern Oregon. Although neither paper dealt specifically with the Coquille, both offered valuable inferential data. Research conducted by the American Indian Health Care Association, other agencies, and certain individuals was reviewed. This review yielded information on the health of Indians in Oregon, the northwestern region of the United States, and across the nation. Relevant details were incorporated into this paper.

Information gathered from all the levels of government providers: from the county, the state, the Bureau of Indian Affairs, and the Indian Health Service has been included. A visit was made to the National Archives in Seattle in an attempt to uncover information about health care delivery to the Coquille people prior to termination. Efforts to retrieve documents related to Coquille health care met with almost no success. Many of the documents have been destroyed. Apparently, little information was ever recorded. A large gap exists in the official records of health care provision to the Coquille people.
between the years 1954 and 1989 as a result of the Termination Acts. Because the government no longer recognized the Coquille as Indian people, it no longer acknowledged responsibility for their health care. The government considered them to be part of the general "white" population and information kept is thus hidden within that category.

A survey administered to members of the Coquille Tribe in 1988 by Oregon State University’s Survey Research Center yielded information on socioeconomic and health issues. A follow-up survey, conducted by Cooper Consultants, Inc. in 1991, filled in data missed by the Oregon State Survey. Copies of these documents were provided to me by the Cultural Specialist of the Coquille Tribe, Sharon Parrish. Data relevant to this research has been extracted from these documents and incorporated into this paper.

Interview Sessions

I interviewed the Health Administrator of the Coquille Indian Tribe's Community Health Department, Eric Metcalf. I conducted follow-up interviews at the Tribal Health Clinic with Eric Metcalf; with the Social Services Coordinator, Beth Scott; with the Community Health Representative, Jane Metcalf; with Director of Health Services, Gwen Elissalde; and with the Program Coordinator for Contract Health Services, Jill Rounds.

Sharon Parrish, Jane Metcalf, and Beth Scott arranged for a number of the elders to be available for interview sessions that were conducted in the Spring of 1995. The interviews were conducted as informal group activities to allow the elders an opportunity to become comfortable with me. Confidentiality was assured to each participant. The
informal setting offered the opportunity for several of the elders to approach me and share their experiences relative to health and health care. This anecdotal evidence is extremely valuable, especially considering the lack of information available from other sources regarding the time between the 1940s and 1970s.

The interviews with the elders yielded the names of local medical practitioners who had served the Coquille people in the past. Attempts were made to contact those individuals. Unfortunately, the doctors who provided health care for the Coquille people during the pre-termination period are now deceased or face health problems of their own that prevent me from accessing information they could have provided.

I interviewed an elder from the Grand Ronde Tribe, Kathryn Harrison, who worked for the Coos County Council on Alcoholism during the late 1970s as administrator of Indian oriented alcohol programs. She shared information garnered from her association with the Indian people living in the Coos Bay area during that time.

I conducted an interview with an elder from the Klamath Tribe, the current Tribal Chairman, Morrie Jimenez, who experienced the termination of the Klamath Tribe. He was able to provide information that offers a comparison to the experiences of the Coquille during termination. His memories and perspectives regarding these issues supply an interesting frame of reference.
3. Historical Background

Ancestral Coquille

The ancestors of the people now known as the Coquille Tribe of Indians lived along the banks of the Coquille River inland to Camas Mountain and for some small distance north to Whiskey Run Creek and south along the Oregon Coast to Floras Lake and Quatomah Creek (Ward 1986:7). The population was divided by language into two major groups, the upper Coquille who spoke Tututni, a language in the Athapaskan family (Miller and Seaburg 1990:580), and the lower Coquille who spoke Miluk, a Coosan language (Hall 1992:167; Zenk 1990:572). The people from these two groups were kin and communicated, traded and intermarried. These social relationships extended to other neighboring tribes (Miller 1990:580; Zenk 1990:572). When women married they went to live with their husband’s people and spoke their language (Thomas 1990:10). This practice of exogamy would eventually play a significant role in the survival of the Coquille as a people.

There was no major tribal structure as is found in other portions of the country, but rather a number of small village sites, probably extended family groupings of 20-80 members, presided over by a village headman (Hall 1991:58; Thomas 1990:10). These village sites were scattered along the banks of both sides of the river and in a few locations along the coast near the mouth of the river (Thomas 1990:4). Permanent dwellings often housed several families. Adolescent boys and single men often shared a dwelling (Zenk
1990:574; Miller 1990:582; Thomas 1990:13). These crowded conditions probably contributed to the rapid spread of infectious disease after the arrival of non-Indians in the area.

Many coastal tribes migrated seasonally up and down the rivers from their base winter villages as the availability of various foods dictated. This may not have been the case with the Lower Coquille (Zenk 1990:573). Perhaps they had no need because of trading arrangements with their up river relations. There was an abundance of resources but people had to gather and dry resources in the summer to prepare for the lean winter months.

Their environment was bountiful and provided the people with food from the ocean and estuaries, the river and the land. The people gathered many types of berries, salmonberries, red and blue huckleberries, salal berries, native blackberries, strawberries, raspberries, and laurel berries. Along with camas roots, immature skunk cabbage roots, and wild carrot roots, many other roots and shoots were gathered. Seaweed was harvested from the shore. Ferns, skunk cabbage flowers and tarweed were gathered in season. Several species of trees provided nuts for the people to harvest. Myrtle nuts, sugar pine nuts, hazelnuts, and acorns were all utilized (Thomas 1990:14; Hall 1991:43-9; Zenk 1990:573; Miller 1990:580).

The shore offered more than seaweed. Saltwater fish, and shellfish were plentiful year round. Herring and smelt were seasonal food sources. Seals and sea lions were hunted. Seagull eggs were gathered. Occasionally a whale would become stranded on the beach. The rivers provided salmon, trout, lamprey eels and other freshwater fish.
Yellowjacket grubs were sometimes eaten. Salmon eggs were smoked. Wild game such as deer and elk and bear were hunted, as were varieties of small game animals (Thomas 1990:14; Hall 1991:43-9; Zenk 1990:573; Miller 1990:580).

Even the very poor had access to adequate sustenance. There were various social mechanisms in place to ensure provision to all members of the village. Food gathered from large fish runs and communal elk hunts was shared with everyone. Chiefs had obligations to provide for all the people. The poor could make use of the "begging social call," a formalized mealtime visit to a wealthy family (Zenk 1990:576). It does not seem likely that mortality due to starvation was a common occurrence, though there may have been certain nutritional imbalances at times (Boyd 1990:136).

The southern Oregon coast has a mild climate without extremes of temperature. Inland, where the Upper Coquille lived, the temperature range was somewhat greater. There is a high amount of rain, especially along the coast. At times it can get very, foggy, windy, wet, cold, or a combination of these conditions along the Oregon coast. The Coquille developed technologies to cope with these conditions.

**Ancestral Disease Prevalence**

Prior to the arrival of non-Indians along the Northwest Coast the aboriginal population was not confronted by rampant lethal infectious diseases. There were only a dozen infectious diseases in the western hemisphere, none of which caused high mortality. These may not all have been present in Northwest populations. Boyd notes the mention of eye diseases and what appears to be leprosy in various historical accounts. Some
osteological remains show indications of treponemal infection. Though there is evidence that tuberculosis may have been present in the Americas prior to European contact, no evidence has yet turned up indicating its presence in the Northwest (Boyd 1990:137).

Nondisease mortality resulted from accidents, warfare, and interpersonal violence. Boyd cites Gould as identifying an occasional case of food poisoning due to ingestion of shellfish tainted with *Gonyaulax catenella*. Boyd then establishes that though mortality due to starvation was not likely, certain nutritional imbalances could easily have resulted from the shortage of particular foods (Boyd 1990:135-7).

**Ancestral Health Care**

There were several sweat lodges in each village for cleansing and healing purposes (Ward 1986:8). In an article on traditional approaches to alcohol treatment in Indian populations, Roberta Hall cites Aaland as claiming that the intense sweating generated in the sweat lodge removes toxic metals, urea, and lactic acid (Hall 1986a:170).

"Medicine men" with mystical powers were considered "shaman," and these were often women (Ward 1986:16; Miller 1990:583). A shaman's primary function was the curing of serious illnesses through supernatural means. The shaman would remove a small disease-causing object or organism, often thought to have been sent by a hostile shaman (Zenk 1990:576; Miller 1990:583). The "medicine man" served as clergyman, physician and pharmacist (Ward 1986:15).

The knowledge of curative powers associated with various plants was not held only by the medicine people. This information was handed down through the generations and
some of the current elders tell tales of grandmothers and aunties mixing up tonics and poultries to treat a number of ills. For the ancestral Coquille the land around them was a virtual pharmacy. They utilized a wide variety of plant materials to treat injuries and illnesses, and as preventatives.

Cascara bark was used as a tonic. Blood purifying tonics were made from wild sage and the roots of Oregon grape (Hall 1991:41). Licorice roots and skunk cabbage roots were boiled to make a tea for treating cold symptoms (Ward 1986:87). Tea made from dried chittum bark was used as a laxative. Licorice fern was used for the same purpose. Oregon grape leaves and yerba buena were both used for kidney ailments. Diarrhea was treated with juice from native blackberries. Salal berries were used for indigestion. Dried myrtle leaves were made into a tea to draw boils. Labrador tea, made from ledum, was used to treat menstrual cramps. A poultice made from pounded wild lettuce was used to fight infections (Hall 1991:42-3).

Contact Period

It is critical to examine the period of initial contact between the Coquille and non-Indians, defined here as 1792-1853. During this period, one lifetime, a culture and people, vigorous and vibrant, was brought to the edge of extinction. It is very difficult to determine an accurate figure for the combined population of the Upper and Lower Coquille at the time of contact. Epidemics began raging through the indigenous populations to the north in the 1770s (Boyd 1990:137), 20 years before the first recorded contact with the Coquille. Due to extensive trading between the natives throughout the
northwest the diseases spread rapidly. It is unlikely that the Coquille were spared from infection by these pathogens, or spared from the extensive mortality that occurred among the people to the north. If these diseases struck the Coquille people before the first non-Indians arrived the initial population estimates by early explorers might be far smaller than the actual aboriginal populations (Hall, R. and D. Hall 1991:107). Boyd estimates a population of only 22,000 for the southern Washington coast and the Oregon coast combined (Boyd 1990:146). Paul, a Coquille elder, cites anecdotal evidence claiming that both the Upper and Lower Coquille each had populations numbering about five thousand (Paul 1995: Interview). Regardless of the total size of the aboriginal Coquille population, within one lifetime it had been reduced to just several hundred.

It is said that, “Oregon Indians began receiving Euro-American trade goods and hearing stories of newcomers by 1700,” and that, “Coastal tribes, from the Tututni to the Tillamook, first met these explorers during the 1770s and 80s when British, Spanish and American ships coursed along the Oregon shoreline in search of sea otter furs and ports of trade” (Zucker, Hummel, and Hogfoss 1983:58). Beverly Ward relates a number of stories of early contact in her book, White Moccasins (Ward 1986:29-30). The first recorded contact between the Coquille and Europeans occurred in April of 1792 when Captain George Vancouver encountered a people of “pleasing and courteous deportment” who were likely related to the Upper Coquilles (Thomas 1990:2). No further contact is recorded until 1826 when Alexander McLeod’s band of Hudson’s Bay trappers visited this area (Hall 1992:168, Thomas 1990:2).
Relations between the Europeans and the Coquille revolved around trade and thus remained peaceful. Fur trade did not create direct competition for resources. It was in the fur trader’s interest to maintain good relations with the tribes (Zucker, Hummel, Hogfoss 193:61). While this statement may be true generally, it should be noted that the Jedediah Smith party was attacked by the Lower Umpqua Indians on the Umpqua River in 1828 and almost all of its members were killed (Zenk 1990:577 citing Morgan 1953:266-9, 274-9).

The level of conflict began to increase sharply as the non-Indians began to settle the land with farming and ranching, both of which interfered with the Indians traditional land use patterns (Zucker, Hummel, Hogfoss 1983:61). A ferry crossing at the mouth of the Coquille River gave rise to a small settlement in the early 1850s (Hall 1991:4). In the fall of 1851 the Coquille village at the mouth of the river was attacked by soldiers from Port Orford. The villagers were chased upriver and after gathering together with allies engaged the soldiers in battle (Victor 1894:288-90, as cited in Hall 1992:180).

The situation for the Coquille got worse when gold was discovered on the beach at Whiskey Run Creek in the Spring of 1853. More than one thousand miners congregated in the vicinity. They created the boomtown town of Randolph. The miners showed no respect for the Indians or their property. Indian women became victims of attacks by some of the miners (Thomas 1990:2). By January 1854 conflicts between the miners and the local Indians had escalated. The miners used this as a justification for the massacre of the Nasomah band of Coquilles as they slept in their village (Ward 1986:48; Thomas 1990:2; Hall 1992:180). The dismantling of the Coquille culture followed soon after.
Post-contact Disease Patterns

The health of the Coquille people prior to contact appears to have been stable and well served. This situation altered drastically following the initial contacts with European explorers. Smallpox, malaria, venereal diseases, whooping cough, influenza, measles, typhus, typhoid fever, dysentery, and tuberculosis swept through the native populations of the Northwest Coast in waves and killed significant portions of the populations (Boyd 1990:137). Estimates for total mortality rates range as high as 75-90% of Oregon’s indigenous population (Zucker, Hummel, Hogfoss 1983:60). The evidence here is sketchy and it is not known exactly how great the impact of these diseases was upon the Coquille, but their close proximity to the harbors in Coos Bay and their extensive trading networks make it unlikely that contact with the newly introduced pathogens could have been avoided. Inferences can be drawn from reports on the surrounding populations to sketch a picture of the devastating impact of European borne pathogens as they infected a people without the necessary immunities to protect them (Zucker, Hummel, Hogfoss 1983:60). Traditional cures could not cope with these new diseases.

