

**MEDICAL ENCOUNTERS IN “CLOSED RELIGIOUS COMMUNITIES”:
PALLIATIVE CARE FOR LOW GERMAN-SPEAKING MENNONITE PEOPLE**

HaiYan (LingLing) Fan

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Abstract

This multi-sited ethnography focuses on beliefs and practices associated with death, dying, and palliative care among the Low German-Speaking (LGS) Mennonites. The qualitative data, collected through participant-observation fieldwork and interviews conducted in three LGS Mennonite communities in Mexico and Canada, show a gap between official definitions of palliative care and its practice in real life. The LGS Mennonites' care for their dying members, in reality, is integrated into their community lives that emphasize or reinforce discipleship by promoting the practices of mutual aid, social networks, and brotherhood/sisterhood among community members. This study also offers ethnographic insights into some difficulties that healthcare providers face while delivering the "holistic" palliative care services to their patients in general, and to the LGS Mennonites in particular. Finally, it provides some suggestions that may aid healthcare providers in developing culturally safe and competent health care services for the LGS Mennonite people living in Canada.

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Chapter One: Introduction

This nine-chapter thesis is the outcome of a two-year study about palliative care among the Low German-Speaking (LGS) Mennonites. In the first section, from chapter one to chapter four, I focus on the general background of this project, the relevant arguments about death and palliative care, and the history of the LGS Mennonites, including a general review of their beliefs. I begin chapter one by answering some general questions related with whom I am working, and how as well as why I am involved in the Low German-Speaking (LGS) communities. These questions were asked by different groups of people, including the participants of this project and others who helped me during the last two years of my research. I also indicate the main purpose of this project, and clarify the uses of some terms that may confuse readers in this chapter. In the chapter of Research Methods, I explain the main methods, participant observation, and interviews used in this multi-sited ethnography. It will also include the discussions of data management and analyses. Chapter three explores some arguments related to death, dying, and palliative care made by scholars and organizations from various standpoints. Chapter four focuses on the LGS Mennonites' historical backgrounds, community life, and some of their cultural beliefs as well as practices in their daily lives. Additionally, I will explore the reasons for identifying the LGS Mennonite communities as "closed religious communities," and their "boundary markers" adapted from Eric Wolf (1955).

The second section, from chapter five to chapter eight, is my ethnographic study, where I discuss the LGS Mennonites' practices related to palliative care in their everyday lives. Starting with chapter five, I show the available health care services in the

communities where I conducted my fieldwork. In this chapter, I also give some examples to illustrate why some services are available but not accessible for some LGS Mennonites. Chapter six discusses how the LGS Mennonites look after their community members, which is embedded in their community lives. In addition, in chapter seven, I use a funeral in a conservative Mennonite village to demonstrate that care for the end-of-life for the LGS Mennonites in general is no different from other forms of care they provide to their community members. Chapter eight attempts to bring different together difference “pieces,” such as children’s death, and burial practices, that I collected during research to give readers a broad picture about the LGS Mennonites’ beliefs and practices related to dying and palliative care. The third section is chapter nine in which I indicate some of the major lessons I learned during the last two years, and provide some suggestions for the healthcare providers, which may be helpful for them when working with the LGS Mennonites.

In Answer to Some General Questions

Whom I Worked for

This master’s thesis contributes to a larger research project that examines beliefs and practices associated with death and dying in the Low German-Speaking (LGS) Mennonite communities. The larger project, entitled *The Discovery of Death and Dying Beliefs and Practices among Low German-Speaking Mennonites: Application to Best Practice Guidelines*, is directed and conducted by Dr. Judith Kulig (University of Lethbridge; Faculty of Health Sciences), and received funding through Dr. Kulig’s

operating grant funded by the Canadian Institutes of Health Research, Population and Public Health Institute, Palliative and End of Life Care Peer Review Committee.

My Involvement in Two Projects

My own interest in cultural beliefs and practices began while I was working for a travel company in Beijing, China. As an undergraduate student majoring in anthropology, I encountered medical anthropology, a subfield which examines cultural and social dimensions of health, illness, and caring often from an interdisciplinary perspective. Originally, I wanted to study foot health, including foot pain, foot conditions, sports injuries, shoes, footwear, and foot care for diabetics. An opportunity to participate in a qualitative study about the LGS Mennonites' beliefs and practices associated with care for the end-of-life led me in other directions, but my intent to engage ethnographic research was finally in place. In fact, this research was organized as a multi-sited ethnographic study of death, dying, and palliative care in several LGS Mennonite communities in Canada and Mexico.

My own thoughts regarding the last two years of my research reminds me, as my Mennonite families and friends would say, that "yes, we should not take things for granted; God has his own plan." I am still not sure that my gratitude for the "higher power" is the same as that of my Mennonite "relatives" and friends, but I respect their interpretations of my involvements in their communities. Indeed, I feel very honoured to be accepted by the community members, and to be included as an honorary member in "my" Mennonite families.

Personal Beliefs of Death and Suffering

I believe that “death” is an unpleasant life event. I also do not like to talk about death and dying with my family members and friends in my daily life since it is a distasteful topic, which may make people recall some bad experiences. For me, talking about death sometimes creates a sense of fear. It may be the fear of losing what I have had or owned, such as family relations, friendships, and the enjoyment of everyday life and work. Ironically, although I am reluctant to talk about death and dying myself, for the study, I encouraged others to share their views about this inevitable part of life. Compared to the visibility of public discussion about how a new life starts, how a life is finished remains out of view (Martocchio, 1982). This, in turn, encourages me to be proactive with the LGS Mennonites, and to actively engage in this project.

Purpose of the Research

Cultural practices and “beliefs” play an important role in the lives of patients seeking medical treatment. This is no different from those who are involved in making decisions about the end of life, especially as the end of life has been thoroughly medicalized in North America and Europe. The primary purpose of this study is to gain an understanding of the LGS Mennonites’ interpretations of and insights into death, dying, suffering, as well as palliative care. The study is also a way to analyze whether health care providers are uncertain about how to address or to empathize with patients’ spiritual or religious needs when providing health care. It seeks to discover both current and potential barriers that affect the Canadian healthcare practitioners to provide palliative care services for the LGS Mennonites living in Canada in a way that respects

spiritual and cultural matters while addressing health issues. Finally, this study attempts to offer some suggestions that can help healthcare providers to develop culturally competent health care services for the LGS Mennonites.

Research Assumptions

This research assumes that religious practices should not constitute obstacles in delivering effective medical treatments or health care to patients. Some health care practitioners may be limited by their biomedical training within minimal cultural preparation for understanding health and disease variation resulting in them focusing on the diagnoses and treatments of diseases. This study intends to demonstrate that health science and religious beliefs are not incompatible, even though some disparities between scientific narratives and cultural narratives may exist. Another assumption is that health care providers who produced and reproduced the medicalization of death are likely unaware of the LGS Mennonites' struggles to accept the services the public health care systems offer, which generally are available to everyone. Healthcare providers' attitudes toward their patients' beliefs play an important role in establishing caring relationships with patients. In the case of LGS Mennonites, their beliefs might be labelled as religion and they inform perspectives and practices on death, dying and palliative care.

This study offers ethnographic insight into various professional care relationships (Charmaz & Olesen, 1997) that emerge at the end of life and at death to aid healthcare providers in developing culturally safe and competent health care services for the LGS Mennonite people living in Canada.

Adjustment and Research Focus

In my original research proposal, I wanted to compare health care providers' religious beliefs and cultural practices with LGS Mennonite people's beliefs and customs to discover both current and potential barriers that affect the delivery of palliative care to the LGS Mennonites. Additionally, I wanted to explore whether Canadian health care providers are uncertain about the necessity of emphasizing or addressing patients' spiritual or religious needs when providing medical treatment. However, as my ethnographic work in the communities unfolded, my research questions required adjustment. The following questions emerged as I became more acquainted with the local health care systems in the communities when I conducted research.

1. What are the beliefs of and attitudes towards life, death, and palliative care among the LGS Mennonites and health personnel in southern Alberta and southern Manitoba?
2. How have palliative care services been delivered to LGS Mennonite patients and their family members in southern Alberta and southern Manitoba?
3. What are the current and potential barriers that affect the delivery of effective health and palliative care to LGS Mennonites in southern Alberta and southern Manitoba?

A few studies related to the health beliefs and practices held by Mennonites in Canada or abroad have been conducted, but there are no academic studies that focus specifically on the LGS Mennonites' understandings of death and its related concepts, such as suffering, palliative care, and the living will (Kulig, 2008). Furthermore, it is

impossible to gather information about morbidity or mortality among LGS Mennonites from Statistics Canada because the collection of such information within this group is not allowed (Kulig, 2008). The lack of reliable information and research studies has left this vulnerable population's voices unheard. Language and cultural barriers, as well as a low literacy skill, have contributed to pushing some LGS Mennonites into a socially and economically marginalized position. These factors together with their physical locations usually in isolated rural areas caused more difficulties for them to access the public health services. Moreover, the lack of the insiders' perspectives on death and dying may cause some difficulties for the health care providers who want to be culturally sensitive and respectful while working with this population.

This study may help health professionals to increase their awareness of cultural influences operating in their clients' lives. Ignoring cultural and religious beliefs is not a way to solve controversies surrounding scientific health practices and religious practices. Developing an accessible health care system can be one of the solutions, but creating a new system takes a long time and requires significant human and financial resources. This research may offer some possible answers to the question of how health professionals can integrate patients' religious and spiritual needs with biomedical treatments in palliative care? This research may also aid healthcare providers to develop culturally competent health care to make death, often a very difficult time, become an easier process for the individuals and for those who are close to them. Finally, this research has the potential to make a contribution to the study of medical anthropology. This multi-sited ethnography provides an interpretation of the meanings and actions

related to death, dying, and palliative care obtained from the author's immersion in different LGS Mennonite communities, and her long-term observation of, and interactions with, the participants.

The Low German-Speaking Mennonite Communities

The LGS Mennonites in this study refer to the Mennonite migrants who used to be identified as "Kanadiers," and their descendants, who migrated to Latin American countries, such as Mexico, Paraguay, Belize, and Bolivia from Canada and have come back to Canada. They also migrated to other countries from the United States and from Europe. In this project, the LGS Mennonites living in rural areas of southern Alberta, and southern Manitoba as well as those living within the *campos* near Cuauhtémoc, Mexico, are identified as "closed religious communities." However, this is not to say that Mennonite people in these communities are isolated from the larger society completely, or that they constitute a homogenous group in which all members think and behave in the same way.

