NATIVE PATIENTS AND THE WESTERN MEDICAL MODEL:

A STUDY OF HEALTH CARE DELIVERY IN RURAL SOUTHWESTERN MANITOBA

Sandra Kay Sherley-Spiers

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of MASTER OF ARTS, May 1987.

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Truth has a face: it is the work of man and earns his bread. Thus in the work of knowledge we intend only to open paths that others can follow. Messengers, of course, carry news that they do not know will be well received in the community. But at first they are made welcome, brought in from the cold and rain, given food and drink and a place to rest from their journey. And it is the same when we get our news from the morning paper over a cup of coffee. We think of the truth as part of the well-being of our community; we receive it as sustenance, or as a friend or guest. That is why the truth is painful when it reveals that things are not well in the land, in our lives, or in our community. John O'Neill, 1974.

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ABSTRACT

The following thesis is the result of a year-long research into the problems effecting health-care delivery in a rural, Southwestern community of Manitoba. Specifically it addresses the relationship between Native patients and their Western health-care providers. At issue is the quality of health care received by Dakota Sioux patients within Hospital District #10.

The purpose of the research was to investigate the types of interactions that take place between Dakota Sioux patients and their Western health-care practitioners. The central focus was on clinical interactions as reported to me through a series of interviews with both Native patients and Western practitioners. Understanding the levels and types of relations between the two parties illustrates that the practice of medicine is both a social and a cultural activity in that it always involves interaction between two or more socially conditioned human beings within a cultural context.

The results of this research indicate that the health-care services to Dakota Sioux patients are being seriously compromised. A contributing factor to this situation is that the health-care providers require sufficient cultural background information about the individual Dakota Sioux patient, his environment and belief systems in order to insure that the medical orders given are realistic and appropriate for that particular patient's situation. There is a requirement to view health as a multidimensional process involving the well-being of the whole person in the context of his cultural environment.

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To the senior staff of the Manitoba Health Services Commission for allowing me access to their comprehensive statistical data base, and to the Board of Hospital District #10 for allowing me to carry out this research within the hospital district, my sincere appreciation.

While this thesis is a collaborative effort with many contributors, I alone am responsible for its contents.

CHAPTER I: INTRODUCTION

PRIMARY RESEARCH PROBLEM

This thesis is based on field work carried out during the period March 1984 through June 1985 at the Oak Lake Dakota Sioux Indian Reserve (#59) and within Hospital District #10 located in Southwestern Manitoba. The emphasis of the research is on the nature of interactions that occur between Dakota Sioux patients and their local health-care providers, which includes both the Western physician and the traditional medicine man.

For the purposes of this study, the focus is on identifying the actual as well as the "perceived" experiences expressed in the reporting of informants. Special attention is given to the relationship between illness behavior, issues of discrimination, and the sociocultural environment. The key to establishing a degree of integration between these categories requires a study of not only Dakota Sioux belief systems surrounding illness, but more specifically, the cultural and cognitive representation of illness episodes.

A definitional note is required before proceeding. The term "biomedicine" is used within this study "...to refer to the preeminent professional ethnomedicine of Western cultures" (Gaines & Hahn, 1985:18). Biomedicine is the dominant model adopted by modern medical practitioners. Consequently, biomedical, Western, modern and scientific will be used interchangeably within the context of this thesis. Classification of medical systems is a problem that is clearly addressed by Press (1980:45-57) who concisely points out the necessity for

precision in utilizing definitions, terms and classifications of medical systems. What is needed, however, is a biopsychosocial model in order to adequately deliver health care to Native patients. This is a theme running throughout the body of this study.

THE PROCESS OF TOPIC SELECTION

The anthropological literature is richly endowed with a complex variety of ethnographies and other writings which range over the totality of the human experience from the exotic to the mundane. What the authors' seldom mention, however, is an elucidation of the process that results in the selection of a particular anthropological research topic. In a few cases a research area is simply assigned to a student by an advisor. In others, probably the majority, the individual anthropologist pursues a speciality area that holds a particular interest. The "process" itself is of vital importance for students of anthropology, for it is reflective of the diversity of the discipline as a whole. It is a major deficiency of the teaching of anthropology, in my opinion, that this process of selection is omitted. Topics do not simply magically appear, presenting themselves for evaluation. Instead, they are ferreted out of the everyday occurrences that take place in society.

Topics Embedded in Daily Living Experience

The origins of an individual's "particular interest" may be as varied as the vicissitudes of fate. For instance, a childhood vacation in the Yucatan may be the imprinting mechanism for a life-long love of Mayan archaeology. The evolution of my own research, however, linking Native Americans and traditional and modern health care, is based less in serendipity and more in my own life experiences.

It is the following biographical events that have made me a "cultural relativist," a position that insists that since cultures are diverse and unique and embody different conceptions of the desirable, they can only be understood and evaluated in terms of their own standards and values (Keesing, 1981:509).

Being the child of a peripatetic military family, and a granddaughter of a full-blooded Cherokee, presented a very interesting socialization process. "Normal" behavior was, for me, whatever the local peoples practiced, whether they were residents of Guam, North Africa, Cuba or elsewhere. My primary language exposure was English in the home, in addition to the common language of the country in which we found ourselves stationed. Tolerance and respect for differences was accepted as a given, for "we" were the strangers--the outsiders. It was "our" customs that aroused curiosity, such as celebrating Thanksgiving, or strange personal behaviors such as taking baths every day, or sleeping under mosquito netting.

Being reared in an ever-changing cultural environment facilitated an easy adaptation to almost any social situation. It also initiated my life-long interest in cultural behaviors and belief systems from around the world. The stage was thus set early in life to pursue anthropological research during adulthood.

Entry into the Field Setting

With my own interests in psychological and medical anthropology and my husband's professional association with hospital administration, dinner conversations often center around medical problems and issues. In the course of one of these exchanges, we were considering why it was so difficult to recruit residents from the local Reserve to serve on the district's Hospital Board. This led to a general discussion of health-care delivery to Native patients in Manitoba, and specifically to problems involved in the provision of cross-cultural health services.

Here is where I felt that my anthropological training and ethnic background could bring a lateral view to bear on the problem of applying the Western biomedical model to health services for Native peoples. As both outsider and insider I would be able to examine critically the interface between biomedical and traditional medicine in a rural region's hospitals. Now, two years after the original field work, this report is being presented in an attempt to elucidate what my informants perceive to be the major areas of concern.

By dealing with "perceptions," this thesis goes beyond the confines of a simple ethnography. By extension, it takes into account the whole issue of hermeneutics, or interpretive anthropology, by incorporating behavior within a conceptual framework based on informant reporting.

MEDICINE IN A SOCIAL AND CULTURAL CONTEXT

The Human Experience of Illness

Blumer has written that "the task of scientific study is to lift the veils that cover the area of group life that one proposes to study" (1969:39). A basic assumption made by anthropologists is that a cultural group perceives and orders its universe in a patterned, orderly and identifiable way. However, since any two distinct cultures differ in the very way that they classify experience itself, the anthropologist has to look for a potential range of different categories, or sets of categories, relating to a particular phenomenon, which in this case is the practice of medicine in a cross-cultural setting.

As Kleinman has pointed out (1980:xii), illness is a reality of individual human experience, and as such, it deserves the attention of anthropological study. Kleinman continues by claiming that there are "universals" in the construction and experience of illness, as well as the organization of treatment (1980:8).

Good and Delvecchio Good carry this concept a step further by including an interpretive accounting of the meaning of symptoms (1981:165). Symptoms for these two researchers are the expression of complex cultural norms which differ from society to society. These researchers continue by arguing that the biomedical approach to symptoms is at once simplistic and does not do justice to the semantic realities of illness. This is the specific result of different ethnic groups varying "...in the specificity of their medical complaining in various medical contexts."

The practice of medicine is both a social and a cultural activity in that it always involves interaction between two or more socially conditioned human beings within a cultural context. Furthermore, medicine consists of a vast complex of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals and symbols that interlock to form a mutually reinforcing and supporting system.

Medical Pluralities

From an anthropological perspective, culture is the blueprint for thought and action and is a dominant force in determining attitudes to health and illness, caring patterns and illness behaviors. The range of cultural behaviors varies with each culture and among cultures. Leininger points out that (1976:9):

> The essential goal for health personnel in beginning to work with a cultural group is to first determine the dominant culture values, priorities, and characteristics of the cultural group, and then determine how best to assist the people.

However, this cross-cultural perspective on the part of Leininger is medically oriented in the sense of being utilitarian for the health-care practitioner; that is, information on a given patient is treated as being separate from the illness experience of a given individual. This is in direct opposition to Kleinman's later

work on client-centered approaches to the delivery of health care cross-culturally. This aspect of Kleinman's model is an off-shoot of Carl Roger's emphasis on the highly personal and subjective experiences of individuals (Rogers, 1951).

All cultures provide their members with techniques for healing which include both medicines and practices designed to maintain or restore health. In other words, the practice of medicine, according to whatever tradition in whatever society, is an art which makes use of a body of specialized knowledge for the maintenance of health and the treatment of disease. In the case of the Dakota Sioux, this position is usually reserved for Shamans and other traditional healers.

Given the Canadian cultural mosaic, it is a natural supposition to assume that there are varying indigenous health care systems at work within the social structure of the country. This medical pluralism within the Canadian multi-ethnic framework has been a "difficult reality" for health personnel reared within the Western medical model to comprehend, let alone overcome (New, 1977). As Spicer states (1979:3):

> In complex societies like our own, there is never a single homogeneous tradition guiding the medical arts. At least as many healing traditions exists as there are peoples with different ethnic backgrounds.

Illness and the Individual

Kleinman recently has argued that "culture affects the way we perceive, label, and cope with somatic symptoms as well as psychological ones" (1980:178). By this he means that illness experiences are socially learned and sanctioned through the implementation of cultural norms which give illness behavior its configuration. An individual's cultural values, beliefs and practices are thus manifested in his perceptions of health and illness.

Medical anthropologists and sociologists maintain that an individual's health and illness status designation can only be fully understood when

examined within a cultural context over a significant period of time (Twaddle, 1974:29). Fabrega (1979:25) summarizes the essential nature of culture by its reference to the symbolic systems of a people.

> Such symbols are observed and reflected in the style of their social and cognitive behavior. Culture, then, is something one infers or abstracts from the distinctive mode of life of a group.

A cultural analysis, that is the study of meanings and reasons for the social action contained in symbols, is an alternative to the more widely employed study of accumulated social facts. By utilizing a cultural analysis, we can better understand persons and their behavior through a knowledge of the contexts of individual actions. Spradley, in support of this position, has written that (1979:6):

> Any explanation of behavior which excludes what the actors themselves know, how they define their actions, remains a partial explanation that distorts the human situation.

The Sick Role: A Sociological Construct

There exists in every societal grouping a set of cultural expectations of patterns of action appropriate for the sick role. From the available cultural repertoire, the individual will select the behavior which he wishes to enact, although perhaps not consciously. This selection will obviously be influenced by the manifest cues already available to the patient, such as the clinical setting and the health-care provider's attitude. All of this relates directly to a universal need for cultural systems to deal with the wider context of illness behavior.

This is in direct contrast to the earlier sociological formulation as set forth by Parsons (1953, 1958) whose arguments are culture and class-bound, focused upon middle-class Western society and an idealized, normative view of the North American physician. More recently, medical sociologists have thoroughly criticized the sick role model offered by Parsons as being too narrow, and which

has now been described as both "medicocentric" and "sociocentric" (Gallagher, 1976:207-18; Segall, 1976:162-169). The North American Indian is excluded in the sociological paradigm of Parsons, and taken into account by current medical sociologists. Foster summarizes the difference between medical anthropology and the Parsonian sociology of illness model when he succinctly notes (1974:3):

> ...there *are* significant differences between the two, in origin, in identification with the actors in health dramas, in research methodologies, in research topics, and in basic conceptual approaches to problems.

Relationship and Meaning in the Clinical Setting

The skills inherent in establishing and maintaining mutually satisfying clinical relationships, as well as social ones, are based upon a knowledge of the psychological and social factors underlying the behavior of individuals, including oneself. "As clinicians, whether Western or traditional, healers must deal with the individual" (Singer, 1977:18). The decision-making process lying behind an individual's choice of practitioner, however, is never single-faceted in design. Instead, it is a penumbra which persists around a central core of health choices intermixed with the positive or negative results of previous health decisions. The Dakota Sioux are today presented with two such circles of choice: traditional and Western medical treatment.

Both medical systems include the semantic categories of "illness" and "health," and each carry meanings that are culturally relevant (Ahmed & Coelho, 1979:7). King places emphasis on meaning systems by stating that (1962:91):

> The beliefs and attitudes about illness that are held by a particular group...become important variables in understanding how the members of that group will perceive injury or illness and how they will act toward it.

Illness, then, consists of behavioral and psychosocial components as well as the purely biological ones. Since the way in which a cultural group

categorizes sickness varies widely, effective health care cannot be provided unless awareness of these variations and sensitivity to the perceptions of health and illness in each culture is taken into account. As Kleinman has reminded us (1980:78):

> ...the major mechanism by which culture affects the patient and his disorder is via the cultural construction of illness categories and experiences.

THE ANTHROPOLOGIST AS ADVOCATE

A Person-Centered Approach

The scope of anthropological inquiry ranges from the complex social systems of whole populations down to "simple" systems of interaction between individuals. Both pose problems relating to the problem of how to deal with people as "persons," for every human being is unique and has characteristics different from all others. In studying even a small society, we are ever conscious of this individual variation, with its private idiosyncrasies and seemingly capricious behaviors. Culture becomes the repository of all possible patterns of illness behavior.

Keeping this in mind, the following chapters will argue that it is the cultural and social structural mechanisms that may interfere with the rights of the individual to receive a high quality of health care. This is true even though some barriers to health care will be self-erected by personal predilections, biases, cultural patterns and life styles.

Differing Taxonomies of Health Care

Within anthropology, health beliefs have been traditionally subsumed under the broader categories of religion, magic or witchcraft (Morley, 1980:2). It is time to change this taxonomy by recognizing that as recent colonizers of North America we have imposed our medical science on Native groups just as we

imposed our alien systems of economics and forms of government. Of undeniable importance is our need to first interpret and then come to terms with the *Zeitgeist* of our discipline through the process of active involvement in finding solutions to the problems we have created for Native groups over the past several hundred years.

Anthropologists' are cognizant of the fact that human group life is the essential condition for the emergence of individual consciousness as well as being a process of formative transaction. What we also need to remember is that the acting units of any society, people, do not act toward the intangibles of culture, social structure or the like; "...they act toward situations" (Blumer, 1969:88). It is in the actual patient-practitioner relationship that cultures meet.

CONCLUSION

When communication breaks down, as it often does, between Dakota Sioux patients and their Western health-care providers in illness situations, the result is often that the actors on both sides of the equation insulate themselves, regardless of their societal positions, through "...blindnesses, half-truths, illusions, and rationalizations" (Goffman, 1967:43).

In these sad, human scenarios there is a direct connection between scientism and dehumanization, for both destroy personality and community in their quest for "Truth." The sciences of man, when they claim to tell us the whole truth about ourselves, are substituting impersonal concepts for a firsthand awareness of responsible existence. Too often, science views the individual as the resultant of biological forces, and deals with him as a statistical unit in the operation of mass movements, both social and cultural. This process allows for the "dehumanization" of individuals, leaving aside the psychological and cultural import of selfhood.

For example, health services research has traditionally been biomedically oriented. I will argue, to the contrary, that it is the role of interpersonal influence and communication in health care that should be the focus of our attention. Of equal importance are the values and cultural contexts of health-seeking behavior. Consequently, this research attempts to elucidate and render intelligible the interactional relationship as it exists between Dakota Sioux patients and Western health-care practitioners. Though no attempt is made to assess the total configuration of reserve life in this whole equation, certain aspects of the Native experience will be touched upon.

While the isolated, rural communities of Southwestern Manitoba may not be as exotic, or romantic, to the anthropologist as the Highland people of New Guinea, the same delicate interwoven processes of human interaction are as strong here as anywhere. For this alone, they deserve the attention of a concentrated anthropological research. In addition, given that these Native communities are undergoing radical social change, it is time for the social scientists' to offer their assistance when requested in making the inevitable transition easier for Native peoples.

This can be accomplished by the anthropologist adopting the role of "cultural broker". This term, as utilized by Weidman (1975:312) and van Willigen (1986:127-140) implies a special mediation role for the anthropologist in establishing linkages between cultures. "This perspective places the anthropologist at the margins of the cultures of both the health care providers and the community" (Weidman, 1982:203, 1979:86). The purpose of this process is the provision of a culturally appropriate delivery of health-care services.

CHAPTER II: THE RESEARCH PROBLEM IN TERMS OF APPLICABLE THEORETICAL MODELS

> Models come into use at various levels of analysis and abstraction. All of us, consciously or unconsciously, create models (hypothetical estimates or projections) in our daily encounters, in and out of research.
> Pelto & Pelto, 1983.

INTRODUCTION

The practice of medicine is both a social and a cultural activity in that it always involves interaction between two or more socially conditioned human beings within a cultural context. From this, researchers in the area of cross-cultural health-care delivery can reasonably argue, without fear of criticism, that increased attention needs to be given to assessing the impact of culture on disease and health (Kleinman, 1980, 1985; Fabrega, 1979; Eisenberg, 1977; and, Young, 1982). What is often neglected is the fact that medicine is primarily a process of social interaction, especially in the treatment of disease and injury, except, of course, in those cases when the patient is unconscious (King, 1962:207). In order to better understand the social interaction as it occurs between Western physician and Native patient, three theoretical perspectives will be applied in this study.

Synthesis of Three Models

The cultural context of medicine and the biohuman paradigm can be examined from a variety of theoretical perspectives. The particular focus for this study derives from three distinct fields of social science: that of medical

anthropology; medical sociology; and, symbolic interactionism. Cultural patterns of illness, systems of meaning in respect to the sick role, alternative medical systems, symbols and language are all concerns common to these three disciplines.

Medical Anthropology

A major thrust within medical anthropology that is of special significance to this thesis is the cross-cultural comparative dimension of health systems. This orientation is found within the writings of Kleinman, Good and Delvecchio Good, Weidman and Suchman, among others. The leading investigator in this field is Dr. Arthur Kleinman, a psychiatrist and anthropologist, whose writings advocate a culturally-oriented approach to the application of medicine.

A pivotal facet of Kleinman's theory is his development of "Explanatory Models," or EMs, a mneumonic for the patient's perception of illness and a device which serves as a system of explanation that allows the patient to interpret the illness experience. Explanatory models are reflections of individual belief maps, both consciously and unconsciously formulated. They function to govern one's attitude towards illness episodes. The essence of Kleinman's work is that we need to be more sensitive to the impact of social, cultural and psychological factors upon that matrix of complex variables that constitute each unique person. Though elaborated primarily in the nexus of a non-Western culture, Kleinman's EMs have application for any individual finding himself in a clinical setting. This is because each one of us has been raised within that collectivity called culture, which has endowed us with a common origin and a shared belief system so that when issues concerning our health are raised, we are able to orient ourselves within culturally determined parameters (Spiers and Sherley-Spiers, 1986:36).

Medical Sociology

The second contributing social science is that of medical sociology from which is drawn insights into the structure of the relationship between physician and patient; the meaning assigned to the sick role; health-seeking behaviors; issues of compliance behavior; social systems; and, the hospital as an institution (Bloom and Zambrana, 1983:73-122; E. Freidson, 1970; E. Mumford, 1983; and, D. Mechanic, 1978).

This is by no means a complete listing of areas of study within medical sociology, rather it is a focused selection of topics which directly relate to the research problems addressed in this thesis. For example, in gaining insight into health-seeking behavior, Mechanic (1978:9) states that from a sociological perspective:

> It is clear that the process of help seeking results from a relatively complex sorting process that is dependent on a variety of factors other than the amount or severity of illness.

In other words, medical sociologists maintain the utilization of health-care services is never simple; rather, it is a complex multifaceted activity with each individual patient developing a unique line of response to a perceived illness episode.

The third contributing social science is that of symbolic interactionism, which constitutes a theoretical perspective developed within social psychology. One of symbolic interactionisms' goals is to study the cognitive and affective elements of human conduct. Both the individual and society are significant factors in understanding social behavior. Of importance within this discipline is the use and misuse of language; the concepts of symbols, objects and meanings; defining power relationships; stigmatization; and, the study of social interaction. In this research, symbolic interactionism is employed in an attempt to more fully

comprehend the clinical setting as it exists between physician and Native patient, as well as to penetrate and elucidate perceptual differences between clinician and client.

The diagrammatic illustration depicted in Figure 1 shows the circumscribed regions of medical anthropology, medical sociology and symbolic interactionism. The shaded area is the intersect of all three, and is called the "idioverse" (Schwartz, 1980:419-441). In Schwartz' terms, the idioverse is not only the individual's personal section of his culture, but also that region which is shared by all others in the society. The idioverse is a reflection of common areas of concern to the theoretical models of the three disciplines utilized in this research, in other words, the common ground shared by all three approaches. It is the examination of this region of synthesis that is the core of this research. It is here that an emphasis is placed upon the individual as a factor within an interactive whole, which includes the totality of the medical experience.

A Working Hypothesis

The thematic argument that runs throughout the body of this exposition rests on the following fundamental hypothesis: Health beliefs and perceptions may be more important to an individual's selection and utilization of available medical systems than the biomedically determined health needs of that individual. This hypothesis finds general support in the literature from both

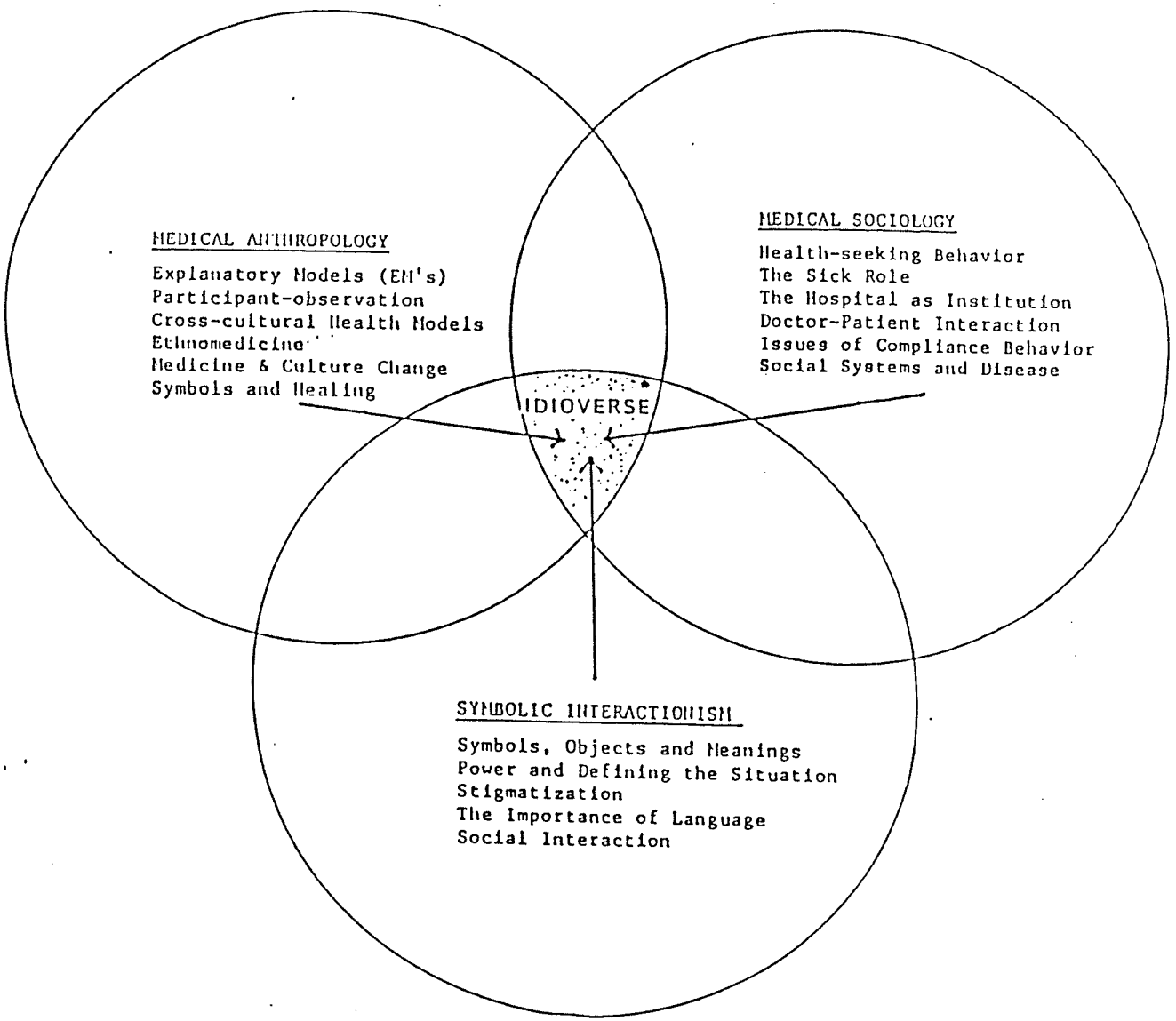

FIGURE 1: Synthesis of Three Theoretical Models

*The "Idioverse" is a construct developed by Dr. Theodore Schwartz, and is taken from his article, "Where Is the Culture? Personality as the Distributive Locus of Culture."

medical anthropology, medical sociology and symbolic interactionism. A classic example is the following quote taken from Suchman (1972:262), who states that:

> ...patients and physicians may differ not only in their perceptions and interpretations of symptoms and illness but also in the relative reliance they place upon the scientific or formal approach to medical care as compared with the more personal, popular or folk means of treating illness. These varying definitions, objectives, and methods may generate conflict, or at least a lack of congruence, between professionals in the health field and their patients. These potential sources of disagreement underlie many of the problems in medical care today.

Parallel to this is the reality that there often exists cultural differences between a physician and his patient, which operate as barriers to effective health care. Gaines' and Hahn's (1985:5) interpretation of physicians as constituting a specific "sociocultural system" reflects a view of medicine as a cultural artifact, which may operate in isolation from the individual patient. This polarity may be expressed in terms of a differential orientation towards such fundamental issues as etiology of disease, functional ability, hierarchical importance of body systems, symptomatology, expectations of care and the selection of curative agents.

All of these factors may profoundly influence the diagnostic process and the course of an illness event. This is, in part, because a patient's belief system is intimately bound, in varying degrees, to therapeutic outcomes. These belief systems are in turn founded on semantic illness networks of health and disease which are themselves grounded in the total configuration of local and historical knowledge. They are specifically modified by such factors as an individual's exposure to and experience with Western medical models of health care. These are factors that directly impact upon the efficacy of a health-care delivery system.

Power Relationships

Many of us have experienced feelings of intimidation while in the presence of medical personnel in a clinical setting, regardless of our cultural background.

We have a natural tendency to defer to the "experts" to interpret a medical problem. Yet, it is important to keep in mind that many behaviors are deemed socially inappropriate to act on, or verbalize, in the clinical situation. These taboos are strictly determined by our perception of our relative status within the social relationship.

At issue here is the use and abuse of power within the clinical setting. Power, that ability to coerce someone to do something against their will, derives from two major sources in this study: The power of the "expert," in this case the physicians' and nurses' biomedical training and use of technical language; and the power that accrues to an individual because of his status within the hospital hierarchy and the local community. The effect of the subordinate power-relationship is exacerbated in the case of Native patients who perceive themselves as somehow fundamentally separate, apart from the White world around them. To illustrate this process, McCall and Simmons (1978:28) state that "position in the social structure also influences the amount, kinds, and variety of interactions a person has."

As individuals, we identify with the "other," socially and personally, through the process of cognitive recognition (Goffman, 1963:113). This is the same process by which we categorize people as being apart from ourselves, and at the same time create our own position in the social world. This social world is itself an amalgam of a "...set of moral norms that regulates the way in which persons pursue objectives" (Goffman, 1963:8). Consequently, social episodes are not only culturally determined, but cognitive objects as well, units of knowledge and expectations that an individual has about a specified sequence of interaction. In discussing the issue of social episodes, we are here indebted to the symbolic interactionist tradition.

THE RESEARCH PROBLEM

Epistemological Questions

The central epistemological questions in this thesis are directed towards an understanding of two distinct sets of phenomena. First, what bodies of knowledge, beliefs and perceptions on the part of Dakota Sioux patients mediate the consultation process, cure-seeking behavior or the decision not to utilize biomedical services. Directly linked to this is the Native health experience with the Western biomedical system once contact is made with a professional health-care worker. Secondly, it is important to elicit the degree of acquaintance with and understanding of Dakota Sioux culture and models of illness held by Western medical providers.

The Issue of Non-compliance

Perceptions of illness, internalized by physician and Native patient alike, are only revealed and understood in an interactional context. This can become a double-edged sword within the doctor-patient relationship due to perceptual dissonance. Cognitive dissonance in the clinical encounter occurs when clinician and client operate from different perspectives in regards to the nature and organization of knowledge. It is, in fact, the differences in knowledge that defines the clinical situation. Physicians, in particular, tend to seek confirmatory evidence to support their diagnoses and treatment regimens rather than confront the possibility that they may in fact be wrong. This leads to Festinger's (1958:156) concept of cognitive dissonance, which is expressed in this case in the lack of authentic dialogue between physician and Native patient, and in the inability to bridge the gulf of misunderstanding between the two actors.

Misunderstanding is a reflection of a dichotomy between two differing medical concepts: disease and illness. This aspect will be further examined in a later chapter. Suffice it to say at this point that the physician's perception of

disease and the patient's perception of illness often lead to conflict expressed as "poor patient compliance." The medical literature is replete with statistical accounts of non-compliance behavior (Becker et al., 1975; Davis, 1966; Gordis, 1979; Dunbar, 1979; Haynes, 1976; and Larson et al., 1979).

Zola notes (1981:241) that physicians are distorting the issue of compliance in two ways:

> We do not sufficiently appreciate what following a medical regime means to an individual, nor do we fully acknowledge the role that health personnel have in contributing to the very non-compliance we seek to reverse.

Stoeckle and Barsky (1981:234) have observed that "illness attribution" is "...what patients think has caused their illness...." By ignoring this reality physicians encounter the issue of non-compliance head-on. The cross-cultural constructs found within illness/disease perceptions are crucial to a fuller understanding of the mechanisms underlying non-compliance behavior. It is clear that, for whatever reason, non-compliance represents a serious problem that denigrates the quality of health care received by Native patients. This, however, betrays a medical bias which is based on the underlying assumption that people who experience illness are obligated to seek professional medical care. Non-compliance in this context may indeed be compliance to an "alternative" system of beliefs and healing practices.

A crucial point to reflect upon is that the perceptions we have of others, which form the bases for our orientation in our interactions, are always incomplete and less than valid. This is especially true in the case of cross-cultural health-care delivery. For example, the anthropological literature

emphasizes the important role that perception plays during medical interventions. As King informs us (1962:219):

> Whatever it be in the way of discomfort, the altered physiological state (of a patient) is undoubtedly a determinant of perception, narrowing the range of attention to stimuli, lowering thresholds for emotional reactivity, changing customary personality manifestations.

APPLICABLE THEORETICAL MODELS

Any problem requires an appropriate method of analysis to decipher the hidden messages embedded within the context. One method used in this study is the implementation of various theoretical models taken from medical anthropology, medical sociology and symbolic interactionism. The previous discussion of non-compliance behavior is indebted to the work of medical sociologists. Now we turn to a more detailed discussion of explanatory models and to the meaning and power that symbols have on identity formation and belief systems for the participants in this research.

Explanatory Models

The medical anthropological model, as formulated by Kleinman, argues that the practice of medicine, if it is to be fully effective, will encompass both the cultural and biological dimensions of human experience. In collaboration with Katon (1981:253), Kleinman claims that a "biopyschosocial" approach needs to be utilized by health-care providers. This holistic strategy is offered to counteract what is often seen as the failure of the biomedical model within the clinical setting.

In an early formulation of ethnomedical explanatory models, Kleinman (1978:429) points out the impact and influence that these models can have in the patients' evaluations of treatment programs. When these evaluations, or

perceptions, differ from the clinical assessment, situations of conflict may result. In attempting to understand and explain conflict situations in interethnic medical practices, Kleinman writes (1980:xii):

> Clinicians tend to be simplistic about clinical practice. Their tendency toward positivistic scientism and atheoretical pragmatism discourages attempts to understand illness and care as embedded in the social and cultural world.

Leininger (1976:16) supports Kleinman's position, noting that "health care norms are largely determined by the culture, with the quality of care contingent upon the perceptions and cognitions of the people." Unfortunately, as this thesis will demonstrate, the cultural aspects of health care norms held by the Dakota Sioux are not taken into consideration in the delivery of health care in Hospital District #I0.

Doctor-Patient Relationship

Medical sociologists have increased our knowledge of the relationship between clinician and client. More recently, they have challenged the Parsonian functional approach to analyzing the social system of medicine. Freidson's work (1970) on the doctor-patient relationship concludes that "...the professional expects patients to accept what he recommends on his terms; patients seek services on their own terms. In that each seeks to gain his own terms, there is conflict." Freidson's assertion here is that the power to actually create illness as an official social role is in the hands of the medicine profession. This is in direct contrast to Parsons who argues that the physician maintains control over illness and the expectant sick-role behavior. It is through this discussion that we learn how physicians create and maintain autonomy through institutionalizing authority. This concept of medicine as an institution accompanied by the concepts of power

and authority are central to the propositions set forth in this study. To understand how the medical profession acquires this power we must turn to a discussion of symbols.