Boyd states that there may have been as many as 200,000 aboriginal people in the Pacific Northwest coastal regions and that within 100 years of the arrival of Europeans this population had been reduced by 80%. The first small pox epidemic, in 1775, reduced the Native American population by over 30%. The frequency, variety, and severity of the succeeding epidemics left no opportunity for the population to recover from these losses (Boyd 1990:135).
Small pox, influenza, measles, and whooping cough are all transmitted by sneezing and coughing, and thus demand dense populations to occur in epidemic proportions, conditions that the indigenous culture provided. Malaria and typhus are spread by insect vectors. Dysentery and typhoid fever are the result of microbes in polluted water. Each of these eight diseases were initially introduced to Native American populations from European hosts (Boyd 1990:137).

Small pox was the greatest killer. It swept through the aboriginal population in waves whenever a new crop of susceptible hosts would be born. Each wave caused slightly lower mortality because the population would contain individuals with acquired immunity from the previous epidemics. This phenomenon concentrates mortality in the young within an affected population (Boyd 1990:137-8). There were major small pox outbreaks along the South Coast in 1775, 1801, 1824, 1838, and 1853. The occurrences in 1801 and in 1853 did not seem to have a significant impact south of Alsea (Boyd 1990:141).

A mysterious epidemic of unknown cause, known as the Mortality of 1824-5, took another 10-20 percent of the population. Sufficient time since the last outbreak of small pox had elapsed that it could have been the causative agent (Boyd 1990:138).

Malaria struck the Northwest Coast in 1830 adding to the already devastating depopulation. According to Boyd, Dr. John McLoughlin said that by October of 1830 three fourths of the Indians around Fort Vancouver had died. The mortality associated with malaria may not have been so significant were it not for the attempts by the Indians to treat the malarial symptoms with traditional sweat lodge steaming followed by jumping
into cold water. Several theories have been forwarded to explain the connection between sweat lodge treatment and increased mortality, yet the issue remains unclear. Estimates of total mortality attributed to malaria vary from locality to locality, but 85% of the population probably succumbed to this disease (Boyd 1990:139-40).

During the 1840s Euro-American settlers brought measles, typhoid fever, dysentery and whooping cough, all new to the native populations. Measles probably took about 10% of the South Coast population (Boyd 1990:141).
4. Imposition of United States Governmental Policies

Early History

Those Coquille who survived the epidemics did not escape unscathed. The encroachment of settlers into Coquille territory led to the murder of many Coquille (Hall 1991:22). Fear of increased hostilities, combined with greed for the Coquille lands, resulted in relocation policies implemented by the United States government. Ward’s book includes this quote taken from the Coos Genealogical Forum, v.3, #3 attributed to Indian agent Josiah Parrish, “From the numerous miners and settlers pressing into this country, they [the Indians] are suffering grievous wrongs, which call for immediate interference of the government. Within six months, four villages have been burned by whites. Many have been killed merely on suspicion of petty threats...” (Ward 1986:50). The Oregon Donation Land Act of 1850 (9 U.S. Stat. 496) granted 320 acres to each United States citizen over the age of eighteen who would settle on “public” (read Indian) lands. These settlers drove the Indians off their lands and away from their villages, preventing them from gaining access to their accustomed food resources. “Where food abundance had once characterized the region, the Indians found starvation and widespread dislocation” (Beckham 1990:180). Roberta Hall writes:

At this time, too, settlers’ claims were being made for the farmland along the Upper Coquille, under the Oregon Donation Land Act. These encroachments were expressed in skirmishes between native peoples and settlers and miners, and these waves of violence culminated in treaties in which the Indians ceded their land and retreated to reservations (Hall 1991:23).
In August, 1855 Joel Palmer, Superintendent of Indian affairs for Oregon Territory "negotiated" the Treaties of 1855 with the Indian peoples who lived on the Oregon coast (Thomas 1990:2; Hall 1991:157). Beckham notes that the Palmer treaties reserved no traditional rights, but did call for educational and health services. He also indicates that the negotiations were probably conducted in Chinook jargon and it is doubtful that any of the Indians who signed the treaties really understood the ramifications (Beckham 1990:182). The Indians signed in good faith and perhaps Palmer did too, but Congress never ratified the treaties.

In 1856 the Coquilles, along with other southern coast Indians, were rounded up by the United States Army and force marched north to Fort Umpqua or shipped north to Portland and then marched through the Willamette Valley and the Coast Range to what was to become the Siletz Reservation. Over one thousand Indians were shipped from Port Orford on a steamer, among them a number of Coquille (Ward 1986:53; Beckham 1990:182-3). They were sent north without supplies or means to derive their livelihood. The government had made no provisions to accommodate the housing, medical and subsistence needs of the Indians they relocated to these places. In 1857-8 there were 205 deaths from starvation and disease on the Siletz reservation (Beckham 1990:183). Many of those who avoided the initial roundup were tracked down and captured or killed by bounty hunters between 1856 and 1859 (Beckham 1990:183).

Many Indians refused to suffer through the conditions on the reservations and began to leave the reservation in the 1870s. It was a risk to return to their homelands, as they could be rounded up and shipped back north, or worse, at anytime, but these risks
declined as the years passed and society no longer saw Indian insurrection as a possibility. A few Indians had been able to stay in the aboriginal lands if they were married to a non-Indian person and these people welcomed their relatives home. Those returning came home to land that had been converted to farms or had been mined and deforested. The ability to assume their traditional lifeways was greatly diminished. Camas fields had been replaced by plowed farmland. Cattle and sheep had drastically altered the vegetation. The returning Coquille were forced to obtain wage labor and to live among the European settlers rather than in villages. The Coquille found it necessary to adopt, at least outwardly, many of the European ways in order to survive. As the years passed, intermarriage with European immigrants and with Euro-Americans began to dilute the degree of Coquille blood*1 among the population. Traditional knowledge and the native languages began to disappear, as well. (Personal communication with Coquille tribal members: February and March, 1995; Thomas 1989:7).

In 1887 Congress passed the Allotment Act (Dawes Act), which was designed to further destroy the Indian culture by distributing the reservation lands to individual members. The communal “ownership” of land was viewed as detrimental to the efforts aimed at instilling American values into the Indian populations. Non-Indians benefited from the drastic reduction in the Indian ownership of land on the reservations. After each Indian was allotted 160 acres, the land left over was deemed surplus and offered to non-

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* The term “blood” is synonymous with “degree of blood” or “blood quantum.” Each of these terms refers to the once commonly held, but erroneous, notion that racial characteristics are carried in the blood. Even though this concept is recognized to have no validity, these terms are still commonly used by the government and by Indian people to indicate the ratio of Indian ancestry.
Indian settlers. The allotted land was held in trust status for twenty-five years after which it could be sold (Hall 1991:23; Zucker, Hummel, Hogfoss 1983:73). The Coquille people who had moved away from the Siletz Agency, and thus were no longer on reservation land, were still able to acquire allotment lands through a special provision in the Dawes Act. After the trust period expired the allotted lands were subject to taxation and subsequent delinquent tax sales if the owners could not make their payments. Much Indian land was lost by this means (Zucker, Hummel, Hogfoss 1983:73). Other allotted lands were lost because the Indian owner did not possess the necessary skills to effectively farm the land and so sold the land for money to survive. When the original allottee died the allotted lands were passed on to the allottee’s heirs. If, however, even one of the heirs wanted to sell the land for cash the government would sell it and divide the proceeds amongst the heirs. When the heirs wanted to divide the land amongst themselves, the parcels eventually became to small to allow the occupants to gain their subsistence from only the land and the Coquille were forced to seek work in town. In these cases the jobs and the land were too far apart to allow commuting and the Coquille could not afford to keep the land if they were not going to be living on it (Hall 1995: Personal communication). The end result of the allotment policy was that most of the Indian land ended up in the hands of non-Indians (Zucker, Hummel & Hogfoss, 1983:73; Hall 1991:114; Thomas 1989:24). Since the allotment lands were not often good farmland, but did usually have stands of timber, timber companies were often the beneficiaries of the Coquille’s plight (Hall 1995: Personal communication).
The passage of the Indian Reorganization Act in 1934, which halted the allotment of reservation lands and made provisions for economic development by the tribes, had little effect on the Coquille because they lived far from reservation communities and had fallen into an uncertain status as far as the federal government was concerned. A tribal hall was built in Empire during the late 1930s for all the Indians in the area (Zucker, Hummel, Hogfoss 1983:75; Beckham 1990:187; Parrish 1995: Telephone Interview).

Termination

Beginning in 1951 the United States Congress, in an attempt to eliminate the costs associated with their treaty and trust responsibilities to Indians, began an effort to invalidate these agreements and, thus, end federal responsibilities. The Bureau of Indian Affairs targeted western Oregon Indians to be among the subjects of this policy and Oregon Governor Douglas McKay supported the Bureau of Indian Affairs' position. In 1954 Congress passed the Termination Act (68 U.S. Stat. 724) intended to end all federal relationship with western Oregon Indians, regardless of whether they lived on a reservation. The Coquille were among those who lost federal recognition of their identity as an Indian tribe and their access to federal services designated for Indian people (Zucker, Hummel, Hogfoss 1983:77; Thomas 1990:26; Beckman 1990:188; Hall 1991:24, 181-91).

The American Indian Policy Review Commission, comprised of three senators, three congressmen, and representatives from seven tribes, appointed a task force to examine the status of Indian tribes not officially recognized by the U.S. government.

The Task Force on Terminated and Nonfederally Recognized Indians, Task Force No. 10 of the American Indian Policy Review Commission, began
operations on August 18, 1975....The purpose of Task Force No. 10...is to gather facts and other information necessary for the American Indian Policy Review Commission to report to the Congress on the status of terminated and nonfederally recognized Indian tribes, bands, and groups and make any recommendations as required by Public Law 93-580 (U.S. American Indian Policy Review Commission 1976:3).

Task Force No. 10 had several purposes:

- To review the historical and legal status of terminated and nonfederally recognized tribes.
- To define federal recognition.
- To assess and evaluate federal funding of Indian programs.
- To collect data regarding the needs of terminated and nonfederally recognized Indian groups.
- To report its findings to the Commission.

In 1976 the American Indian Policy Review Commission published an exhaustive report on the effects of the termination policies. Much of the rest of this chapter is derived from that report.

After study and reflection, the Task Force has determined that the termination acts were passed by Congress under very uncommon and questionable circumstances. The legislation was acted upon in haste, with little debate, as the handiwork of a small number of legislators employing tactics which would not be duplicated today. The Task Force must conclude that the legislation was not given the proper consideration and reflected the efforts of legislators intent on passage of the legislation at a time when it appeared that nothing else was working to “solve the Indian problem” and at a time when the Bureau of Indian Affairs appeared at its worst. The Task Force concludes that termination was another experiment, however ill-conceived and destructive, with no controls and no provisions for reversal.

Termination was not initiated by the Indians, was not adequately understood by them and was, for the most part, not consented to by them. With the Bureau of Indian Affairs’ evaluations of tribes as to their readiness for withdrawal of federal protection and its recommendations to the Congress as to which tribes were ready and with the subsequent Congressional responses to such recommendations, the Task Force can only conclude that the Bureau of Indian Affairs and the Congress made the
selections for the participants in the experiment. The years since termination show that it has not had a positive effect on the lives of the Indians and has indeed made life more difficult for them. Termination has resulted in the loss of tribal lands and the disintegration of tribal society has weakened tribal organizations and placed cultural identity in jeopardy, has left those most in need, the young, the old, the sick, without adequate programs to help them, has eliminated special federal services and rights as Indians and has resulted in the exploitation of tribal members (U.S. American Indian Policy Review Commission 1976:1694).

While the Termination Acts had significant impacts on most Indians subjected to them, the effects may not have been as severe to the Coquille. Interviews with Coquille tribal members\(^2\) who lived in the area indicate that the effects of termination on the Coquille may not have been as devastating as they were to some of the other tribes. The Coquille had no reservation land base to lose, and they had existed within the dominant society in that area for over half a century. There were no full-blood Coquille at the time of termination, all of them having some European ancestry by that time (Rose: Interview in February, 1995). The circumstances following termination demanded that the people gain self-sufficiency. This required getting jobs and with jobs often came health insurance. Considering the inadequate health care delivery system of the Bureau of Indian Affairs prior to this point, health insurance was a boon (Philomena: Interview in February, 1995).

Though the Coquille were able to turn adversity to their benefit in some ways, the effects of termination took their toll in others. At termination there were 269 Coquille tribal members on the rolls, almost all of whom lived in the local area. Many had to leave

\(^2\) Interviews with Coquille tribal members were conducted on several occasions in early 1995 and references to these interviews will utilize pseudonyms, in compliance with University policies, in order to protect the anonymity of the participants. I chose names of my own ancestors and children as a way to honor the contributions made by those who donated their time and memories to this research.
to seek employment. Now fully one half of tribal members live outside of the five county area of southwestern Oregon. This dispersal of tribal members indicates the extent of community breakdown caused by termination (Terran: Interview February, 1995).