The LGS Mennonites' constant migration led to the development of various adaptation strategies for and due to natural and social environmental variability, which becomes one of the characteristics of Mennonite groups. As Fretz described, Mennonites are ethnic groups who

[h]ave a set of unique traditions, beliefs, customs, and social practices that go beyond the conventional views of what constitutes a religious denomination. The particular religious beliefs of the Mennonites have always had strong ethical emphasis, therefore, strong social implications [...] The customary opposition to and resistance to change, the reverence for traditions, plus the emphasis on social isolation and separation from the world have all contributed to establishing Mennonites as a cultural as well as religious group. (as cited in Wenger, 2003, p. 36)

Migration also promoted acculturation in the sense that some LGS Mennonites adopted specific practices and beliefs from the mainstream cultures in different countries. For example, some Canadian-born LGS Mennonites adopt English as their mother tongue, and are actively involved in the public education system. Other LGS Mennonites might have only reached a low level of education, have accompanying low literacy skills, have little knowledge related to high technology (Friesen, 2004), and do not speak English. Because of this internal cultural and educational diversity, they may interpret death and dying differently, not only from the mainstream society, but also from each other. Therefore, the term “Mennonite” is not the name of a homogenous ethnic group. Instead, it is a collective identity representing the Mennonite individuals of diverse cultural backgrounds.

Similar Mennonite groups in Canada and Mexico may have different religious practices. For example, the Old Colony Mennonite churches, perceived as the most conservative colonists in previous studies, may hold a funeral in both High German and in English in Canada. Other Mennonite congregation members, such as the *Rheinlander* Mennonite Churches, and the Sommerfelder Mennonite Churches, share some of the traditional religious practices with their conservative members, but may adjust some restrictions in terms of actual needs. For example, some conservative churches in Latin American countries do not allow their members to use rubber-tired tractors because the acceptance of the modernity is “to give in to the corruption of the world” (Friesen, 2004, p. 134) that also violates the belief of being “external nonconformity and internal conformity” (Epp, 2008, p. 14).

Other Mennonite churches, such as Evangelical Mennonite Churches (EMC) or *Kleine Gemeinde*, Evangelical Mennonite Missionary Churches (EMMC), and Mennonite Brethren Churches may be more open to public education and modern technology compared to the conservative churches. This study recognizes that some LGS Mennonites do not necessarily believe in the dogmatic rules or follow their churches' regulations. Different generations of the LGS Mennonites may also have different interpretations of the rules established by their church leaders. However, how different Mennonite congregations and generations perceive death and dying is not compared in this thesis.

Demographic Information about LGS Mennonites in Mexico and Canada

The specific demographic information related to the LGS Mennonite population in the world is not available. According to Mennonite Central Committee (MCC), there are about 250,000 LGS Mennonites internationally (Janzen, 2010, MCC Networking Minutes Mexico). Today, nearly 80,000 LGS Mennonites are living in Mexico (Janzen, 2010, MCC Networking Minutes Mexico). William Janzen, former Director of the Ottawa office of MCC (2010) in his notes of a presentation given to the Essex-Kent Mennonite Historical Association in Leamington, Ontario, indicated, "In the last 50 years a large number have come from Mexico.... If we count the Canadian born children of the returnees then, people say, there could be 40,000 to 50,000 in Ontario. The numbers for Manitoba and Alberta are only a little lower. Altogether there could well be 80,000-100,000" (p. 10). According to the MCC Alberta office, there are approximately 12,000-15,000 LGS Mennonites in southern Alberta (Banman & Epp, 2010, MCC Networking Minutes Mexico).

Fieldwork Locations

The fundamental feature of ethnographic research in anthropology is fieldwork. My fieldwork was organized around periods of stay in three LGS Mennonite communities: two in Canada and one in Mexico. Each community posed different challenges. First, my time in each community differed significantly. Second, and perhaps just as important, my fieldwork cut across three communities and five languages: *Plautdietsch* (Low German), High German, English, Spanish, and my own language, Mandarin.

Cuauhtémoc, Mexico

My “arrival” experience began in the LGS Mennonite community of Cuauhtémoc. The town of Cuauhtémoc is located about 120 kilometres west of the city of Chihuahua, Mexico, and Highway 16 connects it with Chihuahua. I was told that a railway and a bus line also connect Cuauhtémoc with the “outside world.” Mennonite people established their colonies and villages in the San Antonio Valley, which is about 120 kilometres north of the town of Cuauhtémoc (Fretz & Ens, 2008). Several colonies are in the Cuauhtémoc area, including the Manitoba colony, the Swift Current colony, the Old Mennonite Colony, Colonia Los Jagueyes, Colonia Santa Clara, and Colonia Santa Rita. According to MCC Canada (2011), approximately 50,000 LGS Mennonites are living in this region.

I began my fieldwork in the Cuauhtémoc area with attending a Mennonite Central Committee Canada networking meeting from the April 20 to 25, 2010. At that meeting, I met some MCC employees from different regions of America, including Central, South,

and North, and heard their concerns, challenges, and issues associated with their work specifically related to health and palliative care. The MCC meeting took place at the Steinreich Bible School in the Cuauhtémoc area. The school provides biblical and theological education in High German for students from Mexico, Canada, Belize, Bolivia, and the United States. The centre of teaching consists of several classrooms in different sizes, the administration offices, a small kitchen, and a gym in the middle in which there is a portable volleyball net. There are several posters on the inside walls of the building. For example, the poster of *How to Build a Global Community* listed some suggestions about making connections with “others,” such as talking to strangers, and choosing curiosity over certainty. The next one was *The Fruit of the Spirit*, from Galatians (5:22-23): “22 By contrast, the fruit of the Spirit is love, joy, peace, patience, kindness, generosity, faithfulness, 23 gentleness, and self-control. There is no law against such things.” A computer was on the table close to the main entry of the building, and a sign indicating that a person is allowed to use it for 30 minutes per day was written in English and High German.

The Bible school is next to a two-lane road, and an irrigation canal separates the school and the road, which at the same time are connected by two small bridges crossing the canal. Behind the school is the agricultural land, where Mennonites cultivate oats, corn, and beans (Fretz & Ens, 2008). Across the road, there is a village-run school. A piece of empty land in front of the schoolhouses can serve as a “playground” on which there are two soccer goals facing each other. The physical setting in the Bible school seems like a reflection of some LGS Mennonites’ situations in the global village. On one

hand, they have been increasingly exposed to modernity, perceived as threatening their disciple identity. On the other hand, they are trying to “reproduce an ‘old world’ within the ‘new’” (Loewen, 1993, p. 269).

After the MCC meeting, I lived with my translator, Mei, and her family close to the Manitoba colony for another two weeks. This was my first experience living with a “big” family in which there were parents, two brothers, two sisters, two in-laws, three nieces, and even two dogs in the yard. Although the married brother and sister lived in their own homes, it seemed the house where I stayed was still a busy place in that there were always visitors, including relatives, friends, church members, ministers from other countries, and people whom we just met in the MCC meeting. The house was even busier when there was a family gathering.

When living in the local community, I visited some Mennonite villages. Generally, the Mennonite colonies in the Cuauhtémoc area were built as the Mennonites' ancestors had done in Russia. The villages traditionally were built and managed on the basis of *Strassendorf* and *Gewannflu* (Peters, 1988, Redekop, 1969, Sawatzky, 1971). *Strassendorf* is a settlement pattern which centres on a single-street village (Post & Lutz 1976, Schmieder 1928, Bowen, 2006). The Mennonite village, referred to as a *campo*, is built with one dirt road along which homes, the church, and a single-room schoolhouse are located on either side. The agricultural fields are behind their houses, and I was told that normally the church in a village is close to its own school, so I should not be surprised to see a cemetery behind a schoolyard. *Gewannflur* is known as:

an open field system... a property holding system combining communal and individual rights to land (not uncommon in world history) with communal

regulation of agricultural work (much more uncommon in world history). Individuals (or more precisely, families) owned strips of land systematically scattered through the great fields of the village. However, the community as a whole determined when and (often) with what crops these strips were sown, when they were harvested, when animals were allowed to graze on them, and when they were left fallow. (Hopcroft, 2001, pp. 147-148)

Historically, the land Mennonite people purchased in Mexico was “owned communally in the name of a corporation consisting of men selected by the church in each of the colonies” (Friesen, 1990, para. 12), but the church has the ultimate control of the land with the corporation serving only as the agent. The churches controlled the information related to the land, such as the initial owner of the land, and managed the land, such as deciding which piece of land could be sold (Friesen, 1990). The congregation of the colony, such as the Old Colony Mennonite and Rheinlander Mennonite Churches, divided the land into villages. Mennonite people in Canada before moving to Mexico were able to select the land they wanted in the village, and the richer people might purchase more land (Friesen, 1990) than those who were poor. However, I was told that *Gewannflur* was banned already (Warkentin, 1959; Sawatzky, 1971; Loewen, 2007).

The system was banned because of the combination of World War I, the Great Depression, and World War II during which the LGS Mennonites “lived on individually owned, separated farmsteads orderly quarter sections” (Loewen, 2007, p. 205). Other factors, such as the construction of roads, the acceptance of public education, the use of modern agricultural technology, the churches’ splits, and the development of non-agricultural businesses, for example, mechanic shops and cheese factories, also contributed to the disappearance of the traditional farming system (Loewen, 2007).

Moreover, nowadays the LGS Mennonites do not come to Canada as large settlement groups with agreements from the government to buy a tract of land. The LGS Mennonites resettlements in Canada still can be identified as “chain migration” in that many LGS Mennonites who came back to Canada joined their relatives or acquaintances in this nation.

Winkler, Manitoba, Canada

At the beginning of May 2009, I took my first research trip with Dr. Kulig to the city of Winkler, Manitoba, and talked to the LGS Mennonite ministers, people working for MCC Canada offices, and some LGS Mennonite individuals in person. I also met the research assistants (RAs) who were doing interviews for the Death and Dying project. One of the women from the RA group a year later became my “home-stay auntie” who provided nice accommodations for me during the summer of 2010 while I was doing my community study in Winkler.

Winkler is a growing city located 40 km north of the United States border within the rural municipality of Stanley, about 120 km southwest of Winnipeg. The Provincial Trunk Highway 3 (PTH 3) is a major road connecting to Highway 75 going to the city of Winnipeg. There is no public transportation in Winkler, which means that the nearly 10,000 residents of this area heavily rely on their own vehicles. Taxis are available, but costly. In the middle of July 2010, Mayor Martin Harder said that the city would consider restarting a handi-van program, which was cancelled due to low ridership numbers, or to start a bus-type of public transportation (Sumner, 2010).

Along the PTH 3, there are agricultural lands on which farmers' houses sometimes are surrounded by trees. I was told that Winkler is on the edge of the Red River Valley that has the highly productive heavy clay. It is black and sandy, with no rocks. Because of the quality of the soil, there are more agricultural farms than livestock farms in this area. The common crops planted in the land are corn, beans, and potatoes; sunflower, canola, and wheat are also common in the fields.

Winkler is an important industrial and shopping centre serving people living in or around south central Manitoba, and its business sector has been growing substantially. The Southland Mall is located in the city centre surrounded by Canadian Tire, Staples, Mark's Work Wearhouse, a Superstore, and other retail stores. Along Highway 14, there are a Wal-Mart, a dollar store, a Co-op gas station, automobile dealerships, and some gardening and nursery centres. Next to the highway, some amenities, such as the Days Inn, A & W restaurant, and Boston Pizza, are located.