The Power of Symbols

Underlying this research is a model commonly referred to in the literature as "symbolic interactionism." For those social scientists holding to this theoretical viewpoint, meaning is anchored in the behavior that an individual expresses during the course of his social interaction with others. That is, "human beings act toward things on the basis of the meanings that the things have for them" (Blumer, 1969:2). It must be kept in mind, however, that "the meaning of an act is neither fixed nor unchanging" (Hewitt, 1979:53). Instead, meaning is found within the symbolic world created through individual conduct, and it is socially constructed.

Interpretation of this meaning is central to social interaction, for it is only through an understanding of the acts of another person that the self can appropriately respond to a given situation (Hewitt, 1979:55). Hewitt, expanding on this concept, explains that (1979:26):

> Interaction takes place within 'containers' we call situations, and as these situations are defined by their participants, so the course of interactions is shaped.

In the medical context, patients respond to the clinical environment by utilizing symbols--in the form of language, explanatory models, and cultural norms--thus creating what is, for them, a clinical reality. When the environment of symbols experienced by clinician and patient differs, the behaviors on both sides may prove problematic, as will be demonstrated in later chapters. Both parties need clarification as to what the situation consists of (Kleinman, 1978:429), as well as in the final interpretation of the symbols themselves.

We cannot speak of the essence of "symbols" before having answered the general question: What are symbols, and how are they created? A conventional definition, which is only partial in the full analysis, is given by Plog and Bates, who write (1980:16):

> The words that make up language are not signs, but symbols. What distinguishes symbols from signs is that a symbol is arbitrary. It stands for a thing only because the people who use the symbol agree that it does. Because of this arbitrary quality, symbols are infinitely flexible. They can change their meanings; they can be combined and modified to create new meanings; perhaps most important of all, they can be used to represent things that are not actually present--events of the past and future, abstract entities, and strictly mental phenomena.

What these researchers fail to mention is that symbols are also used to explain the concrete by reference to the abstract. In this case, symbols can be considered not only as a means of communication (language), but also as instruments of expression (art, poetry), knowledge (perception) and control (in the form of values and conduct). In addition, symbols are cultural constructs; that is, they are learned, invented and adapted for social and individual purposes. Symbolic attribution is a matter of cultural determination. Most importantly, symbols mediate the values and cultural norms of human interaction through the primary process of interpretation.

These dynamic attributes of symbol systems are well-documented in anthropology (Maquet, 1982; Sperber, 1979; Firth, 1975; Douglas, 1982; Turner, 1967; and Wagner, 1986). Symbols are often discussed in the literature as if they were only figures of speech. Symbols are that, of course, but more importantly they can be material objects which represent metaphors for nonmaterial constructs. A core example of this concept is that symbols contain

the power to manipulate appropriate responses from individuals. For instance, a country's national flag is an emblem of solidarity, emotionality and, in certain cases, a powerful symbol employed for purposes of propaganda.

A final function of symbols, which is of particular importance to the discussion of health care, is that they serve as identification markers allowing individuals and/or groups to tell themselves and the other segments of society who are their members and from whom they are separated.

Stereotypes and Stigmatization

The following discussion is important to the research problem at hand in that Goffman's model of stereotyping and stigma gives us a convenient analytic framework in understanding the behavior of the Dakota Sioux patient in the clinical setting. Goffman's emphasis on the flow of information between self and other is particularly pertinent, for in the process both parties become inextricably linked--even if they perceive themselves to be poles apart on an "insider"/"outsider" continuum.

A stereotype is a complex set of personal characteristics and behaviors attributed to the person who occupies a given social position. In this research these primary social positions are those of clinician and Native patient. This process of naming or labeling of persons--that is, a taxonomic approach as applied to people--is a tactic full of hidden pitfalls and ramifications. Classification is in itself a social act, and as such in this study entails the participation of at least three different types of persons: the classifier (health-care practitioner); a person or group to be so classified (Dakota Sioux patient); and a public called upon to accept or reject that particular classification (the non-Native community). Whenever people propose to exclude others from their midst

to create the objective "they," there is a requirement to attach stigmatizing labels. McCall and Simmons (1978:111, 113), on the other hand, see stereotyping as an inevitable sequel to all human encounters:

> Stereotyping involves not merely the attitudes of rigid people discriminating against racial and ethnic outgroups. It is an inherent and inevitable aspect of every human appraisal of every person encountered....From the visible clues to social identity, we connect strangers with stereotypes, so that we may predict their behavior and characteristics.

Stereotype building is not a unidirectional process, nor does it occur in isolation. Instead, it is a well-established mechanism central to any psychosocial study of prejudice, racism, ethnocentrism and stigmatization. For example, Gardner and Taylor (1967:1-10) have proposed that stereotypes influence a person's perception of others primarily because of the underlying belief system supporting the stereotype in question. That this is the case is well-documented in the reportings of the Dakota Sioux in a later chapter. The abounding stereotypes surrounding Indians seem to operate as "cognitive filters" which carefully control, modify, or reject, in varying degrees, incoming information. This mechanism results in the concretization of perception of others that does not allow for any modification. Stereotyping is perhaps the best example of that peculiar ability of the human mind to believe fiercely and emphatically in whatever it wants to believe, even when one can demonstrate empirically that the belief is inaccurate.

Stereotyping is integral to that dark side of human nature known as prejudice. Schermerhorn (1970:6-7) indicates that prejudice is a product of historical, economic and political situations. He stresses that "it is not a little demon that emerges in people simply because they are depraved." Rather, prejudice is a dependent or intervening variable that can arise in any episode of

human intercourse. The Dakota Sioux constantly live with the realities of prejudice, for they are daily confronted by incidents of stereotyping and stigmatization.

In the process of assuming the attributes of another, a person whom we perceive as "different," we reduce that person "...from a whole and usual person to a tainted, discounted one" (Goffman, 1963:3). Such an attribute is a stigma, which constitutes a special discrepancy between virtual and actual social identity.

Thus, the stigmatized member of society finds himself in a difficult situation. Society tells him he is a member of the wider group, i.e. a Canadian citizen, which means he is, in some respects, "normal." Yet, at the same time, he is well aware through the way he is treated that he is somehow "different." This is a classic double-bind situation for many Native peoples, leaving very little room for individual maneuvering.

The impact of stereotyping and stigmatization is serious when found within the realm of health care, for it not only leads to overt acts of discrimination, but it also exacerbates the social distance between Native patient and health professional, thereby reducing communication and patient satisfaction.

Symbols and Native Identity

For the purposes of this discussion, the transmission of Sioux identity is tightly encased in symbolic form. It is not custom itself which promotes identity transmission, but rather the meaning that attaches to it, and the way it is demonstrated. For a symbol to be effective in this manner, it must be given a framework in which meaning is imparted. This holds true for both the people who display it and for the people to whom it is displayed. Thus, in order to retain a separate identity, Native groups such as the Dakota Sioux must regularly perform

a systematic set of activities incorporating such attributes as language, art and ideology. Only by undertaking these behaviors are the Sioux able to persist under the rubric of "Indian."

The individuals who operate within the category of "Indian" must have some way of communicating this role to themselves and to others. This is accomplished through the employment of symbols: modes of dress; ways of speaking and comporting oneself; and demonstrations of respect towards ritual objects, or as Firth maintains (1975:167):

> What ritual performances do is to recall and present in symbol form the underlying order that is supposed to guide the members of the community in their social activities.

What we call a symbol, then, is a term, a name, or even a picture that may be familiar in daily life, yet that possesses specific connotations in addition to its conventional and obvious meaning. It also implies something vague, unknown, or hidden from us. Jung states (1964:4) that "...we constantly use symbolic terms to represent concepts that we cannot define or fully comprehend."

In the case of the Dakota Sioux, a classic example can be found in their concept of "bad medicine." This is illness made manifest in one individual through the evil conjuring of another, usually a powerful medicine man, or shaman. The "cause" of the illness is commonly due to envy or jealousy, made real through the employment of a symbol. For the Sioux, this symbol is usually an eagle feather lodged strategically within the human body, resulting in loss of appetite, nightmares, vomiting, headaches, weight loss and even death for the unfortunate victim.

The purpose of such a detailed discussion of symbols, and the development of stereotyping and stigmatization is central to understanding the many facets of symbolic interactionism and how this theory of social interaction colors the clinical setting with Native patients. For example, Native patients

complain that they have difficulties understanding the language employed by physicians, and that they themselves have great difficulty in communicating their illness episode to the satisfaction of the doctor. Native patients also lament about the manner in which the health-care practitioners treat them. These issues are discussed in detail in Chapter V, but first we need to turn our attention to the actual situations of interaction between Western practitioner and Native patient.

SYMBOLS IN THE CLINICAL SETTING

Regardless of ethnic background, all patients come to a hospital setting with a "presenting culture." This is the *Weltanschauung* to which the individual has been socialized and which he recognizes and holds as reality. It is a world view that is "taken for granted until the point of admission to the institution" (Goffman, 1962:12). An individual's knowledge about the world is constructed of concrete impressions and facts, as well as nonmaterial mental representations. These include belief systems, values, folk concepts, perceptions and emotions, which are all culturally embedded in a historical context. All influence a patient's understanding of an illness episode.

For example, how do the professional and paraprofessional health workers within this research interpret behavioral patterns among Native patients that are puzzling and contradictory to the Western mind? What could be the "meaning" underlying the following examples of actual behavior?

A Native patient arrives at the local hospital in the dead of night to remove a seriously ill relative against all medical advice. Elderly Native patients steadfastly refuse to be hospitalized even though they have become critically ill. Native mothers refuse to leave their infants alone in the hospital. A hospitalized Native patient receives a steady stream of family and friends regardless of posted visiting hours. A Dakota Sioux grandmother arrives at the hospital emergency room with a small grandchild--neither of them can communicate in

English. A severe diabetic simultaneously seeks advice and treatment from both a local Western physician and a traditional healer. Native patients utilize the hospital emergency room services rather than consulting a doctor during clinic hours. Many Native patients refuse to comply with the prescribed medical regimen, and more often than not, fail to make their clinic appointments.

All of these behaviors are difficult, if not impossible, for the health-care professional to comprehend without some knowledge of the Dakota Sioux patient's perception of illness, which will be addressed in detail in a later chapter.

For the moment, it is necessary to turn to a discussion of illness, for this concept has proven to be problematic in the encounters between Western physician and Dakota Sioux patient. The terms illness and disease do not stand in any linked semantic relationship, one to the other. As Eisenberg informs us (1977:11), "...patients suffer 'illnesses'; physicians diagnose and treat 'diseases.'" Kleinman et al. (1978) support this assessment. Illness, for these authors, represents the patient's subjective experience of pain and distress. Disease, on the other hand, represents the physician's view of what troubles the patient. Illness, however, may occur even in the absence of disease, as when a visit to the physician reveals no physiological basis for pain or discomfort.

Another area of conflict described by Native patients is reflected in the "non-communication" that so often occurs in the clinical setting involving physician and Native patient. By discounting the statements of the patients in regards to symptom reporting, the physician is denying the patient an active role as participant in the relationship. Instead, the patient becomes an "object" upon which the doctor locates a malfunctioning "part" and offers a treatment program in an attempt to mechanically "fix" whatever is wrong (Goffman, 1962:368). All of

this becomes highly objective and clinical and totally removed from the social referents as understood by the patient. It becomes instead a dehumanizing process, whereby the patient assumes the characteristics of a "thing."

CONCLUSION

In an attempt to explain why Dakota Sioux patients are often reluctant, or uncomfortable, in seeking out the services of Western physicians, the theories of symbolic interactionism, actual patterns of health-seeking behaviors and patient explanatory models will be implemented in an analysis of the data in Chapters V and VI.

The interview schedules are designed in an attempt to elicit answers to the following primary questions: 1) Under what circumstances are professional medical practitioners sought and utilized by members of the Dakota Sioux community; and, 2) What are the levels of interaction and understanding within the clinical setting between physician and Native patient?

Finally, it must be remembered that the research process is itself only a means of interpretation. It uses narrative form to find meaning in the social and cultural realities as they impact on the health-care delivery to Dakota Sioux patients.

CHAPTER III: METHODS OF APPROACH

> Each method, each way of knowing, gives us a kind of knowledge.
> D.W. Fiske, 1986.

INTRODUCTION

One problem of basic research in medical anthropology is to determine what factors, or combination of factors, in the environment--both cultural and physical--produce, encourage or perpetuate what kinds of illness behavior that occur within a given community. This is where the potential usefulness of anthropological concepts in health care settings comes into play. By implementing the disciplines' broad, comprehensive approach to human life, the anthropologist is well-equipped to ferret out the meanings of what are often, on the surface at least, incomprehensible social encounters and episodes. The benefit of this approach is recognized by Forgas (1979:87) when he writes that the:

> definition of social episodes as cultural units has the great advantage that it allows the operationalization and study of stereotypical, commonly occurring situations, avoiding the problems involved in studying unique and non-recurring actual interactions.

Since any two cultures tend to differ in the way they classify experience, the anthropologist has to look for a potential range of categories and sets of categories relating to any particular phenomenon. Consequently, methodology in anthropology has to be able to incorporate the principles that underlie and guide the full process of studying the often confusing character of

the given empirical world. It is the aim of exploratory research to develop and fill out as comprehensive and accurate a picture of the area of study as conditions allow.

Use of the Ethnographic Encounter

The data were collected in this study by incorporating the methodological approach known as the "ethnographic encounter." Ethnography, literally writing about peoples, is based upon firsthand studies of contemporary cultures through field research. Encounter, as defined in this research, is a process derived from psychotherapy. It seeks to encourage improvement in the dialogue between the anthropologist and informants by encouraging openness, honesty and sensitivity to the feelings of others.

By adopting this methodology, the anthropologist is engaging in a search for generalized, shared patterns of interactional behavior that can be shown to impact directly, or indirectly, on belief systems and perceptions surrounding disease and illness episodes held by both physician and Native patient. The "ethnographic encounter" is a complex and dynamic negotiation in which the parties acquiesce, however tentatively, to a certain shared reality for the duration of the interaction. By acknowledging this subjective perspective, Bruner (1986:18) can justifiably argue that "...ethnography is not the privileged authoritative voice about native peoples; it is, rather, one mode of representation."

Ethnographic encounter is based upon a specific methodology which allows the anthropologist to move from theory to a shared reality within the encounter situation. That is, actual, concrete examples of reported behavior become the units of observation. This is in contrast to expected and idealized behavior inherent in all societies. In this manner, observation and data collection are part of the qualitative methods by which the anthropologist is able to describe

and interpret the activities and reportings of informants. A central feature of collecting data is defining how values will be assigned and how they will be measured in order to test the hypothesis put forward. These operational tools of the social scientist are defined by Pelto and Pelto (1983:40-41) in the following manner:

> Operationalism is a research strategy in which primary elements (terms) of descriptions and theoretical propositions are structured, *wherever possible*, in forms that prescribe, or otherwise make intersubjectivity available, the *specific acts of observation* that provide the primary transformations from raw experience to the language of theoretical systems. (Italics belong to the authors).

Rather than limiting theory to a deductive systematization of empirical facts, social scientists are moving towards an acceptance of theory as being a picture, or a model, of impelling generative processes; that is, a diachronic view of events and/or phenomena. The emphasis has shifted from rigid formulae to the construction of models that will descriptively analyze complex interrelationships among observed variables (McCall & Simmons, 1978:253, 255). The selection of a methodological approach is, of course, conditioned by both the subject and content of the research problem as well as the investigator's interests. Of necessity, this results in the anthropologist operating in the field with one foot placed squarely in the everyday world of his informants, and the other in the world of his own anthropological research training and intellectual orientation.

Data Recording and Analysis

The techniques employed in data collection included the use of stenographic note-taking and tape recordings. All of the material was transcribed into a typed format and then analyzed for content relevant to the research. Selected abstracts from both Native and medical informants are to be found in Chapters V and VI. In all cases formal written consent was obtained from

informants prior to interviewing. An example of the consent form is found in Appendix A.

ACCESS TO THE FIELD

Acceptance by the Dakota Sioux

Entry into Native communities by anthropologists is often highly problematic, given the suspicion and distrust that has been generated by social science researchers in the field over the last hundred years. Vine Deloria's introduction to his book, Custer Died for your Sins, contains a scathing indictment of anthropologists (1970:Preface):

> Into each life, it is said, some rain must fall. Some people have bad horoscopes, others take tips on the stock market. McNamara created the TFX and the Edsel. But Indians have been cursed above all people. Indians have anthropologists.

This general antagonism felt by Native peoples towards anthropologists was neutralized, in my case, by a serendipitous event. My formal introduction to the Chief and Band Council was facilitated by a chance meeting with a Dakota Sioux member of the Oak Lake Band. This meeting took place at the United States Customs at the International border early one morning in June of 1984. The individual involved expressed interest in the research and graciously offered to provide a letter of introduction to the Band. This act initiated a long process of negotiation culminating in final acceptance of my admission into the Native community.

Formal Approval for the Research

Data were gathered for this research within the period June 1984 through June 1985. The information was collected during unstructured, informal interviewing sessions with medical and nursing staff, administrative personnel and Dakota Sioux patients. Interviews were conducted in the local physicians'

clinics, in the Reston and Virden hospitals, the Band Council office and within the private homes of Native informants.

The interview schedule directed towards the medical and nursing staff was designed to elicit information on levels of contact and types of experiences with Native patients. Questions were formulated in such a way as to allow the respondent to freely discuss his or her feelings and impressions about the behaviors and understandings of Native patients. Questions were also designed to determine the awareness of traditional healers within the district, and the impact their presence has on health care for the Dakota Sioux. Finally, the degree of knowledge about Dakota Sioux culture was elicited. All of these issues impact directly upon the quality of care given to Native patients. The reader is referred to Appendix B:(II) for a list of questions used in interviews with physicians, nurses and administrators. The results of these interviews are located in Chapter VI.

An ethnomedical interview schedule was designed for use in sessions with Dakota Sioux patients (Appendix B:I). Specifically, questions were directed towards discovering the experiences of Native patients within the Hospital District in order to find areas of potential conflict and misunderstanding. Interviews were restricted to individuals who had actually experienced contact with the Western medical system, such as visits to the clinics or one of the local hospitals. The purpose of this questionnaire was to elicit and gauge the perceptions, beliefs, values and explanatory models held by Dakota Sioux patients. The full documentation of findings can be found in Chapter V.

Formal permission for this study was granted by the Governing Board of Hospital District #10, the Chief and Band Council of the Oak Lake Sioux Reserve #59, and the Faculty of Arts Ethics Committee, University of Manitoba (Appendix C.)

After receiving final permission from all of the agencies involved, a process which began within the Hospital District in February 1984, arrangements were made with the Chief and Band Council to commence the field work. A Community Health Representative (CHR) was assigned by the Chief to work as my primary liaison with the Band during the course of the study.

The Community Health Representative

An elaboration of the role of the Community Health Representative is necessary, as this individual proved to be invaluable to me personally and to the smooth progress of the study. She did not fill the role of principal informant. Instead, as occurs so frequently in anthropological field work, one person in a culture takes on the role of primary contact, acting as both teacher and friend, guiding one through the difficulties of learning how to behave and to find one's way around in the culture. Such was the role of the CHR, Jean Eagle.

From an administrative perspective the position of the CHR on Reserves is part of a general move by the Federal Medical Services to begin the involvement of Native community members in the provision of health-care services. The Community Health Representative Program is designed to provide community health information instruction, to educate Native peoples in safe health practices and to assist communities to identify their needs for effective health services. Other functions include explaining local culture, community health needs and problems to the local, non-Native health-care delivery team. In order to attain these impressive objectives, the CHR undergoes six weeks of "training". This normally takes place under a Public Health nurse on other Reserves. The CHR assigned to the study at Oak Lake did not receive any "training" until she had been in the position for over a year. Her function, from my observation, appeared to be solely that of handmaiden to the the demands of the local Public Health nurse.

The value of the CHR to this study, however, was crucial in that she possessed knowledge of those individuals who were currently under the care of local hospitals and physicians, as well as those persons who had previous experiences with the health-care delivery system. An additional benefit provided by the CHR, due to her fluency in English and Dakota Sioux, was her influential role as translator and interpreter. Her kindness, hard work and commitment to the goals of this research project enabled the field work to proceed with a minimum of difficulties.

INFORMANT PROFILES

In all, data were collected from thirty Dakota Sioux informants, ranging in age from twenty to eighty-one (See Table I). Within the medical setting, two physicians, four nurses and various administrative personnel were interviewed.

From the outset, the women of the Oak Lake community interacted warmly and openly, showing a genuine interest in the research project. The men, however, remained aloof and reticent for some time to participate in the research. They held themselves at a distance, quietly observing my behavior and interaction with the Chief and others in the community. In time their hesitation dissipated and they too expressed an interest in being interviewed, and became just as actively involved in the study as the women.

INTERVIEWS AND OBSERVATIONS

Participant Observation

The utilization of "participant observation" as a research method requires a smaller sample of the population under study, as opposed to the macro technique of survey (Agar, 1980; Pelto & Pelto, 1983; van Willigen, 1986). Participant observation requires that an intimate knowledge of the informant's perspective must be learned and treated with respect. As Agar (1980:114) states

TABLE I: AGE AND GENDER OF NATIVE INFORMANTS

AGE:	20-29	30-49	50-64	65+
	6	11	7	6

GENDER:	20-29	30-49	50-64	65+
MALE	2	5	2	3
FEMALE	4	6	5	3

TOTAL NUMBER OF INFORMANTS: 30

in defense of this emic stance, "the term suggests that you are directly involved in community life, observing and talking with people as you learn from them their view of reality." Participant observation is also an indispensable part of any research program that focuses on the meaning that individuals place on situations and encounters.

By adopting this non-directive role, the anthropologist is in a better position to acquire an understanding of the other's beliefs (explanatory models), as well as an appreciation of the symbolic relationships between client and clinician.

Maintaining an "emic" position allows the anthropological researcher to escape the fallacy of objectively viewing the social world under study. That is, the substitution of an individual outsider's perspective for that of those being studied is studiously avoided. Thus, in order to ascertain the maximum knowledge of a cultural group, the anthropologist utilizes the participant observation stance in order to relate systems of belief, values and behavior within a cultural setting. Becker and Geer (1957:28-32) have outlined the basic assumptions and methods of the participant observation approach:

> The most complete form of the sociological datum, after all, is the form in which the participant observer gathers it: An observation of some social event, the events which precede and follow it, the explanations of its meaning by participants and spectators, before, during, and after its occurrence. Such a datum gives us more information about the event under study than data gathered by any other sociological method.

Interview Technique

A major research problem was the necessity of resorting to an interpretation of the clinical encounter through the use of reporting methods. This process of being one step removed from the actual encounter required extensive interviews with both Dakota Sioux patients and the Western health-care

providers. A detailed analysis of the final transcripts was undertaken to elicit perceived areas of conflict between clinician and client.

Through intensive interviewing of Native patients and their Western health care providers, an attempt was made to understand the patterns of behavior associated with episodes of illness and expectations of care. Because of the tendency of closed questions to constrain responses, the investigator interested in understanding respondents' internalized, and often unconscious, feelings in depth is advised to use an open-ended format. This is a personal predilection on the part of this researcher, and is not a method shared by all anthropologists.

However, this technique made possible a retrospective construction of past illness episodes and medical care experiences. This also allowed informants to speculate on possible changes to the system that would perhaps create a more effective health-care delivery program to the residents of the reserve. Suggested improvements thus elicited included the provision of an adequate transportation system, the development of a clinic on the reserve, together with a contract physician sensitive to the special problems facing Native populations, health education programs directed at target groups (e.g., pregnant women, diabetics, etc.) and active local participation in health-care delivery.

Three crucial interpersonal skills were drawn upon during the interviewing sessions. First, and to this researcher, the most important skill is the ability to engage in active listening. As Carl Rogers states (1961:331), "real communication occurs...when we listen with understanding." A good listener is one who perceives the needs and feelings of the speaker without being in any way judgmental.

Second, the interviewing process itself requires the researcher to have an unconditional acceptance and deep respect for statements made by informants. This allows for the possibility of an unfiltered flow of ideas.

Third, the researcher needs to develop a sensitivity to the local realities of the community under investigation, and not deal with events as objects to be measured but as subjects carrying meaning. In other words, a basic assumption made by anthropologists is that a cultural group perceives and orders its universe in a patterned, orderly and identifiable way.

The purpose of this qualitative research was stated very directly to all concerned: I was a student interested in learning about Native experiences within the Western medical system. Consequently, in writing about health-care professionals and their Native clients, this study is not filled with massive quantification for we are dealing here with individual subjective perceptions of experiences, not statistics.

During the interviewing phase of this study, information regarding the Native informant included age, gender, marital status, number of children, primary language, occupation and education. This was followed by a series of questions directed at health and illness behavior. Examples of questions include: Have you had any contact with doctors or hospitals within the last two years?; What happened that made you seek out a doctor's help?; When talking to the doctor, did you understand what he had to say about your problem?; What do you think caused your problem? For a full list of these questions, the reader is referred to Appendix B (I).

Limitations of the Interview Method

Much time and effort was devoted to looking for meanings that were intended in my informant's disclosures, but were not immediately evident from their answers. For example, random questions covering a wide range of topics were required to establish a comfortable rapport with the respondent. This was necessary before one could elicit any productive information, because the Dakota

Sioux are made uncomfortable by the direct mode of questioning. For the Sioux implicit responses are just as significant as those that are explicit.

The contextual understanding of information requires a close observation of facial expressions, attention to long periods of silence and awareness of body language. These became commonplace techniques employed during the interview sessions to assist in interpreting the meaning attached to statements. A lesson soon learned was that total dependence on purely verbal responses can be very misleading for the enthnographer, in that it may divert the researcher away from the primary objective.

When informants' statements were incongruous or obviously contradictory, it was necessary for the interviewer to remain silent. This allowed time for informants to reflect upon and clarify their statements. A case in point is when health-care practitioners state that they have no special problems with Native patients, and then continue to lament that these same patients fail to comply with a proposed treatment regimen. Another example is when nurses reply that Native patients are just like everybody else, and then go on to discuss how the Dakota Sioux are difficult patients. This incongruity runs throughout the interviews.

Throughout the research there was a concern and a search for patterns in the responses from both sets of informants: health-care practitioners and Native patients. These structures manifested themselves very early in the interviewing process with both groups. The results will be explored in depth in later chapters.

ESSENTIALS OF FIELD WORK

A minimal level of rapport and acceptance is essential to anthropological field work, and one way of establishing this needed support is to guarantee anonymity to all informants. Consequently, the reader will find no names

attached to statements in this work. Thus, an operationalized trust model is an essential ingredient of anthropological field work.

In addition, the uniqueness of the anthropologist's training enables the use of personal experience and resources to establish rapport with not only the community at large, but particularly at the level of the individual. The cooperation and support of the Dakota Sioux was secured, in part, because of the respect given by the researcher to their traditional beliefs concerning disease and illness states. Also, the Dakota Sioux, like any other group, are quick to judge the motives and sincerity of the researcher.

Contact with individual health-care providers, on the other hand, was simplified by the blanket approval received in advance from the Hospital Board, as well as from the physician group. The interviewing procedure was easier in that a "shared" culture was perceived to exist between the researcher and individual informants. They too have a voice and hold equally important perceptions on their side of the equation in this report.

An important discovery revealed in the interview sessions is that people don't talk directly about their personal behaviors, instead they relate personal experiences which are reflections, or surrogates, of actions and feelings. In essence, the communication of experience tends to be self-referential, or as Bruner has written (1986:9-10):

> Expressions are the peoples' articulations, formulations, and representations of their own experience.... Our anthropological productions are our stories about their stories; we are interpreting the people as they are interpreting themselves.

CONCLUSION

To repeat an earlier caveat, the analysis offered here is not intended to serve as a full description of the phenomena observed. In other words, this research does not take into the final equation all the ramifications of what it

means to be Indian. It is rather a selective focusing on those elements within the community that directly impact on the health of the inhabitants.

The medical anthropologist, especially one trained in psychological anthropology, is skilled at distinguishing between the psychological and physiological needs of a people in relation to their cultural orientation and value system. The value and import of medical anthropology in coming to grasps with differences in approaching medicine is clearly expressed by Kleinman (1980:80-81):

> Medical anthropologists have shown that the application of values to types of illness has an important influence upon the decisions people make in responding to particular episodes of sickness....Value structures play a crucial role in evaluations of therapeutic efficacy, with frequent conflicts between the evaluations of practitioners and patients.

This thesis places strong emphasis on the past training and experience of the anthropologist, because both play a major role in how one perceives situations and other people. The careful observation of events increases the researcher's ability to recognize potential areas of conflict and misunderstanding. Exploring the belief systems that underlie expressed behavior is one effective route to understanding and interpretation.

Interest, involvement, subjectivity and empathy become crucial means of grasping the cultural context behavior of Dakota Sioux patients. Consequently, the results of this study indicate a strong need to be cognizant of cultural differences in order to facilitate communication within the therapeutic relationship. This approach strives to reduce the inherent ambiguity in the interactional setting between Dakota Sioux patient and Western health-care providers.

CHAPTER IV: THE RESEARCH SETTING

> Every part of this soil is sacred in the estimation of my people. Every hillside, every valley, every plain and grove, has been hallowed by some sad or happy event in days long vanished. The very dust upon which you now stand responds more lovingly to our footsteps than to yours, because it is rich with the blood of our ancestors and our bare feet are conscious of the sympathetic touch.
> Seattle, a Dwanish Chief, 1854.

INTRODUCTION

"The setting" is a taxonomic device employed by anthropologists in their descriptive analyses, and as such it is designed to set the scene of characters and actions within a particular framework. In this manner, the "who," "what," "where," and "why" of the participants and events are conveniently placed into a contextual field of understanding. This "setting" ideally incorporates not only geographical parameters, but also includes social and cultural factors viewed from a historical perspective as well as that of the current day.

This chapter describes the cultural and social systems in which the Reserve and Hospital communities find themselves embedded. The prevailing rules of conduct and accompanying stereotypes held by each group will also be summarized. The basic definitions of social and cultural systems utilized in this thesis are those taken from Leininger (1970:146-147):

> 1) A system is an assemblage of parts, persons, or objects that are united by some form of order (or relationships) and that show signs of being interdependent in their vital functioning as an organized unit or whole.
>
> 2) A social system refers to an assemblage of people united by some form of regular interaction in which members show sets of behavior which are independent in function and yet, these behaviors are interrelated for the optimal functioning of the whole unit.
>
> 3) A cultural system is concerned with the normative beliefs, values, and action patterns of a designated group of people who show signs of being interrelated and interdependent.

This theory of social systems should not be interpreted as implying that every part of a society or group is rigidly interconnected in some fashion. On the contrary, every social system contains internal discontinuities and contradictions among its parts. This, however, is not necessarily a negative aspect of social systems, for these same contradictions are themselves the vital agencies of social movement and change. Granting that this is so, how does this impact on health care? As areas of dissension, discord, hostility and misunderstanding are uncovered and brought into the light of scrutiny for resolution, improvements in health-care delivery to Native patients may follow.

One of these contradictory elements is the concept of culture itself. Culture is paradoxical in that the individuals within a given society are both the bearers and transmitters of culture to the next generation. However, though customs and traditions are strongly resistant to sudden and radical change, they are at the same time constantly, if imperceptibly, changing. This is especially true in regards to perceptions of health and illness.

A caveat is called for at this juncture, for there are a myriad of external factors, other than culture, which help to shape the configuration of our health-care system. These include political, economic, socio-structural, historical,

perceptual and environmental determinants (Kleinman, 1980:45). Each of these elements directly impacts upon the quality of health care available to Native patients.

PERCEPTUAL DETERMINANTS

Analysis of Rules of Conduct

All cultures provide their members with sets of rules that govern conduct and behavior. As such, "most social behavior can be best understood as the performance of acts which are governed by the rules and roles of the immediate cultural milieu, and where such rules are cognitively represented by the actor" (Forgas, 1979:8).

Where there is any interaction, people will act in accordance with predetermined rules which define "how to act" in light of the expected reciprocal acts of others. This "knowing," however, often fails to transfer effectively into medical situations. Understanding becomes displaced in those situations where the patient, for example, is automatically assumed, by virtue of symptomatology, to be "just another drunk Indian," rather than, in fact, the victim of a heart attack. Even though Blumer may write that "it is the social process in group life that creates and upholds the rules, not the rules that create and uphold group life" (1969:19), I would argue that the attending emergency room physician, in the situation depicted above, not only controls the immediate environment, but also establishes criteria for treatment in accordance with his perceptions. In other words, if the clinician perceives the patient as being under the influence of

alcohol, he will treat him according to the equation Native individual plus slurred speech plus unsteady gait equals "drunken" Indian, until evidence to the contrary cannot be ignored.