It is particularly disturbing and revealing to note that the Bureau of Indian Affairs and the federal government found it hard to recognize or acknowledge the Indians of southwestern Oregon, or to provide them with services, until the opportunity arose whereby they could extinguish the Indians’ claims for those services.

The only group of Indians covered by Public Law 588, who were formally recognized as a tribal unit, but who didn’t actually live on the Siletz and Grand Ronde Reservations, were the Coquelle...which included all those people associated with the Coquille River, in a geographic and demographic sense...some of these lived in the Coquille area, while others were the descendants of the upper Coquilles who were taken north after the 1855 War, and who resided at Siletz (U.S. American Indian Policy Review Commission 1976:29).

The American Indian Policy Review Commission developed a questionnaire to assess the perceptions of Oregon Indians who were affected by the termination policy. On March 13, 1976, the Commission held public hearings in Salem, Oregon, to assess the status of terminated Indians within the state. As a result of these hearings several areas were identified that warranted further study. These areas included:

* The process used to inform Indians of the termination policy.
* Oregon Indians’ understanding of termination policy at the time of legislation.
* The adequacy of compensation received by Indians.
* The process of picking trustees and guardians.
* The adequacy of services rendered.
The particular effects of termination regarding:

family ties
health care
employment
education
alcohol and drug abuse
cultural identity
ability to meet basic needs

The remedies necessary to address the problems caused by termination (U.S. American Indian Policy Review Commission 1976:30).

Some results from the questionnaire follow:

* Only 23% claimed knowledge of meetings about termination prior to its enactment.
* Only 17% took part in those meetings.
* Only 5% felt they had adequate opportunity to take part in the decision to terminate.
* 70% felt the acts were carried out without their knowledge.
* Only 7% understood that Federal service programs would end.
* Only 8% understood that special legal status of tribes would end.
* Only 4% understood that special hunting and fishing rights would end.
* None felt adequate compensation was rendered.
* 67% felt family ties were negatively affected.
* 67% felt school drop-out rates were negatively affected.
* 89% felt alcohol and drug abuse got worse.
* 62% felt Indian crime rate got worse.
* 79% felt Indian health care diminished.
* 70% felt cultural identity was negatively impacted.
* 73% felt employment suffered.
* 77% felt less able to meet life's basic needs (U.S. American Indian Policy Review Committee 1976:35).
The report goes on to state:

The Indians of Southwestern Oregon for the most part did not have active tribal organizations, and it is clear that they did not participate in the decision to terminate. Termination became a reality for most of these Indians when they received notice from the government which told them they had been terminated (U.S. American Indian Policy Review Commission 1976: 47).

Over 20 years passed between termination and the issue of the Review Committee’s report. The economy of the state had changed, technological and methodological advances had occurred in medicine, and a number of events had occurred that may have influenced the circumstances of the Indians during that time. The U.S. American Indian Policy Review Commission considered this when preparing their report:

It is difficult to determine whether the position of Oregon Indians today results from termination or from other factors such as the fluctuations of the local economies which have no real relationship to termination. One way of measuring the success or failure of termination is to view the policy of termination from the perspective of what it was intended to accomplish as compared to what subsequently happened (italics in original) to those Indian groups on whom the policy was applied. The policy of termination was intended to have a positive effect on Indian groups. It was viewed by many of its advocates as a way to assimilate Indians into a society from which they had been alienated. By this view, one of the major sources of alienation stems from the “special treatment” because of their status as Indians. Termination was supposed to end their special status and place Indians on the same footing as everyone else....If termination policy was successful, Indians should be in no worse a position following termination than they were in before and should, in fact, be in an improved position (U.S. American Indian Policy Review Commission 1976:56).

Evidence gathered by the U.S. American Indian Policy Review Commission and during my interviews with Coquille elders indicate that federal termination policies had culturally and psychologically detrimental effects on the Indian people of the terminated tribes. The beneficial effects of termination, in terms of assimilation and economic status,
that were projected by the federal government failed to materialize. In the research I was able to review, the effects of termination on health status and access to health care have not been given as much attention as have economic and cultural impacts.
5. Modern Health

Health Impacts of Loss of Community Structure

The waves of epidemics that occurred through the late 1700s and into the early 1800s initiated the loss of the Coquille culture and the community infrastructure. The members of the Coquille villages operated cooperatively to ensure the health and safety of the village and of all of its members. All of the people were vital to this effort. A small community could survive the loss of several of its members, but when a large percentage of the population was lost to a particular episode of infection, vital tasks necessary to long-term survival could not be performed. The decimated populations were not able to fend off the encroachment of the settlers into their territory. Knowledge, which was traditionally handed down through the generations, was lost due to the death of the elders, or the death of the young who would have been the recipients of this knowledge. The "glue" of culture which held the identity and community of the people together was lost along with the lives of the individuals. "The weakened tribal structures seem unable to maintain and support the cultural aspects of Indian life important to each tribal unit. The result is that a precious cultural heritage is being lost as older tribal members die off without transmitting their knowledge of Indian culture to the young" (U.S. American Indian Policy Review Commission 1976:63).

Waves of government interventions and restrictions continued the negative effects started by the diseases. By enforcing the removal of the people from their traditional homelands and lifeways they effectively eliminated the ability of the Indians to obtain
subsistence in their accustomed manner. To survive, the Indians were forced to adopt the practices of the non-Indians, to speak a new language, assume a new form of commerce, seek employment away from their homes and relatives, intermarry with non-Indians.

Tribal identity, culture, and social stability are qualities of Indian life which are difficult to measure or quantify in any meaningful way. Yet, it is these qualities which many Indians consider critical to their survival. A theme which ran throughout the Task Force 10 staff conversations with Oregon Indians is the belief expressed by Indians that the act of termination has changed them and placed them in a "no-man’s land" where acceptance has been denied them from both the white communities where they reside and also from non-terminated Indian communities (U.S. American Indian Policy Review Commission 1976:62).

The life of the communities and the tribe would never be the same. The population of the Coquille had been reduced to just several hundred. These people were either on the Siletz or Grand Ronde agencies, or scattered throughout what had formerly been their homelands. Those who had made their way back home had no community to which they could return. It is critical that we realize the ramifications of the demise of this community structure. The life of individuals in most indigenous populations is directly impacted by the health of the community in which they reside. When a culture is torn down the individuals within that social structure pay the price. The individual’s identity and sense of place in the world suffer terribly if the community is destroyed. The effects of anomie can be just as devastating as the effects of a particular disease. Termination of tribal status contributed directly to this process. The World Health Organization in its definition of health notes that health is not just the absence of disease, but is rather a state of physical, mental and social well-being. According to this definition the destruction of community negates the potential to achieve a state of good health.
As a result of the end of per capita payments and the inability to find work in the area, many Indians were forced to leave their ancestral homeland in search of employment. The result is family disintegration. Economically, these Indians are in a worse position than they were before. They lost their land, and the compensation received for that loss did not substantially better their economic or social status. Unemployment rates continue to be astronomical....The loss of federal services has dealt a crippling blow to their tribal organizations and has resulted in the erosion of their culture; a potentially binding and supporting force in their lives (U.S. American Indian Policy Review Commission 1976:64).

**Bureau of Indian Affairs Health Care**

During the late 1800s and the first half of the 1900s the Coquille who stayed on the reservations to the north were provided a meager amount of health care by the Bureau of Indian Affairs. The poor conditions on the reservation, however, were more than a match for the health care provided by the Bureau of Indian Affairs and the end results were high incidence of disease and devastatingly high mortality rates (Beckham 1990:183; Sam 1995: Interview; Zenk 1990:578). In 1867 there were only 88 Lower Coquille left on the Siletz Agency (Zenk 1990:578). Many Indians fled these conditions and returned to their original homelands to rejoin relatives who had avoided the round-up and the “march up the beach.” If the health care provided for the Indians on the reservations was inadequate, for the Indians who went home it was almost non-existent. It was fortunate for the Coquille that their families had been joined by marriage to strong and conscientious Euro-Americans who took on the burden of helping the Coquille to negotiate their transition into the new culture being forced upon them (Sam 1995: Interview). The Coquilles who lived in or near their traditional lands relied on these individuals to help them gain access
to health care. Health care for these people was sought through the same channels that the Europeans utilized. Western medicine began to replace the traditional and home remedies that the Coquille once relied upon. Lillian can remember doctors delivering babies at home, but is certain that these services were paid for by the people, not the Bureau of Indian Affairs (Lillian 1995: Interview). This pattern continued on into the 1950s.

A search of records at the National Archives in Seattle for evidence indicating Bureau of Indian Affairs attempts to provide health care to the Coquille Indians during the 1930s and 1940s turned up only a few pieces of correspondence. It is not clear whether this indicates a poor record-keeping system, a loss of original records, or that there was little done so there was little to record. From interviews conducted with tribal members it appears that the latter supposition may be the most likely. Some of the correspondence gathered from the National Archives appears to support this view. There is no doubt that the Bureau of Indian Affairs was aware of the Indians in the Coquille homelands because a letter from district Medical Director, Lynne A. Fullerton, to a Bureau of Indian Affairs dentist Dr. Frank J. Bullard, dated November 21, 1938, states, “Besides the Indians living at Grand Ronde and Siletz there are about 325 living in the vicinity of North Bend and Marshfield.”

Awareness, however, does not translate into concern. In reading a letter dated November 29, 1938 from Dr. Frank J. Bullard to the District Medical Director for the Spokane District, H. J. Warner, one could easily infer a lack of concern by the dentist for the well-being of the Indian children who are the subject of this letter.
I have learned from Mr. Earl Woolridge, Superintendent of the Grand Ronde-Siletz Agency, that there is a group of about twelve school children in the vicinity of Florence, Oregon. He is asking for dental attention for this group, but in as much as I will visit the southwestern part of Oregon before the close of school, I do not think it practical to make a special trip at this time for so small a number of children (Bullard 1938:In Correspondence).

If the close of school he refers to is in June, then it might be six months or so before he ‘visits’ this locality. Even if the close of school he refers to is for Christmas break it might be three weeks before those twelve toothaches received any attention. This seems quite a painfully long time.

Though the Bureau of Indian Affairs might not respond to requests or concerns from Indian people they would eventually act if the requests came from more respected sources. On December 19, 1938 Earl Woolridge wrote to Commissioner of Indian Affairs, Mr. Armstrong.

There is enclosed herewith a letter from Mr. Dean P. Crowell, doctor of North Bend, Oregon, relative to one of our Indians who is apparently in a pitiful condition and urgently needs assistance. I have heard of this case before from several of the Indians when I visited that territory. This letter was given to Dr. Fullerton by the state health officer, Dr. Frederick D. Stricker, and represents one of several similar cases in southern Oregon territory. I believe the Indian Service should do something immediately for this case and since Dr. Fullerton advised me such case could not be cared for at Tacoma I would suggest that this office be immediately authorized to hospitalize Mrs. Peterson at North Bend. Dr. Crowell stated that he would furnish medical services (Woolridge 1938:In Correspondence).

The last sentence is interesting in that it sounds as if the doctor is providing the services on his own. Several of the tribal members interviewed related stories of doctors donating their services to help the Indian people. Dr. Ennis Keizer was mentioned a number of times as being very generous of his time. He donated time every month
working in the clinic at the tribal hall in Empire (Philomena, Sam, Lillian 1995: Interviews).

The following correspondence from H. J. Warner, dated August 24, 1940, to Dr. Frank Bullard, seems to imply the sentiment that Indians off of the reservations were not a high priority.

With reference to the Indians on the Oregon coast, which are now under the jurisdiction of the Grand Ronde-Siletz Agency, you are advised that these Indians have a very vague and uncertain status and, so far as I know, are on no tribal roll. In view of the fact that they are scattered over an area of 200 miles north and south between the Coast Range and the Sea, it does not appear feasible to reach this entire group (Warner 1940: In Correspondence).

Some working trips were made to these outlying areas by both dentists and doctors. A proposed itinerary forwarded by Dr. Bullard notes that he would spend April 17-25, 1939 in the Marshfield and North Bend vicinity. Florence tells a story of her uncle’s cousin that may be related to one of these visits. Her uncle, who was Indian, had a cousin with the same last name who was not Indian. One day at school all the Indian kids, and the cousin, were gathered together and brought to a dentist visiting the school. The officials would not listen to the protestations of the cousin that he wasn’t an Indian and forced him to undergo an examination along with the all the Indian kids (Florence 1995: Interview). This story illustrates the disorganization of the efforts that were pursued.

A letter dated May 5, 1939 from special physician S.E. Johnson to Earl Woolridge at the Grand Ronde-Siletz Agency includes a report of a trip he made to the southwest Oregon coast. In his report it is obvious that he performed some necessary functions, but the last sentence is indicative of the amount of attention these Indians received.
Enclosed you will find a summary and report of the eyes, ears, nose and throat examinations, with recommendations, which I made on a recent visit to Southern Oregon, in your jurisdiction. I was glad to make this survey, as it is a part of my territory which I have never checked (Johnson 1939: In Correspondence).