The main street is a business street where the provincial public insurance company, a local clinic, banks, restaurants, and some family businesses are located. During my first visit with my co-supervisor, people suggested us that we should have a dinner in the Del Rios restaurant, which had a reputation of serving the best Mennonite and Mexican cuisine in the community. However, when I started doing my fieldwork in this area, I realized that the “authenticity” of the food served in this restaurant was controversial in that the Mennonite food in the restaurants was “Mexicanized” and the Mexican food was “Canadianized.”

The city of Winkler offers a variety of outdoor recreation opportunities. An outdoor aquatic centre is next to the Winkler Parkland that also has soccer pitches, tobogganing hills, a tractor pull area, walking and cycling pathways, two tennis courts, a playground, and a campground. Recently, the Bethel Heritage Park was officially opened, and the 18-hole golf course was a popular place for seniors, especially during summer time. There are also many community events. For example, I participated in the MCC soap making event with their volunteers in the Pembina Threshermen's Museum. Additionally, in the summer of 2010, I observed local farmers create a Guinness World record by harvesting 160 acres with 100 combines and several grain trucks in 10 minutes and 15 seconds.

One local hospital is located between the city of Winkler and the town of Morden, and two clinics are in the city. Several places sell natural or organic products, including herbal medicine, and Mennonite Juice, an ethnic medicine, is available in a store that also sells all kinds of nuts in addition to Mennonite and Mexican food. A faith-based nursing home is located at the intersection of Pembina Avenue and 15th Street, and a mental health centre is across the road. There are several senior apartments in the city close to some grocery stores and coffee shops.

Winkler is surrounded by many small towns and by the historical Russian Mennonite villages that were established from the 1870s. Some of them are similar to the ones in the Cuauhtémoc area in that the houses were built facing the only street in the village. Many traditional houses located on the historical sites near Winkler are well preserved. The historical Mennonite houses I visited were built with attached bedrooms, a

living room, a kitchen, a pantry, a garage and an attached barn, which are connected by a hallway inside the building. Normally, the houses had freestanding summer kitchens outside and small barns for chickens and hogs across the yard.

The Mennonites built these houses in a very practical way. Attached barns ensured safety during the wintertime when cows and other animals needed to be fed because when snowstorms came, people could literally become lost and freeze to death going to the barn to check on the animals. During summer, the homes become too warm since wood and sometimes coal were used to heat the stove for cooking, but people could use the freestanding summer kitchens to cook and to preserve the food for the use in winter.

When I was doing my research in Winkler, I had limited mobility; I did not have my own car, and I did not drive. My home-stay family kindly provided transportation to me whenever I needed it. Some friends also drove me to their churches and homes, or took me for a country drive. After I finished my research in the local hospital, I rode my auntie's bicycle to the long-term care centre, which was about 15 minutes away from our house.

People, including Mennonites and non-Mennonites, in Winkler often asked if life for me in rural Manitoba appeared as a "single coat of colour:" lacking pleasures, boring, and isolated. Their worries stemmed in part from experiences with some new immigrants from big cities who lived for some time in their community. It would be an inaccurate assumption if people had thought that living in the countryside is boring and "hard to tolerate" (a non-Mennonite participant's words) in terms of food variety and social life.

To illustrate, my home-stay parents planted various kinds of vegetables and fruits, such as corns, melons, berries, spinach, and rhubarb in their yard.

The variety of organic food reminded me a statement made by Mintz and Du Bois (2002): “Next to breathing, eating is perhaps the most essential of all human activities, and one with which much of social life is entwined” (p.102). Many of the social activities in this community involved buying, selling, and exchanging food. The meats, sausages, and eggs I had at our house were from the local farmers. When there was a potluck, people normally would bring foods made from what they planted in their own yards or gardens. The honey I bought from our neighbour was one of my favourite foods. Food was the embodiment of social networks and people’s identities in this case. It also represented a form of self-care and the idea of “caring for each other” by providing and sharing good or health food with other community members.

Taber, Alberta, Canada

My third field site was located in the Taber area where the corn is sweet. I lived in the town of Taber with a female Mennonite roommate who provided healthcare services to the LGS Mennonites. The town is located in southern Alberta within the Municipal District of Taber, and it is connected with the cities of Medicine Hat and Lethbridge by Highway 3. Along the highway, Safeway, Wal-Mart, Dollar store, liquor stores, Tim Horton’s, Kentucky Fried Chicken (KFC), a 7-11 convenience store, gas stations, and other stores or restaurants are located. A Canadian Pacific Railway line also goes through the town.

In the Tourist Information Centre (personal conversation, August 26, 2010), I was told that food processing, agricultural, and oil and gas are the major economic activities of Taber, and the retail sector has also been growing. The community has various recreational facilities, such as a public library, a golf course, swimming pools, parks, and ball fields. I appreciated the knowledge and information the person shared with me, and I asked one more question before I left: “Do you know approximately how many Mennonite churches there are in the Taber area?” The staff member told me that there was no Mennonite church in the town. The answer was disappointing and unexpected since I knew that there are at least two Mennonite churches in town. I was afraid that I did not speak clearly, so I repeated my question. This time, the staff member said that there might be one at the end of the 50th Street, and there might be some Mennonites living in Vauxhall, a town near Taber, located between the Bow River and the Oldman River. Vauxhall is also called the “potato capital of the West,” and famous for the Vauxhall Academy of Baseball. Before moving to Taber, people told me that more than half of the Vauxhall population are Mennonites. It was clear to me that not many people asked about Mennonites, who seem “invisible” in this area, so the person was not prepared to answer my questions.

Christian diversity is, in fact, prominent in Taber. Besides the two Mennonite churches, one located at each end of the town, Taber is also dotted with other Christian churches, including several Catholic churches close to downtown, St Theodore's Anglican Church, the Taber Evangelical Free Church, the Church of Jesus Christ of Latter Day Saints (LDS), the Taber Congregation of Jehovah's Witnesses, Knox United

Church, Peace Lutheran Church, First Christian Reformed Church, and New Life Church. Additionally, a friend told me that the Buddhist Church of Taber is located along the park road.

In this community, I encountered some difficulties in terms of approaching Mennonite people as well as people who provided health care or social services to this population. There were several reasons for my “unsuccessful” recruitment of participants. First, the LGS Mennonites in this region never established their colonies or villages as their counterparts did in Mexico or in Manitoba, meaning there were no one-street Mennonite villages or concentrated communities outside the town. The LGS Mennonite farmers have scattered across the countryside near Vauxhall, Hays, Bow Island, Grassy Lake, and other towns or hamlets in southern Alberta. Second, the LGS Mennonite migrants coming to this area are relatively young and lack experiences in providing care for people who are dying or are living with life threatening diseases. Third, in this area, some healthcare providers indicated that the LGS Mennonites, especially some people from the conservative churches, do not actively use the public health care services, including the palliative care service, which many non-LGS Mennonites also do not use. Fourth, some LGS Mennonites indicated that they needed their ministers’ sanction before having an interview with me, but some pastors would not give it. Another challenge I had while in this area was avoiding connections with people from other non-Mennonite churches. Some church members actively approached me in different ways, and wanted to share their opinions or experiences related to death and dying with me. I am not biased against any non-Mennonite Christian groups, but the focus of this study is on the LGS

Mennonites, and this research does not yet include other Christians' understandings of death and life.

Clarifications

The discussion of palliative care services in this study focuses on, but is not limited to, care for the end-of-life, meaning it also includes care for terminally ill people, people in long-term care centres, and their families. Additionally, it is about palliative care, but not palliative care programs for the LGS Mennonites. It explores the LGS Mennonites' understandings of death and practices related to care for people living with terminal illness. However, it does not suggest that the health care or social organizations should set up separate programs for this population, which may separate them from other service users with different cultural backgrounds.

The terms, "cultural competence" and "cultural safety" are used in this thesis with the awareness that there are some arguments about the "nature" of these ideas. "Cultural competence and safety" have been seen as problematic because they make a generalization of an ethnic group as a whole, which signifies that there is a homogeneous culture that allows health care providers to interact with their patients from a particular cultural background in a formulized way. In this study, building a safe environment means creating an ethical environment in which people's autonomy, privacy, and identities are highly respected (Eckerman, 1994). Being culturally competent means being sensitive to cultural diversity within minority groups, and acknowledging different traditional beliefs practiced by patients with various social experiences (Gunaratnam, 2007). Moreover, the terms also include the healthcare providers' applying cultural

sensitivity and knowledge (Kim-Godwin, Clarke, & Barton, 2001) properly to their services while helping their clients.

The term, “conservative” as used in this thesis has no negative connotations. It refers to the LGS Mennonites placing more emphasis on preserving the practice domains of tradition and cultures, and placing less emphasis on openness to changing lifestyle or to accepting modernity. Moreover, their community leaders may defend the group’s identities, and prevent the outsiders’ influences on the congregations by regulating their own members’ behaviours. In other words, people’s bodies are the symbolic embodiment of social boundaries and values (Douglas, 1970), which need to be controlled to protect the community’s integrity.

Examples used in this study are real, but to protect people’s confidentiality, the organizations’ and participants’ names are not identified. When it is necessary, a pseudonym is used. The biblical citations used in this study were taken from the New Revised Standard Version of the *Bible* (NRSV), and were indicated or suggested by participants of this project.

I did not try to eliminate all my personal beliefs, or purposely pressure myself to stop thinking while doing my fieldwork in both Mexico and Canada about how my experiences in the Mennonite communities might be done in China. However, my personal reflection on my own experience in three communities should not indicate a negative feeling for or an attitude toward people living in rural areas or in the LGS Mennonite communities. Instead, the local perspectives of death, dying, life, palliative care, and community made more sense after I experienced some of the difficulties local

people have faced, and participated in some of their activities.

It is also undeniable that fieldwork requires first, and perhaps foremost, the “sacrifice” of my own interests or preferences to do my work. I told some people that if it had not been my job, I would not have actively approached people with my face full of scars as the result of the chickenpox (that whole story is told in Chapter Five). Unexpectedly, my attitudes towards my own work in the community illustrated by my desire to start my research while recovering from my illness helped me gain some LGS Mennonite informants’ trust since they have the reputation of being hard workers, and they admire people who work hard.

Being honest and being who I am also helped me to focus on the local cultural beliefs and practices. I honestly tell people that I am not associated with any particular religious organization, nor do I believe in a specific religion whenever they ask what religion I believe in. I do not think my “practices” has affected my involvement with local people in general. Many people I encountered during my research actually appreciated that I was not pretending to be a religious person, or to be who I was not just for the purpose of the study. Additionally, because many people were aware that I did not have Christian and Mennonite backgrounds, they were willing to explain to me what I did not know or understand. I maintained the sense of who I am and what I believe in without being disrespectful. Indeed, I remembered and was constantly reminded by my professors not to make a judgment on the local people’s practices and beliefs.

Limitations

This study is of health care from social and cultural perspectives rather than from a scientific perspective analyzing the characteristics of decisions to receive palliation or to the degree to which the factors are influencing a large population. Additionally, there were not many cases specifically associated with palliative care for people with mental health issues in my research, which might have indicated that further research focusing on the LGS Mennonites' attitudes toward mental health is required.