Interactive behavior in a given environment depends on how individuals perceive that environment. Different situations or episodes determine which role an individual selects as being appropriate in a given setting. A case in point is when health-care providers lament that Native patients are reticent to engage in dialogue, let alone discuss those "sensitive" topics regarding the functioning of the body. For the Native patient, the clinical setting is not socially appropriate for this type of discussion. Native patients become very uncomfortable in a situation where they perceive themselves to be at a social disadvantage.

The patient always brings something with him from his cultural background that will define the way he perceives his relationship with the physician. This intangible will facilitate or impede the interaction and communication between the two parties. Each actor is involved in a process of social interaction, whether they be patient, family or hospital staff member. Moreover, each brings into the relationship a set of perceptual expectations which can become distorted anywhere along the line of communication between staff and patient (King, 1962:308).

Distortions in perception are normal, however, "because the assumptions about and modes of explaining illness vary across groups" (Fabrega, 1979:25). Culture plays an important role in this process as it orientates the individual in dealing with an illness crisis. "...Illness is a symbolic entity, the meaning of which is given by the medical taxonomy of the group" in question (Fabrega, 1979:38). In addition, "...illness constitutes a behavioral alteration that is physiologically and chemically grounded but socially and culturally conditioned" (Fabrega, 1979:47).

Social Psychology of the Group

I agree with Blumer when he states that "the premise of social psychology is that group life is the setting inside of which individual experience takes place..." (1969:102). However, the life experience that the individual brings into a social interactional setting cannot be negated. One does not simply discard, *holus-bolus*, previously held values and beliefs as one adopts new ideas. In other words, cognitive mapping overlaps incoming information without obliterating that data already held in long-term memory. A gradual modification takes place, for after all, group life consists of a network of stimulus-response relations, and is based on interaction between individuals. Or, as Blumer would say, human association consists of two human beings interacting with each other (1969:104, 108).

This group life is based on a community's social organization, which is revealed in the rules of conduct that govern people's behavior in public places, as well as in private settings. Specific acts of conduct are judged as proper or improper by the specific social groups involved (Goffman, 1963:3-5). The concepts of approval that a community assigns carries with it (Goffman, 1963:6-7):

> 1) The strength of approval for upholding a rule; and
> 2) the consequence of failing to uphold a rule. Both refer to classes of acts. Freedom of choice within a class of required conduct may blind the individual to constraint regarding the class as a whole.

These rules become blurred within the clinical setting of the Western physician and the Native patient, because of a "perceived" difference in power. Whenever there is a power differential between two parties, real or imagined, the more favored and dominant group, e.g. physicians, has more freedom to cross barriers of conduct than has the less favored Indian. This sets in motion the artificial construction of social barriers, which social anthropologists have

described as distancing mechanisms. What is missed is that in this process physicians isolate themselves from the patient's interpretation of the illness episode. McCall and Simmons clearly illustrate this paradox when they say that (1978:26):

> An important feature of social boundaries is that they face in two directions: Not only do they prevent us and those very much like us from moving out of our social spheres to interaction possibilities beyond, but they also prevent many categories of dissimilar people from entering the sphere we inhabit.

All social boundaries exhibit Janus-like characteristics: They affect not only WHO we are likely to interact with; they also constrain, in very real terms, WHAT we can do. Over time, they also lead to the development of stereotypes.

The Marginal Position of Natives

The paramount feature which appears to separate Native individuals within this study from their local health-care providers is that they occupy a position that is marginal to the dominant non-Native group. That is, they inhabit that no-man's-land of "not-belonging." They are regarded as being inherently different; as being somehow apart; in short, as the outsiders.

But, different from what? Apart from whom? Outside where? These criteria of differentiation are elusive because they are dependent upon a deceptively simple, two-dimensional geography of social structure--upon the assumption of fixed boundaries. There is an obvious logical slippage in all this, for these boundaries are not real, in the sense of being measurable, especially that junction between the "me" in here and the "you" out there. However, the "we" feeling, that sense of group cohesion, is promoted by a homogeneity of membership. The more alike members feel they are, the easier it is for the group to acquire a sense of unity.

The socially and economically marginal situation of the Dakota Sioux is inherently stressful and a source of much anxiety. People living under these conditions are more prone to create self-directed symbolic threats, such as the belief in "bad medicine." Consequently, the dual problems of poverty and discrimination faced by Indian peoples may contribute to the initial onset of disease and its progression and severity by restricting access to medical services. In this way, economic and social factors interact with cultural ones to produce poorer health conditions among Native populations than in the surrounding non-Native communities. This discussion of perceptual determinants is necessary in understanding not only the clinical encounter between clinician and Native patient, but more importantly in penetrating the existing social relations within Hospital District #10.

THE RESERVE: HISTORICAL PARAMETERS

The Dakota Sioux in Canada

The original presence of the Dakota Sioux in Canada predates the establishment of the International Border by several hundred years. As a nomadic group following the migration patterns of the plains bison, the Dakota Sioux travelled as far north as the Interlake district of Manitoba, and as far west as the foothills of Alberta. With the demise of the large herds of bison and the territorial expansion of White settlers westwards throughout the plains region, these Native peoples were forced into a defensive position. This encroachment onto their traditional hunting grounds inevitably brought them into direct conflict with the military forces of the United States.

As a result of two major military campaigns during the 1860s and 1870s, the Sioux fled to "Grandmother's Land" (Canada) where they sought refuge and protection from punitive retaliation at the hands of the United States Army. This

relocation was intensified following the Battle of the Little Big Horn in 1876 when the Sioux, under Sitting Bull, though half-starved and frozen, were able to escape their pursuers.

The Development of Canadian Reserves

There are currently eight Sioux Reserves in Canada, four located in Saskatchewan and four in Manitoba. The composition of today's population of Sioux is primarily Santees and Yanktonais, with a small group of Teton Sioux (Hunkpapas) living in Saskatchewan. Even though the Canadian Sioux are not Treaty Indians, they have much the same status.

The present location of the Oak Lake Dakota Sioux Reserve #59 was established in 1877 after the community was relocated from the Turtle Mountain region (Howard, 1984:31). This is the smallest of the eight Sioux Reserves in Canada, being only four miles square. As of 1984 the population stood at 320 persons, a small portion of which has relocated to other communities. From historians we hear a great deal about the demise of the Indian on the Northern Plains. Spicer, however, has recently stated that "both the population and the number of Indian ethnic groups are about the same as they have been for the past 200 years" (1982:103).

Divisions within the Sioux Nation

There are three major divisions among the Dakota speaking peoples: the Santees, the Wichiyelas (sometimes called Yankton), and the Tetons. During the late 1600s, all three groups were living around the headwaters of the Mississippi River in the Mille Lacs area of Minnesota (Spicer, 1982:107). As a result of the "Minnesota Uprising" of 1862-63, many of the Santee Sioux retreated into Canada. These peoples were the ancestors of the Oak Lake Sioux community. According to Howard (1984:24), the band composition of today is primarily Wahpekutes; however, there are also Wahpetons, Yanktonais and Sissetons

present. In the course of my interviews, very few of my informants named their band affiliation, which is not surprising for the Dakota Sioux maintain that non-Natives would not appreciate the historical significance of band affiliations.

Subsistence Patterns

The traditional mode of subsistence revolved around the hunting of bison, accompanied by fishing, gathering and hunting small game. Today, however, the economy of the Dakota Sioux is primarily based upon limited employment through the Band Council Office and welfare checks from the Federal Government. They can no longer hunt in the area, as most of the local farmers have fenced off their fields and posted "no trespassing" signs. This act has effectively prohibited hunting by anyone, including Natives. This is a recent change, according to several of my informants, that has resulted in resentment on the part of the Reserve community. Indians now fear being shot at by farmers if they do attempt to hunt on controlled lands. Fishing is also a way of the past, as the Sioux have no easy access to Oak Lake. Even if access were made available, the lake is experiencing high algae and pollution levels together with dam building, which has lowered the water table, resulting in a paucity of edible marine life. There is a small creek running through the Reserve, but it is not very productive, yielding only a few fish.

The Band Council attempted to raise cattle for a few years as a means of securing a stable income for the community; however, the soil on the Reserve was found to be so poor that intensive grazing became impossible. The project was terminated, and the cattle were sold at auction. The condition of the land is not suitable for raising crops either, as it is very sandy and rocky. Paradoxically, other soils in close proximity to the Reserve yield excellent crops. The question must be raised as to why the Sioux were originally placed on lands known to be

non-productive. During the past several years, even the meager kitchen gardens which were planted by individual families were soon decimated by a combination of drought and grasshopper infestations.

These conditions result in the residents being dependent on outside sources for basic subsistence. The Reserve is located approximately 20 miles south of the Town of Virden, and 8 miles north-east of the Village of Reston, making the acquisition of food goods and staples both time-consuming and difficult, particularly during the winter months. There is a small store located on the eastern edge of the community where many residents procure their essential supplies. This, however, is a very expensive alternative for the Reserve community for the goods here are grossly overpriced and inferior in quality to those available in the stores of Reston or Virden. The questionable "benefit" for the residents of the Reserve lies in the availability of "credit" from the store owner. Unfortunately, this credit soon becomes a heavy burden as the Sioux inevitably find themselves getting deeper and deeper into debt. Turning over the majority of their government checks every two weeks to the store owner, they are left with very little to spend on other necessities of life. This vicious circle of debt/dependence has direct implications for the Natives' sense of self-worth and self-image.

Environmental Issues

While the importance of sociopolitical and environmental issues are recognized as crucial variables in health-care delivery services, they are not specifically addressed in this study. This does not mean, however, that these items were intentionally neglected during this research, only that the focus of research was not directed towards these topics. For example, one crucial environmental factor is the supply of safe and clean water to the residents of the Oak Lake Dakota Sioux.

Between 40 and 50% of the homes on the Reserve are without running water. Consequently, water has to be stored in tanks, these being refilled twice a week by a local water truck. Many homes are without indoor washroom facilities, necessitating the use of "outhouses" during all seasons of the year. Homes that are approximately one year old have sinks, toilets and piping installed for water hookup; however, the main services have never been installed to utilize these facilities. The useless conveniences sit in mute testimony to the indifference and insensitivity of the Federal health authorities.

As of 1985 the community was served once a week by a Medical Services nurse from Brandon. She currently takes water samples from local wells and tanks three to four times annually. This is done to test for levels of bacteria that would indicate fecal contamination. I was unable to procure the test results from the Medical Services office in Brandon, and I am unaware of this information being relayed back to the Chief and Band Council.

A cursory review of the Hospital Claims Data Sheets for residents of the Oak Lake Band for 1984-85 reveals a high incidence of acute bronchitis, viral upper-respiratory tract disease, pneumonias, and gastroenteritis (see Appendix D.) This information, freely available to the public through the Manitoba Health Services Commission, clearly indicates that many of these disease states are linked to inadequate water supplies. The group most at risk are children between the ages of 6 months and 10 years of age.

It is well established in epidemiology that conditions favoring the spread of infectious disease will vary depending on the causative organism involved. However, there are some common criteria. The spread of almost all infectious agents is favored by overcrowding, inadequate sanitation, and poor personal hygiene, all three of which are "normal" living experiences for the residents of the Reserve.

It is, for instance, common to find three generations of a family living under one roof. This is not a situation of choice; rather, it is a reflection of the inadequate housing supply available to members of the Oak Lake Band. It is not unusual to find ten to thirteen members of an extended family living together. If, as commonly is the case, the group has to rely on the water truck for twice weekly fillings, then it is apparent that there will, at times, be insufficient water for the entire family. The occupants have no choice but to practice water rationing in order to accomplish the bare minimum of daily tasks.

These tasks include cooking, laundry, bathing and general cleaning of the living quarters. Cooking is an activity that will take precedence over the others. What happens, however, when there is insufficient water to cleanse, and hopefully disinfect, the utensils? If a salad is prepared in an uncleaned pot that was previously used to wash a freshly killed fowl, the end result may well be an outbreak of Salmonellosis in the community.

Medical science's most outstanding achievement in human ecology has been its victory over the infectious diseases. The poor living conditions on Reserves contribute to current-day health problems, and this issue has not been adequately addressed in health-care programs for Natives. Poor nutrition, substandard housing, etc. all result in a reduced immunity and tolerance to pathogenic bacteria and viruses. These "third world" living conditions are a normal part of Reserve life, which unfortunately impacts upon the group least able to resist the effect of disease--the children of the community.

This emphasis on water conditions is not to suggest that it is the only variable involved in the disease states of Native patients. However, it is an example of a crucial element in maintaining good health in any given population.

Cultural Adaptation

Each Reserve community represents different cultural adaptations, based on its own historical circumstances. As such, "each represents a unique expression of contemporary Indian life" (Grobsmith, 1981:37). One element of importance that is demonstrated by the Dakota Sioux involves kinship. Family ties are important, and are the mechanism through which each individual is connected to another. This allows for a certain degree of interdependence and emotional security. To illustrate the importance of familial ties, Devereux writes in his classic text (1951:50):

> Among Plains Indians, and among many other Indian tribes as well, children were habitually raised by their grandparents. This fact presumably strengthened emotional bonds with the tribal past.

This practice continues today. Indeed, many informants stated that a major reason for their dropping out of school was to be able to stay at home with ailing, elderly grandparents. They report that "after all, my grandparents took care of me when I was small, now it is my turn to look after their needs."

Members of the Oak Lake Dakota Sioux Reserve maintain a proud tradition of having been an independent people, in origin at least. Today the Reserve community serves as a reference to the idealized past. It is a symbol invoked by a people who share a common historical style, based on overt features and values. Through the process of interaction, each member of the community internalizes that common identity. This requires continual avenues of validation in order to maintain their role-identification. This is a central function of the pow-wow celebrations held every summer, as well as other more sporadic ritual events.

One feature that separates the Dakota Sioux from the surrounding White communities is the extent of social change to which they have been exposed. In this sense, social change refers to any alteration in the social arrangements of a

group or society. As a response to a wide variety of social conditions, and in reaction to an externally imposed culture, the Dakota Sioux have developed their own unique "ethos"--their own sense of "self" and identity.

MEDICAL SERVICES: HISTORICAL PARAMETERS

Structure and Administration

The major funding agency for Native health lies within the jurisdiction of the Federal Government, which in itself presents a major contributory problem that is only briefly covered in this paper. However, the day-to-day delivery of health-care services to Native patients rests with the Governing Boards of local health facilities which are in turn funded by the Province of Manitoba through the Manitoba Health Services Commission.

Though it is important to remember that this research examines the contextual nature of the perceived, as well as the actual, cultural disparities between Dakota Sioux patients and their Western health-care providers, it is equally important to recognize that it is descriptive of an ongoing dynamic process. Thus, there is a salient, self-evident need to develop more "appropriate" health services and medical care for the local Native population, whose members differ culturally from those who currently have the professional responsibility for the provision of these services.

One possible political strategy would be the transfer of responsibility for health-care to the Dakota Ojibwa Tribal Council, and eventually to the local Bands. "Appropriate" care, however, remains a central issue of concern. This is due to the fact that primary causes of poor health for those living on Reserves today hasn't changed much over the past fifty years. Unemployment, malnutrition, housing and sanitation problems are all issues of major concerns to the Native residents, and impact directly on the state of their health. That the

Dakota Sioux wish to assume self-government within the context of health is clear, for they state (Dakota Ojibwa Tribal Council, Health Position Paper, 1983):

> It is time that the Indian people themselves arrive at an alternative method of health and health care delivery, for we must determine and control our own health care system, in order for it to work effectively. We, the Indian people of the Dakota Ojibwa Tribal Council, thus assert our aboriginal, treaty and constitutional rights to health care, and will have the authority and responsibility to provide the health care delivery to our people. We, as Indian people, must and will determine the course of action and future policy of our health services.

Although the full, complex spectrum of issues that disadvantage the Native population cannot be addressed in the thesis, the alleviation of health problems will have positive benefits for all sectors of Native life.

The Culture of Medicine

For the present, hospitals are the core institutional providers of health care in rural Manitoba, the management and effectiveness of which is dependent upon that delicate and complex relationship between the hospital Administration, the Board, the medical and non-medical staff and the patient population.

Typically the structure of staff composition and patient population of rural, community hospitals differ in their socioeconomic levels and familiarity with each other from that of urban facilities. To a large degree, socio-economic differences are due to the rural hospital being one of the major employers of the community, offering higher wages and status to staff members than can the farm or the shops in the Town. Moreover in rural settings, hospital personnel tend to be more homogeneous than those in urban hospitals. The majority of staff in rural facilities are most likely to be long-time residents of the area, perhaps even born in the local community.

The hospital setting, like any other, strives to achieve an internal consistency among its members through the development of its own culture. The

"culture of medicine" may not be reducible to a single theme, but it is still more than a catchall of diverse customs. Any culture, including that of medicine, is a set of meanings, understandings, and perceptions that are related to each other by an entire web of mutual expectations. In other words, cultural forms take on meaning and are produced within social systems. Thus, individuals encounter the world around them in systems of social relationships.

This enables people to schedule their acts relative to each other, ensuring that interaction takes place smoothly without interference or duplication. Taking the social system of a hospital as an example, one finds a high level of conscious and deliberate system planning, or "rationalization" in the terms of the German sociologist Max Weber. The entire operation of a hospital is split up into a number of discrete, often autonomous departments. Within each of these there is a further subdivision into a multitude of tasks, each of which can be done by one worker or a small team. In these divisions every worker's activities are complementary to the others', and the sum total of everybody's efforts is the completion of tasks. Any social system, though not perhaps consciously designed, first splits the totality of social life into a number of compartments, jobs, offices, or whatever and then relates these parts to each other to make a whole, working organism. Consequently, health institutions may be viewed as distinct cultural and social systems. As such, they are as readily studied and analyzed by anthropologists as are the Tiwi of North Australia.

The culture of medicine reflects all of the major contemporary societal drifts, such as bureaucratization, depersonalization, professionalization, and

urbanization (Rosengren & Lefton, 1969:5). In describing the culture of medicine, Rosengren & Lefton write (1969:71):

> Some of the main features of hospitals, seen as social systems, have to do with the attempt on the part of their participants--the patients as well as staff--to resist the depersonalization which attends organizational life.... Although patients <u>are</u> a part of hospitals, they have ranked rather low on the scale of analytic priority. They are affected by but seldom themselves affect the structural characteristics of hospitals.

All client-serving organizations, including hospitals, "...are at once the servicers and the servants of the local community" (Rosengren & Lefton, 1969:13). In order to maintain control, hospital personnel require the "...collaboration--or at least the passive acquiescence--of the client...in the delivery of the service" (Rosengren & Lefton, 1969:16). To elaborate on this theme further, Goffman informs us that (1962:323-324):

> An important way in which two individuals may deal with each other is as server and served. By exploring the assumptions and ideals behind this occupational relationship, I think we can understand some of the problems of hospitalization.... A <u>personal-service occupation</u> may be defined, ideally, as one whose practitioner performs a specialized personal service for a set of individuals where the service requires him to engage in direct personal communication with each of them and where he is not otherwise bound to the persons he serves.

The different patient populations found within hospital settings have diverse values and beliefs based on their ethnic background. This diversity must be considered in health-care delivery systems (Harwood, 198l). Otherwise, the preexisting social distance between the Western physician and the Native patient makes any effective communication difficult, if not impossible. Consequently, within the clinical setting, Native patients often fail to realize that initially--in theory at least--they have as much control over the interaction as the physician. That this rarely occurs is due to the internalized perceived differences in status

between being Indian and being a White physician. This often leads to misunderstanding as both sides attempt to come to some common ground, yet find themselves moving further apart.

For example, medical staff refer to the non-communicativeness of Native patients as being "stoic." In reality, "...the behavior of an individual while in a situation is guided by social values or norms concerning involvement" (Goffman, 1963:193). The Sioux patient is reticent to discuss publicly what he/she perceives to be a private matter, even though in the presence of a supposedly "objective" professional.

The Hospital as a Social System

Social systems are composed of social groups, links within a framework of privilege and status. With this definition in mind, the composition of a hospital is indeed a social system incorporating and exhibiting its own cultural attributes. The institution we know as "hospital" for all its segmentedness must somehow allow and accommodate the routines of hospital life. To accomplish this, hospitals must guarantee a certain stability to the social relationships among its members. In their study of hospitals as institutions, Rosengren and Lefton clarify this position by stating that (1969:52)

> ...the purpose of hierarchy is communication, control, and the centralization of information for effective decision making and for the operationalizing of central decisions.

Thus, hospital staff find it convenient to employ rules of the road for social interaction that places individual staff members within a sanctioned hierarchy. This implementation of the rules of conduct enables people to orient their acts relative to each other, thus ensuring that the process of interaction goes off

smoothly with a minimum of discord. Goffman (1967:49) details the importance of rules by stating:

> Rules of conduct impinge upon the individual in two general ways: directly, as obligations, establishing how he is morally constrained to conduct himself; indirectly, as expectations, establishing how others are morally bound to act in regard to him.

Social events within the hospital also contain elements of situation and involvement. In this case, "the term situation may be used to refer to any event occurring within the physical boundaries of a situation" (Goffman, 1963:8). The term involvement, on the other hand, "...refers to the capacity of an individual to give, or withhold from giving, his concerted attention to some activity at hand" (Goffman, 1963:43). Consequently, action takes place in and with regard to a specific situation. This action is formed or constructed by individual, or group, interpretation. "Group life consists of acting units developing acts to meet the situations in which they are placed" (Blumer, 1969:85). Such a process of mutual orientation in completing social acts is what we mean by social interaction (Hewitt, 1979:54). This discussion of rules of conduct is important in understanding the social system of hospitals, for it is only through the construction of appropriate social behavior that the primary tasks of medical, nursing and administrative staff are accomplished.

Unfortunately, this process of completing "tasks" may compromise the primary goal of patient care. That a hospital is a social institution with functions, goals and objectives is an established fact, with the major purpose being the effective treatment of patients. Within the hospital environment the patient should be the *raison-d'etre*, the ultimate end of all activity. This reality, however, is often overlooked in the pursuit of the accomplishment of tasks. Many nurses for example feel threatened by direct one-to-one relationships with patients. They maintain distance with peripheral activities, such as filling out forms and

medication orders. Anything, it seems, is less threatening than really getting to "know" the patient and engaging in genuine dialogue. This is a general problem, perhaps the most significant issue facing the nursing profession today, and not one to be fully addressed by this thesis. Sufficient that these distancing mechanisms exacerbate the relationship between the Native patient and the Western nurse.

Development of Medical Services

As previously mentioned, the responsibility for Native health is held in the hands of the Federal Government, who began their role as trustee with the signing of Treaty #6 at Fort Pitt in 1876. At that time, the Commissioners of Her Majesty, Queen Victoria, promised that a medicine chest would be provided by the government to assist the Indians when ravaged by disease.

Shortly after the signing of the Treaty, the Canadian Government established the Department of Indian Affairs under the rubric of the Indian Act. It was the responsibility of the Department to minister to the needs of all Indian people. This included matters of health. During the early part of this century, the Department began utilizing the services of travelling Public Health Nurses to service the remote Indian communities and Reserves. Unfortunately, their functions were highly restricted because of geographical inaccessibility, especially to the Northern Native settlements.

In 1945 the Department of Indian Affairs came under the jurisdiction of the Department of National Health and Welfare; however, Indian Agents for the Government remained as health officers for the Department. Also, much to the dismay of Indian peoples, other health related components, such as housing and sanitation, remained in the hands of the Department

of Indian Affairs. The residents of the Oak Lake Sioux Reserve #59 feel that this was a fundamental error on the part of Government, a pivotal event which leads directly to the poor housing and sanitation conditions on the Reserve in the 1980s.

A degree of decentralization of health administration took place in 1950 when three regional bases were created: the Foothill region, encompassing British Columbia and the Yukon; the Central region, including northwestern Ontario, Manitoba, Saskatchewan and Alberta; and, the Eastern region, covering the Maritimes, Quebec and the southeastern part of Ontario. This move on the part of Government was an attempt to make health-care delivery more appropriate to the Provinces, as well as to speed up the workings of the government bureaucracy.

The Department of National Health and Welfare established the Medical Services Branch in 1962, which was designed to handle the health affairs of Indians in the South, as well as to establish a Northern Medical Unit. By 1966 this administrative area was expanded to cover all of Alberta, Saskatchewan and Manitoba, a conglomerate known as the Prairie Region. Eight years later, in 1970, the individual Provinces became regional areas into themselves. Manitoba was divided into three specific zones : The Pas was established as the base for all of northern Manitoba; Norway House became the station for all Native peoples located in central Manitoba; and, Winnipeg assumed the responsibility for health-care delivery below the 53rd parallel. This tripartite division was created to facilitate the operation of the nursing zone officers. There was no intention to empower the separate administrative units, as this function remained in the hands of the Regional Office, located in Winnipeg (Dakota Ojibwa Tribal Council, Health Position Paper, 1983).

The programs and services offered by the Medical Services Branch cover the following areas: Public Health Programs; Community Health Nurses; Maternal and Child Health; Communicable Disease Control Program; Nutrition; Dental Health; Health Education; Drug Abuse and Alcoholism; Environmental Health; Community Health Representative Program; Non-Insured Health Services; Physician Services; Dental Services; Hospital Services; Medicine and Drugs; Optical Services and Glasses; Referral Unit; and other services, including prosthetics/orthotics and ambulance. Even with all these benefits, the Dakota Ojibwa Tribal Council maintains that the Federal Government "...is failing to provide services adequately for Indian people" (Health Position Paper, 1983:45).

A Description of Hospital District #10

Hospital District #10, located in Southwestern Manitoba, was formed in 1975 with the incorporation of the Virden District Hospital, the Elkhorn Medical Nursing Unit, and the Reston Community Hospital. The total population served by the District in 1983-84 was estimated at 8,752. The District serves the population of the Town of Virden, the R.M. of Wallace, the R.M. of Pipestone, the Village of Elkhorn, the R.M. of Archie, part of the R.M.'s of Sifton, Albert, and Woodnorth, the Town of Oak Lake, as well as the Oak Lake Sioux Reserve #59. While the Virden Hospital is the major health facility, drawing patients mainly from the Town of Virden, the R.M of Wallace and the Reserve, the remaining population of the R.M. of Wallace utilize the Elkhorn Medical Nursing Unit. The majority of the R.M. of Pipestone's population rely on the services provided by the Reston Community Hospital.

The present building that houses the Virden District Hospital was constructed in 1951-52 with a rated capacity of 32 beds. A new complex is scheduled for construction, which will decrease the actual capacity to 30 beds. The loss of a few beds will be made up for in gains in efficiency due to the

modern design of the proposed building. The current building is a T-shaped structure made of reinforced concrete to the main floor, with the main storey being constructed out of brick and tile masonry. All patient beds are located on the main floor on one long wing. At the time of this research, the hospital was served by five physicians, four of whom work out of the local clinic, and the fifth being an itinerant physician based in the Reston Community Hospital, serving the Reston-Melita area.

The Virden District Hospital is situated on the Trans-Canada Highway #1, approximately 29 miles east of the Saskatchewan boundary and 46 miles west of Brandon. The nearest medical facilities to Virden are at Elkhorn, 17 miles to the Northwest, and at Reston, 29 miles to the South.

In 1965, the Reston Medical Nursing Unit was expanded to 17 beds and renamed the Reston Community Hospital. The hospital underwent a total renovation in 1984, adding an adjacent Personal Care Home with a rated bed capacity of 20. In addition, plans are being finalized to replace the Elkhorn Nursing Medical Unit with a 20 bed Personal Care Home that will have a few holding beds for limited medical services.

During the 1970s, two Personal Care Homes of 50 beds each were constructed in Virden, in an attempt to fill the needs of the infirm elderly who could no longer manage their own residences and required a degree of nursing care. There is now also a 40 unit EPH (Elderly Persons' Housing) in Virden, designed to provide independent living accommodations within a group setting.

The increase in Personal Care Home beds in the Virden area is a reflection of the aging population of the surrounding communities. These are principally farmers who move "into town" upon retirement from their many years of active farm life. As people are living longer, these numbers are certain to increase. Southwestern Manitoba communities often have 25% or more of their

population over the age of 65 years. Elkhorn is one of the highest, having at last count over 28% of its residents in this age category. Many of the younger generation are lured into the urban centers of Brandon and Winnipeg in hopes of finding employment, thereby often permanently leaving the rural setting thus exacerbating the situation. The proximity of Trans-Canada Highway # 1 facilitates this leakage of the young out of these small farming communities. With a projected total of 140 PCH beds in the District, the area is rapidly becoming a retirement enclave.

Even with this growth in medical services and facilities, there are no elderly Dakota Sioux residing in any of the Personal Care Homes, nor any Native employee of the District. At the time of this research, one Sioux nurse's aide was being trained in the Reston facility; however, she and her family relocated to another Province. Given the population size of the local Indian Reserve, and the general lack of employment opportunities available to Native peoples, the absence of Native employees within the Hospital District is disturbing.

CONCLUSION

The Health Services Review Committee, in its recent 1985 report to the Manitoba Government, "...documents that the incidence of morbidity is substantially higher for Indians than the general population." They also note that the high health service utilization rate by Indians is a result of environmental and social factors, e.g. high unemployment rates, lack of adequate housing and poor sanitation. What the Committee fails to mention, however, is the lack of awareness and/or knowledge on the part of health providers about Native culture in general and Native belief systems of disease and illness in particular. This is a serious problem that requires immediate redress in the form of educational programs for facility staff. Other possible solutions involve setting up a clinic on

the Reserve with weekly visits by a contracting physician; improved transportation services for the residents of Oak Lake Reserve #59; and, in-service programs for Native diabetics.

In its executive summary (1985), the Health Services Review Committee laments:

> That the health of Manitoba's Indians is far below acceptable levels on any health status index is beyond dispute.... Infant mortality rates and infectious disease rates have consistently been higher amongst Indians.... Indians are hospitalized at a rate 4 to 7 times that of the general population for various disease conditions.... The incidence of otitis media and meningitis amongst Native children would be considered unacceptable in other populations. Indian and Inuit children are now virtually the only source of new rheumatic fever seen in Manitoba's hospitals. Diabetes is now considered to be an epidemic in the adult Indian population.

The Report briefly mentions that the excessive morbidity of Indians and the higher utilization rate of medical services "...may be affected by many other factors, including accessibility to services and the practices of health care professionals." This research contends that it is the actual practices and attitudes of health-care professionals that is the single major problem within the clinical encounter with Native patients. It is the relationship between the health-care practitioner and Native patient that engenders misunderstanding and within which patient noncompliance finds its genesis. Since cultural data are not included on assessment forms and treatment plans for Native patients, it is only reasonable to predict that problematic relations between client and practitioner will arise. For the clinician to achieve positive results in changing health behavior

among the Sioux patients, a knowledge of their basic belief systems is essential, for as Goffman states (1962:341-342):

> ...the patient is very interested in what is happening to his body and is in a good position to see what is being done.... One solution is anesthesia; another is the wonderful, brand of 'non-person treatment' found in the medical world, whereby the patient is greeted with what passes as civility, and said farewell to in the same fashion, with everything in between going on as if the patient weren't there as a social person at all, but only as a possession someone has left behind.

If this is typical treatment for the general population, and the experiential evidence indicates this is so, how much worse is it for Native patients? Those individual's who are perceived as "different" and "apart"? It is well documented that individuals have a tendency to turn to the comfort of things familiar when events take a downturn. For the Dakota Sioux, a return to traditional health practices, often in conjunction with Western medicine, becomes an effective means of maintaining a modicum of control in a hostile environment. This is not surprising when one keeps in mind that nearly all societies have specific roles for the diagnosis and care of the sick. "Most societies define clearly the rights and duties of those roles concerned with the treatment of disease..." (King, 1962:163).

It is therefore appropriate in the next chapter to turn to the actual interactional sequences between health providers, both traditional and Western, and the Native patient.

CHAPTER V: DAKOTA SIOUX PERCEPTIONS OF THE ILLNESS EPISODE

> It appears that in normal social interaction the cultural expectations embodied in the definition of the situation or episode are of prime importance....Forgas, 1979:64.

INTRODUCTION

Social episodes involving illness are defined here as the cognitive representations of a given cultural environment. These are interactional sequences that normally have a shared representation in a given culture. There is a commonality of understanding among individuals within the culture about what constitutes an episode, its primary characteristics, and the norms, rules and expectations that apply. Within a culture the actual designation of health status is shaped by factors both intrinsic and extrinsic to the individual. Intrinsic factors involve perceptions that hold cultural validity as opposed to extrinsic factors which are superimposed by the medical community, whether biomedical or traditional.

In order to illustrate the perceptions held by the Dakota Sioux with regard to illness episodes, a presentation of case studies within categorical themes are offered together with interpretive comments. The categories presented naturally cluster into significant areas of concern to the Dakota Sioux as a community. These problematic areas are almost always dichotomous in nature, and are ubiquitous throughout the reported transcripts. Examples would be the polarities

of traditional versus biomedical healing practices; bad medicine versus good medicine; trust versus distrust; insider versus outsider; and, dissonance versus harmony.

The following analyses are offered in an attempt to develop a map of the cultural landscape of illness episodes represented in the reportages of Dakota Sioux patients. To accomplish this task, all of the following information has been obtained from the Dakota Sioux men and women who took part in this research. Secondly, wherever possible I let the Sioux speak for themselves about their responses to illness episodes, and these will be indicated by a triple star (***) at the beginning of each account. I am particularly interested in this section in how the Sioux perceive themselves in the sometimes perceived unjust world of the white community around them.