Indian people on the southern coast of Oregon could not depend on medical care provision from the Bureau of Indian Affairs. Serious illnesses required that the patient travel long distances to receive care from the Bureau of Indian Affairs. Rose remembers people having to travel as far as Tacoma to an Indian hospital for treatment. Leo remembers his relatives traveling to Yakama and to Tacoma. Lillian recalls that if people got real sick they had to be taken to Tacoma (Rose, Lillian, Leo 1995: Interviews). Daisy remembers that as a child she was stricken with “wet pleurisy” and she would have to be taken in a rowboat from the end of south slough into town to see a doctor. Then a nurse came to her home and convinced her parents that this condition could be a precursor to tuberculosis and that she needed residential care. She was taken to a sanitarium in Salem and kept there for a year. There were no other children and she wasn’t allowed to touch or hug anyone for fear of contagion (Daisy 1995: Interview).

The health care provided the Western Oregon Indians at the time of termination was sporadic and inadequate. It was necessary for these Indians to wait for an occasional visit by a B.I.A. doctor or travel many miles to the Indian hospital at Chemawa in order to receive services (U.S. American Indian Policy Review Commission 1976:62).

Jack remembers being rounded up with a bunch of other young Indian boys and being taken to Chemawa to have their tonsils removed. He said they ran them through like they were taking care of a bunch of young bulls. “None of the kids had anything wrong with their tonsils, it was just the popular thing to do” (Jack 1995: Interview).
Daisy remembers a similar incident in which one of her children was taken with several children from other Indian communities by some woman to Chemawa for removal of their tonsils. The parents were given no information about how long their children would be gone. No one contacted them during the children's absence and then one day, a week or ten days later, they just got dropped back off at home (Daisy 1995: Interview).

Whenever possible the people would use local doctors to avoid the 200 mile trip to Chemawa. Sam says it was fortunate that some people had veterans' benefits because nobody ever had a way to get to Chemawa. Pat said some people had health insurance from their jobs. Terran's family went to regular doctors and "did not mess around with the Indian stuff." The wealthier Indians had access to better care (Sam, Pat, Terran 1995: Interviews). Some health care was obtained through county and school services. Jack remembers that all the immunizations were done in the schools with the whole student body (Jack 1995: Interview).

Though the Bureau of Indian Affairs was responsible for delivery of health care services to Indians in western Oregon those who lived away from the reservations received almost no care. By the 1940s and 1950s it was becoming obvious, even to the federal government, that the Bureau of Indian Affairs was not the appropriate agency to be in charge of delivering health care to the Indian people in the United States. This prompted a change in the structure of health care delivery to Indian people. The government established the Indian Health Service in 1955 to assume these responsibilities. For the Coquille this occurred too late. The government no longer recognized its responsibility to provide health care to them.
Another important measure of the success or failure of termination is the degree to which the Indians are meeting their health, educational, and social and cultural needs. Prior to termination, health care, often inadequate, was provided for the Indians by the federal government. In 1955, the B.I.A. turned over its health services to the United States Public Health Service, and the health services delivered to Indians have dramatically improved. This improvement in health care was made too late to benefit either the Klamath or Western Oregon Indians (U.S. American Indian Policy Review Commission 1976:61).

**Health During Termination Years**

In 1955 the Public Health Service, at the direction of the Transfer Act (P.L. 83-568), was given the responsibility for delivery of health services to Indians. This moved responsibility for the health of Indians out of the Department of the Interior, which houses the Bureau of Indian Affairs, and into the Department of Health, Education and Welfare, which houses the Public Health Service. A special branch within the Public Health Service, the Division of Indian Health, was created to handle these duties (Rhoades, Reyes, Buzzard 1987:352).

The House Appropriations Committee of the Eighty-fourth Congress stated:

Health services for Indians have been provided by the Federal Government for over a hundred years; but in spite of this fact the American Indian is still the victim of an appalling amount of sickness. The health facilities are either non-existent in some areas, or for the most part, obsolescent and in need of repair; personnel housing is lacking or inadequate; and workloads have been such as to test the patience and endurance of professional staff. This all points to a gross lack of resources equal to the present load of sickness and accumulated neglect (Public Health Service 1957:vii).

This apparent concern on the part of the House of Representatives was not intended to deter the efforts underway to cut services to the tribes who were being terminated. The
newly formed Division of Indian Health understood this and voiced its intent to support the termination legislation. The report on the state of health among American Indians published by the Public Health Service in 1957 states:

Since the Department of the Interior retains primary trusteeship functions with respect to Indian affairs, the Department of Health, Education, and Welfare recognizes that the best interests of our Indian citizens and the objective of integrating Indian citizens into local communities can be met only if the two Departments operate under compatible policies and complementary programs. Therefore, it is proposed to provide health services only to those groups and individuals considered a direct Federal responsibility by the joint determination of the Secretary of the Interior and the Secretary of Health, Education, and Welfare (Public Health Service 1957:viii).

Another interesting note, not directly relative to the Coquille but revealing nonetheless, concerns the coordination between the policy making arms of the Bureau of Indian Affairs and the Indian Health Service. In its constant efforts to integrate American Indians into mainstream society (for their best interests) the United States government, in 1952, came up with the “Voluntary Relocation” program. The idea was to move Indian families into cities and away from the reservations, which would remove them from the trust relationship. Jobs were arranged, but they often lacked security. The Bureau of Indian Affairs administered this program and set up relocation offices on many reservations that were used to convince Indian people of a better life in the cities (Zucker, Hummel, Hogfoss 1983:1445-5). How this relates to Indian health is explained by the Commission on the Rights, Liberties and Responsibilities of the American Indian:

These functions of the United States Public Health Service, however, have not yet been closely enough coordinated with activities of the Bureau of Indian Affairs or with those of the tribes. This creates serious management problems and results in the two services often working at cross purposes. For example, the Bureau is encouraging Indians to find employment outside the reservation. The Public Health Service in general restricts
medical attention to those living on reservations. This often means that a sick Indian gives up a good job in a city in order to return to the reservation for free treatment and after his discharge from a clinic or hospital is afraid to leave this medical care (Commission on the Rights, Liberties, and Responsibilities of the American Indian 1961:38).

The Coquille were spared this quandary. They were not allowed access to these services due to the Termination Act signed into law by Congress in 1954, by which the United States government abrogated its treaty responsibilities to the Coquille people. For the following 35 years, until their tribal status was restored, the Coquille people were left to seek health care in whatever ways they could devise. Because of the inadequate health care delivery system of the Bureau of Indian Affairs during the years previous to termination the Coquille were not completely unprepared to face this challenge. They had been in a similar situation for many decades.

When termination took effect members of the Coquille tribe found themselves in a circumstance that demanded self-reliance. The efforts they had made to learn the Euro-American ways of living during the preceding decades served them well. Some had utilized the available services for Indian health when a crisis arose, but now they could not turn there for assistance if they were in need of health care. They had not used the Bureau of Indian Affairs medical facilities to any great extent in the past. For many Coquille the removal of health care had little impact.

Several elders told me they did not even notice when termination occurred. They had not heard much about it and did not even know it had happened until much later. When asked specifically to discuss the effects of the loss of health care services due to termination, the elders responded by saying that it really had little impact because the
service prior to termination was so poor that it was only used as a last resort. Sam said on a scale of one to ten, with one being the low, the service prior to termination would rate a one and after termination would rate a zero. He also said that termination occurred at a time when there was a lot of work available, so people were in pretty good shape financially (Sam 1995: Interview).

Kathryn Harrison, a Grand Ronde elder, worked for the Coos County Council on Alcoholism (CCCA) during the 1970s. The CCCA hired Harrison to develop a program to assist Indian people in Coos County who were experiencing alcohol-related problems. She conducted an in home survey of all the Indian families in the county that the project could identify, by word of mouth or from some type of records, to determine the degree and nature of the problem. The program began to use sweat lodge treatments to address the alcohol issues in a traditional format. Indian people were brought in from the Willamette Valley to lead the sweats.

Kathryn Harrison also said that many of the Indian people who could not afford medical treatment went to a clinic down in Trinidad, California, where treatment was offered to Indian people regardless of whether they were federally recognized or not. She mentioned a woman doctor, Dr. Jens, who would travel out to wherever the Indian people were in order to provide services. She would often travel beyond the end of the roads. She would just take her bag and proceed on foot. Kathryn Harrison said she was known as the “Circuit Rider” because she was always traveling around. Her territory extended down onto the Rogue River. None of the Coquille members that I interviewed mentioned Dr. Jens, however; but this may be because many people have died in the 20 years
between Harrison's period at Coos County and when I conducted interviews with Coquille elders in 1995.

Health of the Klamath Tribe in Comparison to the Coquille

An interview with the Klamath Tribal Chairman, Morris Jimenez, provided a view of the effect of termination on the health of the Klamath people. The effect of termination on the Klamath Reservation is in sharp contrast to that experienced by the Coquille. Prior to termination, the Klamath people had a reservation and with it the community that a reservation implies. There were clinics and a hospital on the reservation, fully staffed to treat most medical and dental needs right at home. Klamath people were able to utilize contract health funds to go into Medford or Klamath Falls to obtain treatment from specialists when the need dictated.

Life for Klamath near the reservation was difficult because many of those who returned from World War II could not find adequate employment. Alcoholism was affecting and killing many of them. The government had made promises to them if they would serve “their country,” but for one reason or another the promises were not kept. The Bureau of Indian Affairs was mishandling tribal funds. The elders were worried that too many of the youth were being lost. Many felt that they would be better able to take care of their people if the Bureau of Indian Affairs bowed completely out of the picture.

In 1958, in payment for their lands, the Klamath each received $43,000 in one lump sum. Then over the next few years received a few more payments of smaller amounts, one about $6-7,000, and one about $1,500. Most of these people had never had substantial
sums of money and were easy prey for unscrupulous lawyers and businessmen in the vicinity, many of whom were censured in later years for their behavior. With little understanding of money management the funds were soon gone and the people were left with no recourse but to rely on the local support services to meet their needs.

The Klamath had not been adequately prepared to meet the challenges of life in the dominant society. The tribe had tried to give classes to prepare the people, but many of the necessary skills were not acquired sufficiently to ensure a successful transition. The changes occurred too fast.

The situation was compounded by the fact that the city of Klamath Falls and Klamath County had not been adequately prepared to meet the new increased demands on the systems, demands that had formerly been met by the Bureau of Indian Affairs. The plan for termination was ill conceived and poorly planned and the whole community, not just the Klamath people, paid the price.

Many Klamath were able to avoid the welfare scenario but to do so required leaving their home to seek work in Medford, Portland, or Multnomah, Lane and Marion Counties. Within 15 years, one third of the Klamath people had left home and by 1980 over one half were gone. For those who were strong in their traditions this caused considerable difficulty because they had to travel back home to gain access to their spirituality and community.

Those who were not well grounded, either in tradition or in the dominant society, were the ones who suffered the most. The termination period brought with it an increase in alcoholism and alcohol related deaths and injuries. The community and all that it
provided the people in the way of support and structure for their lives was greatly diminished.

A survey was conducted by Sandra Joos and Shirley Ewart in 1985 (Joos and Ewart 1988) to determine the state of health among Klamath tribal members 40 years old and older. Forty-one percent lived in the former reservation area, 47% were located in cities throughout western Oregon, and the remainder were either in other locations in Oregon or out of state. The results were compared to results from a study performed by the National Indian Council On Aging, published in 1981, which looked at the health of Indians 45 years and older, three quarters of whom were from rural or reservation areas and the remaining quarter from urban areas. Fewer Klamath elders had medical insurance and more were in need of medical care. They had better eyesight and less heart trouble, but had liver problems at more than three times the rate of the control population. Most of the other categories were similar to each other. The comparison study done by Joos and Ewart indicates that the Klamath elders were in no worse medical condition than Indian elders who had not experienced termination (Joos and Ewart 1988:166-73).

The Coquille, because they had no reservation lands and did not have the same community structure, and because they had coexisted with the dominant society for many years, were not forced to experience the same degree of upheaval in the 1950s as were the Klamath. The actual termination process of the Coquille, as compared to the official legal termination, happened gradually over a period of more than one hundred years which allowed them more opportunity to adjust. This is certainly not to imply that the Coquille avoided the trauma of termination. Their termination did not begin in 1954 with the
Termination Acts passed by Congress. The disruption of their community and lifeways began when they lost their land to the United States and its settlers back in 1856, when they were rounded up and shipped up the beach to the Siletz and Grand Ronde Agencies. The Termination Act was just an additional step down that road.

Health Studies of Southwestern Oregon Indians

During the late 1970s and early 1980s two reports considered the health of the Indians in Southwestern Oregon. One, the Master’s Thesis of Oregon State University student Alison Taylor Otis, dealt with mental health issues, barriers to care, and the advisability of incorporating traditional medicine into the mental health care system when treating Indian people. The other was a fairly comprehensive report of the health situation of the Southwestern Oregon Indians produced by David Lloyd Whited of the Southwest Oregon Indian Health Project and submitted to the Indian Health Service.

It should be noted that the Indians in both studies, though residents of Southwestern Oregon, include many Indians of non-Oregon based tribes. In both reports, subjects were sampled on an availability basis, including as many Indian interviewees as the researchers could find. Random sampling or use of any sampling frame was not possible because there is no census of Indian people in the area and both studies were done prior to restoration, which involved production of a list of registered tribal members.

Otis found difficulty in her data collection because the Indian population in Southwestern Oregon was “invisible” to the health care system, and there were inconsistencies in racial identification of Indians. Her study noted that 31% of all mental
health problems were related to alcohol abuse. Alcoholism was a primary factor in child neglect, divorce, and school drop-outs. The Community Mental Health programs reported only 1% of their users were Indian people, while alcohol programs reported 7-20% Indian usage. Otis thought this might be interpreted as a reluctance to be seen as "crazy" and/or recognition that alcohol programs were more responsive to Indian needs. The lack of culturally sensitive mental health care in the southwestern corner of the state may be significant in this regard (Otis 1981:20-1,25,32).