In general, the LGS Mennonites who participated in the study were those who started accepting some mainstream cultural and health practices, so their standpoints might have been different from those of others who refused to have interactions with outsiders. This research also represented some limitations and difficulties the participants faced, but these constraints were not analyzed in terms of the control of power, and gender inequality within the communities from a local perspective. During my time in the communities, I also met people from various Mennonite groups, such as Swiss Mennonites, Holdeman Mennonites, and Dutch Mennonites. However, I had no intention of comparing, and did not focus on comparison on, how Mennonite groups perceive death and palliative care differently.

Additionally, I met people who did not identify themselves or want to be identified as LGS Mennonites regardless of whether they were the descendants of Kanadiers, or still lived with their LGS Mennonite families. A volunteer woman said, “Yes, I am still going to the church, but not a Mennonite one. I am a Christian, but I do not think that I am an LGS Mennonite. You know...Mennonite is a lifestyle. It is SO (she

emphasized)...very restricted. You cannot watch TV; cannot do this; cannot do that. I was glad that my parents decided to move out of their colony...back to Canada. All my kids go to the public schools now, and they do not have to suffer that." These individuals' personal perceptions on death, dying, and palliative care were also not discussed specifically, but their thoughts on working with LGS Mennonites were included.

Summary

This multi-sited ethnography conducted in Mexico and Canada arrives at an understanding of the LGS Mennonites' beliefs and practices related to death, dying, and palliative care. In addition, it explores how Canadian healthcare providers can provide culturally safe, sensitive, and competent services to dying people and their families. Although the LGS Mennonites and some healthcare providers who have been working with this population are involved in this project, I have not attempted to conduct this research from a "holistic" perspective.

There are two reasons for this decision. First, the term itself is problematic in that it may simplify the effects of interactive forces, such as culture, media, economic systems, health care systems, and history, involved in providing palliative care for the LGS Mennonites. In addition, I do not mean to describe the LGS Mennonites as a homogeneous group, or to stereotype some individuals. The second reason is that my own personal interests, knowledge, skills, language, and other limitations have effects on how I want to approach the topic of this study, and on how I understand or interpret the information provided by the participants (Fortune, 1990; Riessman, 1994). In short, this thesis only provides an alternative interpretation of the LGS Mennonites' perceptions and

practices associated with death and care for people who are dying or are living with incurable life threatening diseases.

I hope the ethnographic insights can help healthcare providers to gain some understandings about their clients' culture, and to improve the palliative care services that exist in current health care systems. However, I acknowledge that I, as the author of this thesis, cannot achieve this goal myself. In fact, the goal also will be affected by the potential readers' willingness to read and to use the information collected during the research on the LGS Mennonites. Knowledge implementation and transformation is a broad topic, and due to timeline, space limitations, and other factors, it is not explored in this project. The methods employed in this research are described in the following chapter, Research and Method.

Chapter Two: Research and Method

This chapter focuses on the methods I used for data collection and analysis. This thesis, as part of a two-year qualitative research study that adopted an anthropological perspective, was conducted to understand the LGS Mennonites' beliefs and practices related to death and palliative care. It included a multi-sited fieldwork conducted over seven months¹ in three places: three weeks in the Cuauhtémoc area in Mexico, three and a half months in the Winkler area in southern Manitoba, and three months in the Taber area in southern Alberta. Research strategies used in this study included participant observation, and both open-ended and informal conversational interviews. The demographic information, participant selection and recruitment, and the techniques used for data collection are presented later in this chapter.

Ethnography and Multi-Sited Ethnographic Fieldwork

Ethnography is oriented toward understanding the insiders' perspectives on, and behaviours related to, particular social and cultural phenomena, in the case of this research, perspectives and behaviours associated with illness, death, and palliative care. Ethnography as a method allows the ethnographer to provide "thick description" (Geertz, 1973, p. 7) along with interpretations of societies and cultures (Marcus, 1995; Robertson & Boyle, 1984; Gozdziaik, 2004; Cook, Laidlaw, & Mair, 2009). Ethnography remains the foundation of anthropological and social science research (Geertz, 1973; Malinowski, 1922; Mead, 1928; Wolff, 1964; Abu-Lughod, 1986). It is aimed at the interpretations of cultures as the webs of meaning of the cultural constructions in which we live (Geertz,

¹ I actually lived in the LGS Mennonite communities for nine and a half months.

1973.) An individual or collective understanding of suffering, illness, and death is shaped by the shared culturally informed knowledge and values that can become significant information for healthcare providers to understand the patients' experiences and needs (Kleinman, 1988), and to provide culturally sensitive or competent services.

Conducting ethnographic research may require the ethnographer to live with local people, which is a way to learn their cultures. In this study, it was essential for me to go to the Mennonite communities to arrive at an in-depth understanding of death and dying and palliative care among this particular group. In addition, many conservative LGS Mennonites want to be separated from the mainstream society by avoiding interactions and relations with "outsiders." Therefore, to approach these people, the ethnographer has to be brought in by local informants.

Unlike a traditional ethnographic work, which is conducted at a single-site location, this is a multi-sited fieldwork designed on the basis of "association or connection among sites" (Marcus, 1995, p. 105). As mentioned in the Introduction, the LGS Mennonite individuals in Canada who are presented in this study are mainly returned immigrants from Latin American countries, such as Mexico, Paraguay, and Bolivia, and those returnees' descendants. Many of them still maintain their religious or cultural lifestyles after moving back to Canada. What may have been shared and transmitted by the LGS Mennonites living in these sites are not only the cultural practices and beliefs (Partington & McCudden, 1993), but also their social relationships and interactions through which people reconfirm their identities. Therefore, the multi-sited ethnographic work allows me to see the relationships among people, the beliefs, history,

places, and social activities as experienced within and across the locations that matter in their lives. Multi-sited ethnographies illustrate transnational processes, lives and things “in motion,” revising the approaches traditionally employed in a single field site while still respecting anthropological traditions and providing researchers with credible ways of creating a broad understanding by synthesizing information gleaned from a variety of locations (Marcus, 1995; Marcus, 1999).

The Role of the Ethnographer: More Than an International Student

I was born in Beijing, the capital city of the People’s Republic of China, and I was raised in a culture that traditionally consists of Confucianism, Buddhism, Taoism, and other cultural beliefs. Additionally, atheism, Marxism, and Mao Zedong’s thought have been applied in China. Christianity, introduced by a Persian missionary into China in 635 AD, only played a marginal role within mainstream Chinese culture. This situation is changing in that Christianity has been growing very quickly in China in recent years, and is supported by “millions of dollars of government funding” (Landau, 2010, para. 3). However, I am not a Christian, and not involved in any religious groups.

I am the only child in my family who are still living in China. Since I was six months old, I spent most of my childhood time in day cares and schools; I grew up with my playmates or classmates. I do not speak *Plautdietsch* (Low German) or High German; I do not know how to bake; I do not play any musical instrument, and I am never able to sing in pitch. “Mobility,” in terms of moving from one country to another, may be the only “similarity” between me, as an international student studying in Canada, and many LGS Mennonites who have had a series of resettlements. However, unlike the early LGS

Mennonites who tried to move away from modernity and its influences, I have heavily relied on modern technology to maintain my relationships and connections with my family and friends in China and other countries.

Knowing What I Need to Know

There were no Mennonites in my life, and the only connection I had with the LGS Mennonites was my co-supervisor who has worked with this group of people for 15 years. Additionally, because of my personal background, I did not know whether nor not the communities would accept me, and I was not sure what I would do to understand death, dying, and palliative care from their perspectives. A very useful suggestion from my professors on my committee was “to be familiar with the Scriptures,” which later helped me to look at Christianity as part of people’s lives and of community life.

Being an Ethnographer

Fieldwork requires the ethnographer to become a “circumstantial activist” (Marcus, 1995, p. 113) in that the ethnographer actively renegotiates and readjusts his or her identities (Marcus, 1995) since the ethnographer’s personal perceptions and values may change and be challenged (Rowan, 1974; Marcus, 1995; Uzzell, 1979) in the context of fieldwork itself, and local people’s expectations for the ethnographer will vary from one person to another (Rabinow, 2007; Rowan, 1974; Uzzell, 1979). The following examples from my fieldwork illustrate these points. For instance, in some contexts, it was not necessary for some LGS Mennonites to know that I read the *Bible* myself. In general, the conservative LGS Mennonites’ expectations are that ordinary people do not have the ability to understand God’s word, so independently reading the Scriptures will lead to

misinterpretations or misunderstandings, which are sinful actions against God. In other circumstances, my knowledge of Christianity and the *Bible* was required. My answers to questions often acted to break the seal to dialogue and discussion of beliefs and concerns. My role as an ethnographer was established and unfolded as a social role in the field, which I believe worked very well locally.

Participant Observation

Participant observation is a key feature of anthropological research, which allows the ethnographer not only to observe the subjects' daily lives, but also to take part in their everyday activities. This is an essential path of knowledge generation. Participant observation, for this study, took place mainly in local hospitals, long-term care centres, local clinics that Mennonite people visit frequently, people's homes, churches, and sometimes, the funeral homes in which observation was used as the main strategy. Additionally, participating in some community events, such as Bible Study Groups, Sunday Schools, and Mennonites' funerals (with permission) provided opportunities for me to collect more detailed information at different times and places.

For anthropological practice, it is crucial to recognize my own values and limitations, and how these actual constraints can affect the fieldwork. As an ethnographer, I wanted to see as much as I could, and to hear as many voices as possible. The combination of participant observation and another ethnographic method, in-depth interviews, helped me recognize and understand the differences between what people say, believe, and what they actually do (O'Reilly, 2005; Lambert & McEvitt, 2002).

The use of overt observation strategy, meaning the ethnographer fully explains (O'Reilly, 2005) the ongoing project and his or her duties to all participants, allows the ethnographer not only to build trust relationships with observed people, but also to “[enjoy] a certain amount of freedom” (Sobo, 2009, p. 109). The public identity provided opportunities to engage in activities involving the broad spectrum of social roles and individuals, embodying their roles and actions in the community from unstructured conversations with some healthcare providers, such as registered nurses and registered nurse assistants, during their lunch breaks to staying with them during their evening shifts, to studying church services. I, as Carnevale (2008) and his colleagues had indicated, extended the “presence of the participant-observer . . . by building trust over time” (p. 22) to “become integrated into the setting” (Carnevale, 2008, p. 22). Concealing my purpose and identity (Davies, 1999) would not have been useful, and would have been unethical for this project. The quality of the data could not be guaranteed by this strategy since people may avoid talking about certain topics in front of a “stranger.”

Translators

The language issue was considered before my fieldwork started. I hired a translator in Mexico. Mei is an LGS Mennonite woman whose first language is *Plautdietsch*, but she can also speak, read, and write in High German, Spanish, and English. She was introduced and recommended by the local MCC employees because of her skills, reputation, and personality. The recommendation, in a way, reduced concerns about spreading gossip or rumour in the local community (Kulig, 1991). Most importantly, working with a translator, who can also be a cultural interpreter, provided

another opportunity to explore different standpoints on what death and dying meant to the LGS Mennonites from various congregations within the community.