SYMBOLIC ILLNESS

Sioux concepts of illness differ from the biomedical taxonomy in that the Dakota Sioux do not share that historical base of scientific medicine, germ theory, etc. that gave rise to the notion of "disease." The biomedical approach has been defined by Engel (1977:130) as follows:

> The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model...only requires that disease be dealt with as an entity independent of social behavior....

On the other hand, the Sioux do have an extensive set of beliefs and practices which have deep roots in their own history. These are linked to the social structure of the group, and to the social behavior of the individual, both of which arise from aboriginal concepts of etiology. For example, illness may be caused by bad spirits--and the spirits are bad either because they have not been

properly appeased, through prayer or tobacco offerings, or because some evil person has manipulated them through the use of "bad medicine." As several informants noted when commenting on why individuals become ill:

> *** Sometimes I think it is bad medicine. You know, you wouldn't think these things would happen today, but they still happen. Some people say, oh that's in the past. But, I don't think so. You have to watch yourself. It's not nice to say, but it's true. You have to watch how you treat other people in order to avoid bad medicine. From what I've learned, and what the elders have passed on to me, most problems that the individual faces is bad medicine--like, someone doesn't like you and wants to get rid of you, well that's when you'd have to see the medicine man.
>
> *** I have a story about a member of my family. He was having trouble with his throat and he couldn't swallow. He went to see the doctors in Melita, Reston, Virden and Brandon for tests. After visiting all these different doctors, he was referred to Winnipeg for further testing, but they didn't come up with anything at all. He continued to lose weight. He lost about 75 pounds in three months. He couldn't sleep, and he had bad dreams that would keep him awake at night. He was seeing spirits in his dreams. You understand what I mean? People would come and talk to him. These were people that were gone a long time ago. They were always bothering him. The family finally talked him into seeing the medicine man. We never thought he would go because he didn't believe in the old medicine. He used to laugh about it whenever I would mention Indian medicine. I told him he shouldn't laugh about

it because he's Indian too. So, he had to find out the hard way, by getting really sick before he finally saw the medicine man who comes up from Rosebud in the States. First, though, he saw the medicine man from Sioux Valley who told him it was too late--he was going to die. He told him, you should have come to see me earlier, now there's nothing much I can do for you. So, his sisters brought him home. They felt so sad that he was going to die, and after thinking about it, they asked the medicine man from Rosebud to come and treat him. This is a very powerful medicine man, and he told him that he wouldn't die. He told him that in a few months he would get his health back and be well again. After seeing the medicine man three different times, a healing ritual was scheduled during which time the medicine man sought the assistance from the spirit helpers to make him well. Anyway, the reason he couldn't swallow was because there was an eagle feather stuck in his throat, which the medicine man pulled out. It was a small feather, all covered with blood and stuff. The medicine man said it was the result of "bad medicine"--someone was jealous of him because he was the alcohol counselor for the Band at that time. Somebody was envious of him and had another medicine man send the bad medicine by placing an eagle feather in this throat, making him very sick. Everyone had noticed how much weight he had lost and how bad he looked. I told his brother to take him to the medicine man for help. Now he believes in Indian medicine--that's good. So, that's the way he got cured.

*** I took my daughter because she was having bad dreams and headaches. We saw the medicine man from Rosebud. He was at Sioux Valley visiting his grandmother, so I took my daughter to him. The first thing you do is to give him some tobacco and 1/2 yard of red material, and when you go and see him, you give him the tobacco first and tell him why you are there. He knows already that you are coming and why, which is surprising, eh? You don't ask, "Can you help me." You're not supposed to say that, because the medicine men don't like that. When my daughter's headaches started, she was seeing the doctors in Virden. They kept telling her she was suffering from migraines. But, she kept getting worse every day, and I was getting worried about her and said to her one day, I'm going to take you to the medicine man. She said O.K. if that's what I want to do. So, I went out and bought some tobacco and red material. Maybe you can buy him a blanket, but you never offer money! So, I took her to see him. She was scared because she'd never been to a medicine man before. When we got there, he was not at home, so we waited around for him to return. His car was there, so we kept knocking on the door, but there was no answer. So, we went to his sister's place, and she said that he was at home. She told us to wait a minute and she would call him. She phoned him, but there was no answer. We went back, and he was home. He said he had someone there that he was treating, and that's why he didn't answer the door or the phone. He went and got his stuff, and then he did his sweetgrass ceremony. He told us to all sit down--me, my daughter, and my daughter-in-law. It's kind of scary. He uses an eagle feather when he doctors people. He knew

right away what was wrong with my daughter. She had a really bad headache when we went in, and he was doing something to her head with the eagle feather, all the time singing and praying. After he was through, he asked her how her head felt. She said the headache was gone. The medicine man told her the headache was caused by way back in time when our ancestors were around. They had broken taboos of some kind, and now their trouble was in my daughter's head. She was being punished for something the ancestors did. I had told her that before, but she didn't believe me. She was surprised when the medicine man told her that, which was good. After that she never had a problem with headaches again.

*** I had to take my daughter to the medicine man once. Someone had stolen her purse, and she was really upset. In our culture, when you lose something that you treasure, such as money or gold, our old people say that O.K., but when you lose a loved one, you'll never have them again. So I told my daughter, we can buy you another purse. I told her not to worry about it, but no--she couldn't sleep at night. I told her I was going to take her to the medicine man to see what he thinks. I took her, and there were a lot of people there that night. He doctored her, and he knew right away who took the purse. He said where she could find her purse, minus the money that was in it. The medicine man told her that the two people responsible for the theft would tell her they did it sometime in the future. He said it was the result of "bad medicine," because someone was jealous of her job.

*** I never used to believe in Native medicine, or anything to do with traditional Indian ways, until last year. I was having this terrible time swallowing food, so I went to the doctors in Virden. They couldn't find anything wrong with me, and sent me into Brandon. They sent me into Winnipeg for further tests, but nothing was found. My family convinced me to see the medicine man, and I did. I almost died. I had lost over 80 pounds, and was really sick and weak. The medicine man cured me--it was "bad medicine."

*** I had a sore throat that wouldn't go away. The doctors in Virden couldn't cure it, so I went to the medicine man. He performed a healing ritual during which time he pulled a really small eagle feather out of my throat. He told me it was sent from the States by another medicine man. Some people didn't like what I was trying to do here as a counselor--they were jealous. The medicine man that cured me told me that in the Indian way, these people went down to the States and had the other medicine man practice "bad medicine" on me. He got out that feather, and there was some black stuff all over it. It was like black jelly. The medicine man told me that was the bad medicine.

*** If you go and see the modern doctors in the clinic in Virden, or the hospital in Reston, and they can't find anything wrong, but you know what is the matter--that is when you go to see the medicine man. The cause is almost always "bad medicine." I see a lot of

that stuff happening today. There are times I want to tell my white friends, but I don't think they would understand. I don't like it when people outside make fun of our ways.

*** Some illnesses, you go to the modern doctors--you know, in Virden or Reston, and the illness goes away with the right type of medicine. But, other illnesses can't be treated by the white doctors. Like with me. I went to Dr. A in Virden, but he couldn't help me. So I decided to go to our own healer. Even I had trouble believing in what he was doing. You know, even though I am Indian and use a sacred pipe at home and pray every night, the ways of the medicine man are so different from the white doctors. I used sweetgrass. Maybe that is why the healers medicine worked and I got better. I just know one thing--it worked.

*** If the sickness is a major thing, you go to the medicine man by yourself at first. Later when he does his healing, it has to be with the whole family present. So, you end up with a large group of people. This is especially true when it is because of "bad medicine." From what I've learned, and what the elders have passed on to me, most problems that the individual faces is because of "bad medicine." Like, someone doesn't like you, and wants to get rid of you--well, that's when you'd have to see the medicine man. Otherwise, you are dead. You have to go through the rituals and prayers and songs to get well and throw out the "bad medicine."

One can see from the statements above that for the Dakota Sioux the locus and danger of "bad medicine" usually rests within the evil thoughts of others, especially when envy and jealousy are present. In other words, not only behavior, but "bad" thoughts have power to cause illness in an individual. In addition, a major characteristic of the Dakota Sioux belief in "bad medicine" is that illness may not immediately follow the infraction of a cultural prescription. Instead, the effects may not be felt for days or even months. The beliefs of the Dakota Sioux regarding this phenomenon cannot be dismissed as mere superstition. They are real and have a profound meaning for the believing individual. This is where the power of belief systems comes into play, for the potency of "bad medicine" lies in the believing. If one acknowledges this cultural tenet, cure can only be found with the help of a powerful medicine man and his spirit helpers.

Clearly, there is no one, typical symptomatic pattern "caused" by bad medicine. However, illness episodes which involve individuals holding positions of prestige and/or paid employment within the community appear to be more common, and it is these individual who are more prone to the effects and power of bad medicine. It should be noted, on the other hand, that in a number of the reported occurrences, patients were taken to the medicine man only after consultation with the local physicians in Reston, Virden and elsewhere. It seems that causality is recognized only after the fact. In other words, when other possible sources of the illness are ruled out, the concept of traditional etiology gains credence.

The conceptual framework within which traditional Sioux medicine is located maintains that illness is caused by the intrusion of either a real or symbolic object into the patient's body. This is usually in the form of an eagle feather--an object held in reverence by the Dakota Sioux. The eagle belongs to

the "Powers Above," including the Thunderbirds, hawks, swans and lesser birds (Howard, 1984:100). This ideology of causation differs from "germ theory" or "systems error" offered by the biomedical model.

In the case of infectious disease, the best evidence that biomedicine offers regarding the capacity of microorganisms to "cause" disease is reflected in the fact that an individual's general good health helps to maintain the body's natural resistance to disease. This finding arises from the fact that many organisms that "cause" disease coexist with the healthy organisms as commensals. For example, among bacteria, *Staphylococcus aureus* is a common opportunistic pathogen that takes advantage of hospitalized patients with lowered immune states who are already in a weakened condition. This bacterium, a normal inhabitant of the skin and mucous membranes, very rapidly develops phage-types of resistance to the common antibiotics. Eradication is often difficult once it has become associated with an infection. It readily spreads from person to person. It has been estimated that between one and 10 percent of hospitalized patients will develop nosocomial *Staphylococcus aureus* infections. Thus, it is often incorrect to say that a given organism is the sole "cause" of an infectious disease. Clearly, factors other than the presence of a given organism determine who develops disease and who does not.

Similarities do exist between the concepts of bad medicine and germ theory, however, for in both the forms of causality are invisible to the naked eye; both entail illness in one form or another; and, both can be treated, if not cured. The difference appears to lie in the eye of the beholder. That is, those who believe in one particular medical system over another are more prone to extol the efficacy of that system in terms of "perception." We are not measuring statistics here, but rather comparing different perceptions--difficult variables to quantify.

Pragmatically, what must be brought into this discussion is the presence (or absence) of medical systems available to any given community.

THE PRESENCE OF TRADITIONAL HEALERS

It seems reasonable to assume that it is the meaning which an individual assigns to the context of an illness episode which is the most important factor affecting his behavior. In addition, since symptoms are rarely unambiguous, and as individuals differ in their interpretation of the costs and sometimes rewards of becoming "sick," the assumption of a sick identity involves a process of negotiation between the person, those surrounding him and the individual filling the healing role (Strong, 1979).

In the case of the Dakota Sioux, the role of healer is not filled by any one individual, but is a position shared by both Western physicians and traditional healers, or medicine men. It is not so much a question of either/or in the utilization of medical services, as it is what shall be the utility gained from each specialist. The Western biomedical physician is sought because of the perceived power of scientific medicine, particularly in regards to the use of antibiotics. On the other hand, the practices of the traditional healer enable the Native patient to understand the basic cause of the illness in question; that is, to place the understanding within a Native context. Put another way, biomedicine asks the question, "How did I get sick"? Traditional medicine asks the more profound question, "Why did I get sick"? There is a wide gulf of meaning and expectation that is exhibited in this dichotomy of How and Why.

As is typical throughout the world where traditional healing systems are found adjacent to modern biomedical facilities, patients will avail themselves of both systems, often simultaneously. This next section will, however, concentrate upon the presence and utilization of traditional medicine by the residents of the Oak Lake Reserve.

The Sioux Medicine Man

The single most important factor in Native healing uncovered in this research is the Sioux medicine man's belief in the effectiveness of his cures and the accuracy of his diagnoses. Several Sioux informants, when encountering traditional medicine directly for the first time, related their feelings of being scared or unsettled upon placing themselves in the hands of the medicine man. They were all told that the cure would be ineffective if they harbored doubts about the medicine man's ability to rid them of their illness.

Westermeyer (1977:98) maintains that "...efficacy does not inevitably depend upon a shared world view between healer and healed." This research testifies to the contrary, for when belief systems are at opposite ends of the healing spectrum, the effectiveness of treatment remains in doubt. If the patient does not believe in the treatment modality offered, it is highly unlikely that a full and complete cure will result. It also gives a convenient "out" for the medicine man if the cure does not prove effective, i.e. you didn't believe strongly enough in his abilities.

One essential prerequisite, then, for the effective care of the sick within traditional Sioux medicine is the patient's belief in the powers of the healer. The traditional medicine man helps to create this spirit of confidence by his application of theology to therapeutics, as well as by the secrecy and awe which surround his vocation. To pursue this further now is to anticipate a later discussion. First we must allow the Dakota Sioux to give a verbatim account of when and why they resort to traditional healers.

> *** We have about 320 people on the reserve, and I'd say there are about 50 people over the age of 65. Most of them understand a little bit of English, but they don't speak the language. Most of our elders, if they are really sick, don't want to go to the hospital. They

want to see a medicine man, and stay at home with their families. They don't associate with the white society. That's why traditional ways are important to them.

*** Today, only the medicine man knows everything about the old ways. If you have a real problem, you have to contact the medicine man from Rosebud, and he will come up. He usually comes up quite a bit in the summer. He is very young to be so powerful.

*** We don't have our own medicine man at Oak Lake, but we do have some people that are working their way up to being a medicine man, or woman. It takes a long time. There are medicine people at Sioux Valley. If the Indians can't live in the white society, it doesn't matter. We have our own culture. Like my grandparents always told me, it is hard to be Indian. I think it was easier for my grandparents. They lived the way they wanted to. They had more freedom to practice Indian medicine in their day.

*** I just recently started seeing the medicine man. I never used to cause I was scared of that stuff. My family, however, talked me into visiting the medicine man. I felt a lot better afterwards. He told me the white man's food was poisoning me and making me sick. You see, I have a white man's sickness called diabetes.

*** It is up to the individual to figure out what is making them sick. They should have a general idea before they visit the medicine man. You don't just go and see a traditional healer every day. You

more or less use it once or twice in your lifetime, and that's only if you really have to. There are many times that the medicine man will tell you to go to the white doctor. What is important is that Native medicine is better at treating the whole person than Western medicine. My family decides when we see a medicine man. For example, when my child was hurt, I only found out after going to the hospital that the medicine man could have helped her better. I mean, he wouldn't have had to cause her more pain by putting in stitches. If I had of known that then, I would have taken her to that person--that Native person.

*** I am a diabetic, so I use the medicine man--you know, Indian medicine. I don't have to use insulin, but I do have to watch my diet. I take my youngest son and daughter with me to prayer meetings at Sioux Valley for curing ceremonies.

*** The first time I came out of the hospital, I went to see the medicine man. This was because the white doctors weren't sure what was wrong with me. Oh, I had a lot of testing and saw a lot of specialists, but they couldn't figure out what the problem was. So, I went to see the healer at Sioux Valley and others. They said--wait--this is something hard for me to talk about, because I believe in it, and I don't like to talk about it to outsiders. I just don't want you to make fun of it, or me. So, well this last one was a powerful healer. He is a real medicine man, and I'm using him a lot now for my whole family. He is really helping me with my problems.

*** I was raised by my grandmother, and I've seen through her over the years what traditional healers can do and how good their medicine is. They have prayer meetings to help the sick and their families. That is good. When I was young, I was not interest in Indian medicine. But today, I know it's a good thing they are doing. They can help you. For the last two years, I've really been involved with medicine people to help me and my little girl. The white doctors say she is sick, but the medicine man tells me she will be O.K. I believe in Indian medicine, and I believe in the medicine man and what he tells me.

*** Today my health is better, thanks to the medicine man. Sometimes it just works that way. You're 100% again. So, instead of running and spending money on gas to go to the doctor in Virden or Reston, I just see the medicine man.

*** I always go to the medicine man first. He will tell me if I need to see a white doctor--like, if you have to have an operation or something. The medicine man will know, and he sends you to the doctor. But, I would always ask the opinion of the medicine man first.

***My family has seen the medicine man quite a few times. This is because we thought one of my children had other problems--you know, things making him sick besides his health or something--and, we wanted to find out. But, the medicine man said the child was

O.K.. That is, the problem was not because of the spirits. He gave me some medicine to use. The medicine man said the child just needed more attention from us.

*** I would probably go to the doctors in Virden first, and then I'd see the medicine man to see if he can help me or the kids. I usually see the medicine man from Rosebud. He's really been through a lot. Since he was young, the spirits have been after him to be a good medicine man. He's on his way now, for he is very powerful.

*** Personally, for my family--for my father and his father--we have never been involved in traditional lifestyles. We grew up in a white community outside the reserve. So, we go and see a white doctor. But, I know of a number of people that see the Native healer in Sioux Valley. We have some medicine people on this reserve too, but they are still learning. I know there is one guy that comes up from Rosebud. I think our elders today are more comfortable with traditional medicine.

*** I haven't used Indian medicine--you know, in the traditional way. No, I've never done that. Some people on the reserve still use the medicine man. That is because they have strong beliefs about that. I respect the choices that others make. I honor that.

*** I have considered going to the medicine man, but I've never really been sick enough. I do think about it though, especially when I have bad dreams and can't sleep.

*** Myself, I have never gone to the medicine man for me, but my family goes. My younger brother is epileptic, and he has seizures, so my mother takes him to the medicine man. The last time was just a few months ago. The medicine man comes up from the States--from Rosebud.

*** I don't bother with white doctors anymore. I use the healer in Sioux Valley to cure whatever is wrong with me. The white doctors really get me all confused. They said they couldn't help me. So, I stick to Native medicine. It helps.

*** My older child and I have seen the medicine man several times in the past couple of months. I go to the medicine man--not those white doctors. I figured it was something in the Indian way that was the matter with me, so I didn't bother going to those other doctors in Virden. You see, I thought I was going crazy because I was having such bad headaches. So, I went to the medicine man. We have healers on this reserve, and on other reserves near here; however, my family uses the one from Rosebud.

*** Native medicine is important to us Sioux Indians. We have one powerful medicine man who comes up from Rosebud, and there is another one who comes all the way from New Mexico. Both of these men are Sioux.

*** In the 1930s, 40s and 50s we always used the medicine man. But anymore people started going more and more to the white doctors in town. This is because we got too far away from our own doctors. You see, for a long time we didn't have a medicine man on our reserve, so--we had to use the white doctors.

*** You have to pay the white doctor, but not the Native doctor. Medical services would probably get unhappy about that! Of course our medicine man doesn't expect to get paid for what he does. If you have the spirits helping you to heal, you are there to help your own people. Years back, the medicine men always traveled by horse. Of course, today they use cars, and that takes gas and money. To help out, you may offer to fill his tank with gas after the healing ceremonies.

*** If the medicine man can't cure you, he tells you to go and see the white doctors. Most of these medicine men, though, can cure most anything--diabetes, heart trouble and skin disease. The medicine man will tell someone with diabetes to see the white doctor, but he also tells them to continue seeing him. I think that's good. That way, you have someone taking care of the illness, and

someone else keeping the spirits happy and quiet. That's important, for if the spirits are angry, lots of people will come down sick.

*** Every family on this reserve has seen a medicine man and attended healing ceremonies. They can't say they haven't. Mind you, lots of people don't like to talk about Native ways, just in case you might laugh, or make fun of us. I would bet every family has used Native medicine, and they all know about it. They know how powerful it is. That's why some people get scared--because of the power.

What these transcripts reveal is that one essential prerequisite for the effective care of the sick is the patient's belief in the powers of the healer. The voices of the Sioux in these reports indicate the continuing presence and importance of traditional healing methods to themselves and to their families.

By linking Native theology to medicine, the traditional healer is able to create a spirit of confidence among his people. This is accomplished by weaving a tightly knit fabric of the intertwined influences of human nature, culture and religion into medical practices. Through the combination of the sacred and the secular, the Sioux medicine man is able to utilize the mysterious and supernatural powers of the spirit world along with his gifts as a healer to help his people. Perhaps Hultkrantz (1980:85) has most succinctly summarized the importance of theology in Native healing. He states:

> It is obvious that the medicine man is more religiously and mystically gifted than other vision seekers....He possesses a stronger supernatural power and generally has access to more helping spirits than other visionaries. Above all, he can cure the sick. This in itself indicates his control of extraordinary supernatural power, since healing often requires the highest mobilization of all physical and psychic resources, visionary insight (clairvoyance), ecstatic disposition, ventriloquism, dexterity, and gymnastic fitness. We may add one more characteristic of the medicine man: he uses his supernatural power for the benefit of society....It is his calling to sustain the community in its entirety and on this sustenance his social prestige and his political power are established.

In addition to his religious powers, the medicine man is empowered by a sense of magic and deeply-held respect by the community. The assemblage of these three elements makes for an atmosphere which is dynamically charged, for it addresses not only the physiological state of the patient, but the psychological needs of the individual as well. In fact, it may be cogently argued that belief systems act in given ways out of psychological necessity. This does not deny that these very systems may be structured by external circumstances, forcing their shape to adapt to outside pressures.

There is confusion within the anthropological literature as to the classificatory difference between a medicine man and a shaman. The term "medicine man" is a Western taxonomy devised by the French Jesuits in the seventeenth century (Hultkrantz, 1980:84). This was a title given to individuals who possessed healing capabilities. In Sioux, however, a "medicine man" is a *wakan* man--an individual who has access to supernatural powers when engaged in healing activities.

One major characteristic of the medicine man is the fact that "...he uses his supernatural power for the benefit of society" (Hultkrantz, 1980:85), not solely in the art of healing. In light of this responsibility, the *wakan* man of the Dakota Sioux attains the status of shaman--one who can establish direct contact with the

spirit world. This is in direct opposition to Hultkrantz' position on using the term shaman in place of medicine man (1980:85-86), and is supported by the Sioux conception of guardian spirits attained through vision quests that lead an individual into the realm of medicine and religion. Thus, it would be an epistemological error to deny the Sioux healer the title of shaman.

The Use of Herbal Medicine

Now, as in the past, the Dakota Sioux have within their presence practitioners of herbal medicine, the knowledge of which is held in the hands of the medicine men. Some of the elders within the community acknowledge that they know which plants to use as medicinals, and how to prepare them. However, the majority in the community commented that they did not have the training to prepare traditional medicine. On the other hand, a number of informants gave evidence that at least one member of their family still retained the required knowledge and necessary skills. The importance that traditional medicines have for the Dakota Sioux is demonstrated in the following excerpts.

> *** Sometimes you have to get the medicines from the medicine man, but other times you can make it up yourself. But, each illness is different. Each one needs a different medicine. One medicine man might make up a whole batch for you to take, and another might mix the dry parts and tell you how to add the water or other liquid.

> *** Preparing medicine is a special knowledge. Well, I know there are a lot of people who don't believe in Indian medicine, but I also know a lot of people are coming back to the old ways and the medicine man.

*** For colds and the flu I treat myself. I prepare my own medicines--you know, Indian medicine. I never go to the white doctor for those things.

*** I don't prepare my own medicines because I can get them from a person here on the reserve. If not, I go to the medicine man at Sioux Valley, but he is still in training. Curing is a gift. Not everybody is able to cure others. All Indian medicine comes from the ground--from roots and other growing things such as plants and trees. I believe that Indian medicine is the only medicine that can cure Indian sicknesses. White doctors don't know how to treat Indians when they fall sick, because these are usually Indian sicknesses which come from the spirits and the ancestors.

*** The medicine man usually tells me how to make my medicines and when to take it. I don't know how myself. I do have members of my family who can make up special medicines for colds and arthritis, but not spirit sickness.

*** I think most people get their medicines from the medicine man. At least I do, because I don't know how to fix them myself. I know some of the plants, but not enough.

*** Whenever I have a cold, I mix up a medicine--it's like a ginger root--you boil it and then drink it. It works every time. My cold goes away along with my stuffy nose and sore throat. My father taught me how to make this medicine.

*** Most families know how to make the everyday kind of medicines, such as for colds and stiff joints. But, if it is really serious, then you go to the medicine man. He makes the medicine for you, and tells you when to come back. It is just like the doctors in Virden--you have follow-up appointments with the Native doctor too.

*** The younger generation doesn't know how to make Native medicine, but the older people, yes, they how how. The younger people are starting to show an interest in the old ways. I think that is good. They need to learn from the elders.

*** Years back the only sickness we had was tuberculosis. Those of our people who went into the special hospitals never came back. They died. Those that went to the Native healer lived. I remember a time when my father handled medicine. He was not a medicine man, but he knew how to fix Native medicine. A lady came to him with her parents to ask for help. She had tuberculosis. Two of her brothers had died from this. Her parents ask my father for special medicine. He made them something, and if it turned clockwise in the container, the young woman would live. At that time I found it kind of hard to believe the medicine would work. That woman was so thin. She was to take three doses of the medicine and come back after three weeks for more. My father said that within a year she would be O.K. and gain back all the weight she had lost. And, she did live and gain back the weight. Why can't I learn the same "way" of healing people?

*** If I have a bad cold, I use a plant called muskrat root. That is Indian medicine. It works too. I boil it, and then I drink it. It always cures me of a cold. The elders still prepare their own medicines.

*** I usually get my medicines from the medicine man. He tells me how to make it, and what it is, and what it is for. Most people today don't know how to make the medicines, except for the elders. My boy was cured of asthma when he was little by using Indian medicines.

*** Our elders know how to take care of themselves the Indian way. But, for us younger people, we have to go to the doctor in town. If the white man's medicine doesn't work, then we will ask for the medicine man to fix us something. I buy things like cough syrup and vitamins in town, but for other medicines, you have to have help.

*** My mother still uses Indian medicine. She learned how to choose the plants or roots and prepare them from my grandmother. I can remember my grandmother visiting and telling us how to prepare skunk oil to use for sore throats and headaches. Of course the medicine man today uses all these medicines, and he knows how to make them.

These transcripts indicate that the value of indigenous health care systems is determined by their ability to remain effective and relevant over time. Indigenous health systems have diversified into generalists and specialists who

provide services to fill the gaps, uncertainties and disappointments created by the biomedical system (Leininger, 1976:13). In his discussion of traditional healing, Westermeyer (1977:97) writes:

> ...the category (of traditional healers) will include shaman, spirit or witch doctor, and herbal doctor. Their training ordinarily consists of apprenticeship to an older healer. The conceptual basis for their practice is the theological-philosophical world view of their cultural peers. Ordinarily their powers to heal stem from preternatural powers possessed by or at the disposition of the healer.

To anticipate the imminent decline and demise of traditional Sioux healers is a serious misreading of their cultural history. These healers continue to play vital roles as first-line practitioners, serving the Dakota Sioux community at large, and providing a continuity of traditional systems of belief. It is also a mistake to direct attention in the study of Dakota Sioux medicine solely upon the pharmacologically active components of herbal remedies. By doing so, we ignore the source of their continuing power. The enduring value of Sioux medicine lies not only in its physiologically active properties, but also in the context of its application.

PROBLEMS FACING THE NATIVE PATIENT WITHIN THE WESTERN MEDICAL SYSTEM

As discussed in the earlier theoretical chapter, interaction may be thought of as a process--a series of mutually interrelated behaviors on the part of two or more individuals or groups in which each step is designed to arise meaningfully out of the preceding steps. Unfortunately, the unique interaction between physician and Native patient, with its overtones of issues of compliance, discrimination and prejudice, and arenas of dissonance and perception is fraught with difficulty and misunderstanding. Each of these topics will be addressed in this next section.

Issues of Discrimination and Prejudice

Repeatedly in this study the Dakota Sioux state that they will more often than not remain silent whenever they feel that social relationships are unclear. This is not a new finding, for Basso's work with the Indians of the Southwest reveals the same response to problematic social encounters (1970:227). This acceptance of the silent role, however, does not imply the absence of other feeling states, such as hostility, bewilderment and/or fear, and reactions of indignation to being treated as somehow "different." In addition to illustrating how inherent stress accompanies these encounters, the following transcripts detail how blatant overt, as well as covert, acts of discrimination and prejudice operate within the clinical setting involving Western health-care providers and Dakota Sioux patients.

> *** I never bother going to Virden because, you know, I've heard so many things about the doctors at the clinic and how they treat Indians. For example, some kids from the reserve had a fever--they were really sick--and people took them in a rush to the hospital in the middle of the night. The doctor got really mad. I guess he didn't like getting up in the middle of the night. He told my people the kids weren't sick--there was nothing wrong with them. This was Dr. Z. He gets pretty mad at the mothers you know. He says that they are supposed to know how to treat a sick kid, and to know when they are really sick, and when they can wait to visit the clinic during the day. But, you know, some of the mothers don't know what to do. So, I don't bother with the doctors in Virden. I go to Reston all the time.

*** I can't stand people who treat us badly. I know sometimes the doctors run behind in their schedule--their offices are just too busy. But, why is it they make Native patients wait? If you are a white person, you are in and out in no time. If you are Native you stay in there for hours--waiting.

*** A little girl that my aunt is taking care of came up with a serious problem last year, but nobody knew what was wrong with her. The doctors in Virden couldn't find anything wrong with her, so they referred her to a specialist in Brandon. The girl had T.B., which is very rare for us now. During the time before they knew what was making her sick, her grandfather walked to the police station here on the reserve to ask someone to take the child to the hospital in Virden. In the emergency room, Dr. D came and started asking the girl a whole bunch of questions, like where did she hurt. He started pushing her on the chest, and she started to cry. Dr. D got mad, picked up a box of kleenex and threw it at her telling her not to be such a baby--there was nothing to cry about. My aunt doesn't speak English, so she had to just sit there. She started crying herself. The girl was 10 years old, and she was scared of being sick, but she was more frightened of Dr. D. This type of thing is a real problem for our people. It makes you feel sad that the doctors treat Native patients that way, especially when they don't speak the same language. Dr. D was really unkind to my Aunt and the child, which was unnecessary in my opinion. I think they treat us that way because they know they can get away with it!

*** My first and last trip to see a doctor in Virden was really bad. Dr. Z just doesn't seem to care. When I would ask him a question about my child, he would yell at me and tell me it was my fault the child was ill. I didn't like that.

*** The white doctors tell me to eat special foods because I am a diabetic. Us Indians can't afford special foods. We have to eat whatever is in the kitchen cupboards.

*** A few years ago, I had to take my daughter into see the hospital in Virden. She had a fight with her husband. The nurses were very concerned, and they called Dr. Z because he was on call. He said he would be over in a little while. So we sat, and we waited, and we waited, and he never showed up. My daughter's head was bleeding pretty bad, and I was getting really worried, so I went up again and ask the nurse when Dr. Z would come. The nurses said they didn't want to call him again, for then he would get mad. So, I ask to talk to him. My daughter was in real pain, and when Dr. Z came on the phone, I told him who I was, and that we had been waiting for a long time. He gave me a really bad time. He said, 'don't you know that we doctors have to have our dinner'? By this time, we had been waiting over two hours! So, I got really mad, and asked him if he was coming or not. He said no. I ended up taking her to Melita where they put her in the hospital.

*** The Tribal Police sometimes have to take people into the hospital for treatment. Sometimes, though, we don't receive any

response from the doctors or the nurses. For example, one particular case we ended up having to drive the patient into Brandon to receive medical care. This was because Dr. C refused treatment. The patient was a girl who had been raped, and we needed proof by the doctor. The girl was a juvenile, and we needed a sperm test done, but Dr. C wouldn't do it. The Dakota Ojibwa Tribal Council was supposed to notify the administrator at the hospital to file a complaint, but nothing ever happened. The worst part is that the RCMP officer that was with me was going to take action against the doctor. I assumed that he would because he was a good cop, and I expected him to follow up. I guess he didn't bother because the girl was Sioux and not white.

*** Not long ago we had to take our baby into the hospital in Virden. Dr. A admitted the child to hospital because he couldn't breathe. The baby stayed in hospital a whole week, and then I asked Dr. A if the baby could come home, but he said no. That Friday night we get a call about 3:30 in the morning telling us to come in because the baby had gone into convulsions. My husband and I went, and we waited, and waited, and waited. Finally, about 7:00 we ask for the doctor, but the nurses said he was having his breakfast and then was going to church. We wanted to know why the baby had convulsions, but the nurse told us we had to wait for Dr. A. Well, we'd been waiting since 4:00 a.m. We wondered what time church was out, and the nurse said about 11:00 a.m. We stayed there that whole morning, and finally called Dr. A at 1:00 P.M. He was pretty upset that we called, because by that time he was eating his dinner.