Otis also reported that 21% of total mortality was alcohol related, 75% of all suicides were alcohol related, and the mortality rate due to cirrhosis of the liver was four times higher than in the general population (Otis 1981:21).

According to Whited, 6.43% of Oregon's problem drinkers were Indian, but only 1% of Oregon's population was Indian (Whited 1979: 85). Surveys conducted among Southwestern Oregon Indians revealed a ten times higher rate of alcohol abuse and a five times higher rate of drug abuse among the Indian population than among the general population even with a notable avoidance to answer questions related to substance abuse (Whited 1979:70).

Of the surveyed Indian population in Southwestern Oregon, 42% had no health insurance (Whited 1979:57), fewer Indians saw the doctor, but those who did saw them 25% more than the general population (Whited 1979:54). A similar pattern was noted regarding dental care. Indian patients waited until dental problems were severe before seeking help. Then the care necessary required many more visits (Whited 1979:81). Mental retardation, cerebral palsy, autism, ulcers, and blindness were all present in the
Indian population at twice or more the rates in the general population (Whited 1979:70). Thirty-five percent of Indians experienced vision problems, 21% were overweight, and 7% had high blood pressure (Whited 1979:72).

Even though the data above are not specifically related to the Coquille it is reasonable to assume that the health problems they faced were very similar to those reported for the total Indian population in the southwest corner of Oregon. During this same time period Indians across the rest of the country and in much of the rest of Oregon were eligible to receive health care from the Indian Health Service.

Indian Health Service and Health Status of Indians Since Its Creation

The federal government, recognizing the ineffective efforts of the Bureau of Indian Affairs to deliver adequate health care to Indian people, reassigned this responsibility to the Public Health Service, which then created the Indian Health Service in 1955 to provide the needed health care to Indian people. Unfortunately for the Coquille, they were no longer, in the eyes of the government, Indians. Thus, their access to the improvements in health status enjoyed by Indians across the nation was denied by the termination policy.

Though the Indian Health Service provided no assistance to the Coquille or the Indians of the other terminated tribes, it has been effective in improving the health of the Indian populations it has served. The Indian Health Service has set goals and been successful in achieving many of them.

The IHS goal is to elevate the health status of American Indians and Alaska Natives to the highest level possible. The mission is to ensure equity, availability and accessibility of a comprehensive high quality health care system providing maximum involvement of American Indians and Alaska
Natives in defining their health needs, setting health priorities for their local areas, and managing and controlling their health program. The IHS also acts as the principal Federal health advocate for Indian people by ensuring they have knowledge of and access to all Federal, State, and local health programs they are entitled to as American citizens. It is also the responsibility of the IHS to work with these programs so they will be cognizant of entitlements of Indian people (Indian Health Service 1992:1).

Along with the first appropriations from Congress to the Public Health Service, to be used specifically for health services to Indians, came instructions to conduct a survey of the state of health among Indian people. This study focused on nine reservations with varying levels of care available to them. The results were published in 1957 and established a baseline health status from which priorities could be determined, and against which progress could be measured (Public Health Service 1957:vii). To gauge the effect of their efforts the Division of Indian Health identified several major areas of concern, developed and applied policies, implemented a tracking system and produced annual reports titled *Trends in Indian Health* to detail the progress. Each of these reports now looks back over the preceding ten years and tracks many health criteria. The results are remarkable in many of the categories. However, this is not at all surprising when one considers how much room there was for improvement when the Indian Health Service was established.

It must be noted here that the data collected by the Indian Health Service only represent the situation of the Indians who were eligible to receive assistance from the Indian Health Service and not all of the Indians in the United States. The Indians from terminated tribes, many of the Indians in urban areas, and Indians who, for any of a number of reasons, were unable to establish documentation of enrollment in a federally
recognized tribe are not considered in these evaluations. Nonetheless, the Indian Health Service has produced some impressive results.

The Indian population has been growing rapidly for the past several decades. This is due to the high birth rate, 28.1/1000 among Indians, compared to 16.7/1000 for the United States all races 1989-1991, and to the decrease in infant mortality since the 1950s (Young 1994:39). Another factor to consider is a tendency for some to alter their choice of the ethnicity they claim at different points in time to take advantage of circumstances. As the political climate changes, the benefits associated with being Indian change. And, as the social climate changes the "popularity" of being Indian changes, as well. Since the 1970s it has become easier in this country to claim one's American Indian/Alaska Native heritage. It is difficult to determine the effect this might have on results when seeking to establish rates of mortality and morbidity within a population over time. One would think that those who are able to successfully "pass" as Indian or non-Indian might also be those who are more acculturated and thus, perhaps, less susceptible to risk factors which plague more traditional Indian populations. If these individuals make up a portion of the increasing population being served by the Indian Health Service, then they might also account for a portion of the increased health status of Indian people claimed by the Indian Health Service. In an article titled American Indian Intermarriage, Sandefur and McKinnell cite Passel and Berman as showing that between 1960 and 1970 67,000 people changed their self-identification from "white" to Indian, and between 1970 and 1980 as many as 358,000 did so (Sandefur and McKinnell 1986:348). McKenney says:

Several factors influence race and ethnicity findings when census data are used as denominators and public health surveillance data are used as numerators. For example, census data rely on self-identification for race
and ethnicity, while public health surveillance efforts employ a variety of methods, including direct interview, interviewer’s observation, and reporting by health providers. Although numbers obtained through self-identification and enumerator observation for white and black populations generally agree, there are substantial differences for the other groups....For example, the increases in the American Indian population during the last two decades exceeds that which can be attributed to natural increase, and probably reflects a shift in self-identification (McKenney 1993:7).

The 1957 survey determined a total of 507,000 American Indian and Alaska Native people in the United States, 305,000 of whom were eligible for services from the Division of Indian Health. The numbers in both these criteria have continually escalated over the following four decades (See Figure). In 1994 the Indian Health Service provided care to 1,400,000 individuals, an increase of more than three times since 1974. While the total number of individuals served has increased dramatically, the percentage of the total Indian population who is being served has steadily decreased. Sixty-six percent of Indian people received service from the Division of Indian Health in 1954, by 1966 the percentage had dropped to 63, by 1974 it was down to 55, and in 1994 was around 50% (Public Health Service 1957:1; Indian Health Service 1966:1, 1974:6, 1994a:28).

![Graph of Increase of Indian Population and of IHS Usage, 1957-1994](image)

Increase of Indian Population, and of IHS Usage, 1957-1994
The age distribution among the Indian population varies considerably from that among the All Races population category within the United States. There are far more young Indian people than in the All Races categories and the opposite holds true in the over 65 portion of the population. These differences have remained fairly constant over the last 40 years as is indicated in Table 1 (Public Health Service 1957:12; Indian Health Service 1966:2-3; 1974:9; 1994a:28).

In 1957 the survey conducted by the Public Health Service identified areas of concern which demanded immediate attention. The four leading causes of mortality in Indian populations were tuberculosis, influenza and pneumonia, enteric diseases, and accidents, each of which occurred at many times the national averages (Table 2). By 1966 each category except for accidents had dropped in incidence per thousand population. The ratio comparing Indian mortality frequencies to the national averages, for each category except accidents, also decreased, though the disparity between Indians and the rest of the country remained great (Public Health Service 1957:41; Indian Health Service 1966:17).

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<tbody>
<tr>
<td>Indians Under 5</td>
<td>16%</td>
<td>17%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>All Races Under 5</td>
<td>10%</td>
<td>11%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Indians Under 20</td>
<td>50%</td>
<td>55%</td>
<td>54%</td>
<td>----</td>
</tr>
<tr>
<td>All Races Under 20</td>
<td>33%</td>
<td>38%</td>
<td>38%</td>
<td>----</td>
</tr>
<tr>
<td>Indians Over 65</td>
<td>6%</td>
<td>5%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>All Races Over 65</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
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</table>

Table 1: Comparison of Age Distribution
The rate of incidence of tuberculosis per 100,000 Indians in the 1960s was over 250. It dropped to 138/100,000 during 1969-72, to 90/100,000 in 1973-76, and it was only about 25/100,000 by 1984-88. Still, this was three times the national rate, although only 10% of the incidence in the early 1960s (Young 1994:60).

By 1974 tuberculosis, pneumonia and influenza, and enteric disease were no longer in the top four leading causes of death among Indian populations, but accidents still accounted for 20% of all Indian deaths, while in the rest of the nation only about 6% of deaths were due to accidents. By 1974 heart disease had become a major concern accounting for 18% of Indian mortality, and malignant neoplasms had experienced a rise to the number three spot with 8% of mortality among Indians. Between 1957 and 1974 diabetes mellitus, homicides, suicide, and cirrhosis of the liver had all experienced major increases (Public Health Service 1957:42; Indian Health Service 1966:16; 1974:31-2).

<table>
<thead>
<tr>
<th></th>
<th>1957</th>
<th>1966</th>
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<tbody>
<tr>
<td><strong>Indian Tuberculosis</strong></td>
<td>8.1%</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>All Races Tuberculosis</strong></td>
<td>1.6%</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Tuberculosis Ratio Indian / All Races</strong></td>
<td>5.1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Indian Pneumonia &amp; Influenza</strong></td>
<td>10.5%</td>
<td>7.0%</td>
</tr>
<tr>
<td><strong>All Races Pneumonia &amp; Influenza</strong></td>
<td>3.1%</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Pneumonia Ratio Indian / All Races</strong></td>
<td>3.4</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Indian Enteric Disease</strong></td>
<td>5.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>All Races Enteric Disease</strong></td>
<td>----</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Enteric Disease Ratio Indian / All Races</strong></td>
<td>----</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Indian Accidents</strong></td>
<td>14.1%</td>
<td>18.8%</td>
</tr>
<tr>
<td><strong>All Races Accidents</strong></td>
<td>6.4%</td>
<td>5.8%</td>
</tr>
<tr>
<td><strong>Accident Ratio Indian / All Races</strong></td>
<td>2.2</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Table 2: Mortality Due to Particular Causes 1957 & 1966
Young notes, "Over the past several decades Native Americans have undergone the "epidemiologic transition," characterized by the decline, though not disappearance, of infectious diseases and the increasing importance of the chronic noncommunicable diseases, accidents, and acts of violence as causes of mortality and morbidity (Young 1994:94)." By 1994 heart disease, accounting for 22% of deaths among Indians, had taken the number one spot. Accidents and malignant neoplasms occupied the second and third places with 15% each (Indian Health Service 1994b:50).

This shift in importance is due in part to the "modernization" of Indians as they become more acculturated and adopted different lifestyles, but it is also due to the effectiveness of the efforts of the Indian Health Service in combating infectious diseases. One striking example is the decrease in infant mortality rates of the last several decades, particularly those caused by enteric diseases, influenza and pneumonia. In 1957 the main causes for infant mortality in post-neonates\(^3\) were pneumonia and influenza, and diarrheal diseases. In 1966 respiratory and digestive diseases still accounted for most of the deaths in this age group, but the total number of deaths had been reduced by almost 40%. By 1974 Indians were experiencing lower rates of mortality in this age group than was the nation as a whole. This trend has continued to the present time. The leading cause of death for Indian post-neonates in the early 1990s is Sudden Infant Death Syndrome, which occurs in Indian populations at twice the national rate (Public Health Service 1957:51,53; Indian Health Service 1966:10,72; 1974:21,23; 1994b:42).

\(^3\) The term neonate refers to infants between birth and 28 days old, while post-neonate refers to infants between 28 days and one year old.
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</thead>
<tbody>
<tr>
<td><strong>Indian IMR</strong></td>
<td>76</td>
<td>38</td>
<td>23</td>
<td>10</td>
</tr>
<tr>
<td><strong>All Races IMR</strong></td>
<td>28</td>
<td>25</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td><strong>Indian Neonate IMR</strong></td>
<td>28</td>
<td>18</td>
<td>12</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>All Races Neonate IMR</strong></td>
<td>20</td>
<td>18</td>
<td>14</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>Indian Post-neonate IMR</strong></td>
<td>53</td>
<td>25</td>
<td>11</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>All Races Post-neonate IMR</strong></td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Table 3: Infant Mortality/1000 Livebirths 1957-1994

The decrease in infant mortality had a positive effect on another health indicator, life expectancy. The gap between Indians and the national average for life expectancy has been reduced from about a 10 year differential in 1957 to only about two years difference in 1994. At the same time the overall length of life for Indian people has increased by about 13 years, from 60 in 1957 to 73 in 1994 (Public Health Service 1957:38,40; Indian Health Service 1994a:76). We must bear in mind that data obtained from the Indian Health Service are derived from only those Indian people who utilize the services provided by that agency, and that this data does not provide us with knowledge regarding the health of the other 50% of the Indian population in the United States.

While the Indian people in the rest of the country were experiencing rapid improvements in their health status as a result of the IHS interventions, the Coquille and Indians from other terminated tribes did not find themselves so fortunate. Any improvements in the health status of the Coquille people were accomplished without the assistance of the IHS and at the initiative of the Coquille themselves.
Health of the Coquille and Other Indians in the Late 1980s

A major problem arising from the termination of the Coquille is that the ability to track the health status of these people became much more difficult. This research has established that the Coquille received little health care prior to termination, and the care they did receive either was not noted or the records were not retained. Therefore, there is no baseline from which to make conjectures. The Indian Health Service did not provide care to the Coquille during termination so no records can be obtained from that agency. Records of the results from the health survey conducted by Kathryn Harrison for the Coos County Council on Alcoholism were destroyed in the 1980s. The doctors who provided service to the Coquille tribal members are now deceased or in ill health themselves and not available to be interviewed. Records kept when Coquille people used the health care options that were available to them would not necessarily identify them as Indians, much less as Coquille.