In Canada, I accompanied healthcare providers who became emergent volunteer translators while delivering health or health-related services to the LGS Mennonite people. The processes of transformation of information from one language to another cross not only the linguistic boundaries (Torop, 2002), but also the cultural boundaries, and involve the translator's choices related to translating the correct meanings (Temple, 2004). Sometimes, the meanings of the questions had to be interpreted instead of translated directly since other languages may not have the equivalent words matching the English expressions. For example, there are no specific terms for germ and palliative care in *Plautdietsch*. In addition, I am working in English, which is my second language. Therefore, it was necessary for me to make my questions clear and easy to understand for the translators.

Interviews

In addition to participant observation, my project relied on interviews with Mennonites and other people to collect understandings and perceptions of life, death, and palliative care. According to Charlotte Aull Davies (1999), the information participants shared with me was emic data, reflecting insiders' perspectives, which were also a form of social and cultural realities. To ensure the quality and completeness of the interviews, I progressively established relationships with participants in three ways: (1) arranged meetings and appointments; (2) met and interviewed interviewee's friends; (3) and

finally, built rapport through daily interactions, such as working together and going to church services together, which also led to interviews.

This study included standardized open-ended interviews and informal conversational interviews. The use of open-ended questions allowed the interviewed people to talk about various dimensions related to the topic of this study and avoided imposing a frame of reference on them, meaning leading the interviewees so that they would give the “right” answers. The formal interview normally lasted between one and three hours, and sometimes, it took more than one interview to discuss some specific questions (Appendix 4) or to continue when the interview was interrupted due to special circumstances.

Interviewing is exhausting for both the ethnographer and the participants (O'Reilly, 2005). Additionally, interviewing involves not only planning, talking, and asking questions, but also reflection. After an interview, I needed time to reflect on (O'Reilly, 2005; Kulig, 1991) the information gathered through the conversation for its relevance to the questions and its ability to clarify issues.

The informal conversational interviews with healthcare providers and the LGS Mennonite people helped to avoid the “communicative hegemony” identified by Briggs (as quoted in Kingfisher, 1996), which may “violate local norms of who gets to ask questions of whom, under what circumstances, and concerning which topics” (Kingfisher, 1996, p. 23). The conversational interviews, in this study, normally did not start with the discussions of death and dying, or palliative care directly. Instead, they sometimes began with a variety of topics, such as baking, gardening, babysitting, family

reunions, and the chickenpox scars left on my face. Alternatively, the interviews sometimes began with participants asking questions of me. For example, they might ask for more details about my social and cultural background. Specifically, a young LGS Mennonite woman wondered why I do not use makeup like other (Canadian) girls do, and whether or not Chinese girls are allowed to wear short skirts. Her friend asked if I felt lonely as the only child in my family. Some people wanted to know whether or not I worked for the Chinese government, and if it was true that Christianity is forbidden in China.

There were approximately 100 audio-recorded hours of formal and informal interviews collected during the field study. It was almost impossible to count the total number of formal and informal interviews that were conducted through my fieldwork since I could have a formal interview with a person, especially, a healthcare provider, and several informal conversational interviews with the same person in different times at different places. Also, the interview might switch from formal to informal. That is, when a formal interview was interrupted, and the interviewee did not have time for another appointment to finish this interview, I might have informal conversational interviews with this person if there were opportunities.

Participant Selection

Participants in this research were selected on the basis of their backgrounds and experiences. They included the LGS Mennonite individuals who, generally, were from conservative Mennonite churches in all three geographic locations. Research participants also included Mennonite healthcare providers and non-Mennonite healthcare providers,

who did not have Mennonite backgrounds or did not identify themselves as Mennonites.

This study included both male and female participants, and the exclusion criteria were:

1. People who were under 18 years of age.
2. Healthcare providers who did not have any experience in caring for LGS Mennonite people.
3. Adults who were not capable of providing informed consent.

Participant Recruitment

For the formal interviews, this project used purposive and snowball sampling methods, which intentionally focused on observing how the health care services, especially palliative care, were delivered in local clinics, hospitals, and nursing centres, and how local people practiced palliative care. The informal conversational interviews were “opportunistic” in the sense that they would happen at any time and at a variety of places. This meant that during potlucks or trips with elderly Mennonite people, or after a church service, informal conversations could take place.

Demographic Information

The demographic information for 15 LGS Mennonite individuals and 34 healthcare participants are presented in the tables below. The participants included 5 LGS Mennonite men, 12 LGS Mennonite women, 13 male healthcare providers, and 21 female healthcare providers. The majority of LGS Mennonites who participated in this research were born in Mexico. In terms of the educational level (Table 1), the LGS Mennonite men generally had more years of education than the LGS Mennonite women did. However, the levels of education taken in Mexico might not necessarily have been equal to the same grade levels

in the Canadian education system. The two systems, especially considering the nature of colony schools, are not comparable. Some LGS Mennonite women indicated that they could only speak *Plautdietsch* or speak a form of a broken mainstream language (Table 2), either Spanish in Mexico, or English in Canada.

There were widows and one widower in the LGS Mennonite group. Three women indicated that they had miscarriages, and one of them stated, “I did not know why I lost my baby. . . . The doctor told me I had diabetes, but I did not know.” The LGS Mennonite participants’ demographic information also revealed some reasons, including heart diseases, accidents, and cancers, for the spouses’ or children’s deaths. Additionally, it may also show some connections between death and medical conditions, such as diabetes and heart diseases. Some participants changed their original church memberships to other churches (Table 3), which also include non-Mennonite churches or less conservative Mennonite ones.

The health care personnel demographic data were collected from 34 healthcare providers (Table 4), and 23 of 34 people had Christian backgrounds. Fifteen healthcare participants could speak *Plautdietsch* at different levels, and a few of them indicated that they could speak both *Plautdietsch* and High German, or could master High German only. Several healthcare providers indicated that they were not affiliated with any religious groups.

The demographic data presented in this chapter do not include the personal information of the participants who agreed that I could use their interviews, but were unwilling to give their detailed demographics. Although often they briefly told me about

their religious and social backgrounds, there were some concerns or difficulties related to giving their information to an “outsider.” For example, some people might have been afraid that their fellow church members would know that they discussed their religious beliefs with outsiders. Another reason was that the conversations were conducted randomly, and the participants (such as LGS Mennonite visitors in hospitals from Bolivia or other countries) did not have time to fill in the demographic forms, and it was impossible to reconnect with them again to obtain their information.

Table 1: Participant Numbers, Age Range, and Education Range (in 2010) (n=17)

Gender	Participant Number	Age Range	Education Range
Female	12	23-54	0-16 years
Male	5	20-89	9 years -16 years

Table 2: The Range of SSL or ESL Class Attendance² (n=17)

Spanish (in Mexico)			
Gender	Yes	No	Range of Attendance
Female	3	3	<ul style="list-style-type: none"> ▪ 1 learned as a child ▪ 1 learned since Grade one ▪ 1 learned for 3 years
Male	2	0	<ul style="list-style-type: none"> ▪ 1 learned as a child ▪ 1 learned for 6 years
English (in Canada)			
Gender	Yes	No	Range of Attendance
Female	3	3	<ul style="list-style-type: none"> ▪ 1 Canadian born LGS Mennonite ▪ 1 learned for 3 years ▪ 1 learned as a child
Male	3	0	<ul style="list-style-type: none"> ▪ Canadian born LGS Mennonites

² SSL stands for Spanish as a Second Language; ESL stands for English as a Second Language.

Table 3: The Religious Affiliation of Participants (n=17)

Religious Affiliation	Old Colony	Rheinlander	General Conference	EMC & EMMC	Other
(current) Number of Participants	6	0	0	5	6
(past) Number of Participants ³	7	2	1	3	2

Table 4: HCP⁴ Numbers, Christian Background, and *Plautdietsch* Skill (n=34)

Numbers	Gender	Christian Background		<i>Plautdietsch</i>	
		Yes	No	Yes	No
Female	21	18	3	5	16
Male	13	13	0	10	3

Other Data

The supplementary data included the detailed obituaries as keepsakes used in funeral programs. There were also the printed resources given to the family members of the palliative care patients to help them prepare for death and to handle their grief. These data provide a general understanding of the experiences and perceptions of life, death, and palliative care LGS Mennonites' have had in medical encounters with healthcare providers.

Data Management and Analysis

Data in the field notes were marked with date, year, location, the sequential number of the interview, and the code names of the participants in an event. The audio

³ Because of personal reasons, 2 LGS Mennonites who gave their demographic information did not indicate which churches they attended before they switched to their current churches.

⁴ HCP stands for Healthcare Participants.

files of the interviews were organized separately in terms of date, location, and the participants' statuses (LGS Mennonite individual or healthcare provider). The printed resources were also categorized and labelled before being filed.

The data analysis is a very complex process through which the unfamiliar information gathered through research is transformed into knowledge, so it is necessary for the ethnographer to think about how the analysis can be best supported (Patton, 2002). This project relied on my own field notes, and used Halcomb and Davidson's six steps of data management method with some adjustments. The authors suggest that ethnographers invite outsiders who are not involved in the project to conduct the secondary content analysis to ensure the ethnographers' analyses are accurate. However, I analyzed the data on my own because of the confidentiality concerns. To ensure the rigor and trustworthiness of my analysis, I employed other research methods, which are discussed in the next section.

The steps Halcomb & Davidson (2006, pp. 41-42) suggested are:

Step 1: Audiotaping of interview and concurrent note taking

Step 2: Reflective journalizing immediately after an interview

Step 3: Listening to the audiotape and amending/revising field notes and observations

Step 4: Preliminary content analysis

Step 5: Secondary content analysis

Step 6: Thematic review

I took detailed field notes during the fieldwork and through some interviews that were not audio-recorded. In many situations in which writing or audio-recording were both inappropriate, detailed summaries of the event or conversation would be produced as soon as possible. It was also useful to review the field notes constantly, and to have a

personal reflection journal separate from the field notes. I listened to the audio-recorded conversations again to add the essential information into the notes “to ensure that the notes provide an accurate reflection of the interaction” (Halcomb & Davidson, 2006, p. 41). Additionally, the key terms or themes that appeared in people’s conversations would be marked during note taking and reviewing. Highlighting the main themes, and their relevant evidence in the notes, sometimes, involved re-listening to the recorded interviews repeatedly to make sure that they were the participants’ original words.

Rigor and Trustworthiness

In this study, reflexivity and triangulation were used to ensure the credibility and validity of research outcomes. Reflexivity means that ethnographers are aware of their limitations, and able to reflect on how these constraints may affect their research work as a whole (Rabinow, 2007). I acknowledged that my interpretations of people’s behaviours were subjective and partial. Moreover, I recognized the challenges I encountered in the locations. For example, one of the most difficult questions for me to answer was: Do you pray? Another one was: How do you feel about God? These challenges might have helped me to integrate into the local communities, or they may have stopped people from engaging in a deep conversation with me. Because of these challenges, I constantly had to reflect on my fieldwork methods so that I would find different ways to approach different participants.