He finally came to the hospital around 2:00 P.M. and said we could take the baby home. We wanted to transfer the baby to the hospital in Brandon, but Dr. A said no. He simply discharged him, telling us that the convulsions were caused by giving the baby too much medication. Even the nurses were telling us to take the baby into Brandon. So, we took him, even though Dr. A refused to give us a referral. The doctors in Brandon said the baby should not have been discharged, but kept in the hospital under observation. The baby stayed another week in Brandon. Anyway, now I don't trust Dr. A. He acted like he was mad at us because we wanted him to come to the hospital and explain to us what had happened. I think he made a mistake and was blaming us for it. You see, the medicine he gave the baby caused an allergic reaction, but Dr. A wouldn't admit that. So, he got mad at us.

*** I had a gallbladder infection once, and Dr. A gave me some pills, but they didn't seem to help. So, I went into Brandon to see the doctors there, and they gave me tests and put me on a different medicine. Dr. A didn't like that one bit. He told me that because I was Indian I probably didn't take the medicine correctly that he gave me. That really made me mad.

*** One night at about midnight, I had to take my son into the emergency room in Virden. He was burning up with a fever and in pain. Dr. Z saw him in the emergency room, and told me it was some kind of food poisoning. He wanted to know everything he had eaten that day. I told him he hadn't eaten much of anything

because he'd been sick all day. Besides, we all eat the same thing, and nobody else was sick. Dr. Z said the nurse would give him two big medicines, you know, the kind they put into needles and squirt into kids mouths. He said everything should be cleared up by 6:00 a.m., and he left. The nurse was trying to give him the medicine, but my child was all hot and crying for me. She said, 'listen here you little shit,' and she was shaking him. I told her not to do that, but she wouldn't listen to me. I phoned the next day and told the head nurse about it, but I know nothing ever happened. After all, we were just dirty Indians--that is what the nurse had called us. They don't seem to care about us.

*** Sometimes I wonder if we should bother taking our kids into the clinic in Virden. The doctors talk to you as if you don't know anything, especially if they say there is nothing wrong with the kids. But, if you don't bring them in, then the doctors really get upset with you. They will yell at you and ask why you didn't bring them in sooner. They will tell you that you are stupid and irresponsible. So, sometimes I really don't know if I should take the kids in or not, or just keep them home and give them aspirin.

*** I remember one incident that happened about my second week as a Tribal Police Officer here. I had a woman who had been in a bad accident. She had a really bad cut on the upper forehead that required medical attention. This was about 5:00 a.m., so I contacted the Virden hospital to advise them that I was bringing this woman in for medical treatment. I also gave them a brief outline as

to what the patient was experiencing, and what she required. We waited almost two hours in the hospital for the doctor. I asked the nurse what time she expected the doctor to come, and she said any time now. Then I asked her if she had contacted the doctor after I had called in prior to my departure from the reserve. She said yes. By the time the doctor got there it was 7:00 in the morning! The patient was really getting uptight, and kept asking me where the doctor was. She was getting really frustrated, and when the doctor finally arrived, she asked him why it took so long to get to the hospital. I guess this remark offended the doctor, because he turned around and said to her, 'if you're going to have that kind of attitude, come back at 9:00 a.m. when the clinic is open.' I thought he was joking, but no, Dr. Z turned around and walked out! In my opinion, with the doctor knowing that the patient was a little intoxicated, he should have been more patient and just ignored the comment she made. However, she did have a right to be upset. Why did Dr. Z make us wait so long? I didn't have a chance to talk to him because he just walked out muttering about drunken Indians. We waited a bit longer thinking he would come back. He didn't. We ended up driving the patient to Melita. By this time it was 10:00 in the morning. She was admitted to hospital right away and stayed for about three days with stitches in her head. As police officers, we are required to document the people involved in injury cases, and the times and places. In this case, everything was documented--the exact words of Dr. Z, and his refusal to see the patient. This information was then forwarded to our police chief in Brandon.

*** Dr. Z really doesn't treat us very nice. He yells at us, and tells us we are bad parents because our kids seem to get sick more often than white kids. That is what he says. He tells us we don't know how to take care of our children. That really makes me mad. Children are very special to us. They always have been. But, what do you do when you don't have enough money to buy food that is good for them, or have a warm enough house in the wintertime, or have running water to keep them clean all the time? It is really hard being an Indian mother with little kids.

*** I remember, not too long ago, one of our elders was really sick. He was in pain and was having trouble breathing. The police took him into Virden, because we weren't sure what was wrong with him. Dr. Z came to the emergency room, took one look at the man and walked away. I ran after him and asked him were he was going. He told me that he didn't have time for drunk Indians. Finally Dr. A came in and told us our elder had suffered a bad heart attack, and that he was admitting him into hospital. We were really upset at Dr. Z's attitude. That man might of died right there in the emergency room just because he was Indian!

*** If I have a serious medical problem, I usually go straight into Brandon. There is no long waiting in Brandon. They have a bigger and better hospital, and they have more doctors. Besides, they don't treat you bad because you're Indian like they do in Virden.

*** One time we had to take a guy into Reston with a severe cut on his forehead. He had been hit with a broken bottle during a fight. We finally got him into the emergency room around 4:00 in the morning. Nobody even looked at him until almost 6:30 a.m. Finally they took an x-ray about 7:30 to make sure there wasn't further damage to his head. We didn't get out of there until 9:00 that morning. I don't think it should have taken them that long. After all, we were the only ones in the emergency room all that time. It seems to me that Natives have to wait longer than other people.

*** Dr. C and Dr. Z don't even bother to tell you what it is that they are giving you. They just give you the prescription and tell you to go to the pharmacy. If you ask what it is and what it will do to you, they get really mad. They tell us we wouldn't understand anyway, so why should they bother? I don't like it when they treat me as if I am stupid or something.

*** I have some concern with the doctors in Virden. Especially with Dr. Z. He has a really bad attitude when it comes to us Indians. One time I had to take a thirteen year-old girl into the Virden hospital. This girl had been abused by her father. He had come home drunk, and he had punched her around the chest and on her face. So, she ran away from home. She went into the police station for help. I took her into the hospital because she was complaining of a sore jaw and an earache. This was after clinic hours--after supper. I took her into Virden because I know there is always more than one doctor around. I called the hospital, and the

nurse told me that Dr. Z was on call. She told me to call Dr. Z at home. When I called to tell him why I bringing the girl in, he said it was not really necessary because it was only natural that she was sore after being hit by a fist, but this was not a case of emergency. He told me to take her home and give her aspirin, or some pain killers, if I had any. I was really upset. But, what could I do? If Dr. Z refused to see her, there was no sense driving all the way into Virden. When I contacted our office in Brandon and told them about the case, they told me to write up a report. I was told the doctor would be questioned, but who knows? I never heard anything more about it.

*** A year ago I had to take a woman into the Virden hospital. It was after clinic hours--after supper. There are many times when people from the reserve have to go after hours because they just don't have the transportation during the day. When we got into the emergency room, Dr. D was on duty. When he came to see the woman, he told me that it was not really a case of emergency. His attitude was really bad. He was very rude and rough with this lady. He told her that the next time she thought something was wrong with her, she could wait and go to the clinic during the day. He told her she was wasting his time! When you continually have this type of experience with the doctors, you start to wonder why. I have the feeling they just don't like us because we are Native and have brown skin. I wonder how the doctors feel when it is a white person coming after hours? I bet they aren't treated badly like we are.

*** A few nights ago we had to take a young mother and her children into the emergency room at Virden. This was after supper, and the clinic was closed. Dr. Z was on call, and he really gave her a bad time. He yelled at her, and called her names. She was crying by the time we left. I was really upset. Why does he treat us that way? If he doesn't like us because we are Indian, then he should move somewhere else and just treat white people.

*** You know, some people are quite open about not liking me because I am Indian. One of the first questions I asked myself when I was growing up was why did I have to be Indian? The second question I asked myself was what can I do to help myself when people treat me like dirt? Once I had a doctor tell me that most Indians were alcoholic. It is a stereotype that every Indian is a drunk Indian. I can feel pain too. Prejudice hurts me just like it does anybody else. I guess Indians aren't supposed to have feelings.

*** Forty or even fifty years ago, the white doctors around here were O.K. They even made house calls on the reserve. To them it didn't matter if you were black or green or blue--they seemed to care about you as a person. Everybody was just equal. Now, most of these doctors don't treat us right at all. Let me put it this way. People on the reserve are dependent on everybody else. I found out that if you live off the reserve, you are treated differently--better. If you live off of the reserve, it is good, but if you live on the reserve,

forget it. People treat you like dirt, especially some of the doctors in Virden. Sometimes the discrimination can be pretty ugly. I've had to learn to live with it, and avoid it when I can.

*** Years ago, our kids got kicked out of the school in Pipestone. We were told that our kids were dirty and had lice. Our kids were not fit to sit in school beside the white kids. Things haven't changed. You still don't find any respect for Indians by the whites around us. They just keep calling us freeloaders, drunks and dirty Indians. But, you know, you have to look back in history. Why did we Sioux end up on reserves in the first place? There is a good reason. The whites wanted our lands, and they took everything they wanted, and then they tell us we are not able to take care of ourselves. How is that for talking with a forked tongue? The doctors today are even worse than the Indian agents of long ago.

*** I usually see Dr. A, but not long ago I had to see Dr. Z because he was the only one around. I was not too happy with Dr. Z because of the way he treated me. He was not at all friendly. He acted like he just wanted to get rid of me real fast. He was rough and unpleasant. Maybe he treats me that way because I am Indian. I don't think he treats the white people like that. I have heard other people on the reserve say that Dr. Z treats them bad too. I think he just doesn't like Indians. I felt bad towards Dr. Z, and Dr. C too. None of them treat us nicely. I've even heard some terrible things about Dr. D, especially the way he treats our kids. Not just kids, but Indians period!

*** I was really unhappy when I was in the hospital. The nurses weren't friendly at all. I felt very uncomfortable because I had the feeling they just didn't care about me because I was Indian.

*** The nurses get really mad at us when we go to visit a relative in the hospital. Once when my mother was really sick, we all wanted to be with her, but the nurses yelled at us and said only one person at a time could stay with her. We had to wait outside the hospital on the steps. The nurses told us that all of us sitting in the room with our mother wouldn't make her any better. I don't think that is right. Our mother was very scared, and she wanted us all to be with her. Maybe it's just because we are Indian. The nurses always act like they will catch something from us. That's bad, you know?

*** Years ago, the nurses in Virden were nice to us, but not any more. They are unfriendly, and they are prejudiced against us because we are Native. You can tell by the things they do, the way they treat you and the way they talk to you. They treat us like children who don't know anything. That makes me mad.

*** One thing I don't like is when I have to take the kids into the clinic in Virden. Even though I am always on time, they always make me wait two hours or more. I don't like sitting there waiting and waiting, especially with small kids. That is something us Indian people are always complaining about--waiting. The doctors make us wait because we are Indian. They see their white patients first,

even though I know my appointment was before theirs. Somebody should do something about that. It isn't fair. But, if you complain to the doctors, they tell you if you don't like it to go somewhere else. Where are we going to go? It takes an hour to get into Brandon, and who can afford the gas? The doctors in Virden know we don't have a choice. I wish we did.

*** Dr. A is my family doctor. I've had to see Dr. Z several times when Dr. A was on vacation or something. I don't like Dr. Z at all because he gave me shit a couple of times. I don't think he should have done that. He yells at me and tells me that if I'd seen a doctor sooner, I wouldn't be so sick. He really gave me shit. He even told me I was stupid. Dr. Z is too cold and uncaring, especially with us. That is because we are Indian. He just doesn't seem to care about us at all. Why do you think he treats us so bad?

*** The nurses just don't understand why the whole family wants to stay when one of us is in the hospital. This is especially true if a parent or grandparent is sick. They want their family to stay with them because they are afraid of being in the hospital. Besides, they are used to having all their family around them. The nurses get really upset. Sometimes they get nasty and say that hospitals aren't places for dirty Indians to party!

*** My grandmother was in the Reston hospital, and she didn't like the way the nurses were treating her. She felt they were being mean and too rough with her. We see that happening to our elders,

and it makes us mad. We don't treat our elders that way. We love and respect our elders for they are our teachers. The nurses treat them like shit. When my grandmother got a needle in her hip, she said the nurse just jabbed it in really hard. She didn't speak English, so she was trying to tell the nurse in Sioux that she really was hurt, but the nurse didn't understand. Our reaction was that we got mad. After that, the family decided to take my grandmother out of the hospital. We did too. We brought her home and then she was able to die in peace with all her family with her. Everyone felt better for doing that.

*** It is very hard on us when our elders die. We younger ones expect it to happen, but it is still hard for us to lose our elders. We know it is coming sooner or later, and we try to keep them at home. That is what they want. They cry if we take them to the hospital. They tell us the nurses and doctors are rough with them. So, we keep them at home.

*** Just recently I had to take my little boy into the emergency room in Virden. He had fallen off a chair and hurt his penis. His penis was all swollen, and it had white stuff coming out of it. I got him to the hospital at 7:00 P.M., but I had to wait almost two hours before Dr. C got there. I don't know why it took him so long, because I know he lives really close to the hospital. But, he was having his supper, and we had to wait. My little boy just continued to cry. Dr. C finally came and said my boy just had a bruised penis, not an emergency at all. That took him all of five minutes, and he was

gone. In the meantime my little boy was in pain and crying. I get really mad when that happens. Dr. C didn't even give him anything for the pain. He said the swelling would go down by itself in a few days. The problem is, my son's penis got infected, and then he was really sick. I blame Dr. C for that. It was his fault for not paying attention to my child. He acted like he didn't care.

*** I wish the doctors and nurses would treat us Indians like they do everybody else. Because we are Indian, we always have to wait three or four hours before a doctor will see us. We always have to wait longer than white people. Why do they make us wait so long? Dr. Z tells us we shouldn't complain, after all, Indians are known to be stoic. What do you think he means by that?

*** I don't think the doctors understand Native problems or our traditions. Maybe they don't want to. I think that after all these years, they should understand something about us. We are worried about what will happen to us when Dr. A retires. We don't like to think about it, but we have to. Who will look after us? Dr. Z? Dr. C? That scares us.

*** One time I had to go to the doctor because my head hurt. I had a sinus headache, and my eyes were all red and puffy. So, I'm sitting there not feeling good and the doctor says to me, 'Well, what happened? Were you on a tear last night drinking'? I told him I was sick. He said, 'Sure, that's what all you Indians say.' That is when I got up and walked out of his office. I don't have to take that

kind of treatment from anybody. When he said that, it made me feel so small, and at the same time, I was very angry.

*** Dr. Z is the biggest problem facing the Dakota Sioux. He doesn't even try to hide his feelings about us. He wears his prejudice like a new suit, and makes no bones about it. He calls us names, insults our intelligence, tells us that we are dirty and stink and that if he didn't have to, he wouldn't touch us. Why doesn't medical services do something about him?

By necessity, any encounter requires that the participants "take each other into account," (Blumer, 1969:108). This process means that "...two individuals are brought into a relation of subject to subject, not of object to object, nor even of subject to object" (Blumer, 1969:109. *A priori*, the desired state of having a subject to subject encounter is lacking in the clinical setting between physician and Native patient. Instead, the transcripts reveal a subject to object relationship. This is a major pitfall of interactional transactions between individuals sharing different perceptions and statuses. The result is the placing of severe constraints on any negotiation process between the physician and Native patient, which reduces the flow of information on both sides (Stimson & Webb, 1975:114-123).

The Sioux clearly demonstrate that their interaction with physicians may best be characterized as asymmetrical. This is most evident in the physician's reported level of intolerance, and even contempt, for the Native patient involved (Weidman, 1979:86). Thus, the key to unlocking misconceptions lies in understanding not only the perceptions but the experiences as well that a Sioux patient undergoes when receiving medical services from the local health-care practitioners.

Strong (1979:218) has demonstrated that distortions are most likely to be present during the clinical situation based, not only on misinterpretation, but on the differing levels of the participants' perceived and real status:

> Groups with little political or financial power and of a degraded social status have often been treated in very different ways from their more fortunate brethren.

The results of this section substantiate that a high proportion of Dakota Sioux patients have experienced not only episodes of degradation but open forms of discrimination and prejudice. As a result of these questionable practices by the health-care providers, the Dakota Sioux do not always follow the instructions of the physicians regarding follow-up visits or taking prescribed medicines.

The Problem of Noncompliance

Often the problem of noncompliance is simply the result of a misunderstanding of directions given by the physician, such as how often a particular medicine needs to be taken; should the drug be taken with food; how long must the prescription be continued; and, most importantly, what to do if the medication is not effective in relieving the symptoms? In other instances, refusal to take the prescribed medication may be intentional. This research acknowledges that this problem is not unique to the Dakota Sioux.

Indeed, compliance with a given medical regimen presents itself as a universal area of conflict within the encounters experienced by doctors and their patients. That this is the case is evidenced by the number of articles and books written on the topic of compliance. The reader is referred to the works of the following for an in-depth appreciation of patient compliance or non-compliance: Barsky & Gillum, 1974; Becker & Maiman, 1975; Davis, 1966, 1968; Dunnell & Cartwright, 1972; Francis & Morris, 1969; Korsch & Francis, 1969; Kosa & Zola, 1975; Stoeckle, 1978; Suchman, 1965; and Zola, 1966; 1972 and 1973.

As this study is primarily a description of the Dakota Sioux and their encounters with Western physicians, there has been no attempt made to include a wider comparative database. However, the comparative data are available within the literature for the interested researcher.

For the purposes at hand, the issue of non-compliance is a double-edged sword with the physician being as much responsible for Sioux patients not following a particular regimen as the patient himself. Primarily this is the result of physicians ignoring, or failing to appreciate, their own roles within the delivery of health care (Zola,1981:241), as well as understanding (or acknowledging) the cultural expectations of their Native patients.

For instance, a significant factor that mediates compliance behavior among the Sioux is that they maintain attitudes, beliefs regarding efficacy and motivations which shape their illness experiences. Often these are not the same as those expected by their western clinicians. This is where the cogency of Kleinman's explanatory models become evident (1980:90-91); for,

> beliefs about illness, the central cognitive structure of every health care system, are closely tied to beliefs about treatment....Thus ideas about the cause of illness...are linked to ideas about practical treatment interventions.

Beliefs about illness are directly linked to the meaning that an illness episode holds for the Dakota Sioux patient. Within Sioux culture meaning is always embedded in cultural and semantic illness frames of reference. Kleinman's work illustrates this process, for he writes that "culture exerts its most fundamental and far-reaching influence through the categories we employ to understand and respond to sickness," to which he adds, "...patients articulate sickness in an idiom of illness that tends to be concrete, preoccupied with existential meaning, and thoroughly social" (1978:428). The following transcripts are offered to illustrate more clearly the argument just put forword.

*** The doctors in Virden said one of my tubes keeps blocking up, and I was supposed to take this medicine daily to keep my stomach clean. You know, to keep my intestines cleaned out. I really don't understand what my intestines has to do with my tubes. I still continue to have problems, and I guess I will. The doctors told me it will never go away. They didn't say why though. I'll have to continue taking the medicine, and continue to live with the pain. So, I'm taking the pills every day, but I don't see that they are doing any good. The pain is still there. Perhaps I'll ask the medicine man about these pills.

*** Dr. X never bothers to explain to us what all the medications are or what is wrong with us, he just gives us a lot of medicine. Sometimes, for example, I know tempera is good for you and antibiotics. But, if Dr. X gives me or the kids something else, no I just leave them or take them home and throw them away. I just take, or give my kids, the main things. I just take the stuff that is supposed to help me or the kids--not all that other stuff. Dr. X is always giving us things like vitamins and other little things in addition to free medicine besides what you went there for in the first place.

*** If the prescription is a liquid, I know you have to take it until it is all gone. With the tablets for colds, if the kids and I are over our fevers or whatever and there are still pills left, I keep them until

another time. You never know when someone else will get sick again. I just put them up on the shelf. I especially save medicine that was made for the children.

*** Dr. X is really nice. He is always giving away free medicine. He gives me these certain pills for my head colds. He is easy to get medicine from. My sister had a bad cold and went in to see Dr. X. He gave her about five or six different things to take all at once. I said my goodness, you're going to be out of it taking all those pills. He also gave her some pain killers,and some sort of capsules and a spray for the back of her throat, and a cough syrup and some more pills. She took all of them like he said, and she was just sitting around like a space cadet--like she had been sniffing glue or something. I had told her not to take all the drugs, but she said that the doctor told her to. It was an awful lot of medicine for just a cold and sore throat. She is only young, and doesn't know which medicines to take or when.

*** Dr. Z put me on some kind of tranquilizer for my headaches, but I didn't agree with taking that kind of medicine. I don't like taking drugs that make me feel weird or nothing like that. You never know the effect they will have on you, so I refused to take the pills. I threw them away.

*** Our elders won't go to the white doctors or to the hospital. If you try to get them to take a doctor's pills, they will spit them out saying

it is bad medicine. They are afraid of pills and stuff. It's really because they don't believe in the white doctors medicine. They only believe in the medicine man.

*** When you only have $70 a month to buy food for your whole family, you can't eat all the things the doctors tell you to. I have cravings now that I am pregnant again, but I can't afford to buy the fruits, vegetables and high protein meats that Dr. A tells me I need. I am forced to go to a guy that knows me before the welfare money comes in, and I have to buy food on credit. Then, when our check comes in, we have to pay our bills. Some of our kids are on the milk program offered in school, and that really helps. What I don't understand is why Dr. A yells at me when he sees the kids eating a candy bar. They crave sweets too you know. He tells me I am a bad mother because I don't feed my kids right. That's when I get mad, and I throw his medicines away. What the hell, you can't live on pills!

*** I don't use any of the medicines that the doctors give me. That is because once when I was really sick and losing a lot of weight, the doctors in Virden told me I had ulcers. The drugs they gave me made me even worse, so I went to my father, and he gave me traditional medicine. After taking it, I vomited for two days and nights. After that he gave me something again to start the vomiting. Everything just came out, and then I was O.K. You see, it wasn't ulcers at all. I started eating again, and I wasn't sick anymore,

and I started to gain weight. Months later I went back into see Dr. Z, and he said he was wrong--I didn't have ulcers to start with. Now I don't trust them or their medicine. Look in my cabinet. I must have thirty different bottles of drugs just sitting there. I will give them to somebody one of these days.

*** We have a real problem with Dr. C and Dr. Z. They never tell you what the medicine is for. That is a problem for us. They should explain to us what the drug is and everything. They just tell you to take whatever until it is all gone. They don't tell you what to do if the medicine makes you even sicker! I broke out in hives once because of a medicine. My whole body was on fire, but I didn't know it was the medicine, so I kept on taking it. They had to put me in the hospital and pump my stomach to get rid of the medicine. Now I don't trust the doctors. I don't go anymore. I don't take any more pills at all. I go to my own kind of doctor. He takes care of me. There's nothing wrong with me anymore.

*** Dr. A doesn't even do any tests anymore. He just tells me I am getting old and puts me on strong pain killers. He doesn't usually even tell me what is wrong with me. I have been going to Dr. A for a long time now, but this last time when he put me on those pain pills, I was so sick. I didn't like the strong pain killers that Dr. A gave me. Myself, I am always afraid to take those medicines. You know, any kind of pills don't agree with me. Now I only take aspirin, vitamins and cough syrup. Everything else got thrown in the trash.

*** Dr. X gave me some medicine not long ago for a sore throat. He gave me four bottles of some stuff, and told me to finish all of it. I took it, but it made me so dizzy that I stopped using it. That medicine really made me sick.

*** Sometimes people think that once they aren't sick anymore they can stop taking their medicine. Once they are feeling better, it is hard to make them understand why they have to go back into the doctor for a follow-up visit. With some people, it is really hard to get them into see a doctor. You have to really encourage them to go. In some cases, they still hang on to their traditional ways; sometimes they are just scared--especially the older people; and, sometimes it is simply too late. They just won't go to the white doctors or take their medicines. Our elders want to stay at home when they are sick--not in hospitals.

Staying in hospital is difficult for Dakota Sioux patients, and the records clearly illustrate that premature self-discharge is a common activity. In many cases this is due to the feeling of isolation from family support systems. In other cases the impetus for leaving hospital against medical advice is motivated by strange noises and unfamiliar equipment, terrible smells and primarily being made to feel inferior.

For instance, if a Native patient feels slighted by the attitudes or behaviors of the nursing or medical staff, or confused and frightened by the proposed treatment regimen, he may simply gather his belongings and leave. Sometimes the patient's dislike of the food offered by the facility will be sufficient reason to

trigger his desire to return home. The reasons are multiple in origin, making optimum health-care delivery difficult for the physicians and nurses, if not impossible in many instances.

On the other hand, Dakota Sioux informants failed to categorize non-compliance as an issue of any particular importance. What is necessary to keep in mind is that "understanding the efforts of the patient to adapt to the world of the hospital requires information from two areas, that of psychological processes and that of cultural background" (King, 1962:360). However, when cultural pressure fuses with physical and psychological need, the enforced dependency of hospitalization makes for difficulties in adaptation.

Continuing with a medical regimen implies a multitude of mutual understandings: what the illness is and what can happen if the drug therapy is not maintained; why it is important that the medication be taken on a regular schedule with (or without) food; how long the drug is to be taken, particularly antibiotics; what to do if the medication makes you more ill than you were before you started; what potential side effects to look for; and, most importantly, why it is necessary to see the physician for a follow-up visit. A major stumbling block to all these issues is language.

The Role of Language

Given that many Dakota Sioux patients are not totally fluent, or comfortable, utilizing English as a first language, let alone with the jargon employed by health-care practitioners, it is easy to recognize a potential area of conflict in the delivery of adequate health care. In specific, Eisenberg and Kleinman (1981:16) criticize physicians for their ambiguous use of language, irrational forms of logic and lack of clarity in the clinical setting. "Medicalese" thus becomes a very real problem for Native patients, and as such, it is not surprising that we should find confusing metalanguages taking place between physician

and patient. Even in the clinical setting where both parties share the same cultural experiences, and language, Stimson and Webb write that (1975:121):

> the diagnosis or label for the condition which the doctor gives the patient, assumes a general knowledge of the medical terms on the part of the patient.

Unfortunately, within the cross-cultural setting of this research where there is an absence of a "shared" knowledge between physician and client, the Dakota Sioux patient has to rely upon his own perceptions of the meanings attached to the statements of physicians. This action involves a form of interpretation which often fails to render a correct translation of clinical information. The attitude of the clinician during this exchange impacts as well on the interpretation (hermeneutics), involved. As Blumer suggests (1969:15), "...action on the part of a human being consists of taking account of various things that he notes and forging a line of conduct on the basis of how he interprets them."

When interpretation fails to render an adequate line of conduct, situations become confused. The way language is used to communicate in social situations, especially within clinical settings, is an issue of vital importance in the delivery of adequate health care. Language is a code, designed to facilitate communication between two or more individuals. For the Dakota Sioux, the English language--an idealized standardization required in contacting the white world around them--is not the idiom of everyday speech.

> *** The doctors really get me confused. I ask them to please tell me in a lower bracket of language. Even though I speak English, Sioux is my Native tongue. I am not an educated man, so most of the time I can't understand what the doctors are saying. They get

really irritated when you ask them to speak more clearly. I think they just like to confuse me. That way it makes them look smarter than me. Why can't they talk normal?

*** Most of our elders don't speak English, and they only understand a few words. When they have to go to the doctor, a younger person in the family has to go with them in order to translate. But, you know, a lot of those words the doctors use can't be translated into Sioux. That makes it very difficult for us.

*** I have never been to school, and I don't speak or understand any English. That is why I refuse to go to the white doctors or their hospitals. How could I ever tell them what I am feeling? That would be to frightening for me.

*** I only speak Sioux. When I go to the doctors, one of my children has to go with me to translate. We usually end up laughing at the words because they don't make any sense.

*** Most of the time I don't have any idea of what the doctors are telling me. They never bother to take the time to explain what they mean. Dr. Y will tell me to take a certain medication, but then he won't tell me what it is for or anything. My English is pretty good, but most of the time I still can't understand what they are saying. They use such big words. Have you looked at the words on the prescription bottles? Most of them can't be pronounced, much less understood. And, they never put on the bottles what the medicine

is for. That is bad you know, for sometimes people can get confused on which medicine is which. Anymore, I go to the pharmacist and ask him. He will take the time to explain what the medicine is for. I can understand him.

*** We have a real problem on this reserve. The older people only speak Sioux; the ones in the middle speak a little Sioux and a little English; our younger people can understand a little bit of Sioux, but they can't speak it; and, our children are losing the language completely. It really gets confusing when we go to the clinic or to the hospital. You end up with four generations trooping in to help with the language. The nurses laugh at us.

*** Some of our people don't understand what the doctors say. That is because they don't speak English. I have an aunt who needs to have her gallbladder taken out, but she is too scared to go into the hospital. She doesn't understand English except for a few words here and there. She stays home and suffers because she just doesn't understand. It's mostly a language barrier. It is our older people that just really don't understand what is going on, and that scares them. When we try to explain this to the doctors, they act like they don't see why it is a problem. Oh well, what can you do?

*** Most of the time our elders don't understand anything the doctors are telling them. They really don't understand what is happening to them when they have to go to the hospital. This is

because they don't speak English. Their children speak English, but not very good. Even they don't understand some of the English words. So, one of the grandchildren ends up going with them, but then they have trouble explaining in Sioux. We end up having the whole family go. Sometimes we get across the meaning, and sometimes we don't. It would make it easier if the doctors would talk so we could understand what they are saying. When you ask them to explain, they get upset and ask you if you are deaf. What a stupid question!

*** Sometimes I have a hard time explaining what is wrong with me in English, and I always have a hard time understanding what the doctor is trying to tell me. Dr. Z is especially bad. He tells me that after 100 years of being exposed to English, we must be pretty dumb not to understand. I told him he's been around long enough to learn Sioux. That really got him mad. It's true though.

*** Lots of white people are against Indians, and they don't try to hide it, especially some of the doctors. They talk to us as if we were really stupid. If they wouldn't use such big words, maybe we would understand better.

*** Dr. Y is very good at explaining what is wrong with you. He makes sure to talk so we can understand what he is saying. Mind you, some of our people don't ask, mainly because they don't know how. Sometimes the medical words are just too big for them, and

then they are afraid to ask what it means. I don't know why they don't ask, maybe it is because some of them don't understand English.

*** Because I have had an education, I make sure I understand what the doctors are telling me. There are many times when they talk in their own medical language, and I can't understand that. So, I always ask to make sure that I know what is wrong with me. Most of the doctors talk 'down' to us because we are Sioux. I don't think they should do that. Just because our understanding of English may not be too good doesn't mean that we are stupid. That is how they treat us most of the time.

Most of us accept language as we accept the air we breathe: we cannot get along without it, and we take it for granted almost all of the time. Few of us are aware of the extent to which language is used dishonestly to mislead and manipulate. Few of us are fully conscious of the ways, subtle or not so subtle, in which our use of language may affect others. Still fewer of us recognize that our very perceptions of the world are influenced, and our thoughts at least partially shaped, by language.

These would be reasons enough for health-care practitioners to pay close attention to their own use of language. For, if it is true that we are all in some sense prisoners of language, it is equally true that liberation begins with an awareness of that fact. To foster such an awareness is a vital goal, especially within the clinical setting. It is thus necessary for clinicians to be encouraged to use language more responsibly and effectively in their dealings with Dakota Sioux patients.

Improper use of language leads to overt (and covert) manipulation of situations. Research into the possibility of manipulation being used as a strategy in obtaining power within the clinical setting is needed to further our understanding of the process involved. When faced with trying to find an agreed upon definitive analysis of manipulation, there is to be found a general disagreement as to whether a practice by one actor on another was in fact manipulative. Most people, in fact, seem to approve of the results of manipulation, especially if it is utilized as a last resort in achieving a goal. On the other hand, the evaluation of instances of manipulation arouse negative responses, not because of the results they produce, but rather because of the nature of the process involved. People don't like the feeling that they have "been had" (Sherley, 1982).

What the transcripts in these last three sections reveal is that language plays a major role not only in the development and continuation of prejudice, but also in the misuse of power by clinicians. The Sioux have themselves identified specific ways in which language, often very subtly, induces and shapes prejudice. For example, some labels, such as "blind man," are exceedingly salient and powerful. They tend to prevent alternative classification, or even cross-classification. Ethnic labels are often of this type, particularly if they refer to some highly visible feature, e.g. Negro, Oriental, Indian. They resemble the labels that point to some outstanding incapacity--*feeble-minded*, *cripple*, *blind man*. These become symbols of "primary potency," and they act like shrieking sirens, deafening us to all finer discriminations that we might otherwise perceive.

PROBLEMS AND RECOMMENDATIONS

The Dakota Sioux recognize continuing sources of health problems for the community at large. They also have specific ideas about how to improve the

current delivery of health-care services to the reserve. As these two issues are closely related, the following discussion will combine the findings into a cohesive whole.

Recognized Health Problems

The informants in this research are quite clear about what they consider to be areas leading to health problems. These cluster under the rubric of alcoholism, suicide and interrelations with the public health nurse.