Two studies done in the early 1990s found that there is substantial racial misclassification of American Indians by health care providers and by those filling out death certificates. "One third (33%) of the infants recorded as being Native American on their birth certificates were not recorded as such on their death certificates. A study linking 1960 census records and death records found that 17% of individuals who reported their race to be Native American in census returns were classified as White on their death certificates" (Frost, Taylor, and Fries 1992:958). Another study compared racial classification of individuals on the Oregon Injury Registry to Indian Health Service client files. This study found that when the two sets of data were linked the number of Indians
was actually 68% higher than was recorded by the registry alone. It also found that racial misclassification occurred more frequently as blood quantum decreased. Indians with 100% blood quantum were accurately identified 89.5% of the time. Indians with 50-99% blood quantum were accurately identified as Indian 80% of the time. When the blood quantum dropped to 25-49% the accuracy of racial classification dropped to 31%. And for those individuals with 1-24% Indian blood quantum, the Oregon Injury Registry classified them as Indian only 5.6% of the time (Sugarman et al., 1993:682). Due to their history the Coquille, as a tribe, have a lower degree of Indian blood than many other tribes, and thus they stand a greater chance of misclassification.

Another problem with health and census recording systems is that there is no mechanism for recording joint classification or biracial or biethnic heritage. The percentage of Americans who fit into these categories is constantly increasing and truly accurate health statistics should note this, whether explanations for variation in disease incidence is genetic or cultural, or an interaction of both.

Due to these barriers it is not possible to obtain a definitive picture of the health of the Coquille during this period. We must instead rely on anecdotal reports and assume they offer an accurate representation even though they do not offer as complete a picture as is desirable. We can also look to reports on the health of all Indians in the area and trust that these will provide a fair representation of the Coquille.

A socioeconomic study of the Coquille Tribe was done by Oregon State University’s Survey Research Center in 1987. A survey was sent to 226 households and 153 (68%) responded (Oregon State University Survey Research Center 1988:1). Health
issues were one of the areas examined in that study. While this evidence is incomplete it is relatively current, and it is the only evidence available that deals specifically with the health of the Coquille. The survey questions were asked of a single member of the household and the answers were given for the household as a unit. This method makes it difficult to analyze the data because it does not provide us with exact rates, but only estimates of prevalence. For example, if a respondent was asked if anyone in the household had hearing problems and the answer was yes, we would not know if all six members had hearing problems or if only one member was afflicted. This study also does not indicate if the member exhibiting the symptoms was an Indian or not. A condensed version of the health related results obtained from this survey is provided in Table 4.

<table>
<thead>
<tr>
<th>Problem/Condition</th>
<th>% of Households Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Problems</td>
<td>61%</td>
</tr>
<tr>
<td>Dental Problems</td>
<td>49%</td>
</tr>
<tr>
<td>Allergies/asthma</td>
<td>39%</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>35%</td>
</tr>
<tr>
<td>Hearing Problems</td>
<td>31%</td>
</tr>
<tr>
<td>Arthritis/Rheumatism</td>
<td>28%</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>19%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>12%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>10%</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>10%</td>
</tr>
<tr>
<td>Ulcers</td>
<td>9%</td>
</tr>
</tbody>
</table>

*Table 4: Percent of Coquille Households That Report at Least One Household Member Suffers From These Conditions*
In 25% of Coquille households someone should have seen a doctor but did not. Though dental problems were reported in 49% of households, only 30% reported a household member seeing a dentist. While 31% were hospitalized only 11% went to see a doctor. There was no health insurance in 18% of the households, but over 50% had health insurance provided by an employer and almost 30% had health insurance through a private company (Oregon State University Survey Research Center 1988:10-13).

Sources for information on health and disease of Indian people in the 1990s include a major study conducted by the American Indian Health Care Association to assess the health status of Indian people in eight northwestern states, Washington, Oregon, Idaho, Montana, North Dakota, South Dakota, Minnesota, and Iowa (American Indian Health Care Association 1993a, 1993b). T. Kue Young, of the University of Manitoba, produced an exhaustive work titled *The Health of Native Americans: Toward a Biocultural Epidemiology* (Young 1994). Both of these documents provide a comparison of Oregon Indians to Indians in the northwest region, and further comparisons to the All Races population of the United States. Several of the health categories noted in the 1988 Coquille Socioeconomic study have been selected. Please note that here, too, the problems with inadequate or misclassification of race may affect the applicability of the data. Though these results do not specifically indicate the health status of the Coquille they provide an additional frame of reference within which to view the data provided by the Oregon State University Survey Research Center.

Indians in Oregon had a lower mortality rate than Indians in any other state in the northwest region, and lower even than the Oregon all races rate, 686/100,000 compared
to about 800/100,000. Within the region, Oregon’s All Races category had the highest mortality rate for heart disease, but Oregon’s Indians had the lowest heart disease mortality rate (American Indian Health Care Association 1993a:33). Indian women in Oregon died from heart disease, diabetes and cancer at half the rate of Oregon women in the All Races category (American Indian Health Care Association 1993b:45).

The regional Indian tuberculosis rate was more than five times the national rate for All Races (Young 1994:58), and in Oregon the Indian rate was four times higher than Oregon’s All Races rate (American Indian Health Care Association 1993a:29). Even though the disparity is great, this still represents a remarkable decrease from the rates of the past.

Nationally, Indian rates for cardiovascular diseases and hypertension are roughly equivalent to the rates for All Races (Young 1994:123). Between 1955 and 1985 the Indian rate for cancer mortalities was consistently lower than the All Races rate (Young 1994:95-6). Strokes were recorded at lower rates in Indian populations than in the nation as a whole (Young 1994: 122).

Diabetes is found at higher levels in the Indian population of the United States than it is in the All Races category, but it appears at widely different rates by region. Of the Indian Health Service’s eight areas, the Portland Area Office is among the three lowest in rates of diabetes within its population (Young 1994:145).

Obesity is a major concern because it is linked to so many other diseases: hypertension, diabetes, gall bladder disease, ischemic heart disease, and some cancers. Indians in the United States exceeded the All Races rate of the nation in all age/sex
groups. Twenty-four percent of men in the all races group were obese compared to 34% of Indian men. For women, 25% of the All Races category and 40% of the Indian population were obese (Young 1994:145).

Alcoholism-related diseases in the nation's Indian population occurred at seven times the national rate in 1970, but in 1985 this figure had dropped to four times the national rate. This problem in Indian populations is directly linked to the accident rate and to the suicide and homicide rates (Young 1994:201). A genetic link, though often discussed, has still not been adequately verified. The relationship of alcoholism to the breakdown of family and community can be attested to by almost all American Indians who have been reared among their people. This affects health in numerous ways from malnutrition to child abuse/neglect, and mental health issues to liver malfunction, as well as showing relationships to accidents and acts of violence mentioned above. It would be difficult to find an Indian person who has not been affected, in some way, by alcoholism.

Though Oregon's Indian women died from accidents at half the rate of Oregon's Indian men, their rate was still twice that of women from Oregon's All Races population. Indian men died from accidents at slightly higher rates than All Races men in Oregon. Between the ages of 25 and 34, Indians in Oregon died from accidents at twice the All Races rate (American Indian Health Care Association 1993b:44-46). It is interesting to note that while Oregon's All Races group experienced mortality due to accidents at a higher rate than any other state in the region, Oregon's Indians died from accidents at still higher rates (American Indian Health Care Association 1993a:33). Across the nation
motor vehicle accidents account for 40% of the accident mortality among Indian people (Young 1994:177).

Deaths from suicide and homicide are recorded at higher rates in Indian populations than the nation's general population, though the suicide rate for Indians is not as excessive after the age of forty-five. These deaths are linked to the mental health of individuals and to the social health of the community, both of which need significant attention (Young 1994:189).

**Socioeconomic Comparison of the Coquille to Oregon and to Indians in the Region**

Health of populations and health risks faced by these populations cannot be considered as only biological phenomena. It has by now been well established that socioeconomic factors play a significant role in determining the health of communities and individuals (Williams 1993). Race and ethnicity figure into the equation as well. A clear understanding of the causes of poor health and the remedies that prove effective must derive from a consideration of all these aspects.

Larger societal factors - socioeconomic, political, and legal - affect health through intermediary mechanisms and processes, including health practices, psychosocial stress, environmental stress, psychosocial resources, and medical care. These surface causes, in turn, affect health status through biological mechanisms and processes.

At least three important implications can be derived from the multidimensional model. First, even though their contribution to health is likely to be small, genetics and biological factors should not be ruled out. Second, social and economic structures by which groups live can shape values and behaviors in ways that have health consequences. In the United States, the differentials in health status associated with race are smaller than those associated with socioeconomic status as measured by income, education, occupational status, or some combination of the three. Third, the conceptual development of measures of racism and racial discrimination
at both individual and institutional levels is needed to understand racial differences in health. According to the multidimensional model, age and gender also must be considered, and the processes by which all these factors relate to each other and influence health status must be understood within a historical perspective (Williams 1993:9-10).

If we adopt this biocultural model of epidemiology, then an examination of the socioeconomic characteristics of the Coquille people should provide, if not an exact accounting of the current health status, at least an informed view of the level of health risk they face. The following section supplies a comparison of the Coquille, Oregon Indians, Indians in the northwest region, the Oregon All Races category, and the All Races sample of the five southwestern Oregon counties which comprise the Coquille health service district. The comparisons will be limited to age distribution, education, income, and employment. Gender is noted only in the age distribution of the Coquille. The data that follow were derived from the 1990 Oregon Census, the American Indian Health Care Association's 1993 Regional and Oregon Reports, the Socioeconomic Profile and Needs Assessment Reports on the Coquille Tribe and the Coquille Elders produced in 1993, Socioeconomic Assessment of the Coquille Indian Tribe conducted by Oregon State University Survey Research Center in 1988, and a listing of Coquille members by age and gender printed out for this study by the tribe in February of 1995.

The numbers of male and female Coquille members in each age category is similar until the older ages when there are more females represented. Table 5 shows that there are more tribal members outside of the health department service area, which means that they are not eligible for contract health benefits. However, the members outside the Coquille service area may receive care at any Indian Health Service clinic, provided they
are able to get to one. They may, if they choose, come home to receive treatment from the tribal clinic, just as if it were any other Indian Health Service clinic (Coquille Tribe 1995: Printout).

### Table 5: Age Distribution of Coquille Tribal Members By Gender, and Distinguishing Those Inside or Outside of the Coquille Health Department Service Area

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Total Male</th>
<th>% Male</th>
<th>Male In</th>
<th>Male Out</th>
<th>Total Female</th>
<th>% Female</th>
<th>Female In</th>
<th>Female Out</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>36</td>
<td>11%</td>
<td>20</td>
<td>16</td>
<td>31</td>
<td>9%</td>
<td>16</td>
<td>15</td>
<td>10.1%</td>
</tr>
<tr>
<td>5-14</td>
<td>82</td>
<td>24%</td>
<td>39</td>
<td>43</td>
<td>87</td>
<td>26%</td>
<td>43</td>
<td>44</td>
<td>25.4%</td>
</tr>
<tr>
<td>15-24</td>
<td>58</td>
<td>17%</td>
<td>26</td>
<td>32</td>
<td>60</td>
<td>18%</td>
<td>17</td>
<td>43</td>
<td>17.8%</td>
</tr>
<tr>
<td>25-34</td>
<td>49</td>
<td>15%</td>
<td>16</td>
<td>33</td>
<td>39</td>
<td>12%</td>
<td>17</td>
<td>22</td>
<td>13.3%</td>
</tr>
<tr>
<td>35-44</td>
<td>50</td>
<td>15%</td>
<td>20</td>
<td>30</td>
<td>48</td>
<td>15%</td>
<td>22</td>
<td>26</td>
<td>14.8%</td>
</tr>
<tr>
<td>45-54</td>
<td>27</td>
<td>9%</td>
<td>9</td>
<td>18</td>
<td>29</td>
<td>9%</td>
<td>8</td>
<td>21</td>
<td>8.4%</td>
</tr>
<tr>
<td>55-64</td>
<td>18</td>
<td>5%</td>
<td>8</td>
<td>10</td>
<td>16</td>
<td>5%</td>
<td>9</td>
<td>7</td>
<td>5.1%</td>
</tr>
<tr>
<td>65-74</td>
<td>13</td>
<td>4%</td>
<td>8</td>
<td>5</td>
<td>7</td>
<td>2%</td>
<td>5</td>
<td>2</td>
<td>3.0%</td>
</tr>
<tr>
<td>75+</td>
<td>2</td>
<td>6%</td>
<td>0</td>
<td>2</td>
<td>12</td>
<td>4%</td>
<td>6</td>
<td>6</td>
<td>2.1%</td>
</tr>
<tr>
<td>Totals</td>
<td>335</td>
<td>100%</td>
<td>146</td>
<td>189</td>
<td>329</td>
<td>100%</td>
<td>143</td>
<td>186</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 6 offers a comparison of the age distributions of the Coquille, Oregon Indians, the All Races population within the five county area served by the Coquille Health Department, and the Oregon All Races population. The most striking difference occurs at either end of the age ranges, with Indians having a much larger number of young people and far fewer old people. This holds true for Indian people throughout the northwest region as well, where 52% of Indians are under 25 and only 36% of the All Races
population is under 25, and only 4.6% of Indians are over 65 while 12% of the All Races population is 65 or older. In the region 12% of Indians are under 5 and the same age group for all races is only 7% (American Indian Health Care Association 1993a:11). The Coquille have 10.1% of their population under 5 and 53.3% under 25. Only 5.1% of the Coquille Tribe is over 65 years old (Coquille Tribe 1995: Printout).