Triangulation, also called cross-checking or cross-examination, is:

the combination of at least two or more theoretical perspectives, methodological approaches, data sources, investigators, or data analysis methods. The intent of using triangulation is to decrease, negate, or counterbalance the deficiency of a

single strategy, thereby increasing the ability to interpret the findings. (Thurmond, 2001, p. 253)

This project used the combination of methodological triangulation, data triangulation, and theoretical triangulation (Denzin, 1970; Thurmond, 2001) to “explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint” (Cohen & Manion, 1986, p. 254).

The methodological triangulation (Denzin, 1970; Thurmond, 2001) requires the ethnographer to use mixed methods for data gathering. In this project, I used participant observation as well as formal and informal conversational interviews in three locations to identify the consistency or conflicts between people’s beliefs and actions. The three essential factors in data triangulation are time, space, and people (Denzin, 1970; Thurmond, 2001; Mitchell, 1986), meaning various locations and times, and a variety of participants will help increase the validity of the research data (Denzin, 1970; Thurmond, 2001; Mitchell, 1986). My project was a multi-sited ethnography, including participants from different congregations, age groups, and social environments. Indeed, it included both men and women with different educational backgrounds.

Theoretical triangulation uses more than one theoretical method to analyze and to interpret the data (Denzin, 1970; Thurmond, 2001) to give “a more detailed and balanced picture of the situation” (Altrichter, Posch, & Somekh, 1996, p. 117). In this process, first, I discussed my understandings of the patients’ words and their behaviours related to the focus of this study with healthcare providers based on the daily observation of the home visit. Second, comparing the similar data analyzed in other projects from different perspectives (Davies, 1999) helped me to identify my own bias. Third, crosschecking the

consistency of the related information presented in historical literature reinforced my consideration of my participants' historical and cultural backgrounds, which was also a way to prevent personal bias. Fourth, constantly revisiting the LGS Mennonite communities in Canada allowed me to discuss my interpreted meaning of the participants' words (Kvale, 1983; Allen, 2010), and to clarify questions or concerns generated during the process of data analysis. The monthly teleconference with the research team of "The Death and Dying Beliefs and Practices" project also provided an opportunity for me to ask questions related to the meanings of participants' behaviours or words. In addition, the questions could be sent to some of the participants by e-mail. Fifth, the participants' feedback on my initial analyses of the research data also ensured the credibility of the research outcome. Overall, by using the triangulation strategy, the rigor and trustworthiness of this research study were extended because the "most persuasive evidence comes through a triangulation of measurement processes" (Webb, Campbell, Schwartz, & Sechrest, 1966, p. 3).

Ethical Approval

The ethical approvals were obtained from the University of Lethbridge Human Subject Research Committee (Appendix A), the Regional Health Authority Central Manitoba Inc. (Appendix B), Alberta Health Services (Appendix C), and the local long-term care centres where I conducted my research. I explained the purpose of the study to the participants by myself or through the translators, and asked the healthcare providers for permission to observe the patients in the wards. Before asking for written or verbal consent from participants, I explained the possible risks, and clearly indicated that they

had the right to ask me to turn off the audio-recorder and to refuse to answer any questions or to withdraw from the study at any time. Additionally, the participants were informed that if they withdrew, their information would be destroyed, and would not be used in final reports. The case numbers were used to manage the consent forms and the field notes. All data are stored and locked in an office at the University of Lethbridge.

Summary

Doing multi-sited ethnographic fieldwork is both challenging and encouraging. This research method is particularly useful in this study because it provides a background for the connections between the LGS Mennonites' lifestyles, their resettlements in different countries, and the importance of a large tract of land (Loewen, 2001). This chapter also discussed various research strategies used to collect and to analyze the ethnographic data, which enhance the trustworthiness and rigor of this thesis. Additionally, ethical concerns are infused in these processes of data collection and knowledge production. However, obtaining the approved ethical declarations from different research committees involved in this project does not guarantee an ethical research, so it is important to learn the local moral codes, or moral behaviours. In the next chapter I focus on a brief review of the arguments related to death, dying, and palliative care in previous studies.

Chapter Three: Literature Review

Krakauer, Crenner, and Fox (2002) stated, “the process of dying, perhaps more than any other moment in the course of medical care, can accentuate cultural differences between patients, families and providers” (p. 184). Therefore, an understanding of the cultural meanings of death and dying cannot be separated from how palliative care is provided in a community. These differing meanings of death and care are apparent in the communities in which I conducted research, and different meanings of death and care orient the scholarly literature and articles as well.

A Biological Determination of Death

James L. Bernat, from the Neurology department of Dartmouth-Hitchcock Medical Center, stated, “The definition and determination of human death is one of the oldest and most enduring problems in bioethics and biophilosophy” (2010, p. 242). For several decades, the absence of breathing was used as the only criterion of physical death. Later, the disappearance of heartbeat was added to the determination of death. However, the development of modern technology, prolonging people’s lives without restoring their health (Kaufman, 2005), challenged these deciding factors.

The Law Reform Commission of Canada provided a definition of death and proposed that it should be adopted across the nation. The criteria of death suggested in *the Canadian Law Reform Commission’s Definition of Death 1979* include:

- A person is dead when an irreversible cessation of all of that person’s brain functions has occurred.
- The irreversible cessation of brain functions can be determined by the prolonged absence of spontaneous circulatory and respiratory functions.

- When the determination of the prolonged absence of spontaneous circulatory and respiratory functions is made impossible by the use of artificial means of support, the irreversible cessation of brain functions can be determined by any means recognized by the ordinary standards of current medical practice.

In Canada, there is no federal statutory definition of death⁵ as a biological phenomenon. According to the *Guidelines for the Diagnosis of Brain Death* (Canadian Neurocritical Care Group, 1999), “Brain death is equivalent to death of the individual, even though the heart continues to beat and spinal cord functions may persist....Brain death must be determined clinically by an experienced physician and in accord with the accepted medical standards” (p. 64). Indeed, the provinces and territories have jurisdiction over the legislation concerning the determination of death.

For example, the province of Manitoba uses the definition of death described in *The Vital Statistics Act* (2008, Section 2): “For all purposes within the legislative competence of the Legislature of Manitoba the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs.” In Alberta, there are “no explicit legislative criteria for the determination of death” (Downie, Kutcher, Rajotte, & Shea, 2009, p. 855). Moreover, the determination of death explained in *Human Tissue and Organ Donation Act*, SA 2006, c H-14.5 is used for the purpose of organ donation.

Death from Social Perspectives: Brain-Dead, Deceased Body and Personhood

Ohnuki-Tierney (1994) reminded people that although death has been interpreted in biological terms, the explanations or definitions are culturally and socially constructed.

⁵ The article, *A Review of the Literature on the Determination of Brain Death* has provided more information related to the concepts and controversies related to brain death.

Using brain death as a decisive factor of death has reinforced the scientific, rational, and objective principles of French rationalism (Erickson & Murphy, 2003) and reemphasized Descartes' mind and body distinction. The famous philosophical statement, "I think therefore I am," reflects the idea that "the true site of 'personhood' and the 'self' (as well as of the personality and the unconscious) [are] within the brain itself, rather than in the body as a whole" (Helman, 2007, p. 40). McMahan (1998) also argued that "the capacity for consciousness is necessary for our continued existence and thus that when a human being irreversibly loses this capacity, he or she dies or ceases to exist" (p. 252).

Some scholars have argued that with the development of life-support technology, people are able to prolong their lives without having a high level of consciousness. However, the bodies are only surviving without having a meaningful life since the scientific notions of 'longevity' and of 'life enhancement' (Helman, 2007) do not mean living better or indicate an improvement of the quality of a person's life. They also do not "necessarily lead to the growth of greater spiritual wisdom or awareness" (Helman, 2007, p. 12).

The idea that there is only a body, made from flesh and cells, left when a person's brain, the centre of rationality and regulation, has lost its functions (Bowman & Richard, 2003) has been challenged. Kaufman (2000), who wrote about the personhood and social relations of people in the permanent or persistent comatose condition, argued against viewing persons in a vegetative state as bodies who do not have "self" and "agency." This contrasts with the implicit mainstream Western perspective that brain-dead people should be defined as "functionally dead" (Halley & Harvey, 1968), meaning they will not

undertake their social and economic responsibilities.

New technology along with the bodies in the “liminal” state (Van Gennep, 1960) blur the boundaries between dead and alive, between existence and non-existence (Lock, 1995; Lock, 2002; Bird-David & Israeli, 2010), and between subject and object (Bird-David & Israeli, 2010; Bordo, 1987; Levi-Strauss, 1969). The brain-dead and technology-supported bodies make it difficult to judge and to make a prediction of death as “a biological phenomenon [through which a] living being ceases to be alive” (McMahan, 1998, p. 250). In addition, the denaturalized (Franklin, 1995) bodies have challenged people’s “familial and social relations, and habitual ways of thinking about the self as a conscious, experiencing object” (Kaufman, 2000, p. 70).

Some scholars have also argued that the body itself is embodied personhood (Kontos, 2005). Frank (1995) stated, “The body itself is the message; humans commune through their bodies” (p. 50). The author explained that there were different ways to read the body messages, such as body movements and facial expressions: “The commune of bodies involves a communication of recognition that transcends the verbal” (p. 49). Kontos, when writing about providing health care to people with Alzheimer’s disease, pointed out, “the body is a substantive means by which persons with severe cognitive impairment engage with the world” (2005, p. 556). According to Kinjo and Morioka (2010), family members and caregivers would respond to the body messages by taking on their “narrative responsibility” (p. 92). This allows them to reinterpret/retell the (dying) person’s stories and narratives. For instance, a family member may apply facial cream on the patient’s face, or turn the person over in bed to avoid bedsores according to the

caregivers' own understandings or assumptions of the (dying) person's body language. Additionally, these actions, according to Van Manen, "may also be part of inviting a 'reuniting' or 'reemplacing' of the patient in a 'liveable' relation with his or her body" (as cited in Malone, 2003, p. 111).

Death-Denying or Death-Accepting

Brain death has profoundly affected how people conceptualize death, and it can be seen as a new way to talk about death in Western society, which has been labelled as death-defying or death-denying (Appleton, 2004). The categorization is generally based on three premises (Zimmermann & Rodin, 2004): (1) death is a taboo subject; (2) death is medicalized; (3) death is institutionalized.

Death as a taboo subject.

Some studies, such as Gorer's *The Pornography of Death* and Aries' *Western Attitudes Toward Death: From the Middle Ages to the Present*, argued that death is a taboo topic, and people in Western society are prohibited by their customs from talking about it. According to Gorer (1955), people have been afraid of talking about death because they deeply associated it with catastrophe and horrible imaginings. The belief in the inevitable process of secularization (Walter, 1991) also weakened people's trust in religion with which people could cope with death (Crow, 1989) and its related issues, such as anxiety. Elias (1985) argued that rituals and formalities might no longer be used as coping strategies since people were losing their trust in the two practices. At the same time, people did not want to express their grief in public spaces (Elias, 1985; Walter, 1991, Mellor & Shilling, 1993). Moreover, death, especially the experience of death, is

not only privatized (Turner, 1991; Bauman, 1992a; Bauman, 1992b) and individualized (Walter, 1991) in the modern society, but also subject to medical power (Turner, 1987) and the media (Mellor & Shilling, 1993).