> ***The public health never comes around to see me. Why do you think that is? That makes me angry. I stand at the window and watch her drive by to visit other people. Why not me? Aren't I sick enough for her attention?
>
> ***I don't understand why the public health nurse doesn't know more about us Sioux after spending the last thirteen years with us. My only contact with her has been a negative one.
>
> ***I only use the public health nurse for Band-Aids. When my kids were younger, I took them to her for their baby shots. That is about all she does for us.
>
> ***If you go and ask the public health nurse what she thinks about us organizing to have a medicine man visit us once a week, you can imagine what she will say! One time I was sitting with my uncle when the nurse came to visit. My uncle doesn't understand English very well, and he never had any schooling. Anyway, the nurse came into his house, and they ended up getting into an argument

about water. My uncle said that he had been using the water for fifty years and never got sick. He couldn't understand why the nurse wanted him to take a sample of the water. He told her that was what she got paid to do since she said it was necessary. My uncle also told her that no matter what we Sioux tried to do about getting rid of her, she would be around on this reserve until she is ready to retire! Any time you talk about Sioux medicine, she gets very angry and yells at everybody about how 'primitive' Indian medicine is. She says it is all a bunch of hogwash and should be outlawed. Who does she think she is?

***When I was told to bring my child to the public health nurse because she was sick, I refused. All she does is give needles which makes the kids cry. She is really rough with them, and is always yelling at us for not taking care of them. I don't like that. No, I don't like that at all. I wish she would go away.

***I see the nurse when I need a Band-Aid and stuff like that. That is about all she is good for. I don't know why Medical Services makes us keep her around. Nobody gets along with her. You would think that after so many years, she would understand something about our culture and language. But, she doesn't. She tells us that we have to learn English and how to live like white people. That is pretty dumb considering we live on a reserve in the middle of nowhere! She makes some visits I guess, but I don't

know where she goes. Everyone is always complaining that she doesn't come to visit them. She must do something, but I don't know what.

***Sometimes the public health nurse goes to homes to visit, but the people don't like her. She doesn't speak or understand Sioux, and our elders don't speak or understand English. To try to make them understand, she yells at them. She acts like they are deaf or something.

***The nurse came to see me two times when I was sick. She told me to go on a diet and watch my sugar. She's always after me to lose weight, but as long as I can remember, I've been chubby. I've lost a little bit of weight not--about 35 pounds. I really got upset with her about my weight. She's no skinny thing herself, so why should she yell at me and tell me I am too fat? I told her she needed to go on a diet.

***I don't see many people going to see the nurse, just the one's who are diabetic. Of course there is the baby clinic where the nurse gives the kids their needles. She really doesn't do much for us.

The office of the public health nurse is provided by Medical Services to Native groups within Manitoba. The duties of the nurse at the Oak Lake reserve include educating the Sioux as to disease prevention and health maintenance. By definition the nurse is there to be a source for any physical ailments and psychological ones that may effect the health of an individual. A major function

of the public health nurse is to act as a referral agent between the reserve community and the health-care professionals in Reston, Virden and elsewhere. The position of the public health nurse is also designed to assist in pre- and post natal health, guidance with newborn baby care including immunization against preventable diseases, and preventing disease among school-age children by arranging medical and dental examinations. It should be noted at this point that the public health nurse refused to take part in this research. Her reason for refusal was that the study would "only stir people up."

Other serious health problems facing the Dakota Sioux are alcoholism, lack of transportation to see a physician, poor living conditions and suicide. Every one of my informants discussed how these issues effect not only individuals, but the community as a whole.

> ***I know that our reserve is supposed to be dry, but alcohol is one of our biggest problems. It seems to be a problem for everybody. We have a counselor to help people who have problems with alcohol. We also have AA meetings here on the reserve, and a number of people attend, but not enough.

> ***We definitely have a big problem with alcohol, even though we are supposed to be a dry reserve. We have a lot of problems with drinking, and the results of drinking. It is mainly our teenagers and elders that have a drug abuse problem. These are the age groups that we concentrate on in trying to help. The problem usually gets much worse during the winter months when people are shut in and have nothing to do. There is no recreation around here except for television. We don't have as much trouble in the summertime.

People get into trouble because of fighting and impaired driving. Most of our people are unemployed, and they just sit at home with nothing to do but drink. That's the reason I think they go for the bottle.

***The alcohol education program seems to be attracting a number of teenagers. We can't make people come. They have to come to the program on their own. Sometimes we have to send people to an alcohol rehabilitation centre for help. Nothing can help a person who doesn't want to be helped though. They have to admit that they have a problem. That is very hard for some people to do.

***Alcohol is our number one problem, especially on weekends. Drinking and fighting becomes a pattern for many of our families. It is a big problem for us. In the long run, alcohol hurts everybody. If people were working, I don't think alcohol would be such a problem. Some people use up their whole welfare checks on alcohol, and then they have no money left for food. It makes me sad. The Sioux never used to have this problem.

***Even though this is a dry reserve, alcohol is a major problem. It is the drug of choice, and it is getting worse. The Dakota Ojibwa Tribal Council spends millions of dollars every year on child welfare, drug abuse and stuff like that. I disagree with spending that much money on reserves. I think we should do away with the reserve

system, and let the Sioux live like everybody else. Then you wouldn't have these other problems. As long as we are confined to reserves, we will continue to have problems.

***In recent years we have had two suicides--both of them male, and about six attempts. These are usually males in their late teens or early twenties. There have been two murders, and both of them were alcohol related. Suicide never used to be a problem for us. It just shows how desperate people are.

***There have been a few suicides in the last couple of years. But what I find frightening is the number of young people who try to commit suicide, and fail. Our young people face a much more difficult life than we did. I think it was easier when I was young.

***Within the last ten years the number of suicides has increased tremendously. It is scary, because these are mostly our young people. A number of them were alcohol related. What can you do?

***To make it easier for us, I think it would be nice to have a clinic right here on the reserve. If nothing else, it would be nice to have a doctor visit the reserve. We used to have a doctor you know. He would come out about once or twice a week. I think our health was better then.

***Long ago we Sioux did not have sickness like we do today. Sickness came to the Sioux because so many people started living

close together in one place rather than roaming around depending on the seasons. We used to have stiff bones from sleeping on the ground, but nobody had cancer or diabetes or T.B. Those are all white man's sicknesses.

***I would like to see the medicine man and the white doctor working together. I think that would be good for us Indian patients. We used to have a druggist in Virden who was very interested in our medicine. He used to be very strong about knowing Indian herbs and roots that were really good for curing. He was very interested in our people. One time he made a trip to Calgary, and when he got back he told us a story. You see, one of the hospitals in Calgary had a medicine man on staff, and he was able to use his medicines. When a Native patient came in the hospital, the medicine man was allowed to treat them and pray for them. Why can't we have the same thing in Virden or Reston? I think that would be good.

***We are going to have real problems in the near future. What happens when Dr. A retires? And, our problems with the nurses and hospitals are only going to get worse, especially with the way they treat us today. I was thinking how nice it would be if we had our own clinic on the reserve, and not only have a white doctor visit, but have our own medicine man visit too. That's just an idea I have. It would also be good to have Native nurses. Up north, the Indians have more education and better medical services. They

are much more educated than the Sioux. They are forced to go to school. They get more attention and money than we do. Why do you think that is so? We need help too.

***The elders on this reserve need better medical care. They should be looked after by the whole community, not just by their own families. I also think doctors should visit the reserve on a regular basis, especially because most of us have trouble getting into town. Transportation is a serious problem. We make appointments at the clinic, and then we have to cancel them because we have no way of getting into town. The doctors get really angry with us because of that. But, we have no choice. We can only go when someone is around to take us, and that is usually at night after supper. The doctors get really upset because we have to use the emergency room. What are we supposed to do?

***Many of our people need to use the hospital after hours due to the lack of transportation. The doctors seem to be unaware of this problem, even though we tell them often enough. They really resent having Indians come into the emergency room, even if it is a real emergency!

***Transportation is a serious problem. Sometimes our own police have to take people into the hospital, or we can use the ambulance from Reston if someone is really hurt. We don't like to use the ambulance service though, because the drivers are always talking ugly to us--calling us drunken Indians and stuff like that.

***Next to alcohol abuse, transportation and communication with the nurses and doctors is a problem for most of our people. This is especially true for our elders. They always have to take a family member with them to interpret for them. Most people on the reserve don't have vehicles to get to the doctors. This is the main reason people don't go back in to the doctors for a follow-up visit. They can't.

***I don't think we should have to live on reserves. Living here is a big problem for us. We have no work, no running water, houses that are falling down around us, land that won't grow anything, and nothing to do. People say that if we move off the reserve, we will lose our culture. But, I've seen people live in the city and still maintain their Native traditions. It all depends on the person. For now, though, we need transportation. Medical Services should give us a van like they have at Sioux Valley, then we could go to the doctors.

***The Sioux have many living problems, mostly the lack of sanitation and good water. Also many people have trouble with not having transportation to get into see the doctors. A few of the doctors are good to us, and some of them seem to shy away from helping you once they know that you are Native. Those doctors won't take us as patients. We have trouble with alcohol, no employment and people fighting because the reserve is too small for all of us. Some of our people leave because they have no other

choice. They have no housing and no work. We have a three-year waiting list for housing! What is a person to do? They have to leave.

***I wish we had good doctors in Virden. I guess it's better in Reston. Most of us Native see either Dr. A or Dr. Y, because they seem to care about us, not like Dr. Z. I think the doctors should learn more about our culture and our ways.

***We have more sickness today than ever before. We used to be in good health. Maybe it is the food we eat now, and all those pills the doctors give us. Why is it we all have diabetes now, and high blood pressure? It's the food! The doctors tell us, no more than 1800 calories per day; no fried foods; no fatty foods; no red meat; no wild meat; eat vegetables and fruits and drink milk.

***Most of our kids have problems with colds and stuff like that. They don't eat too good. It seems like more and more people are diabetic today. I think it is coming out of all the canned foods we are eating today. Years back, we never used to eat out of a can, and we never had a problem with sugar. It is the canned food that is making us sick.

It is obvious from these interviews that the Sioux are in a position of feeling helpless about their circumstances. They are victims in a vicious circle of poverty, unemployment and discrimination. To compound the problem, they are blamed for problems over which they have no control. For example, over and over again the physicians blame the Sioux for utilizing the emergency room

instead of coming into the clinic during office hours. They are blamed when their children become ill, and told they are irresponsible and bad parents. They are verbally castigated when they fail to keep an appointment with a physician and when they do not comply with a medical regimen. They are yelled at and psychologically abused by their health-care practitioners. Their feeling of outrage is understandable given the circumstances.

CONCLUSION

This chapter has brought together a multitude of issues, ranging from the use of traditional healers to everyday problems involving encounters with outside physicians. Issues of transportation, inadequate water supply and housing, discrimination and abuse have all been elicited and discussed.

That all patients have a right to expect personalized and continuous care is recognized in the mission statements of most health-care facilities. The reality of the situation for the Dakota Sioux patient is normally very different. It is not only the depersonalization that takes place, for this is a common complaint for all hospitalized patients. What makes the experience unique is the sense of total isolation that the Sioux patient experiences in his contacts with Western medicine. Alienation from the very individuals who are in the "helping" professions exacerbates this feeling of being somehow "different." Cooperative claims are thereby nullified, and the encounter fails in achieving its desired aim (Goffman, 1963:113).

The need for respect as persons first and patients second is clear. For instance, when utilizing a hospital's emergency room, Sioux patients are often made to feel guilty that they are "wasting the doctor's time." This is usually the result of the patient being made to feel that the problem at hand is trivial and not worthy of the physician's time and attention. The resulting emotional turmoil is

evident: "The doctor's don't like us because we are Indian;" "Why do they always make us wait so long;" or "Why do they have to treat us as if we are all drunk Indians and totally irresponsible, like children." These statements reveal a real breakdown in communication. The consequence is a lack of trust, which is a deficiency that has negative connotations for a successful medical intervention within the clinical setting. In other words, practitioners not only gain respect by giving respect, but in the process also improve their effectiveness.

Consequently, the extent to which the Federal health nurse, or the local physicians, are utilized by the Sioux community depends, to a large extent, on the amount of esteem these individuals are able to command. A clinician with a "proven" track record in dealing with Dakota Sioux patients is sought more often to treat everything from minor cuts to severe illness episodes than his counterparts in the same clinic or hospital.

This behavior is no different than expressed by that of the larger community, for we all have personal reasons for selecting the health-care provider of our choice. The bottom line rests only only on efficacy, but on respecting the individual involved, as well as the degree of sensitivity to cultural differences expressed by that person. As Leininger is quick to point out (1976:vi):

> Understanding, respect,compassion, and patience--all based on knowledge--are critical in order to work effectively with people whose values differ from those of the health worker.

Unfortunately, the saliency of Leininger's warning is unheeded in everyday encounters between Western physicians and Dakota Sioux patients. Too often the social distance between the two parties only increases with each exposure, leaving mutual trust, respect and cooperation by the wayside (King, 1962:219). The result is a bifurcation of utilization of medical services.

Western scientific medicine, for example, involves largely impersonal relations, procedures unfamiliar to laymen, a passive role for family members, hospital care, and considerable control of the situation by professionals. By contrast, Sioux medicine is largely a matter of personal relations, familiar procedures, active family participation, home care, and a large degree of personal control of the situation by a patient or his family. Given the active presence of these differences, it is easy to understand why motivation would be necessary for a Dakota Sioux patient to have any strong preference for Western medicine, or as Lieban says (1976:294):

> When objective indications of advantages of modern medicine are not self-evident, the probability of traditional medical beliefs determining decisions grows.

It is this understanding of differences that becomes the key in the provision of effective cross-cultural health care. If it is absent, the result is a turning away from the Western medical system and placing a heavier reliance upon traditional methods of healing. This cognitive dissonance arises because the Native patient and the Western health professional share quite different perceptual worlds, with the patient normally being held responsible for gaps in communication due to cultural differences, behaviors and past experiences.

The Western practitioner, on the other hand, sees himself under no obligation to share his experience, or his view of the world as a part of the clinical event. The patient is the one expected to be the "sharing" contributor by providing symptoms and previous medical experiences to the physician.

It is the latter which is of import in this discussion, for experience is embedded in the personal reflection of an active self, not simply a description of outward behavior. In the words of Bruner (1986:5), "the communication of experience tends to be self-referential." There is a wide gulf in meaning when

one says "I am feeling sick" as opposed to saying, "My behavior tells me I am sick." The question remains, how is this translated from the Sioux perspective to that of the Western clinician? It is to this question that the next chapter turns.

CHAPTER VI: WESTERN BIOMEDICAL PRACTICES AND DAKOTA SIOUX PATIENTS

> ...since we have come to the understanding that science is not a description of 'reality' but a metaphorical ordering of experiences, the new science does not impugn the old. It is not a question of which view is 'true' in some ultimate sense. Rather, it is a matter of which picture is more useful in guiding human affairs. Willis Harman, 1977.

INTRODUCTION

When non-critically internalized by the Western health-care practitioner as an "objective truth," the biomedical model has "...no means for taking into account patient and lay perspectives on a given sickness episode, to say nothing of alternative therapeutic formulations held by other healing systems" (Kleinman, 1980:18). Sadly, though not unexpectedly, the health professionals encountered in this research expressed little, if any, sensitivity to or acquaintance with the views and opinions of Dakota Sioux patients *vis a vis* the clinical reality.

Nor do the health-care providers acknowledge that their Native patients commonly seek advice and healing from traditional medicine men in conjunction with visiting the local hospitals and/or medical clinics. This discrepancy in awareness inevitably leads to a doctor-patient relationship which is "...narrowly focused on a mechanistic view of bodily dysfunction that divorces sickness from everyday experience and from other human problems" (Kleinman, 1980:303).

While the patient is attempting to understand and come to terms with the illness, in all its guises both social and psychological, "...the practitioner is concerned only with 'curing' the disease" (Kleinman, 1980:355).

In order to illustrate the practices, beliefs and perceptions held by the Western medical profession in this study, a series of interviews are offered. The narratives are placed first within a thematic structure, followed by an interpretive analysis. The categorical themes fall into distinct fields of interaction: concepts and perceptions of Dakota Sioux culture; issues of compliance; continuing medical problems; blaming the patient for ill health states; poor communication due to language barriers; lack of awareness of traditional medical beliefs; modes of utilization of hospitals; and, the core problem area of prejudice and stereotyping.

The data which follow have been obtained, with consent, from the health-care providers who agreed to take part in this research. A triple star (***) at the beginning of an interview will indicate informant dialogue. The accounts include two physicians, four nurses and two health-care administrators within the hospital district. Even though there were five physicians serving the area at the time of the research, three stated they had no contact with Dakota Sioux patients. However, the reader is referred to the transcripts in the previous chapter, which clearly illustrates that all five physicians do in fact have dealings with Dakota Sioux patients.

A brief profile of the physicians within the district indicates that of the five, four received their primary medical training in England, and are of British or Irish descent. The fifth doctor is from Southeast Asia, with training having been completed in the United States. The length of physician tenure within the district ranges from five to twenty-five years.

CONCEPTS AND PERCEPTIONS OF DAKOTA SIOUX CULTURE

Cultural data are currently not included on the assessment forms and treatment plans developed for patients within the hospital district, and as a result, problematic relations between client and practitioner arise. Dakota Sioux patients find that they are effectively dissected from their cultural meaning system. The local health-care practitioners, in ethnocentric fashion, have each internalized their own individual constructs of what constitutes Native culture.

> ***The Dakota Sioux do not engage in prenatal care, and this is a very big concern of mine. But, you see, their heritage is such that, culturally, having babies is part of their everyday life. It isn't an illness; instead, it is an altered state of health. This is really a shame, because prenatal medicine is one of the most effective forms of preventative medicine that we practice. I feel that the Natives simply don't appreciate what prenatal care is all about. Without the grandmothers, the Sioux nation would never survive!

> ***They think so differently from us. You know, the earth is a part of them, and it is a concept that I simply cannot grasp. Their perceptions of illness are so different from ours. For example, when I give them advice about what do to, that advice is not culturally designed. I try to give them only scientific advice, which they don't understand.

***They are very quiet when they are in the hospital. Since they are so quiet and submissive, I really cannot communicate with them. It is very difficult. It doesn't work having two Native patients in the same ward, because then they become quite noisy and fight a great deal.

***Most of the cases that we see here are acute cases. However, there is quite a difference between the Dakota Sioux male and female patients that come in. I seldom see a male complaining of any illness problem. Most of the males I see are acute cases that are seen in the emergency room. These are usually the result of a stabbing accident, or a gut wound received while being drunk. These cases are usually brought in by the RCMP. Those are the males. Now, the female patients I see are usually pregnant, or they come in because of some abdominal pain. Their complaints are similar to my white patients.

***There is a very good reason so many of my Native patients want to be referred into Brandon. See, this way they can travel. They have a piece of paper signed by me which they can then present to the Band Council for gasoline, mileage, food and lodging in Brandon. If they have problems that I cannot take care of here, and I send them into Brandon, they will be glad to go--even to Winnipeg. I had one patient who got very upset with me because he wanted a referral to Winnipeg, and I told him it was unnecessary to go that far, as I was going to refer him to Brandon. He informed me in no uncertain terms that he didn't want to go to Brandon; he wanted to

go to Winnipeg. Apparently, he simply wanted to visit friends or relatives in Winnipeg. These are always valid cases of illness; however, traveling is a side benefit to get away for a few days.

***Most of my Native patients view Western medicine as 'cold.' I think it is because some of the Native patients, the male especially, I think it is the way he talks. He tries to look like the boss. He talks loud, and he shouts at everybody. He demands treatment right now! He can't wait, and if he has to wait, he informs you that he will report you. He demands your attention right off. In the emergency room, they act the same way. Most of the time they are drunk when they come into emergency. They even fight with the RCMP. They won't physically abuse me, but they will abuse me verbally. So, what the RCMP officer does is shout back at them, and then they quiet down. Whoever has the loudest voice wins.

***Sioux males do not come voluntarily into hospital. They are almost always brought in by the RCMP. The male won't come on his own even if he is bleeding to death. For instance, a family on the reserve will call the RCMP and report that there is a guy bleeding to death in the field. The male, however, will not say, 'Hey, I'm injured, and I need help.' Forget it. What I think it is, is fear. You know, you show them a little needle, and they run because they are afraid of it. It will probably hurt. Probably they are afraid of pain. They don't want to suffer pain. The way they explain it is that they want to inflict pain on someone else because they know how much it hurts.

***When Sioux males are hurt, when they are injured, they won't seek help unless somebody forces them into the hospital. A male coming in alone into the emergency room is rare. I don't know what their experiences are like in Winnipeg. Maybe it is the same.

***The Natives have a preference for certain types of doctors, especially loud doctors. They like doctors who are domineering.

***We see a few suicide attempts. These are mainly females--maybe ten females to one male. The male is usually not suicidal because of their 'macho' attitudes. The males will mutilate themselves to show that they are manly and can endure pain. Those are not suicide attempts. The females come in claiming overdose, but on laboratory tests, there has been no medication taken, or such a small dose that it isn't even toxic. It is a feigned suicide attempt in order to get away from whatever is bothering them at home. There are some genuine suicide attempts, but not many. These are usually prescribed medications that they have taken which don't even belong to them. They don't take their own medications in an attempt to commit suicide because they believe that their own prescriptions won't hurt them.

***Their culture is so different. They will tell you that there are so many things different about them. For example, a big problem we have here in the hospital is knowing what a child's name really is. See, a baby boy will come in named 'John Bear,' and then the mother will bring him back in several months later and say the

child's name is 'John Buffalo.' This bugs our records because who is this child 'Buffalo'? I have tried to look into this, but I still don't understand it. I think it is because of the female. You see, the female will have an offspring with a certain male being the father on her request. It is the female that approaches the male for an offspring. The male usually doesn't refuse. So, she gets an offspring from this male. She will then ask for support from this male, and if he refuses, she will have to look for another male to support the child. Therefore, she can't keep the name the child was born with, for now she must adopt the new male's name. I really find the whole thing very confusing.

***When I have Native patients in hospital, I find them to be very cooperative, but very quiet. You know, leave me alone--I don't want to tell you anything. If you will leave them alone, they will soon tell you what is wrong. As a rule, most of them are really quite good. The main problem is that they always have too many visitors, and when we tell them they can only have two at a time, they become very belligerent and noisy. You see, they want their whole family to stay with them. That is really not practical in a hospital, because it interferes with the nursing schedule.

***Their reserve is dry now, but they still come into town to buy alcohol. They can buy it here, but then they can't take it back to the reserve. Sometimes you will find a little carry-on in town with them being drunk. Indians like to fight. Of course, they make their own laws out there. They aren't subject to the same laws as we are. Frankly, I think the government has spoiled them.

***All the people from town usually go to the reserve for the pow-wow, but the Indians don't really say too much to us. They have other Indians who come up from the States, and from all over to dance in the pow-wow. They have beautiful costumes. They even got a $15,000 grant from the government for prizes. The townspeople were really unhappy about that. I mean, they do get all the extra things that we don't get, and uh sometimes, we are shortchanged. For example, we applied for a grant for 'fun-day' and only received a measly $500. People really resent that.

***A number of Natives work out on the highway in gangs, and on the railroad. But in town, you don't see any of them employed. Some of them may work in Brandon or at the Band Council Office. They even held a wedding in town, with the traditional wedding dance and everything. It was a first for us. It really went quite well--no fights or anything like that. Even the whites seemed to enjoy themselves. Mind you, we stayed apart.

***When Natives are hospitalized, they are very quiet and usually very stubborn about taking their medicine. Understanding Native culture was never a part of my nursing training. I don't think the nurses even think about it. There is currently no special emphasis placed on ascertaining a Native's belief system about illness. I just don't think it has been given any importance. It is never brought up at staff meetings. As far as the difference between the Native population and anybody else, I don't think there is a difference.

***I can remember one Sioux patient in particular. He was quite open about talking about his culture, and that kind of thing. He was quite subjective about the way young people were behaving in his culture, especially about alcohol and getting into trouble. I think he was more or less going along with the white person's way of thinking.

***I worked once with a young girl who had been tortured by some other members of the reserve. She had been told to keep her mouth shut, and she did. She was really good at that. She wouldn't discuss anything. Again, there were two step-brothers who came at each other with a passion. One guy ran over the other with a truck. Those are the main dealings I've had with Native patients. They seem to be very violent, and make difficult patients.

> ***I don't see any necessity to even think about how Native patients view illness. It really doesn't make any difference. More often than not, they are very quiet patients; however, some individuals are difficult, and many are very stubborn.

These statements illustrate that psychological support and respect for Dakota Sioux culture are two vital attitudes missing within the practitioner/patient relationship. Dakota Sioux patients are often perceived as being inherently stubborn or difficult, or constitutionally stoic.

In general, Native patients have no special place in the bureaucratic perspective of the local hospitals except insofar as they are regarded as "objects" to be processed rather than as "persons" with whom to negotiate. Due to the segmented hierarchy which is a feature of all hospitals, this process of objectification may be an inevitable outcome for any patient; however, the claim of this research is that Native patients are much more likely to be misunderstood than other patients. In fact, even though depersonalization is a reality for any hospital patient, Bloom and Zambrana (1983:84) support this study's findings that poverty-level patients and racial minorities experience more depersonalization than other groups.

Depersonalization and discrimination are serious matters, and not to be taken lightly, for when meanings of illness episodes are not shared by physician and patient, incongruities in definitions and expectations arise. These lead to conflict and dissatisfaction for both parties. It also leads to non-compliance on the part of Native patients.

COMPLIANCE WITH THE MEDICAL REGIMEN

Many Dakota Sioux patients appear to have great difficulty conceptualizing the deferred, yet potentially positive effect of a particular medical regimen. There is a perception among the Western practitioners that the Native has an expectation of "instant symptomatic relief" for his complaints. In addition, the physicians in this research complain, with great frequency, about a lack of compliance thereby implying an absence of obedience and adherence to their moral imperatives. Yet, moral suggestions may work in subtle ways. They may operate by creating and maintaining a social distance between the doctor and his patient. This stereotypical patient processing allows the physician to maintain control over the situation, relegating the patient to a submissive and passive role.

> ***Infant mortality among the Sioux is much higher than it should be. Another thing is that Native babies suffer more minor illnesses which are not well treated because of the peripatetic nature of the mothers. They will go from doctor to doctor. For example, a patient will say, 'Oh. I see you have my grandson down for a visit today. Well, he's in Brandon seeing so and so.' They really don't follow through with medical treatment, nor do they return for a follow-up visit like I tell them to. Therefore, their illnesses last longer than they should

> ***The Public Health nurse on the reserve will make a suggestion to a Native patient to come into my office for treatment. The patient, however, will most likely not come in, or he will go to a doctor in Brandon. The end result is two or three different physicians treating a patient for the same problem. It is such a waste of time.

***Ultrasonography has recently become a very valuable tool, and I have never been able to get even one of my Native patients to undergo this testing procedure. I believe the reason is fear.

***I have a number of Native patients; however, most of them don't show up for their clinic visit. Yesterday's list might give you an idea. Four Native patients were scheduled, of whom only two showed up, which I suppose is par for the course. On an average I probably see around six Native patients per day. Mind you, they don't take their medications that I prescribe. I wonder what happens to all those prescriptions?

***It is very difficult to follow-up on a Native patient. They will come in with a complaint, and they want immediate relief at that instant. If they don't get it, they are somewhere else. So, I tell them to come back, but I never see them again. They don't adhere to any regimen, not even prenatal care. They will be here today, in Brandon tomorrow, or up in Virden the following day. I don't know what the reason is, but this is my observation.

***If one of their children is ill, they are a little bit more concerned than if it was a problem of their's. If you ask them to bring the child back in for a follow-up visit, they will. Now, it might not be the same day as the appointment is scheduled for. The reason they will give is that they had no transportation. This is a difficulty I face as a physician.

***Compliance is a very difficult problem when dealing with Native patients. I really don't think they understand how important it is to follow my orders. For instance, even the male that I suture, you know, I tell him 'stitches come out in seven days.' You won't see them again. You won't see them in a month, or in a year. They simply don't come back. I don't know what happens; however, you might see them later on in the year, and you ask them who took out the stitches. They will tell you they took them out themselves. It is very difficult for me as a physician. I know that they go wherever they wish to go. They are here, they are there, or they are somewhere else.

***When it comes to prenatal care, only some of my Native patients show up. If you will check the records, they usually come in no more than four or five times. They will come when they have the occasion to even though the usual checkup is every month, and then every week the last month or two, but they don't adhere to that. After their delivery, I tell them to come back and see me in six weeks. I very seldom ever see them again.

***Native mothers will give their children prescribed medications as directed. However, if the medication is for themselves, they don't take it. At least I am very doubtful if they take their medications. I don't think they comply very closely. If they don't get relief within twenty-four hours, that's it. They say, 'no good.' If it doesn't work instantly, they say your medicine is no good.

***I don't understand how they interpret what I tell them, but the fact that I observe that they want instant relief makes me wonder. Probably it is because they are so mobile. They don't want to be kept in bed or away from what they are enjoying. They don't even want to be hospitalized. The males especially will sign out of the hospital if you keep them in for more than two days. They will do this against my advice, even if they are very sick, they will say they don't want to stay in hospital.

***I admit a Native patient in the morning, and they sign themselves out in the evening. They don't want to be held down--especially the males. They will tell me they don't want to stay in hospital. This is also true to a certain extent of other adult members of Oak Lake. They don't want to be tied down.

***Native patients are difficult to deal with. There is no established rapport between my Native patients and myself. They bounce around between physicians, unlike their white counterparts. Say a Native mother delivers her baby in Brandon, and then they come to me at the first sign of trouble with the infant. The nurses think that is really funny, and they will comment, 'Why is it they deliver elsewhere, and then have you take care of the baby'? Who knows?

***There are several ways of treating an illness. You have to find the cause of the problem. If you have a headache, O.K., I try to find out why. We call that an etiological treatment. If you treat the etiological source, the pain will stop. The other way of treating

patients is to treat the symptoms. If you have a headache, all you have to do is give the patient a symptomatic medication such as an aspirin, a sedative, or a sleeping pill. Of course, the headache goes away while you are taking the medication. Once you stop taking the pill, the reason for the pain is still there. I think symptomatic medicines work for Native patients because it is instant! You have a headache, you take the medicine, and it disappears until tomorrow. I think symptomatic medicine is good for Native patients. That way they can go wherever and have a good time. This is good treatment so far as they are concerned. But, when they get back, they could have a bloated stomach or a ruptured appendix. O.K. That's another disease. But, in the meantime the doctor gave them medicine, and that makes him a good doctor. Also, the doctor who takes out the appendix is a good doctor. The doctor who wants to keep them in hospital, now he is a bad doctor. They want immediate relief!

***As a nurse, it really bothers me when Native women don't come in for prenatal care. They usually don't show up until they are seven months pregnant. On the average, I would say it is a real problem.

***Native patients check themselves out of hospital against medical advice. Some just want to go home to die, for you see, the older ones prefer to die at home. That is their choice. They are, however, much better than they used to be. They used to come in and have their babies and change their names three or four times

while they were in here. We sometimes get an older male who wants to get out of hospital on a pass to attend to his welfare check, and then he never comes back. We may have people come in that should be here a week or more, but when they decide to go, they just walk out.

***Because of their lack of understanding, a number of Native patients come into hospital with an overdose of medication. They don't understand when you tell them the dose to take, so they take all of it! Sometimes it is an attempted suicide where the patient has taken sleeping pills and tranquilizers all at the same time. Perhaps they were fighting with their husbands or something, and they just want to get away from home.

***Compliance is a definite problem for diabetic Native patients. They simply don't understand about eating properly and obeying the doctor's orders. They more or less do whatever they want, and then they don't understand why they get sick. Yes, I would say that compliance is a serious problem for Native patients, and I think the fault lies with the doctors. The doctors don't take the time to explain in a way the Native can understand. They have to accept responsibility for non-compliance.

***Native patients are really bad about checking out of the hospital when they aren't supposed to. This is usually the case if there is a social event they want to attend, or a pow-wow, or a party. That's O.K. I guess if you're well, but if you're sick, it could mean trouble. Mostly, they get away with it.

***Some Native patients follow along with what we want them to do. Some won't. I think they just don't understand the importance of medical care.

The health professionals depicted in the above transcripts consistently refer to perceived, fundamental differences between male and female Native patient behavior. At times, they offer contradictory statements, such as Native males being afraid of needles yet capable of self-mutilation. One comment in particular illustrates this lack of understanding on the part of physicians: "The males will mutilate themselves to show that they are manly and can endure pain." This aspect of Sioux culture has nothing to do with being "manly." Rather, self-mutilation, a conspicuous feature of the Sun Dance religious festival, is purely symbolic. After decades of being outlawed both in Canada and the United States, Sun Dance activities are once again becoming annual events for the Dakota Sioux and other groups.

In their discussion of non-compliance, the health-care providers omit several important reasons for the lack of compliance on the part of Sioux patients. Namely, the Native patient's common refusal to comply with medical advice *may* be part of a more generalized reaction against the larger white society around them. Clearly the Sioux do not feel comfortable in the alien surroundings of the local hospitals. More importantly, the issue of compliance

rests on a clear, unambigious understanding of instructions. Once again the issue of language becomes a crucial ingredient in health-care delivery.