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Coquille</th>
<th>Oregon Indian</th>
<th>Five Counties</th>
<th>Oregon All Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>10.1%</td>
<td>10%</td>
<td>6.6%</td>
<td>7%</td>
</tr>
<tr>
<td>5-14</td>
<td>25.4%</td>
<td>19%</td>
<td>14.5%</td>
<td>14%</td>
</tr>
<tr>
<td>15-24</td>
<td>17.8%</td>
<td>19%</td>
<td>11.1%</td>
<td>15%</td>
</tr>
<tr>
<td>25-34</td>
<td>13.3%</td>
<td>17%</td>
<td>13.2%</td>
<td>17%</td>
</tr>
<tr>
<td>35-44</td>
<td>14.8%</td>
<td>15%</td>
<td>14.9%</td>
<td>16%</td>
</tr>
<tr>
<td>45-54</td>
<td>8.4%</td>
<td>9%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>55-64</td>
<td>5.1%</td>
<td>6%</td>
<td>10.7%</td>
<td>8%</td>
</tr>
<tr>
<td>65-74</td>
<td>3.0%</td>
<td>3%</td>
<td>10.8%</td>
<td>8%</td>
</tr>
<tr>
<td>75+</td>
<td>2.1%</td>
<td>2%</td>
<td>7.2%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Table 6: Age Distributions Comparing Coquille Tribe to Other Oregon Populations

In an analysis of data (Hall 1986b) collected for studies on Indians in Western Oregon during the late 1970s and mid 1980s Hall came to these conclusions:

Charts of age distributions in the Indian and general populations provide a stronger contrast of health conditions in the two groups than do statistics of disease prevalence...Contrasts in longevity between Indians and the general population are congruent with the finding that Native Americans tend to incur chronic diseases normally associated with old age at younger ages and in greater frequency than the rest of the population (Hall 1986b).
That Coquille people live beyond the age of 65 only one third as often as members of the general Oregon population is evidence that the standard of health of the Coquille people is significantly lower than that of the rest of the population.

The educational levels achieved by Coquille members, when compared to Oregon Indians, regional Indians, and the Oregon All Races category, are quite surprising, as they show that the Coquille have attained higher levels of education than all the other groups. Only 16% have not completed high school, while in Oregon the All Races figure is half again as much at 24% (Oregon State University Survey Research Center 1988:4). The reports from the regional Indian health study use slightly different categories at the low end, which show that in the Oregon Indian population 14% have not completed the eighth grade and in regional Indians the corresponding figure is 16% (American Indian Health Care Association 1993a:15).

<table>
<thead>
<tr>
<th>educational level</th>
<th>Coquille Tribe</th>
<th>Oregon Indians</th>
<th>Regional Indians</th>
<th>Oregon All Races</th>
<th>Five County All Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th Grade</td>
<td></td>
<td>14%</td>
<td>16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td>16%</td>
<td></td>
<td></td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>High School Graduate</td>
<td>46%</td>
<td></td>
<td></td>
<td>37% (18-24) 38%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(25+) 33%</td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>38%</td>
<td>24%</td>
<td>22%</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(18-24) 32%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(25+) 44%</td>
<td></td>
</tr>
<tr>
<td>College Degree</td>
<td>18%</td>
<td></td>
<td></td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>At Least High School Diploma</td>
<td>84%</td>
<td></td>
<td></td>
<td>76% (18-24) 70%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(25+) 77%</td>
<td></td>
</tr>
</tbody>
</table>

Table 7: Educational Achievement Levels
At the other end of the educational range the Coquille have 46% high school graduates, 38% with some college and 18% with a college degree, for a total of 84% with at least a high school diploma. The Oregon All Races populations have slightly less with 37% high school graduates, 39% with some college and 18% with college degrees; 76% have at least a high school diploma (Oregon State University Survey Research Center 1988:4). The census indicates 24% of Oregon Indians attended at least some college (Bureau of the Census 1990a:18) and regional Indians show a rate of 22% in this category (American Indian Health Care Association 1993a:15). For the five county area 18-24 age group, 38% have graduated from high school with 32% more attending some college, for a total of 70% with at least a high school diploma. The 25 and above age group for the five counties shows 33% with high school graduation and another 44% with some college, for a total of 77% with at least a high school degree (Bureau of the Census 1990b:199-200).

Employment figures for the Coquille and the five counties All Races group are based on potential workforce population, but these figures do not indicate what percentage of the total population is included in the workforce population. Though the percentage of the population classified as non-workforce is indicated for the Oregon Indian, the Oregon All Races, and the Regional Indians groups, the factors which place them in this category are not discussed. The reasons an individual is not in the workforce are critical to health care systems development, e.g., if the majority of the non-workforce population is under five years old it would demand different systems than would be required if it were older than sixty-five or made up primarily of disabled individuals.
The employment figures for the Coquille and the five counties show percent of population not in the workforce, percent unemployed and percent employed. The figures for the employed are not divided into full-time and part-time. Part-time workers are often underemployed, especially if they are seasonal workers, and may lack health insurance offered to others. Indicating only whether an individual was employed during a given year may disguise the part-time underemployed. The Coquille show higher numbers in full-time employment than the five counties, at 72% and 67% respectively, but also almost twice as high in unemployment at 11% and 6% respectively. Part-time workers for these two groups comprise 17% of the Coquille and 24% of the five county workforce (Bureau of the Census 1990b:7; Oregon State University Survey Research Center 1988:5).

<table>
<thead>
<tr>
<th>% Full-time</th>
<th>Coquille Tribe</th>
<th>Five County Service Area All Races</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>72%</td>
<td>67%</td>
</tr>
<tr>
<td>% Part-time</td>
<td>17%</td>
<td>25%</td>
</tr>
<tr>
<td>% Unemployed</td>
<td>11%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Table 8: Employment Characteristics of Coquille Tribe and the All Races Population of the Five County Health Service Area

The data collected for the Oregon Indians, the regional Indians, and the Oregon All Races category are based on total population, including all age groups, rather than potential workforce population, and thus cannot be directly compared to the Coquille and the five county populations. The Oregon Indian population had 49.9% of its members actively engaged in the workforce, while 10.5% were unemployed and the other 39%
were not in the workforce. Data on regional Indian population show 46.6% in the workforce, 10.4% unemployed and 43% not in the workforce. The Oregon All Races population was more fortunate with 56.9% employed, only 5.1% unemployed and 38% not included in the workforce (American Indian Health Care Association 1993a:16; American Indian Health Care Association 1993b:19; Bureau of the Census 1990:19).

The different methodologies and the problems inherent in each of the methods used make analyzing this data difficult. One aspect that stands out clearly is that Indians experience unemployment at much higher rates than the All Races populations. While it is not clear from this representation what causes this discrepancy, the following section on income levels per household should help to describe the ramifications for the people involved.

<table>
<thead>
<tr>
<th></th>
<th>Oregon Indians</th>
<th>Regional Indians</th>
<th>Oregon all Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Employed</td>
<td>49.9%</td>
<td>46.6%</td>
<td>56.9%</td>
</tr>
<tr>
<td>% Unemployed</td>
<td>10.5%</td>
<td>10.4%</td>
<td>5.1%</td>
</tr>
<tr>
<td>% Not In Workforce</td>
<td>39%</td>
<td>43%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Table 9: Employment Characteristics of Oregon Indians, Regional Indians and Oregon All Races Populations

Coquille households received Aid to Dependent Children or Public Assistance at four times the rate for Oregon All Races families, 16% and 4% respectively. Coquille households were below the poverty line at over twice the Oregon all races rate, at 19% and 8% respectively, and well below the Regional Indian rate of 31%. Oregon Indians, at
21.6% of households, experienced lower poverty rates than other Indians in the eight state northwestern region (American Indian Health Care Association 1993a:19; American Indian Health Care Association 1993b:22; Oregon State University Survey Research Center 1988:8).

<table>
<thead>
<tr>
<th></th>
<th>Coquille Tribe Households</th>
<th>Oregon Indian Households</th>
<th>Regional Indian Households</th>
<th>Oregon All Race Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Below Poverty Line</td>
<td>19%</td>
<td>22%</td>
<td>31%</td>
<td>8%</td>
</tr>
<tr>
<td>% W/Children Under 18 Years</td>
<td>29%</td>
<td>43%</td>
<td>50%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Table 10: Poverty Level Comparison of Selected Populations

When households with children under the age of 18 are examined, 29% of Coquille households, 43% of Oregon Indian and 50% of regional Indian households, but only 6% of Oregon All Races households, are below the poverty line. Coquille elder households lived in poverty at a rate of 14% (American Indian Health Care Association 1993a:19; American Indian Health Care Association 1993b:22; Oregon State University Survey Research Center 1988:6). Average household income for the Coquille was $18,000 in 1988. Josephine County, at $20,900 per household, showed the lowest income of the five counties during 1990 and Jackson County, at $25,100 per household, showed the highest income (Bureau of the Census 1990b:223-224).
6. Health Related Efforts of the Coquille Tribe Since Restoration*4

Beginnings

The Coquille people remained without federal recognition until June, 1989, when Public Law 101-42 (Hall 1991:195-9) was passed by Congress. This bill restored the government-to-government relationship between the United States and the Coquille Tribe of Indians. Restoration brought with it a re-establishment of health, education, and economic development services to which the tribe had been denied access for thirty-five years (Thomas 1990:28).

With restoration of the Coquille Tribe the Indian Health Service received appropriations to fund the health care services needed by the Coquille. The members of the Coquille Tribe became eligible to receive care from the Indian Health Service for the first time. This new status allows them to receive care at any Indian Health Service operated clinic. This was a wonderful opportunity for those few tribal members who lived close to an Indian Health Service clinic. However, one half of the Coquille membership resides in the southwestern corner of Oregon where there were no Indian Health Service clinics at the time of restoration. In order to receive medical or dental service they had to travel four hours to the Chemawa clinic in Keizer, Oregon.

This was certainly not a practical solution to the health care delivery problems the Coquille had been dealing with for decades, so the tribe chose to take advantage of

*4Except where noted the following information is derived from interviews during the Spring of 1995 with Eric Metcalf, Jill Rounds, Beth Scott, Jane Metcalf, and Gwen Elissalde, staff members of the Coquille Tribe Community Health Department.
opportunities opened up by the Indian Self-Determination and Education Assistance Act of 1975, P.L. 93-638.

In places where the IHS does not have its own facilities, or is not equipped to provide a particular service, it uses contract providers such as hospitals, State and local health agencies, tribal health institutions, and individual health care providers. Services purchased through contract may include primary, secondary, and rehabilitative care, specialized diagnostic and therapeutic services, and public health and community outreach activities.

Tribally contracted health programs are conducted primarily under authority of the Indian Self-Determination and Education Assistance Act, P.L. 93-638. Enacted in 1975, this law includes the authority for Indian tribes, at their own initiative, to manage health programs or portions of programs currently operated by the IHS (Indian Health Service 1984:3).

In 1991 the Coquille Tribe established the Community Health Department to serve tribal members in the five southwestern Oregon counties with the highest concentration of Coquille members. Coquille members living outside the five counties must seek service at a direct care Indian Health Service clinic. They are not eligible for contract health care.

**Organization and Staffing**

Within the Community Health Department are the Administration Office, the Human Services Division, the Health Services Division, and the Contract Health Division. The Administration Office is staffed by the Health Administrator, an Executive Secretary, and an Office Manager.

The Contract Health Division authorizes services to tribal members living within the service area. The services are provided by local practitioners and paid by the tribe. This division is staffed by a Program Coordinator and a Billings Clerk.
The Human Services Division offers social services, alcohol and drug prevention, mental health services, Indian Child Welfare programs, and youth activities. The Human Services Division has on its staff a Director, an Alcohol and Drug Counselor, a Social Services Coordinator, and an Indian Child Welfare Coordinator.

The Health Services Division provides a Community Health Representative who arranges for hospital, home, and clinic visits; administers the distribution of durable medical goods; and coordinates the optometry and elders programs. A receptionist for the clinic is on the staff of this division. The creation of a Direct Care Facility within the Health Services Division moved out of the planning stages in 1995 with the hiring of a Nurse Practitioner who also takes on the duties of the Director of Health Services. This will allow the expansion of the number and kind of services provided to include chronic and acute direct care, health promotion, health protection, and preventive services. It is scheduled to open in July, 1995.

When the Direct Care Clinic opens any Indian Health Service eligible person can receive services there. There are an estimated 10,000 eligible Indians in Southwest Oregon. It is anticipated that the level of usage will increase dramatically once word of its opening circulates. This will demand increased staff. Plans are in place to hire a Certified Medical Assistant, two more Community Health Representatives, and a Registered Nurse. Further in the future it is anticipated that the need will demand the hire of another Nurse Practitioner, a part-time Dentist, and a Physician.
Services From the Contract Health Division

The Contract Health Division authorizes and pays for health services for members who live in the five county service area in Southwestern Oregon. Funding is available to cover only certain levels of care. These levels are determined on a need basis, with Levels One and Two covering the most urgently needed services. There are nine levels for dental and five levels for medical. Each level contains specific treatments. The limited funding is usually sufficient to cover the first two levels of both medical and dental services.