Some scholars have commented on how death has been treated in Western society from other standpoints. For example, Aries (1974) stated that talking about death in public is shameful, threatening to a happy social life (Zimmermann & Rodin, 2004), so it had to be managed privately. This argument may reflect the belief of a binary structure in the sense that living people are in the public sphere, and the dying or dead bodies should be hidden in hospitals or funeral houses (Mellor & Shilling, 1993). Dumont and Foss claimed that “society must deny death if it is to get on with its everyday business, yet it must accept it if its members are to retain contact with reality” (as cited in Walter, 1991, p. 305). Walter (1991; 1994) followed this idea, and indicated that Western culture denies, but simultaneously accepts death. He argued that the information related to death, bereavement and funerals was in the newspapers. Since the discussions about death and dying have not stopped, Walter (1994) insisted the problem was not as Gorér assumed: that people treated death as a moral taboo and avoided talking about it. Instead, the issue was that none of these discourses represented the dying or the experiences of the dying and the bereaved.

Death is medicalized.

Being sick and old are devalued in Western society that worships being young and healthy as the representation of the future (Mellor & Shilling, 1993), so “the discussion of death...has become largely a preoccupation with sickness” (Giddens, 1991,

p. 204). Parsons (1951) indicated that the sick role is also a social role; those who are sick are temporarily deviant, and not only have some privileges, such as exemption from normal social roles, but also are expected to accept the medical care system's diagnoses, and to meet the system's expectations. Parker-Oliver (2000), furthermore, stated that when the label of "sick role" does not fit those who cannot survive, or recover from their diseases, or take the normal social roles again, a "dying role" (Parker-Oliver, 2000, p. 493) emerges. According to Noyes and Clancy's (1977) definition of dying role, elders should be categorized into this group because many of them are becoming so dependent on others that their autonomy and self-control abilities are challenged (Macleod, 2007). This reflects a mainstream attitude towards death and dying closely related to aging and long-term care service users (Wass & Neimeyer, 1995).

The advanced medical treatments are perceived as a strong promise that will help people to defy death (Kalish, 1984) so that they can regain their personal value. During the last few decades, keeping people alive with breathing machines or mechanical ventilators has shifted from an experimental practice to standard care (Koenig, 1988; Kaufman, 2000), and the healthcare providers have become "habituated to its use" (Kaufman, 2000, p. 72). This practice required health care institutions to recruit more healthcare providers and to rely on more advanced technology than before, but it did not provide more information or knowledge for people to cope with death and its related issues (Mellor & Shilling, 1993; Wass & Neimeyer, 1995).

This argument about prolonging life through technology seems based on the separation between nature and culture in the sense that death is a natural fact (Mellor &

Shilling, 1993), and the improved medical machines and medicines are cultural products with the means to control and manage nature. It is undeniable that when medicalization fails to stop or denaturalize death, it also fails to show that death is a purely medical issue (Aries, 1975; Bauman, 1992a; 1992b). In these cases, death symbolizes the failure of rationality (Bauman, 1992a; 1992b) and modernity (Lee, 2008) because expertise cannot control life.

However, some studies have argued that biomedicine is like many other forms of medical treatments “embedded in particular cultural, socioeconomic and technological conditions” (Bates, 2000, p. 502). Therefore, modern medical technology or medicine should be seen as an alternative health care or healing strategy (Bates, 2000) instead of as the absolute solution to all problems. Moreover, when the modern technology or medicine is identified as a “promise” that can cure all diseases and prevent death, the healthcare practitioners automatically become responsible for making the “promise” happen (Mellor & Shilling, 1993). In this case, the failure of the technology means the failure of people, including both those in “sick roles” and healthcare providers.

Barger-Lux and Heaney (1986) demonstrated that people pay attention to the “manipulation” function of new technology, but ignore what the technology does to people’s social relationships. For example, Siminoff and Chillag (1999) stated that one of the main reasons that people in the U.S. agreed to donate their organs after death was this belief: their characteristics would be passed onto the organ recipient, and the dead persons, in a way, would live in others. Nancy Scheper-Hughes and Margaret Lock’s (1987) idea of personhood focused on people’s self-awareness, agency, and the

experiences of their bodies in the world. However, Strathern argued that “persons are ‘partible’ rather than autonomous or self-contained” (as cited in Kaufman & Morgan, 2005). Konrad (1998, p. 645) stated, “Social relations reveal the persons they produce.” In other words, personhood is produced and reproduced through the production and reproduction of social relations.

Death is institutionalized.

It has been reported that currently more people die in hospitals than in their homes. The institutionalized death has been seen as a form of control of death, or a form of death denial by hiding it from the public. Ivan Illich (1976), in *Limits to Medicine: Medical Nemesis, The Expropriation of Health*, criticized the medicalization and hospitalization of life. He stated,

Life is thus reduced to a “span,” to a statistical phenomenon which, for better or for worse, must be institutionally planned and shaped. This life-span is brought into existence with the prenatal check-up, when the doctor decides if and how the fetus shall be born, and will end with a mark on a chart ordering resuscitation suspended. Between delivery and termination this bundle of biomedical care fits best into a city that is built like a mechanical womb. At each stage of their lives people are age-specifically disabled. The old are the most obvious example: they are victims of treatments meted out for an incurable condition. (p. 79)

The hospital-based approach to care for the-end-of life was also criticized for its isolated social environment that separates the dying people from the rest of society (Christakis & Allison, 2006; Noonan, 1996). Unlike the home which can be seen as a material form of space (Somervill, 1992) that symbolizes love, belonging, relationships, intimacy, security, privacy, independence, and a sense of control (Watson & Austerberry, 1986; Gurney, 1990; Somervill, 1992), the hospital is an unfamiliar institutional space

(Malone, 2003) where the social values created by people's experiences and ideals of homes (Somerville, 1992) are challenged (Van Manen, 1998; Malone, 2003).

Moreover, the procedural structural changes in hospitals also challenge "the three types of proximity" (Malone, 2003, p. 111). Ruth E. Malone stated that physical proximity, referred to as nearness, includes the physical actions of care, such as touching and washing the patient's body. Narrative proximity helps the healthcare providers set up conversations with their patients, and through the dialogues, the two parties gain an understanding of each other. Moral proximity refers to the healthcare providers' attention to patients' interests. She argued that organizational restructuring, such as an increasing emphasis on cost-efficient nursing practice, and the digitalization of health care practice, which may potentially change the healthcare providers' roles and responsibilities, may weaken the three interrelated proximities.

Some studies argue that the increasing rate of dying in hospitals may relate to the changes of family and social structures. For example, families used to be the primary institution providing health care to their own members, and looking after their aged relatives (Parsons, 1951). Nowadays, the size of a family in Western society tends to be smaller (Sussman, 1959) than before, and the family relationships are more complicated due to divorce, remarriage, or cohabitation which may have an effect on people trying to decide who should take the responsibilities for care (Field, 1994). David Field also argued that women used to be the caregivers in their homes, but in the current society, many women work outside of their houses as paid employees. Because of these changes in the social system, some families may have limited resources to provide care for people

with terminal diseases or for their dying family members. Also, in Western society, “the health care system is designed in a way that favours an institutional, technologically supported death” (Heyland, Lavery, Tranmer, Shortt, & Taylor, 2000, p. 14), which may have some negative influence on the quality of palliative care for the patients who are willing to accept a “natural death” at home.

Forbes (2001) gave a picture of nursing homes as “‘heaven’s waiting room’, a place where death is cold, lonely, and painful,” and Diamond (1983) described nursing homes as trouble, because partly they emphasized the medical tasks and ideologies. However, some studies indicate that there are social relationships developed in many healthcare organizations that may make the institutionalized spaces like homes for their residents. One example includes the metaphors of home and family (Moss, Moss, Rubinstein, & Black, 2003) used in some long-term care organizations, which are also called long-term care homes or nursing homes.

David Sapir described metaphors as “*tropes*, those figures of speech that operate on the meaning (the ‘signified’) rather than the form (the ‘signifier’) of words” (1970, p. 3, italicized by the original author). Lakoff and Johnson (1980, p. 3) stated, “Metaphor is pervasive in everyday life, not just in language but in thought and action.” The use of the terms, *home* and *family* justifies for both nursing home residents and the staff members that family and family members (staff members) are expected to provide care for their loved ones or relatives (patients) (Moss et al., 2003). As a result, the employees working in these organizations may prefer to give their patients a hug instead of keeping a professional distance from the dying people (Moss et al., 2003). There are kinships,

family-like relationships developed between the two parties (Chichin, Burack, Olson, & Likourezos, 2001; Moss et al., 2003), and according to Monahan and McCarthy, keeping the bond with residents was identified as a main reason for some healthcare assistants to keep their jobs (as cited in Moss et al., 2003).

Death from a Religious Perspective: The Three Death and Birth Experiences

Vera Kalitzkus (2004) indicated that “death and dying are always culturally defined and embedded in a system of cultural beliefs and values” (p. 142). One description of death from a Christian standpoint is that a Christian’s physical death is the third death and birth experience for that dying person through which the individual leaves his or her Christian life in the material world, and is born into a holy life (Metzler, 1989). Metzler, (1989) explained that the three death and birth experiences⁶ indicate the three transitions through which a person three times leaves a familiar world, and enters a new and unfamiliar world. The life after the third death or the experience of the third birth is unexplainable and far beyond people’s comprehension.

Death and Spirituality

Young and Koopsen (2005, p. 245) indicated, “Dying is a profound process of spiritual transformation.” Christians, who believe in the promise of an afterlife, perceive death as a transition to eternal life. Through this passage the flesh body, the sinful “old man” in Wesley Myland’s term (as cited in Jacobsen, 2003) dies, which symbolizes the shared experience with Jesus of death (Davis, 1976). Generally, the immortal soul goes to

⁶ The first death and birth experience is when the infant is born, and the second experience happens when a person is baptized (Metzler, 1989).

the eternal home where the individual experiences “the fullness of knowledge of God and [unites] with Him” (Puchalski & O’Donnell, 2005, p.118). Christians, in general, believe that people are saved from sins and become members of God’s kingdom through life, death, and the resurrection of Jesus (Mennonite Church, 1995). This belief not only represents a sense of trust in Jesus who promised to come back, but also indicates a hope that God’s promise will happen, but not yet (Davis, 1976).

Lydia Neufeld Harder (1998) also indicated that the holy incarnation of God in Jesus allows Mennonites to see a relationship between the Lord and people, or between spirit and flesh. The definitions of spirituality vary from one person to another. From a general Christian perspective, “God is spirit, and those who worship him must worship in spirit and truth” (John 4: 24). William James (2002) defended spirituality in terms of an individual’s religious experience, as “*the feelings, acts, and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine*” (p. 38, italicized in the original resource). Hinshaw (2002), furthermore, indicated that spirituality “allows a person to experience transcendent meaning in life. This is often expressed as a relationship with God, but it can also be about nature, art, music, and purpose in life” (p. 565).