> ***I often wonder how well their English is because, you see, I really don't think they understand most of the time. I have encountered many Sioux patients who could not speak English, nor understand it. These patients always have to have a family member accompany them into my office or hospital. The family translates my instructions. Mind you, I really don't know if they are honestly telling the patient what I say is necessary. Sometimes I think they tell them something totally different! It can become very confusing because I really don't think they grasp the directions I give them.

> ***I truly believe that the Sioux have different concepts of bodily function, for I often have to explain anatomy to them. I have to explain several times. Even after five or six explanations, I don't think they really understand what I am saying. They will say, 'Just relieve me of my pain. That is all I am interested in.' If you can relieve them of their pain, then you are a good doctor--one they can trust.

> ***If my Native patient is elderly, a family member will always come to interpret. Whether or not the translation is accurate I have no way of telling. Of course most of our Native patients are familiar with modern medicine around here. I think they are comfortable with our type of medicine--sort of.

***There was one lady that I had to assist the nurses with. She had a language problem in that she spoke only Sioux. I think she finally understood what was going on, but she had real problems with compliance, which seems to be true of many Sioux patients. Perhaps they don't comply because they fail to completely understand what the nurses or doctors are telling them. I really am not too sure.

***The main cause of non-compliance is because of language. After all, if you or I can't understand what a doctor is instructing us to do, we would be just as bad as the Sioux in not following orders. Even though we both speak English, I bet there are times that we can't understand the physicians. Sometimes I think the doctors try to snow people with language. It makes them more powerful, don't you think?

Language, in this particular instance, becomes the key to unlocking misconceptions resulting in non-compliance. The very process of instruction by physicians to their Native clients reveals more the clinicians' expectations than it does the patient's understanding. The assumptions of the two participants operate in two totally different worlds of awareness. For example, the literature is replete with case studies of physicians who "think" that their patients have a greater understanding of their disease process than in fact is the case (Pratt et al., 1957; Samora et al., 1961).

These expectations of the physician result from his own clinical experience and medical training. The expectations of the Dakota Sioux patient are molded more by cultural understandings of the illness episodes. Consequently, physicians and Native patients intersect in a region of interaction where

communication is a crucial link in the process of illness definition. That conflicts may be more readily resolved by clarifying language within an interactional setting is a concept deriving from the work of Kurt Lewin (1935) and his human relations approach to communication.

When language becomes a barrier to understanding, the Native patient naturally feels dissatisfied with the treatment plan offered. Often this is due to the physician failing to gain the patient's trust and confidence. The result is a turning away from Western medicine to that of traditional healing.

AWARENESS OF TRADITIONAL HEALERS

What my informants in the medical profession consistently fail to recognize is that alternative, yet coexistent, models of health and illness operate in a socially sanctioned modality outside the parameter of the biomedical approach. The local physicians certainly evidenced an awareness of Native healers during interview sessions. However, in reply to direct questioning as to the presence and activities of traditional healers, responses were colored by veiled contempt.

> ***Sometimes I think that my patients see the shaman first before seeing me. I also believe that they see him <u>after</u> visiting me to make sure that what I tell them is correct. For you see, we do have shamans in the district. However, I am well aware of the medical view towards Native healers. On the other hand, those physicians working in foreign countries learn very quickly to get in on the right side of Native healers, for they are the traditional providers of health care. You need their assistance in order to deliver adequate care to the population. You see this happening quite frequently in places like Africa and South America. The difference here, I suppose, is

that the Natives have had sufficient time to adjust to Western physicians and medicine, and to move away from superstitious belief systems.

***The medicine man is a fake you know. It is all slight of hand stuff, similar to pulling rabbits out of a hat. They chant and sing and beat on drums. I don't call that medicine!

***I know of at least one medicine man around here. He comes over now and then and asks me questions about what I do in certain situations. For example, he may send his daughter into see me because she is experiencing stomach pain. He will come in with her and ask me what I will give to relieve the pain. Also, there are medications that you can buy over the counter, and I know that he purchases these to use with members of his family and the community. He was in here one day with his wife, and he told me that he had given her several pills of Atasol as well as an anticholinergic. So, I asked him where he got the medication, because I suspect that he must have tons of all kinds of medication stashed away out there on the reserve. I know for certain that I had not prescribed those medications for his wife. He probably gets all the left-over drugs from people on the reserve, for after all, he is the medicine man. He will come into my office and say, 'What do you do for so-and-so? I have a patient with this type of condition. What do you give'? I don't know how often the people on the reserve use the shaman, but I see him on the highway between Virden and Melita almost every day. Maybe he also consults with other

physicians like he does with me. I don't know anything about how he practices his medicine. For all I know, he may be practicing what he picks up in the local hospitals. Sometimes I suspect that he is the one taking out all my stitches! Where do all my stitches go to? Maybe the Public Health nurse takes them out. I don't know.

***I think that the practice of using more than one medical system is inherent to man because I observe the same activity here among the general populace with intelligent individuals. They have cancer, right? You've seen those people. The doctor can't cure them, so off they go to Mexico or anywhere to have a fake healer work of them. What I do see, however, is that the white patient adheres more closely to the medical regimen for a longer period of time. They give you a little bit more time to cure the illness than the Native patient. The waiting period for the Native is probably an hour, or a day, and then they are off to the shaman. What can you do?

These comments illustrate a limited knowledge about what in fact the medicine man does, as well as precluding the validity of any alternative viewpoint from gaining credibility or ascendancy among the protagonists from the biomedical perspective. One detects a note of sarcasm as well as ridicule on the part of the health-care providers towards traditional medicine. Perhaps this is to be expected in light of the competition that traditional healers offer towards Western physicians' dominance over the medical field.

The medical practitioners interviewed fail to recognize the legitimacy of Native healers. Economically, socially and symbolically the therapeutic practices that are part of traditional Sioux medicine compete with modern medicine. In

some instances there is complementarity between the two systems. For example, when the medicine man informs a diabetic patient to continue taking his insulin while maintaining his visits to the traditional healer is a classic case of non-conflictual medical treatment. On the other hand, when the medicine man instructs a patient to throw away his prescriptions obtained from the physician and take traditional medicines instead, we have an instance of non-complementarity of medical systems. The position of Western medicine in the total slate of contestants is unique, for as Weidman notes (1979:85):

> Since it emerged in the Western world, that social institution called 'scientific' or 'modern' medicine has been sanctioned internationally as being ultimately responsible for the health of national populations.

This is the direct result of the medical profession receiving a stamp of legitimacy and a resultant increased authority. The science of modern medicine is built upon complex technologies and organizations leading to greater control of issues of health throughout the world. This activity is taking place at the expense of traditional systems of healing. The most serious challenge to Western medicines' potential for interactional control lies in the process of knowledge retention. Altering the knowledge base of patients might lead to a more open form of negotiation between physicians and their clients.

A case in point is the increasing activity and power of the United Nations World Health Organization, which describes health as a state of "complete physical, mental, and social well-being, and not merely the absence of disease and infirmity" (Mead, 1953:28). This topic is too complex for an in-depth analysis within the confines of this thesis. However, it is important to note that under the aegis of "professionalism," Western medicine has achieved dominance over alternative healing systems. This results in ethnocentric attitudes on the part of Western health-care providers, leading to stereotyping and prejudice. It also impacts directly on the issue of efficacy, for it is impossible to assess one

therapeutic system in terms of the paradigm of another therapeutic system. The question that we should be asking, according to Kleinman (1980), is should they be compared?

RELATIONSHIPS BETWEEN HOSPITAL PERSONNEL AND NATIVE PATIENTS

Cultural forms are both produced and take on meaning within social systems. Individuals employed in hospitals experience the world around them in systems of social relationships, that are based in part on social disjunctures. For example, a positive tie has meaning between nurse and patient only when that patient is placed within the category of "good patient." This carries meaning only when it is contrasted with the other polarity, the classification of "bad patient." It is through this mechanism of exclusion of "others" that the bonds of institutional group membership are predicated.

Thus, the in-group (medical staff) needs an out-group (patients) against which it can compare itself. That is, groups define themselves in large measure in terms of what they are not. It is the perception of a threat external to a given in-group that spurs the members to align themselves in terms of their common interest and affective ties, and to act collectively as a cohesive whole. This action takes precedence over current factional concerns, and will be manifested in direct proportion to the level of the perceived threat. From this it may be suggested that every individual act of identification within the hospital implies a "we" as well as a "they." It is within this dichotomy that the "I" is located, bringing the problem back to the level of the individual patient or staff member.

These structured relationships between staff and Native patients have implications for perception. The patients who are too demanding, who attempt to impose their will upon hospital personnel, who complain, or who don't comply with medical instructions will be perceived as "bad patients." They will be

labelled as a disruptive influence and will receive a variety of subtle acts of retribution designed to reestablish the status quo, which is control by the medical and nursing community. This process is not unique to Natives as patients (Lorber, 1975:213); however, the impact is more devastating because of the prejudice which accompanies the various acts of retribution.

The attitudes of hospital staff towards Dakota Sioux patients are variously revealed by the different health-care informants as benign, indifferent, non-problematic or infantilizing, as the following excerpts demonstrate.

> ***I don't see any signs of prejudice against Native patients in this hospital. That is because we are really fortunate in having a marvelous mix of nurses, mostly married women who have children, which of course gives them a sort of tolerance which is ideal for working with recalcitrant patients, mainly children. So, they treat recalcitrant patients, those who don't function well within the hospital setting, in the same manner as they deal with their children. We have an advantage in being a small hospital, for here we have very little structure to our hospital society. It is a very easy-going relationship. There may be criticism directed at certain individuals who may have over-stepped the mark on occasions, or prejudice if they have over-stepped on several occasions, such as coming into the hospital drunk at three in the morning to visit a relative, waking other patients in the process. At these times, we have to call the police to remove the drunk person from the hospital. Of course, city hospitals have become urban jungles; therefore, I'm certain they experience much more in the way of prejudice than we do.

***We do not have a problem with racial prejudice here because our nurses know most of the families and the way they will behave. Most of our nurses have been working here for a long time, and they understand how difficult Native patients can be. They have to be treated differently. Sometimes in the city I've seen it differently where if you are a Native patient, the nurse will ignore you. I know the difference because I worked in Winnipeg. There, all Native patients are considered drunks. Some nurses there would just turn their backs and let someone else take care of them. They won't touch them.

***We have a very good working relationship with Native patients, but we live among them. We have one Sioux girl in training at the moment. I don't know, you see them in the stores, you see them everywhere--shopping, here or in Brandon. They are all over the place. There is an occasional rotten apple in the barrel, but on the whole, no problem. Sometimes you might encounter acts of prejudice, such as in town. At one time the Native children came to our school in Pipestone, but the community voted it down. Now the children are bussed into Virden. They work for the farmers, and they work for the grain elevator. You don't dare pay them until they get the job done because if you do, you'll never see them again. They do a lot of their shopping in the grocery store in Pipestone, and they go to the bank here in Reston. The various farmers have employed them in the summer for years.

***The Sioux have their own pride sort of personality. Seen and not heard type of thing. Good listeners. I have certainly seen a tremendous improvement in them over the years. I think the kids are sort of a happy group in a way--you know, the little ones. They seem to be well looked after in comparison to years ago when I first started working here. Of course, there are some very headstrong ones, and you can't tell them anything. For example, they will take the birth control pill, but you can't talk them into a tubal.

***The Sioux used to have a real problem with scabies and head lice, but you seldom see that now. We do have a large number of children coming in with upper respiratory diseases. They have a tendency to have quite fat babies with short necks, and they are sort of inclined to upper respiratory illnesses.

***We only get the Natives from Oak Lake here. The patients from Sioux Valley go into Brandon. I think it may have something to do with the doctors here accepting Native patients. It has been my impression that the English doctors in particular have a prejudice against Native patients.

***The interaction between the doctors and Native patients varies. I've seen different attitudes by different physicians. Some of our physicians are very tolerant, and others are not. Sometimes this is a real problem that comes up in our nurses' meetings. However, it is very difficult to change the status quo.

***I would think that there is a very definite prejudice against Natives by the medical and nursing staff. Of course, there is a big difference in the Native families that we see, and naturally those who comply are the ones that we can talk to very easily. Those that give you a lot of trouble are the ones, you know, that aren't very good patients. The staff doesn't interact very well with those patients. There is also an attitude difference on the part of the physicians when dealing with Native patients. Dr. A sees most of them. Native patients are quick to sense these attitudes, and they know which of the doctors believe in their problems.

***It is going to take a long time to change how people think. Prejudice starts way back. It is possible that Native patients get the brunt of prejudice because they are the only visible ethnic group around here.

It will not have escaped the attention of the reader that there is in the above a tendency on the part of the health-care practitioners to externalize, minimize, distance and project the realities of prejudice towards Native patients within the Hospital District. In this manner, the problem becomes one concentrated within the urban setting, such as Winnipeg. Unfortunately, prejudice links directly into the development of rigid stereotypes, a topic of earlier discussion in Chapter II.

Only one of the health-care informants appeared to be cognizant of the reality experienced by Native patients. This particular nurse had a special sensitivity to the needs of Native patients which was lacking on the part of other staff members. Basically, Native patients appear to threaten the staff's

perception of their ability to assume responsibility in a logical and competent manner. King (1962:339) attempts to analyze this phenomenon from the following point of view:

> Two sets of orientations toward the patient...are important in the structuring of relationships between hospital personnel and patient: one is the dependency of the patient and assumption of responsibility for him; the other is the need for psychological support and respect for the individual.

The apparent problem for the Dakota Sioux patient lies in cultural expectations that differ from those of their health-care providers. Note the following discussion by Mechanic (1978:417):

> Patients tend to hold views concerning their illnesses, and they have expectations about the way the doctor should deal with them. These expectations may come from family and friends or they may be a consequence of particular subcultural learning. If the doctor fails to understand these expectations and cultural stereotypes, much of his ability to affect the patient's behavior may be undermined. In short, the fact that an approach to the patient's condition is scientifically correct does not necessarily mean that it is effective or consistent with lay expectations.

It is this split reality which separates the clinician from his client resulting in poor communication at the level of interaction. Competence in interpersonal relations is just as important as one's technical and professional skills. One of the largest barriers to overcome within the doctor-patient relationship in this research is that of differing status, or social class. Differences between the two parties impedes the flow of information.

Consequently, one approach to the application of Native health-care is to understand the symbolic meaning or the interpretation of the social world of clinician/client. For the health-care professional to be fully effective in dealing with Native patients, he has to understand the meaning the illness episode has for his

client. Or, in Weberian terms (1947:88), the physician must be cognizant that social action refers to action which the individual attaches subjective meaning, making it personal and real to that individual.

CONCLUSION

Perhaps the findings of Good and Delvecchio Good (1981:174) may help in finding meaning in the above reportages by health-care practitioners. They argue that "an interpretive social science involves conscious translation across meaning systems to arrive at understanding the realities of others." These researchers expand on this concept by stating (1981:167, 175):

> Whatever the biological correlates or grounds of a disease, sickness becomes a human experience and an object of therapeutic attention as it is made meaningful....Each medical subculture provides distinctive interpretations of human suffering and healing. Each provides explanatory models of illness, models of human physiology and personality, and forms of therapies, and each is grounded in a particular cosmology, epistemology and set of values. Clinicians routinely treat patients whose understanding and experience of illness are rooted in medical subcultures that have little in common with their own.

Kleinman's position is clear on this issue when he writes that (1980:297) "...the physician's failure to translate the biomedical concept into an idiom the patient could comprehend" may affect whether the patient returns and follows the treatment regimen. In addition, each individual patient has one or more explanatory models (EMs) that enables them to comprehend an illness episode. Thus, Kleinman (1980) advocates that all medical systems perform a number of core tasks: (1) construct the meaning of the illness experience, i.e. explanation of the cause and interpretation of the condition; (2) manage the illness experience, i.e. decide what type of condition it is; and, (3) define who is a relevant helper as well as what type of intervention technique to use.

Consequently, by failing to deal with the concept of "meaning," modern physicians are guilty of distorting the various aspects of the illness experience which produces poor health-care delivery to all patients, but more so to those from minority backgrounds (Kleinman, 1980:63).

This is one vital area in which Western medicine will remain deficient unless changes take place. Currently, the practice of medicine within Hospital District #10 does not take into account the powerful influence of meanings derived from the interplay of the Native individual with his family and his culture on his illness states. It is conveniently overlooked by physicians and nurses that illness entails certain meanings which cannot be taken out of context.

It is imperative to contextualize the elements of a patient's culture, and to recognize that social life must fundamentally be conceived of as the negotiation of meanings. As Sapir (1932:236) noted over fifty years ago:

> The true locus of culture is in the interactions of specific individuals, and, on the subjective side, in the world of meanings which each one of these individuals may unconsciously abstract for himself from his participation in these interactions.

At the level of doctor-patient interaction, doctors operate under little if any external constraint, to which we may add that the way in which medical power and authority is delivered at the level of this interaction between doctor and patient has not been adequately analyzed within the research literature. Another dilemma encountered in this assessment is the realization that cross-cultural understanding is but one approximation of reality. The anthropologist in this case is, at best, a mediator across cultural codes.

An issue which must be addressed is the variation in socio-economic conditions that currently exist between Native and non-Native patients. Even though differences may be a factor in medical decision-making processes, Spicer (1979:6-7) suggests that the choices involved in using, or not using, Western

medicine are not wholly class determined. He maintains that the continuing popular ethnic traditions, related to the subcultural systems operating within our society, are of importance in differential usage of Western medicine. It is on this basis that Spicer writes (1979:16):

> Despite their many real triumphs over particular diseases, practitioners of Western medicine cannot assume an ultimate disappearance of all other medical traditions and practices.

Thus, a physician's effectiveness in treatment varies with his understanding of how the patient perceives the situation and the meaning attached to the event. If the clinician clings to a rationalistic explanation of medical events, in terms of cause and effect, which is the central feature of scientific medicine, then the Dakota Sioux patient cannot be reached and dialogue will remain a distant and unattainable goal.

Anthropological studies (Young, 1976; Evans-Pritchard, 1937; Geertz, 1966; and Turner, 1967) emphasize that the narrowly-defined scientific criteria postulated by Western medicine are insufficient in observing and measuring the efficacy of traditional medical systems. In fact, Weidman writes that (1979:85):

> Because of its legally-sanctioned status and accompanying prerogatives, it is fairly typical that orthodox health practitioners routinely disregard the health beliefs and customary health behaviors of their clients. The practice is understandable in light of the premises upon which this superordinate health care system is based. It is inexcusable in humanistic terms.

In an interpretive enterprise, Weidman is saying that biomedicine narrowly defines an individual patient's problem by focusing on *curing* at the expense of *healing*, thus producing dissatisfied patients. On the other hand, Gaines and Hahn (1985:12) argue that traditional healing systems often seem to be more efficacious than biomedical physicians "...because folk healers focus on and treat illnesses in terms of their symbolic meanings...."

In conclusion, it is evident that the health-care practitioner requires sufficient cultural background information about the individual Sioux patient, his environment and belief system in order to insure that the medical orders given are realistic and appropriate for that particular patient's situation. One difficulty lies in educating medical staff of the importance of cultural differences and expectations. These are alien notions that run counter to the training of the health-care professional and stand in stark opposition to his beliefs. In essence, what is significant to the Dakota Sioux patient may not be so for the doctor, who may (and often does) dismiss the patient's perceptions and interpretations as having little relevance. The sad result is that the physician will never be in possession of all the information that may be relevant to a particular illness episode, making adequate health-care delivery difficult, if not impossible. Recommendations on how to overcome the problems outlined in this chapter will be addressed in the concluding chapter of this thesis.

CHAPTER VII: CONCLUSION

> It is only when we have the courage to face things exactly as they are, without any sort of self-deception or illusion, that a light will develop out of events, by which the path to success may be recognized. I CHING, or BOOK OF CHANGES, 1950.

INTRODUCTION

A salient point in this thesis is the recognition that cultural patterns are of crucial importance in the practice of medicine and the development of public health programs for Dakota Sioux patients. Culture, in anthropological terms, can have a variety of possible interpretations. That is, culture is relative to the time, place, people and events in which it is located. Consequently, there is an urgent need for Western health-care providers to incorporate the Dakota Siouxs' pre-scientific concept of illness as a sociocultural phenomenon.

Holism and Health Care

There is a requirement to view health as a multidimensional process involving the well-being of the whole person in the context of his environment. This inevitably leads one to a position consistent with that of Smuts (1926:xiii):

> If one accepts the concept of Holism, one can draw various conclusions from it...and these are still significant for various of our modern problems. These wholes, he asserts, are not to be thought of as tightly contoured things, separate from all others both in structure and activity. Every object, every concept, has a series of complex relationships with its neighbors and interpenetrates them. None can be understandable outside its environment, its context. All things interact.

The Significance of Explanatory Models

Distinctive cultural variation is a ubiquitous phenomenon. As such, anthropology is no longer limited to the study of isolated communities in exotic parts of the world. Instead, cross-cultural research within the confines of North America has become a legitimate field of investigation. At issue within cross-cultural health care is the need to be cognizant of cultural differences in order to facilitate communication within the therapeutic relationship. An awareness of the value and utility of explanatory models, that is the construction of meaning associated with an illness experience, would assist in reducing the current ambiguity in the interaction between Dakota Sioux patients and their Western health-care providers.

Here we are studying peoples of two different cultures. It is imperative that each come to understand the other, especially in terms of their health-illness patterns and viewpoints, culture, values and expectations of health care. Bridging this gap will be a real challenge, requiring an awareness of differences, and a sensitivity and commitment to change. Intractable, rigidly held beliefs will preclude any movement towards a subjective and valid health-care delivery system. However, it must be noted that belief systems are incredibly resistant to change. What is required is the dedication, patience, time and education in order to learn alternative ways of viewing health care.

The Search for New Cultural Forms

In this current period of rapid, technological change, the Dakota Sioux cannot avoid becoming actively involved in the turmoil of biomedical advances. However, this is just one facet of social change confronting Native groups. In a real sense the Dakota Sioux have been excluded from much of the progress made by the larger Canadian society which surrounds them. There is a tangible sense of anomie on today's Reserves brought about by an inability to develop new cultural alternatives which would facilitate adaptation to an ever-developing technological world.

There is a need among the Dakota Sioux for self-reliance, self-government, adequate education, employment and better living conditions which can be adapted to the contemporary world but still meaningfully linked to their cultural predecessors. The lack of these opportunities explains, in part, the preoccupation of some Native groups with a return to the old religions and customs of their ancestors. New cultural forms cannot be created in a vacuum. Instead a reconstruction will necessitate a synthesis of traditional cultural attributes with the realities of the l980s.

ISSUES REQUIRING RESOLUTION

By focusing on the attitudes and perceptions that occur between physician and Dakota Sioux patient, this study has attempted to reach the level at which cultural differences are most deeply rooted--in the structure of social intercourse. To accomplish this, it has been necessary to look for generalized, shared patterns of behavior exhibited by both sides engaged in the dialogue, as well as to uncover points of disagreement.

As is evident to the reader from the preceding chapters, cultural differences between patient and doctor have received a great deal of attention in this thesis. The tenor of contemporary writers and scholars quoted in this thesis

suggest that much of the conflict experienced within the clinical setting can be eliminated, or at least drastically reduced, through cross-cultural training and exposure to alternative views of health care.

This discussion of alternative views brings us back to the original hypothesis of this thesis which states that health beliefs and perceptions may be more important to an individual's selection and utilization of available medical systems than the biomedically determined health needs of that individual. To test the truth of this proposition, theories have been applied from medical anthropology, medical sociology and symbolic interactionism.

It may be that an acceptance of cultural differences cannot be mediated in the immediate future, given the entrenched position of the Western biomedical model in the training of new physicians and nurses. It is also possible that attempting to bring together traditional forms of healing and the biomedical model is counterproductive in the delivery of health care to Native patients. Perhaps having a choice between systems is more efficacious than discovering that in the process of improving health-care delivery to Native patients traditional forms have been eliminated from competition in the health field.

The application of cross-cultural health care has potential for the future. However, the very real danger is that it may be utilized as just another technique in the practitioner's black bag when dealing with "cultural others." This means that the health-care workers within Hospital District #10 have the task of coming to a mutual accommodation, an integration of their training and technology with Native values and beliefs. This will be a prerequisite to any improvement in the quality of health care for Dakota Sioux patients. Integration will require involvement in three areas of application: diagnosis, treatment and compliance. The fact that there is little integration evidenced in the reportings of informants leads to the serious issue of "cultural imposition" (Leininger, 1972:7):

> This term refers to subtle and less than subtle ways that an outsider imposes his own values, beliefs, and practices upon another individual or group. Cultural imposition often occurs as Western health 'experts,' consultants, and/or types of health workers impose their health ideas upon the culture they are supposed to help.

It goes without saying that medical orientation influences the medical care one seeks, but good or bad experiences with medical care may affect subsequent health orientation. For the majority of Dakota Sioux patients, medical interventions with local health-care providers have proven to be irksome at best. This is because the medical programs affecting Native patients are less flexible than they might ideally be due to the tendency of health-care professionals within the District to resist experimentation in social arrangements for giving care, in the belief that by so doing, they are protecting the integrity and quality of that care.

RECOMMENDATIONS

From the beginning of this research, the provision of more medical care services to Native populations serviced by Hospital District #10 has been but a tangential issue. Of greater importance is the need for a quality of care that addresses culture-specific problems facing the Dakota Sioux patient. A listing of these concerns would, by necessity, include the reduction of stress brought about by exposure to highly technical and medicalized language during the encounter session, as well as an appreciation for the socioeconomic disadvantages facing the Native patient.

One possible element to be included within the Hospital District is a collaboration between the local clinicians and the Dakota Sioux traditional healers. There are obvious benefits to this approach. First, is the provision of increased psychological comfort for the patient and his family. In itself this is conducive to a more beneficial therapeutic outcome (i.e., lowered mortality and morbidity). Secondly, good relationships between the health-care worker and the

Dakota Sioux patients would result in earlier and more frequent referrals to appropriate facilities. As this relationship proceeds over time, healers would become more adept at referring appropriate cases in an earlier and more treatable phase in the disease process. This cooperation would enhance medical care for the general populace as a whole.

What is called for is a "rapprochement" between the Western biomedical model and Native beliefs in etiology and cure, for then health-care practitioners and Native patients alike would be dealing with the same problems--one might even say the same realities--instead of passing each other like bishops on a chess board. In addition, it should be realized at this point that procedures adopted by Native healers in the milieu in which they operate are often more effective than so-called scientific procedures due to their acceptance by the populace as "legitimate." Westernization is often superficial and not infrequently even after successful treatment at a Western medical facility, a patient is likely to return to the traditional healer to have "the real cause" of the illness dealt with.

The recommendations derived from this research were presented to the Chief, the Band Council and members of the community in June 1985. Specifically the Dakota Sioux were advised to seek membership on the Hospital Board in order to have an elected voice in policy and procedure development in the delivery of health care to the district as a whole. Secondly, recommendations were made to assist in acquiring a transportation system for members of the Reserve to use when visiting physicians in the Virden and Reston clinics and/or hospitals. Thirdly, the Chief and Band Council were offered assistance by this researcher in contacting the necessary individuals responsible for developing a clinic on the Reserve. Finally, and most importantly, the Dakota Sioux were

encouraged to become more actively involved in issues directly related to their own health care, and to document cases of discrimination and abuse received at the hands of health-care providers within the district (Appendix E).

Recommendations were delivered to the members of the Hospital Board in January 1986 which included the following: set up an ad hoc committee from the Board to work directly with the Chief and Band Council of Oak Lake Dakota Sioux Reserve #59 on perceived issues of conflicts and misunderstandings; make a formal invitation to the Chief and Band Council for representation on the Hospital Board; support the formation of a clinic on the Reserve; incorporate into the current patient assessment protocols a series of ethnomedical questions for Native patients; and finally, to establish a Native diabetes program to inform and educate the Dakota Sioux as to the nature of the disease. The Board was advised that all of these recommendations were advocated in order to incorporate local cultural expression in order to make meaningful and tolerable that which is currently feared and avoided. Special attention is required to understand the cultural content of illness behavior among the Dakota Sioux in the hope that changes in attitudes and behaviors may follow (Appendix E).

CONCLUSION

Given the fact that all cultures are continually changing and evolving, it would seem expedient, minimally in terms of survival, to urge the need for tolerance, flexibility, and adaptability in the delivery of health care to Native patients. Consequently, the data collected during this research indicate that a more appropriate form of health care may be developed when Native patients and their models of illness, physicians and their practices, and the institution of medicine are understood within their respective social and cultural contexts.

Perhaps, in order to facilitate some solutions to the difficulties outlined in this thesis, it will be necessary to distinguish the more intransigent elements that

have been enumerated. This would include the insistence by the health-care professionals in acknowledging only one beneficial medical system, and similarly the insistence by Dakota Sioux patients upon incorporating Native healing beliefs into the medical equation.

No doubt there are different levels of belief inherent within this dichotomy, but it is only by distinguishing the various problems and assessing their relative importance, that we will be able to gain an insight into the difficulties and possibly suggest solutions. To assist Native populations in their attempts to be free from disease, we must recognize that they must also be free from repression, hunger, and discrimination. Also the larger, host community has to reach an awareness of the daily living conditions faced by Native peoples. It is clear that efforts to improve health care must be accompanied by intrinsic changes in attitudes and perceptions for all concerned. Thus, this study has attempted to bring into focus a questioning of the relationship between beliefs and perceptions as they impact on individual behaviors and actions during illness episodes. It may well be argued that culture mediates all human perceptions, including what it means to be sick.

Finally, it is likely that the psychological value of traditional Sioux medicine, provided one believes in them, may be a better means of care for native patients than many Western medicines. Unfortunately, patient's expectations often exceed the ability of healers, whether they be indigenous or Western in orientation, for as Morley and Wallis maintain (1980:15):

> Medicine, in the ethnomedical sense, is to be seen as more than the fiat of the Western medical paradigm. The really fundamental *sine qua non* of medicine in both traditional and modern industrial societies is that it is a social phenomenon and can only be fully understood as such.

In conclusion, the value of this research lies in providing medical staff, nurses and other health-care practitioners within Hospital District #10 with a clearer appreciation and understanding of Dakota Sioux culture.

Also, findings from this study indicate that the Western biomedical model does not have a wide-spread acceptance among Dakota Sioux patients. Rather, it is actively being modified with varying degrees of nativistic beliefs and supplemented by a complex armamentarium of Native healing practices. In addition, local health-care providers appear to be unaware of the depth and significance of Native culture, its ubiquitous nature, and its relevance to health-care delivery in the 1980s.

Serendipity may not have played a major role in the selection of this research topic; however, it has definitely colored the manner in which the ethnography has finally reached written form. Even after the termination of field work activity, the friendships made and ties to the ongoing concerns of the reserve community continue unabated.

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APPENDIX A: EXAMPLE OF CONSENT FORM

RESEARCH PROJECT: NATIVE PATIENTS
AND THE WESTERN MEDICAL MODEL

This research project addresses the symbolic interaction between Native patients and health-care providers within Hospital District #10, located in Southwestern Manitoba. The focus is two-fold: First, to determine the degree of acquaintance with and understanding of Native culture and models of illness on the part of health-care providers; and secondly, to explore the presence (or absence) of explanatory models of illness and disease on the part of Native patients that may be in conflict with the accepted Western medical model, and to explore the effect this may have on and the utility for Native patients.

The project is being conducted by Sandra Kay Sherley-Spiers, under the direction of the Department of Anthropology, University of Manitoba. There are no funding agencies involved at this time. The research forms the basis of fieldwork experience in partial completion of requirements for the Master of Arts degree in anthropology at the University of Manitoba. In addition, it is hoped that the information gathered will develop into an instrument of value, both to the health-care providers and the Native patient, in facilitating interaction within the health-care delivery field.

The researcher involved recognizes the private nature of the information given, and to maintain your privacy and anonymity, any information that would reveal your identity will not be utilized.

If you feel that this research is such that you don't want to participate, you are naturally free not to do so. I do, however, appreciate all the help that you can give me. All data does, however, remain within the exclusive discretion of this researcher as to its final disposition. This includes publication, reports, thesis and/or related formats.

Thank you for your consideration and cooperation.

I have read and understand the foregoing, and agree to freely participate in this research project.

Your Signature _____ Date _____

Project Staff Signature _____

Project Staff:

Sandra Kay Sherley-Spiers
Department of Anthropology
University of Manitoba
Winnipeg, Manitoba R3T 2N2
Office telephone: (204) 474-8471
Home telephone:

Consent form: #1

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APPENDIX B: INTERVIEW SCHEDULES

APPENDIX B (I): ETHNOMEDICAL INTERVIEW SCHEDULE WITH NATIVE PATIENTS

1. Have you had any contact with doctors or hospitals within the past two years?

2. What happened that made you seek a doctor's help?

   a. at any point during the illness episode did you treat yourself?
   b. at any point during the illness episode did you seek the advice of a Native healer?
   c. did you discuss your illness with family members or others in the community before seeking help?

3. When talking to the doctor, did you understand what he had to say about your problem? Did he tell you what was wrong with you? Is this the same as what you think caused the illness?

4. What do you think caused your problem?

   a. why do you think it started when it did?
   b. when this problem began, what else was happening in your life? What other things were you doing?
   c. are these events related to your problem? If so, how?