Level One covers emergency and acutely urgent medical care services. Examples of diagnoses which fall within Level One for medical are airway obstruction, puncture wounds, delirium tremens, suicide attempts, diabetic ketoacidosis, and obstetrical emergencies.

Level Two medical care covers preventive care services such as prenatal care, cancer screening, public health intervention, immunizations, family planning services, mammography, screening for known diseases, vision examinations, and HIV testing.

Level One for dental care includes emergency services such as simple extractions, re-cementing crowns, reduction of jaw fractures, draining oral abscesses, and one or more periapical radiographs.

Level Two dental care provides sealants, athletic mouth guards, periodontal maintenance, topical flouride, and adult and child prophylaxis.

The funding must be allocated carefully to ensure coverage throughout the year. The levels authorized can be added or removed depending on availability of funds. Clients who desire services not currently funded, but within the Indian Health Services medical
priorities, may choose to be placed on a deferred list. If funding is available at the end of the year these deferred procedures will be performed on a first come, first served basis. There rarely are sufficient funds to cover more than the predetermined levels of care.

The occurrence of a catastrophic case could potentially dry up the years funding for a particular Contract Health Agency, but the Indian Health Service has provided a mechanism to ensure that this will not happen. The tribe must pay for the first $16,000 in such cases and the Indian Health Service will pay for the remainder.

Any tribal members wishing to utilize contract health services must first seek funding from all other sources including the Oregon Health Plan and any work related insurance they may be eligible to receive. Failure to do so results in denial of eligibility. These other funding sources will be billed by the tribe for services rendered whenever possible.

Allocation of funding to the Contract Health Division from the Indian Health Service is determined by bureaucratically obtuse formulas which no staff member seems to understand completely. Items considered are total eligible clients in the service area and total number of units of service provided in the previous three years. Therefore, in order to obtain as much support as the system permits, it is important for the tribe to convince all eligible members to sign up whether they utilize the service or not. When applying for reimbursements for units of service, the units are determined by number of purchase orders turned in. If a purchase order contains, for example, twenty prescriptions it counts the same as one containing two prescriptions, yet staff do not have the time to spend on the paperwork necessary to bill each incident or item separately. It is not clear how much
difference this makes in total dollars available. The Contract Health Division also acts in an advocacy capacity for tribal members seeking alternate resources.

**Services From the Human Services Division**

The Social Services branch of this division provides a transportation program, home visits, child care assistance, and general assistance. It also coordinates a baby equipment loan program and a coats for kids program. Along with the Health Services Division it offers support services and community activities for tribal elders. It was through this program that I was given the opportunity to meet with the elders for interviews. On my first meeting with them we all went on a paddle wheel boat ride up the Coquille River to look at old village sites.

The Alcohol and Drug Prevention branch of this division provides education, intervention, and prevention services. Individual, family, and group counseling sessions are offered. Assessments and referrals are conducted. Aftercare is provided as are 12 step programs. Outreach and home visits are offered.

The Indian Child Welfare/Youth portion of the Human Services Division provides health promotion and disease prevention activities for the young people of the tribe. It coordinates a tribal foster care program. It conducts sports camps for the youth. The March Community Health Department Newsletter mentioned an upcoming snow camp at Diamond Lake and a rafting trip down the Rogue River. These trips provide an opportunity to instruct the youth about health issues in a variety of unique ways.
Tribal members may access mental health services through the Mental Health branch of the Human Services Division. Assessments and referrals are provided. Home visits are conducted.

**Services From the Health Services Division**

The Community Health Representatives act as ‘in the field’ social workers assisting tribal members with anything that may impact their health. They provide bicycle helmets and hearing aid batteries. They work with the Social Services to provide activities for the elders. Aerobics classes are offered. Home, hospital and clinic visits are conducted. They run an optometry program. Durable medical goods are distributed through this branch of the Health Services Division.

The Chronic/Acute Direct Care branch of the Health Services Division was in its development during the Spring of 1995, when this study was done, and had not yet begun to offer a full range of services. It has listed areas of health service that will be the focus of its attention:

**Preventive Services -**
- Maternal and Infant Health
- Heart Disease and Stroke
- Cancer
- HIV Infection and STD
- Immunization and Infectious Diseases
- Clinical Preventive Services

**Health Promotion -**
- Physical activity and Fitness
- Nutrition
- Family Planning
- Health Education
One of the first programs to be implemented will be a comprehensive health assessment of as many tribal members as can be reached. For the first time a clear picture of the health of the tribe will be available. Planning for service delivery and assessment of effectiveness of programs already in place will be based on solid data. Staff hope that each tribal member will have been surveyed by September of 1995.

The surveys will include a Modified Feetham Family Functioning Survey to determine how individuals relate internally to their families and externally to their communities. It will assess social support networks. It ascertains the level of affiliation with family and community and also the level of individuation from family and community.

An Advanced Health Assessment will be administered to each adult client utilizing services at the clinic. It will ascertain medical history, current health status, medications being used and frequency of particular examinations. It will assess family health history. It will look at the individuals psycho-social history, sexual history, gynecological history of women, and reproductive history of men. It will determine the levels of tobacco, alcohol, and drug usage. This survey will also assess environmental hazards and safety of the clients. There are mechanisms, checks and balances, which can be used to compare results with the Feetham Survey. Questions asked in one format may be understood differently when asked in another.
A Pediatric Health Assessment will be administered also. It is similar to, though not as involved, as the one for adults. The Pediatric Health Assessment will be modified for administration to adolescents.

The Oregon Coalition on Breast and Cervical Cancer has joined with the Portland Area Indian Health Board to implement a program designed to provide each Indian woman in the state of Oregon with a provider breast examination, a mammogram, a pelvic examination, a PAP smear, and instructions on how to conduct a breast self-examination. The Direct Care Clinic will be part of this five year program.

Once the clinic becomes operational, medications will be prescribed, administered, and dispensed. The Nurse Practitioner will be able to provide over 90% of the services that a primary care physician would provide. The scope of care will increase once the new clinic is built on the Coquille’s newly established reservation.

**Plans for the Direct Care Clinic**

Building plans for a new clinic to be built on reservation land in Coos Bay were complete at the time of this study, Spring of 1995, but an environmental impact statement and wetlands assessment needed to be done before the tribe could apply for a loan. The Coquille Economic Development Corporation (CEDCO) was preoccupied during the time of this study with the development of a casino and other projects. The tribal council has determined that a stable economic base must be ensured prior to the extensive capital outlay necessary to build a new health clinic.
The facilities from which the Community Health Department now operates were barely sufficient in 1995. If necessary, the tribe could open the Direct Care Clinic there on a limited basis. The main option under consideration is the lease of four suites in another larger building and the move of the whole Community Health Department there until the new clinic is built.

Negotiations were in progress in the Spring of 1995 regarding the total dollar amount the Coquille will receive for the provision of direct care services to its population. Because of geographic barriers, namely the 200 mile drive to the Chemawa Indian Health Clinic, and because there were as yet no facilities, a weighted formula, which takes these factors into consideration, will be used to determine the amount of money awarded. The weighted formula would deliver 9% of the total Western Oregon Service Unit Direct Care budget to the Coquille. If the disbursement negotiations considered only the Coquille population, which is 6% of the Western Oregon Service Unit population, in the formula the amount awarded would drop to 6%. Either way the funding will not be adequate to fund the need the clinic must meet. The options the Coquille Tribe faces are limited: either they can take what is not enough or allow the geographic barriers to prevent them from almost all service.

The clinic will be able to bill insurance companies and the Oregon Health Plan for all clients eligible to access those funds. This will help offset the cost of service delivery. When the clinic receives its Federally Qualified Health Care status, an application process currently underway, it will allow the clinic to bill in a manner that rewards preventive care practices. For instance, all dental visits will be billed at a flat rate. This means, for
example, that if a root canal has to be performed the clinic will likely lose money, but if a cavity has to be filled the clinic will profit. This raises preventive care to a higher priority.

Plans for the future include the option of making an arrangement with the management of the new Coquille casino to deliver health care services to casino employees. These people may or may not be tribal members, and they may not even be Indians, but services provided to them could be billed to their insurance carrier. This could be a beneficial option for all parties involved - the employees, the casino management, and the Coquille Health Clinic.

The initial funds are not expected to be sufficient to staff and equip a fully operational clinic the first year, but most of the medical and pharmacy services will come on line immediately. The monies allocated for dental services will initially be spent on equipment purchases, while staffing for the dental unit will occur later.

The Heritage Place

The Heritage Place is a commercial venture established by the Coquille Economic Development Corporation that incorporates health and cultural values. It is a large facility built near Bandon, Oregon’s, South Jetty, on a spiritual site of the Coquille tribe, known to them as Grandmother Rock. The Heritage Place is primarily an assisted living facility, but it also includes a wing for the treatment of patients afflicted with Alzheimer’s disease and other neurological disorders. The basement of the facility is expected to house the tribal museum, the tribal library, and the Bandon Historical Society Museum.
This facility is not operated by the Coquille Tribal Health Department, but does employ tribal members as well as other people from the local area. One of the goals of the Coquille tribe is to use their benefits for the benefit of the surrounding community. By providing employment for local people and by creating a facility that is accessible to non-tribal members they are moving toward that goal.
7. Conclusions

When this project began the intent was to determine the effect of the Termination Acts of 1954 on the health status and health care delivery systems of the Coquille Indian Tribe. As the research progressed it became clear that the health of these people was not the result of a single act or moment in time, but rather the culmination of a process that began with the arrival of non-Indians on the shores of the Pacific Northwest Coast more than two hundred years ago. An understanding of the results of this process, the current state of health among the Coquille, was not possible without historical context.

Evidence indicates that the indigenous ancestors of the people now known as the Coquille enjoyed a sustainable and meaningful life. The environment, community, and lifeways provided a situation conducive to good health. The introduction of European borne diseases against which the Coquille had no immunities began two hundred years of devastation to the culture, the communities, and to the individual members of these communities.

Culture and community structure are critical to the maintenance of health, particularly for a group of people whose pattern of subsistence centers around village life. The new diseases that swept through the villages caused 80-90% mortality between the late 1700s and the late 1800s. The culture, the knowledge, and the community structure died with the population.

Government policies took up where the diseases left off. A series of destructive policies imposed upon the survivors of the epidemics came close to bringing about their
annihilation. One of the most devastating impacts on the health of the Coquille culture and community occurred as a result of the Removal Policies in the 1850s. These policies took Coquille lands and relocated the Coquille people far from their homelands with no resources to provide for their own subsistence. During the next hundred years the Coquille were subjected to regulations and policies designed to cause the destruction of their culture and their identity as a people. These policies reached their nadir with the legislation of the Termination Acts in 1954.

The people had no choice but to adopt new behaviors in order to survive. There were not enough potential spouses left within the communities from which partners were customarily chosen, so they married outside those parameters. This had the side benefit of allowing them to learn the new technologies and social systems inherent in the Euro-American culture. Intermarried people were not sent away to the reservations and thus were able to stay in partial contact with some aspects of traditional culture. Intermarriage resulted in the dissolution of the Coquille blood, which afforded the subsequent generations with some protection from racial discrimination.

That the Coquille have survived is clear. They are not the same people any longer in terms of their culture or their gene pool, but no cultures are static. Most societies, however, are not forced to change so much or so rapidly. That these changes would have an impact on their health is expected, but the exact nature of this effect is difficult to ascertain. With the limited data available dealing strictly with the Coquille, comparisons to their past or to other populations, while possible, cannot supply direct evidence. Some inferences can be drawn from populations similar to the Coquille.
One area for which fairly complete data have been collected regards the socioeconomic status of the Coquille tribal members. This type of information is often used to infer health risk in populations. The Coquille people rate lower than the All Races category in most socio-economic categories considered, education levels achieved being the most notable exception. The Coquille population is younger and they have fewer elders. The income level of the tribal membership, as indicated in 1988, just prior to restoration, was below that of the surrounding communities and the rest of the state; poverty was more prevalent among the Coquille than the general population. It appears that the people of the Coquille Tribe are at considerably higher health risk than the general population, but the actual state of health has yet to be documented.

One of the most evident effects of governmental policies on the Coquille is their recognition that they themselves must accept responsibility for health care provision to their people. To rely on the beneficence of the Great White Father in Washington could prove fatal. The fickle nature of governmental policies, especially considering the rhetoric and actions of the Republican Congress elected in 1994, has focused the tribe’s efforts even more intently on achieving self-sufficiency in all aspects of tribal concern. Their goal is to become independent of the need to rely on the federal government for provision of services necessary to the maintenance of tribal members.

The Coquille have been surviving for two hundred years in contact with Euro-Americans and have experienced many stresses during that period. Now that the tribal population is once again growing, the opportunity to thrive is within reach. The circle of community and responsibility to each other is once again surrounding the Coquille.
As the Coquille Tribal Health Department expands its operation and is able to provide a greater level of service to its members, and to other Indian people who reside in the area, the whole community will benefit. The only health services available to Indian people in the Southwestern corner of Oregon are those provided by the county and by private practitioners. As Indian people begin to utilize the health services offered by the Coquille it will relieve pressure on the rest of the health care system.
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