5. Tell me about your experiences with the local physicians and nurses.

6. What would make you seek out a doctor's assistance? Are there certain types of illnesses that don't require a doctor's help? If so, what are they.

7. What use do you make of traditional Sioux medicines?

   a. what types of problems are best treated by Native remedies?
   b. do you make your own medicines or does someone prepare them for you?
   c. what types of illness episodes require the assistance of the medicine man?

8. What do you see as the primary health problems facing the residents of Oak Lake Reserve #59?

9. What changes would you like to see take place in regards to health-care delivery involving Dakota Sioux patients?

APPENDIX B (II): INTERVIEW SCHEDULE WITH HEALTH-CARE PROVIDERS

1. As a physician/nurse what problems, if any, do you encounter when dealing with Dakota Sioux patients?

2. Is there a particular pattern of medical problems that the Dakota Sioux experience?

3. Are you aware of the presence and activities of medicine men in the district?

4. Do your Native patients comply with your recommended treatment plans?

5. To your knowledge, is there a language problem between staff and Native patients? If so, what is the extent of the problem, and how do you overcome it?

6. Do you ever encounter Native patients who do not speak English? If so, how do you deal with this problem? Who serves as interpreter?

7. Do you think that your Native patients understand the nature of their illness and the treatment plan offered?

8. Do you see and treat many Native patients? If so, how often and where?

9. To what extent to Native patients utilize the hospital and/or clinic?

10. How do the nurses/physicians interact with Native patients?

11. To your knowledge, do the Dakota Sioux have a problem with suicide?

12. Are you aware that Native patients utilize both traditional and Western medicine simultaneously at times? Does this concern you?

13. How long have you been working within Hospital District #10?

14. How often do Native patients utilize the services of the emergency room?

15. Tell me what you know about Dakota Sioux culture.

16. Are there specific areas that you as a nurse/physician see that might present problems when dealing with Native patients?

APPENDIX C: COPIES OF LETTERS OF APPROVAL

HOSPITAL DISTRICT No. 10

VIRDEN DISTRICT HOSPITAL
RESTON COMMUNITY HOSPITAL
ELKHORN M.N.U.
DISTRICT AMBULANCE SERVICE
MERRY MANOR RESIDENCE
DR. R. S. HARRIS REHABILITATION CENTRE

PLEASE REPLY TO: VIRDEN DISTRICT HOSPITAL
P.O. BOX 400
VIRDEN, MANITOBA
ROM 2CO

Mrs Sandra Kay Sherley-Spiers

Winnipeg.MANITOBA.

January 3 1985

Dear Mrs Sherley-Spiers,

RE: Native Health-care Project-
Hospital District #10

At the last meeting of the Governing Board, the Board was pleased to approve the continuation of your project into 1985.

When you do have some tentative findings from your research I know that the Board would be receptive to you making a presentation at a future Governing Board Meeting, to discuss your findings and any possible implications for changes in our District Health-care policies,

We look forwards to hearing from you when your research is more advanced,

Yours truly,

Jake Thiessen
Chairman. Governing Board

cc file.

HOSPITAL DISTRICT No. 10

VIRDEN DISTRICT HOSPITAL
RESTON COMMUNITY HOSPITAL
ELKHORN M.N.U.
DISTRICT AMBULANCE SERVICE
MERRY MANOR RESIDENCE
DR. R. S. HARRIS REHABILITATION CENTRE

PLEASE REPLY TO: VIRDEN DISTRICT HOSPITAL
P.O. BOX 400
VIRDEN, MANITOBA
ROM 2CO

TO WHOM IT MAY CONCERN

June 4 1984

This is to advise that Ms Sandra.K.SHERLEY has been given permission by the Governing Board of Hospital District #10 (Virden-Reston-Elkhorn) to undertake a research project during the summer of 1984-to interview both patients and staff and to carry out detailed analyses of related medical records:at the discretion and under the direction of the Assistant Administrator (Patient-care),as may be found valuable.

Approved at the regular meeting of the Governing Board of Hospital District #10 Thursday May 3 1984.

cc file.

Jake Thiessen
Chairman.Governing Board
Hospital District #10

Telephone
854-2959

OAK LAKE SIOUX BAND

P.O. BOX 146
PIPESTONE, MANITOBA
R0M 1T0

November 9, 1984

WINNIPEG, Manitoba

Dear Mrs. Sandra Shirley-Spiers,

We, Chief and Council of the Oak Lake Sioux Reserve are in support of your Research Project. (Native Patients and the Western Medical Model)

We feel your research will be benefical to the Oak Lake Sioux Reserve and also Hospital District #10.

Therefore this letter is our approval for you to proceed with your research and we will be looking forward to reviewing your information that you have compiled in your project upon completion.

Yours Sincerely,

CHIEF

COUNCILLOR

COUNCILLOR

COUNCILLOR

MEMO

This is to advise that Sandra.K.Sherley-Spiers will be conducting a medical research project this summer within Hospital District #10 with the approval of the Governing Board.

The project forms part of her post-graduate studies in Anthropology at the University of Manitoba,where she is working under the direction of Professor.J.Kaufert of the Health Sciences Centre.

As part of her research she will want to carry out interviews with both staff and patients and review selected medical records.

Participation by staff & patients in this research will be optional,though your co-operation will certainly be appreciated.

M.Spiers.

To:
H.Elliot.MONA Rep
Lynn Isaac .MONA Rep
G.Thiry .Virden
H.Tolton.
E.Hildebrandt
M.Nugent
M.Bulloch
D.Yeo
M.Turnbull
J.McDonald.

APPENDIX D: M.H.S.C. REPORTS

MUNICIPALITY A06 OAK LAKE SIOUX INDIAN RESERVE

DIAGNOSTIC CATEGORY	TOTAL CASES	TOTAL DAYS	OAK LAKE RATE PER 1000 POPULATION CASES	OAK LAKE RATE PER 1000 POPULATION DAYS	MANITOBA RATE PER 1000 POPULATION ALL RESIDENTS CASES	MANITOBA RATE PER 1000 POPULATION ALL RESIDENTS DAYS
16 SYMPTOMS,SIGNS,ILL-DEFINED CONDS. (780-799)						
	8*	29*	24.2*	88*	8.3*	56*
17 INJURY+POISONING (800-999)						
089 FRACTURES (800-829)	3	27	9.1	82	4.7	106
090 DISLOCATIONS (830-839)	1	4	3.0	12	.5	3
092 INTRACRANIAL INJURY,EXCL.SKULL FRAC (850-854)	3	3	9.1	9	1.1	5
094 OPEN WOUND,HEAD,NECK+TRUNK (870-879)	1	4	3.0	12	.5	2
103 BURNS (940-949)	1	11	3.0	33	.3	5
105 TRAUMATIC COMPLICATIONS+UNSPEC.INJ. (958-959)	1	1	3.0	3	.3	2
106 POISONINGS BY DRUGS,MEDICIN.BIOLOG. (960-979)	1	1	3.0	3	1.0	4
107 TOXIC EFFECTS,NON-MEDICINAL (980-989)	1	1	3.0	3	.2	1
	12*	52*	36.3*	157*	12.7*	161*
18 FACTORS INFL.+CONTACT HEALTH SERV. (V01-V82)						
115 HEALTH SERVICE FOR SPECIFIC PROCED. (V50-V59)	1	3	3.0	9	1.9	18
	1*	3*	3.0*	9*	6.0*	59*
GRAND TOTALS	102**	516**	308.2**	1,559**	146.1**	1,574**

OAK LAKE RATE

MANITOBA RATE

UTILIZATION REGARDLESS OF WHICH HOSPITAL

MUNICIPALITY A06 OAK LAKE SIOUX INDIAN RESERVE

DIAGNOSTIC CATEGORY	TOTAL CASES	TOTAL DAYS	OAK LAKE RATE PER 1000 POPULATION CASES	OAK LAKE RATE PER 1000 POPULATION DAYS	MANITOBA RATE PER 1000 POPULATION ALL RESIDENTS CASES	MANITOBA RATE PER 1000 POPULATION ALL RESIDENTS DAYS
09 DIS.OF DIGESTIVE SYSTEM (520-579)						
060 HERNIA OF ABDOMINAL CAVITY (550-553)	1	3	3.0	9	2.6	15
061 NONINFECTIOUS ENTERITIS+COLITIS (555-558)	5	9	15.1	27	2.5	16
063 OTHER DIS.OF DIGESTIVE SYSTEM (570-579)	2	27	6.0	82	4.6	47
	8*	39*	24.2*	118*	16.3*	129*
10 DIS.OF GENITOURINARY SYSTEM (580-629)						
068 INFLAMM.DIS.OF FEMALE PELVIC ORGANS (614-616)	1	6	3.0	18	.8	4
069 OTHER DISORDERS OF FEM. GEN.TRACT (617-629)	1	2	3.0	6	3.6	21
	2*	8*	6.0*	24*	10.2*	74*
11 PREGNANCY,CHILDBIRTH,PUERPERIUM (630-676)						
072 COMPL.MAINLY REL.TO PREGNANCY (640-648)	7	15	21.1	45	6.3	22
073 NORMAL DELIVERY,CARE IN PREGNANCY (650-659)	8	31	24.2	94	9.2	42
074 COMPL.OCCURRING LABOR+DELIVERY (660-669)	2	12	6.0	36	4.6	20
	17*	58*	51.4*	175*	22.4*	90*
12 DIS.OF SKIN+SUBCUTANEOUS TISSUE (680-709)						
077 OTHER INFLAMM.COND.OF SKIN (690-698)	2	15	6.0	45	.3	5
	2*	15*	6.0*	45*	2.1*	22*
13 DIS.OF MUSCULOSKEL.SYST.+CONN.TIS. (710-739)						
079 ARTHROPATHIES+RELATED DISORDERS (710-719)	2	43	6.0	130	2.7	43
	2*	43*	6.0*	130*	6.7*	85*
14 CONGENITAL ANOMALIES (740-759)						
083 CONGENITAL ANOMALIES (740-759)	1	3	3.0	9	1.1	8
	1*	3*	3.0*	9*	1.1*	8*
15 CONDITIONS ORIGIN.IN PERINATAL PER.(760-779)						
085 OTHER COND. ORIG.IN PERINAT.PERIOD (764-779)	2	16	6.0	48	.4	4
	2*	16*	6.0*	48*	.4*	4*
16 SYMPTOMS,SIGNS,ILL-DEFINED CONDS. (780-799)						
086 SYMPTOMS (780-789)	8	29	24.2	88	7.8	40

PREPARED BY M.H.S.C.

A44I741RPT4 — 1984/85 HOSPITAL UTILIZATION BY MUNICIPALITY — JUN 10 1985 — PAGE 26

MHSC COMPUTER REPORT NO.

MUNICIPALITY A06 OAK LAKE SIOUX INDIAN BAND NSTING

DIAGNOSTIC CATEGORY (ICD-9 CODES)		TOTAL CASES	TOTAL DAYS	OAK LAKE RATE PER 1000 POPULATION CASES	OAK LAKE RATE PER 1000 POPULATION DAYS	MANITOBA Rate PER 1000 POPULATION ALL RESIDENTS CASES	MANITOBA Rate PER 1000 POPULATION ALL RESIDENTS DAYS
01 INFECTIOUS AND PARASITIC DISEASES	(001-139)						
001 INTESTINAL INFECTIOUS DISEASES	(001-009)	3	13	9.1	39	.8	4
002 TUBERCULOSIS	(010-018)	2	36	6.0	109	.2	4
008 OTHER DIS.DUE TO VIRUSES	(070-079)	1	13	3.0	39	.5	2
		6*	62*	18.1*	187*	2.3*	22*
02 NEOPLASMS	(140-239)						
023 BENIGN NEOPLASMS	(210-229)	1	2	3.0	6	1.4	11
		1*	2*	3.0*	6*	9.3*	165*
03 ENDOCRINE,METAB.DIS.IMMUN.DISORDERS	(240-279)						
028 DIS.OF OTHER ENDOCRINE GLANDS	(250-259)	1	8	3.0	24	1.7	28
		1*	8*	3.0*	24*	2.5*	38*
05 MENTAL DISORDERS	(290-319)						
034 NEUROTIC,PERSONALITY,MENTAL DISORD.	(300-316)	2	2	6.0	6	2.7	40
		2*	2*	6.0*	6*	6.0*	145*
06 DIS.OF NERVOUS SYST.+SENSE ORGANS	(320-389)						
041 DISEASES OF THE EAR+MASTOID PROCESS	(380-389)	1	6	3.0	18	1.3	5
		1*	6*	3.0*	18*	6.3*	97*
07 DIS.OF CIRCULATORY SYSTEM	(390-459)						
042 ACUTE RHEUMATIC FEVER	(390-392)	1	7	3.0	21		
045 ISCHEMIC HEART DISEASE	(410-414)	3	16	9.1	48	6.0	75
048 CEREBROVASCULAR DISEASE	(430-438)	1	2	3.0	6	2.7	105
		5*	25*	15.1*	76*	16.2*	282*
08 DIS.OF RESPIRATORY SYSTEM	(460-519)						
051 ACUTE RESPIRATORY INFECTIONS	(460-466)	9	27	27.2	82	3.3	15
052 OTHER DIS.OF UPPER RESP. TRACT	(470-478)	1	3	3.0	9	3.8	9
053 PNEUMONIA AND INFLUENZA	(480-487)	14	90	42.3	272	3.9	46
054 CHRONIC OBSTRUCT.PULM.DIS.	(490-496)	4	15	12.1	45	4.3	44
056 OTHER DIS.OF RESPIRATORY SYSTEM	(510-519)	3	10	9.1	30	1.0	11
		31*	145*	93.7*	438*	16.4*	128*

BY AGE GROUP AND DIAGNOSTIC CATEGORY FOR THE 12 PAYMENT MONTHS ENDING MARCH 31, 1985 85 04 1

MUNICIPALITY # A06 OAK LAKE SIOUX INDIAN RESERVE

WESTMAN REGION

AGE GROUP	DIAGNOSTIC CATEGORY	NUMBER OF DISCRETE PATIENTS **	NUMBER OF SERVICES	COST	# PATIENTS PER 1000 POPULATION	POPULATION AS OF DEC 1,1984
	MUSCULOSKELETAL DIS	52	225	2,710.60	157	
	CONGENITAL ANOMALIES	4	8	750.35	12	
	PERINATAL DIS	9	43	890.40	27	
	ILL-DEFINED CONDITIONS	73	204	2,961.91	221	
	ACCIDENTS POISONINGS	112	372	5,708.30	338	
	SPECIAL CONDITIONS & INFANTS	97	301	3,444.30	293	
	BLANK DIAGNOSTICS	10	47	329.85	30	
	TOTALS	321	3,752	54,003.20	970	

See page 541

** UNDUPLICATED COUNT FOR EACH DIAGNOSTIC CATEGORY IN EACH AGE GROUP AND FOR TOTALS IN EACH AGE GROUP

BY AGE GROUP AND DIAGNOSTIC CATEGORY FOR THE 12 PAYMENT MONTHS ENDING MARCH 31, 1985 85 04 17

MUNICIPALITY # A06 OAK LAKE SIOUX INDIAN RESERVE WESTMAN REGION

AGE GROUP	DIAGNOSTIC CATEGORY	NUMBER OF DISCRETE PATIENTS **	NUMBER OF SERVICES	COST	# PATIENTS PER 1000 POPULATION	POPULATION AS OF DEC 1,1984
	BLANK DIAGNOSTICS	4	10	48.00	33	
	TOTALS	113	1,088	17,997.48	934	
30-64	INF PARASITIC DIS	19	61	548.85	241	79
	NEOPLASMS	2	5	213.90	25	
	ENDO NUTRIT METAB DIS	24	72	868.05	304	
	DIS BLOOD	5	10	117.60	63	
	MENTAL DISORDERS	17	76	783.45	215	
	NERVOUS SYSTEM DIS	43	118	1,915.05	544	
	CIRCULATORY DIS	9	23	288.95	114	
	RESPIRATORY DIS	44	153	1,835.25	557	
	DIGESTIVE DIS	17	73	1,898.25	215	
	GENITOURINARY DIS	21	83	1,417.65	266	
	OBSTETRICAL COND	1	2	298.20	13	
	SKIN & S C DIS	22	76	959.60	278	
	MUSCULOSKELETAL DIS	26	152	1,618.45	329	
	PERINATAL DIS	1	1	12.80	13	
	ILL-DEFINED CONDITIONS	24	63	841.15	304	
	ACCIDENTS POISONINGS	33	87	1,597.50	418	
	SPECIAL CONDITIONS & INFANTS	25	54	512.50	316	
	BLANK DIAGNOSTICS	2	24	175.60	25	
	TOTALS	78	1,133	15,902.80	987	
65+	INF PARASITIC DIS	2	2	25.60	167	12
	ENDO NUTRIT METAB DIS	3	11	140.80	250	
	MENTAL DISORDERS	1	1	12.80	83	
	NERVOUS SYSTEM DIS	8	23	378.65	667	
	CIRCULATORY DIS	6	63	421.50	500	
	RESPIRATORY DIS	7	32	387.00	583	
	DIGESTIVE DIS	2	2	25.25	167	
	MUSCULOSKELETAL DIS	8	41	470.05	667	
	ILL-DEFINED CONDITIONS	2	2	25.60	167	
	ACCIDENTS POISONINGS	4	28	317.90	333	
	SPECIAL CONDITIONS & INFANTS	4	10	79.15	333	
	TOTALS	10	215	2,284.30	833	
TOTAL	INF PARASITIC DIS	83	231	2,598.70	251	331
	NEOPLASMS	5	12	453.20	15	
	ENDO NUTRIT METAB DIS	41	101	1,233.50	124	
	DIS BLOOD	17	27	315.00	51	
	MENTAL DISORDERS	27	137	1,794.95	82	
	NERVOUS SYSTEM DIS	178	362	6,020.05	538	
	CIRCULATORY DIS	19	91	788.65	57	
	RESPIRATORY DIS	207	898	10,758.46	625	
	DIGESTIVE DIS	70	199	3,535.63	211	
	GENITOURINARY DIS	63	228	2,979.15	190	
	OBSTETRICAL COND	13	59	4,135.10	39	
	SKIN & S C DIS	91	207	2,595.10	275	

TOTAL BAND LISTING ON and off RESERVE

M.H.S.C COMPUTER REPORT NO.

M.H.S.C. REPORT ON UTILIZATION OF MEDICAL SERVICES BY MANITOBA RESIDENTS

BY AGE GROUP AND DIAGNOSTIC CATEGORY FOR THE 12 PAYMENT MONTHS ENDING MARCH 31, 1985

85 04 17

MUNICIPALITY # A06 OAK LAKE SIOUX INDIAN [illegible]

TOTAL Band LISTING

AGE GROUP	DIAGNOSTIC CATEGORY	NUMBER OF DISCRETE PATIENTS **	NUMBER OF SERVICES	COST	WESTMAN REGION # PATIENTS PER 1000 POPULATION	Oak Lake POPULATION AS OF DEC 1,1984	
0-4	INF PARASITIC DIS	19	38	521.75	388	49	: Aged 0-4
	DIS BLOOD	3	3	40.90	61		
	MENTAL DISORDERS	1	1	13.85	20		
	NERVOUS SYSTEM DIS	21	52	736.55	429		
	RESPIRATORY DIS	47	393	4,590.65	959		
	DIGESTIVE DIS	18	61	749.65	367		
	GENITOURINARY DIS	1	1	13.85	20		
	SKIN & S C DIS	19	38	525.10	388		
	MUSCULOSKELETAL DIS	1	2	63.05	20		
	CONGENITAL ANOMALIES	1	2	264.80	20		
	PERINATAL DIS	8	42	877.60	163		
	ILL-DEFINED CONDITIONS	10	31	497.40	204		
	ACCIDENTS POISONINGS	10	38	564.70	204		
	SPECIAL CONDITIONS & INFANTS	20	95	1,009.10	408		
	TOTALS	51	797	10,468.95	1,041		
5-14	INF PARASITIC DIS	24	106	1,175.05	343	70	: Aged 5-14
	NEOPLASMS	1	1	12.80	14		
	DIS BLOOD	1	3	25.95	14		
	NERVOUS SYSTEM DIS	38	64	1,131.50	543		
	RESPIRATORY DIS	43	120	1,558.61	614		
	DIGESTIVE DIS	16	24	306.43	229		
	GENITOURINARY DIS	2	4	41.15	29		
	SKIN & S C DIS	21	30	362.20	300		
	MUSCULOSKELETAL DIS	3	3	38.40	43		
	CONGENITAL ANOMALIES	2	5	461.70	29		
	ILL-DEFINED CONDITIONS	9	34	511.13	129		
	ACCIDENTS POISONINGS	16	64	973.50	229		
	SPECIAL CONDITIONS & INFANTS	20	48	645.00	286		
	BLANK DIAGNOSTICS	4	13	106.25	57		
	TOTALS	69	519	7,349.67	986		
15-29	INF PARASITIC DIS	19	24	327.45	157	121	: Aged 15-29
	NEOPLASMS	2	6	226.50	17		
	ENDO NUTRIT METAB DIS	14	18	224.65	116		
	DIS BLOOD	8	11	130.55	66		
	MENTAL DISORDERS	8	59	904.85	66		
	NERVOUS SYSTEM DIS	68	105	1,858.30	562		
	CIRCULATORY DIS	4	5	78.20	33		
	RESPIRATORY DIS	66	200	2,386.95	545		
	DIGESTIVE DIS	17	39	556.05	140		
	GENITOURINARY DIS	39	140	1,506.50	322		
	OBSTETRICAL COND	12	57	3,836.90	99		
	SKIN & S C DIS	29	63	748.20	240		
	MUSCULOSKELETAL DIS	14	27	520.65	116		
	CONGENITAL ANOMALIES	1	1	23.85	8		
	ILL-DEFINED CONDITIONS	28	74	1,086.63	231		
	ACCIDENTS POISONINGS	49	155	2,254.70	405		
	SPECIAL CONDITIONS & INFANTS	28	94	1,198.55	231		

MANITOBA HEALTH SERVICES COMMISSION

A441732-REP1 1984/85 TABLE 19 A JUN 10 1985 PAGE 00274

RESIDENCE NO. A06 NAME OAK LAKE SIOUX INDIAN . POPULATION 331

BAND LISTING

LOCATION of HOSPITAL UTILIZATION for ALL BAND MEMBERS

HOSP.NO.	HOSPITAL NAME	CASES	DAYS
0180	VIRDEN DISTRICT HOSPITAL	51	195
0001	BRANDON GENERAL HOSPITAL	19	162
0164	RESTON COMMUNITY HOSPITAL	14	61
0016	HEALTH SCIENCES CENTRE	6	14
0171	BIRTLE HEALTH SERVICES DISTRICT	5	46
0005	ST. BONIFACE GENERAL HOSPITAL	2	16
0184	MELITA HEALTH CENTRE	2	4
0017	REHABILITATION CENTRE FOR CHILDREN	1	11
0210	PERCY E.MOORE HOSPITAL	1	1
3000	SASKATCHEWAN	1	6
	TOTAL ACT.TREAT.HOSP.	102	516
	CASES / 1000	520	← cases per 1000 population
	DAYS / 1000	2,633	← Patient days per 1000 population

MANITOBA STATUS INDIAN POPULATION*

Region	Indian Bands	December, 1982 Total Band Listing	December, 1982 Band Members With Winnipeg Postal Address	June, 1983 Total Band Listing	June, 1983 Band Members With Winnipeg Postal Address	December, 1983 Total Band Listing	December, 1983 Band Members With Winnipeg Postal Address	June, 1984 Total Band Listing	June, 1984 Band Members With Winnipeg Postal Address
Central	Dakota Tipi	133	14	140	18	147	26	141	20
	Dakota Plains	158	6	163	6	156	8	159	8
	Long Plains Sioux	1,017	194	1,006	218	1,020	212	1,044	210
	Sandy Bay	1,982	212	2,019	248	2,058	264	2,073	261
	Swan Lake	538	174	555	188	554	184	555	180
	Sub-Total	3,828	600(15.7%)	3,883	678(17.5%)	3,935	694(17.6%)	3,976	679(17.1%)
Eastman	Berens River	975	97	993	117	999	128	1,009	156
	Bloodvein	540	57	557	63	559	59	557	80
	Buffalo Point	22	0	22	0	22	0	21	0
	Fort Alexander	2,717	931	2,762	,003	2,754	1,015	2,759	1,063
	Hollow Water	529	87	534	87	543	100	546	93
	Little Black River	321	109	321	105	321	102	335	107
	Little Grand Rapids	924	39	939	39	947	56	955	54
	Poplar River	590	81	598	77	611	78	618	94
	Roseau River	863	214	866	206	858	208	858	212
	Sub-Total	7,481	1,615(21.6%)	7,592	1,697(22.4%)	7,614	1,746(22.9%)	7,658	1,859(24.3%)
Interlake	Brokenhead	496	287	495	298	506	295	501	290
	Dauphin River	99	17	107	17	110	19	109	18
	Fairford	960	196	975	188	981	201	1,009	217
	Fisher River	1,222	328	1,225	323	1,243	319	1,245	330
	Jackhead	344	91	358	108	357	119	358	114
	Lake Manitoba	643	214	689	237	693	242	709	254
	Lake St. Martin	862	265	877	280	880	293	868	315
	Little Saskatchewan	340	104	341	105	341	110	349	110
	Peguis	2,355	658	2,373	649	2,376	627	2,414	667
	Sub-Total	7,321	2,160(29.5%)	7,440	2,205(29.6%)	7,487	2,225(29.7%)	7,562	2,315(30.6%)
Norman	Barren Lands	304	8	304	7	310	8	308	8
	Chemahawin	459	21	479	19	489	19	498	20
	Churchill	353	42	365	51	365	52	367	49
	Cross Lake	2,309	62	2,332	59	2,361	68	2,358	83
	Fox Lake	364	35	370	36	366	43	362	37
	Garden Hill	1,816	173	1,855	198	1,889	221	1,908	222
	God's Lake	1,177	135	1,200	138	1,205	166	1,233	176
	God's River	272	9	280	18	283	20	291	17

MSIP84

MANITOBA STATUS INDIAN POPULATION

Region	Indian Bands	December, 1982 Total Band Listing	December, 1982 Band Members With Winnipeg Postal Address	June, 1983 Total Band Listing	June, 1983 Band Members With Winnipeg Postal Address	December, 1983 Total Band Listing	December, 1983 Band Members With Winnipeg Postal Address	June, 1984 Total Band Listing	June, 1984 Band Members With Winnipeg Postal Addres
Norman (Cont'd)	Grand Rapids	357	33	360	34	368	31	374	25
	Matthias Colomb	1,330	57	1,350	53	1,363	60	1,366	54
	Moose Lake	357	19	362	21	368	22	359	19
	Inuit & O.O.P. Indians	399	212	429	225	453	249	505	284
	Nelson House	2,035	62	2,068	66	2,076	65	2,098	73
	Northlands	407	1	409	1	417	1	433	5
	Norway House	2,597	248	2,622	252	2,648	254	2,673	273
	Oxford House	1,209	18	1,234	18	1,238	19	1,261	20
	Red Sucker Lake	365	15	381	22	390	21	409	26
	Shamattawa	611	16	624	17	627	17	638	17
	Split Lake	1,231	22	1,248	38	1,276	44	1,285	53
	Ste. Theresa Point	1,578	96	1,591	81	1,614	74	1,641	92
	The Pas	1,351	67	1,362	79	1,391	85	1,392	78
	Wasagamack	707	38	706	48	719	51	728	53
	War Lake	88	1	87	1	89	2	93	3
	York Factory	416	25	419	18	423	14	422	14
	Sub-Total	22,092	1,415(6.4%)	22,428	1,500(6.7%)	22,728	1,606(7.1%)	23,002	1,701(7.4%)
Parkland	Crane River	215	42	217	37	231	40	239	35
	Ebb and Flow	701	125	719	128	728	131	744	152
	Indian Birch	143	3	149	5	149	10	152	11
	Pine Creek	687	203	706	208	714	208	728	211
	Shoal River	554	88	566	93	570	92	587	88
	Valley River	383	57	379	62	383	74	367	77
	Waterhen	426	63	435	76	453	78	450	77
	Sub-Total	3,109	581(18.7%)	3,171	609(19.2%)	3,228	633(19.6%)	3,267	651(19.9%)
Westman	Birdtail Sioux	240	13	243	12	246	13	246	22
	Gamlers	14	1	14	1	14	1	15	1
	Keeseekoowanin	317	31	323	38	335	31	352	35
	Oak Lake	313	30	321	31	327	35	331	41
	Rolling River	374	70	377	60	371	58	367	58
	Sioux Valley	1,024	57	1,029	53	1,044	71	1,068	71
	Waywayseecappo	802	94	792	86	802	90	792	86
	Sub-Total	3,084	296(9.6%)	3,099	281(9.1%)	3,139	299(9.5%)	3,171	314(9.9%)
Manitoba		46,915	**6,667(14.2%)	47,613	6,970(14.6%)	48,131	7,203(15.0%)	48,636	7,519(15.5%)

*Source M.H.S.C. Table 3 Population by Mailing Address
**Revised Total.

MHSC/MIS
January 1985

January 9, 1986

RECOMMENDATIONS

Research into the health-care delivery concerns of the residents of the Oak Lake Dakota Sioux Indian Reserve (#59) indicate the following problem areas:

1. Lack of adequate transportation for individuals seeking medical attention and services. This is a serious problem resulting in excessive use of the emergency room facilities during the evening hours. The lack of transportation also is reflected in the high number of clinic appointments not being attended by Native patients.

2. Communication discontinuities between Native patients and physicians during the clinical interview. In many cases, this is the result of poor English skills on the part of Native patients. On the other hand, physicians often assume that they are being understood, when in fact they are not.

3. Lack of awareness on the part of the health-care practitioners within Hospital District #10 regarding Native customs and beliefs surrounding the "meaning" of health and disease states, and what therapeutic threatments are believed to be efficacious.

5. A continuing pattern of "non-compliance" with prescribed medical treatment.

6. Diabetes is a growing problem among the Dakota Sioux. As this is not a traditional disease for these individuals, there is a great deal of misunderstanding and fear surrounding diabetes, i.e. how it is contracted and how it is treated.

6. An abnormally high level of upper respiratory disease among Native children compared to the general population within the Hospital District. In part, this is a reflection of the poor socio-economic conditions on the reserve.

To improve the health-care delivery system to Native patients, the following recommendations were presented to the Chief and Band Council in June 1985:

1. The Band Council was advised to draft a letter to the District Administrator, Mr. Ken Mitchell, with a copy to Mr. Jake Thiessen, Chairman, Governing Board, Hospital District #10, at the following address: Virden District Hospital
   P.O. Box 400
   Virden, Manitoba ROM 2CO

The purpose of the letter was to seek an appointment of at least one Native representative to the Hospital Board, with one additional person holding a non-voting position.

Traditionally, the Dakota Sioux do not make decisions in isolation. Rather, the decision-making process is a group activity. Consequently there may be times when the Native representative to the Board will have to take recommendations back to the Chief and Band Council before committing a final vote on a particular issue.

2. The Band Council was advised to seek funding from Medical Services for a vehicle to transport individuals to Virden and Reston for medical appointments.

3. The Band Council was advised to approach both Drs. Yates and Cleto to ascertain if either of them would be interested in developing direct services to the Native community in the form of a Federally and Provincially sponsored clinic located on the reserve.

4. The Band Council was encouraged by this researcher to become active participants in the health-care delivery system as it applies to Native patients.

To improve the health-care delivery system to Native patients, the following recommendations are being presented to the Hospital Board:

1. Set up an ad hoc committee from the Board to work directly with the Band Council on perceived issues of conflict and misunderstanding.

2. Make a formal invitation to the Chief and Band Council for representation on the Hospital Board.

3. Support the formation of a clinic on the reserve.

4. Incorporate into the current patient assessment protocols a series of ethnomedical questions for Native patients (see attached).

5. Establish a Native Diabetes Program to inform and educate the Dakota Sioux as to the nature and treatment of the disease. It is advocated that this program incorporate local cultural expression in order to make meaningful and tolerable that which is feared and avoided. With attention to cultural content, changes in attitudes and behaviours may follow.

The value of this research lies in providing medical staff, nurses and other health-care practitioners within the Hospital District with a clearer appreciation and understanding of Native cultural values and beliefs that currently impact upon the health-care delivery system.

I offer my services to work with the administration to conduct an in-service day to present my collection of Native beliefs, issues and perceived conflicts concerning health and illness states. The health-care provider, guided by an increased sensitivity to Native beliefs and problems, will then be able to predict with greater accuracy the outcome of specific treatment, the patient's likelihood of compliance to a prescribed regimen and levels of patient satisfaction.

Findings from this study to date indicate that the Western medical model does not have a wide-spread acceptance among Native patients; rather, it is modified with varying degrees of nativistic beliefs and supplemented by a complex armamentarium of Native healing practices. In addition, local health-care providers appear to be unaware of the depth and significance of Native culture, its ubiquitious nature, and its relevance to health-care delivery in the 1980s.

I would like to take this opportunity to thank the members of the Hospital Board, the administration, and the local health-care practitioners for their cooperation in making this research possible. Hopefully the research project will have a positive impact on health-care delivery to the members of the Oak Lake Dakota Sioux Reserve.

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