For Christians, the Spirit of God is seen as God’s presence and active power in the world that in turn is created through Spirit (Mennonite Church, 1995; Harder, 1998). Therefore, a disciple’s body is not only physical, but also spiritual in the sense that the body should be the embodiment of God’s work and word in the physical world similar to the body of Jesus Christ (Fraser, 2005). This can be a reason for the prohibition of

cremation practiced by some Christians. Fraser (2005) pointed out that the Christians' bodies are the temples of God, and are cleansed from sins and sanctified by Jesus' blood.

The "protection" of body reflects an idea that the discipleship is not stopped by the death manifested in the physical non-existence. Rather, it is the Christians' hope that their relationship with the Lord continues through death (Snyder, 1995). According to Davis (1976), "This continues [and] becomes the basis for a new set of relationships" (p. 102). In this case, death, a process of suffering (Mimica, 1996), and a person's development (Robben, 2005), "became sublime and even beautiful because...people could look forward to a reunion with family members already in heaven" (p. 4).

Death and Lifestyle

According to the *Longman English Dictionary Online*, lifestyle is "the way a person or group of people live, including the place they live in, the things they own, the kind of job they do, and the activities they enjoy." Some medical dictionaries refer to lifestyle as a person's habitual activities, meaning the consistency of personal behaviours, including thinking styles, social or personal interactions, and other activities. In the health science field, a lifestyle may be seen as the reflection of the quality of a person's life. Lifestyle, in the working document, *A New Perspective on the Health of Canadians*, was identified as

a category. . . [that]consists of the aggregation of decisions by individuals which affect their health and over which they more or less have control. . . . Personal decisions and habits that are bad, from a health point of view, create self-imposed risks. When those risks result in illness or death, the victim's lifestyle can be said to have contributed to, or caused, his own illness or death. (Lalonde, 1974, p. 32)

From an anthropological perspective, people's ideologies, cultural beliefs, social values and economic systems are all embedded in the way they live. For example, Martocchio (1982) stated that the early Christians believed in "salvation as a community" (p. 9), and that God saves people, as individuals in community (Mennonite Church, 1995). This is the foundation for the development of the community of discipleship, a moral community (Harder, 1998), created "only through the cooperation and the solidarity of all of its members" (Demmer, 2010, p. 114). The community is like a "collective body" (Adler, 1996; Gould, 2006), which consists of different interrelated and interdependent parts that are functioning in different ways. To build a physically and spiritually healthy community, the individual parts and the community have to be treated as a unit (Scheper-Hughes & Lock, 1987; Gould, 2006). Additionally, Winland (1993) indicated that the community life is a shared way of life.

The emphasis on community is also an acknowledgement of being dependent on Spirit and other disciples. Cornelius Buller (1998) argued,

The limited independence of personal existence is rooted in creaturely interdependence and ultimately in dependence on God. Sin is the failure to acknowledge God as God and oneself as a dependent creature. This failure brings the death of the self (Rom. 1:28; 2:12) and the destruction of community. (p. 84)

To be a member of the disciple community, the believers are expected to live like Jesus did (Snyder, 1995; Harder, 1998), looking after his people and calling a company of disciples (Mennonite Church, 1995). For example, a passage in Matthew described this interdependence:

For I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me

clothing, I was sick and you took care of me, I was in prison and you visited me.
(25:35-36)

The *Bible* or the Scriptures, used by Christians, are sacred texts. Lambek (1990) stated, “Texts by themselves are silent; they become socially relevant through their enunciation, through citation, through acts of reading, reference, and interpretation” (p. 23).

The term, *community*, should be seen as a verb rather than a noun in that a community is created through its members’ collective actions (Gould, 2006; Durkheim, 1949). The community’s coherence and personal as well as cultural identity as God’s followers are reproduced through rituals (Turner et al., 1996), such as the participation in care groups, church services and funerals, which ensure the endurance of the social body (Mellor & Shilling, 1993; Schepers-Hughes & Lock, 1987; Turner, et al., 1996). This sense of community may contradict the mainstream’s cultural notion of self-care: that individuals are responsible for their own health (Mellor & Shilling, 1993).

Death as Learned Knowledge

Some scholars have demonstrated that death threatens people’s ontological security (Giddens, 1991; Kierkegaard, 1999; Mellor & Shilling, 1993; Walter, 1991). The threat is from a contradiction between people’s acknowledgement of the inevitability of death and their limited access to knowledge of what death leads to (Mellor & Shilling, 1993). Silverman (2004) argued that through history, many people died at home, and the deceased bodies were cleaned or prepared by their family members as part of the family duties. In this case, death became an interaction between the deceased and the families or

friends. It is also a “visual knowledge” (Gillison, 1997, p. 171) that allows people to observe their own cultural practices.

Elias (1985) also analyzed parents’ unwillingness to talk about death to their children in contemporary society, and indicated that parents were uncertain about how to describe death in ways that will help their children to be aware of death without scaring them or passing the parents’ own anxiety to the children (Willoughby, 1936). Naylor (1989) used Roberts’ study to indicate that traditionally, children learned about death through participating in the death rituals, such as viewing the body, and going to funerals. “Children made a common habit of visiting a house where someone had just passed away to ask reverently to view the body, a request that was never refused” (as cited in Naylor, 1989, p. 56).

In Gorer’s study (1965) related to discussing death with children, he found that in some Christian families, the parents would explain death to their children in terms of their beliefs, such as going to heaven, or being with God. Silverman (2004) along with other scholars (Walter, 1999; Aries, 1981) stated, “basic religious faith provided structure for people to be ready to ‘meet their Maker’ and to accept their fate or destiny” (p. 130).

Good Death and Dignity

There is no universal understanding or definition of “good death” (Webb, 1997) or “dying well” (Byock, 1996). Some previous studies have suggested that a good death involves bringing dignity into the process of dying (Turner, et al., 1996). Proulx and Jacelon (2004) indicated that dignity consists of an internal dimension and an external dimension. The internal aspect of dignity is the recognition that all people hold inherent

human worth which is reflected in their experiences (Jacelon, 2003; Proulx & Jacelon, 2004; Holstein, 1997; Moody, 1998), and the external aspect includes people's personal values, such as physical comfort, pain management, autonomy, preparedness, personal connectedness, peacefulness, adjustment, discretion, open communication, spirituality, or being surrounded by families and friends (Proulx & Jacelon, 2004; Hart, Sainsbury, & Short, 1998; Field, 1989; Holstein, 1997; Moody, 1998).

However, some scholars argued that the dying person should be perceived as a whole, meaning the recognition of the integrity of the person (Pellegrino, 1990; Widang & Fridlund, 2003). Widang and Fridlund (2003) explained, "The word integrity has its roots in the Latin word integer, which means wholeness, completeness and unimpaired unity" (p. 48). Harvey Max Chochinov (2006) used Cassidy and Davies' work to argue that the "integrated whole, [is] more than the simple sum of physical and psychological 'parts'" (p. 87). He articulated that a dying person is still a social being, who also can be seen as the embodiment of social relations (Bourdieu, 1990; Durkheim, 1995). The social relations in this sense do not only refer to the relationships between the dying persons and their family members or caregivers, but also refer to their relations with the communities in which they live, and the society.

There are several examples in previous studies that explained how a dying person has been related to others. Aries (1974) and Martocchio (1982) illustrated that a verbal will given by a dying person to his or her family members symbolizes a trust relationship between the two parties. Aries also suggested that the changes in the forms of wills might suggest the dying people's fear: their wishes and wills would not be listened to or be

obeyed (as cited in Martocchio, 1982). Chochinov (2006) indicated that an individual's fear of being a burden to others suggested a negative self-perception that he or she is undesirable or worthless in the relationship because the person's dependence will bring extra work to others who also have multiple social roles to play (von Faber & van der Geest, 2010). It may also suggest the feeling of helplessness, and frustration since complaining is valued negatively (von Faber & van der Geest, 2010) and accepting death is highly valued (Martocchio, 1982; Aries, 1974; von Faber & van der Geest, 2010) in some societies.

Another example is related to communication. Metcalf and Huntington (1991) stated that in Western societies, normally when a death happened, the immediate family would receive the news first. Other relatives who happened to be around when the death occurred would be informed, by physicians or the immediate family members, if they should not tell others of this event (Metcalf & Huntington, 1991). Additionally, there are many cultural rules related to how people communicate their grief and sadness with others. For example, in some cultures, expressing a personal feeling in public is not an appropriate behaviour. Crying in front of others is seen as a sign of weakness, or being angry in public is perceived as a lack of self-control by some people. In those cultures, people may choose to share the death story with others, such as their friends, church members, and people from the same support group as a way to cope with the loss and grief (Bosticco & Thompson, 2005).

Hertz (1960) and Morrison (1971) argued against the idea that death is an event or an instance. They insisted that death is a process through which people learn to plan their

own lives and to gain a sense of who they are (Feldman & Snyder, 2005). Through the process, social relationships are also maintained, produced and reproduced. Veatch stated that death “rarely ends a social relationship. In other words, it is not only dying that is a social relationship but also death. It is NOT the case that death kills identity whatever legal, financial and moral changes are prompted by these bodily changes” (as cited in Kellehear, 2008, capitalized by the original author). However, people’s beliefs or values may change or are challenged through the dying process. Chochinov (2006) pointed out that “This affords an opportunity, a moment of insight, to re-evaluate life activities and to choose those that add greatest meaning, purpose, and value in the time left” (p. 88).

Palliative Care

A close examination of the definition of palliative care “revealed a heterogeneous terminology” (Radbruch, & Payne, 2009, p. 280). The various terms used to refer to palliative care, such as hospice, continuing care, end-of-life care, thanatology, comfort care and supportive care (Elsey & McIntyre, 1996; Radbruch, & Payne, 2009) may reflect different approaches to palliative care services cross-culturally.

The definition of palliative care given by the Centres for Medicare and Medicaid Services (CMMS, 2008) is similar to the one provided by the World Health Organization (WHO, 2002), which focuses on improving the dying people’s and their families’ life quality through pain relief and the prevention of suffering. (Table5 listed some definitions provided by different organizations.) Additionally, WHO describes the time phase when palliative care can be introduced to a patient. Palliative care “is applicable early in the course of illness, in conjunction with other therapies that are intended to

prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications” (WHO, 2002). Palliative care, in Canada, has been used interchangeably with end-of-life care or hospice palliative care (Health Canada, 2009).

Table 5: The Definitions of Palliative Care

Organization	Definitions of Palliative Care
EACP (2009)	Palliative care is interdisciplinary in its approach and encompasses the patient, the family and the community in its scope. In a sense, palliative care is to offer the most basic concept of care – that of providing for the needs of the patient wherever he or she is cared for, either at home or in the hospital. Palliative care affirms life and regards dying as a normal process; it neither hastens nor postpones death. It sets out to preserve the best possible quality of life until death.
CMMS (2008)	Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other issues.
Health Canada (2009)	<p>Palliative care is an approach to care for people who are living with a life-threatening illness, no matter how old they are. The focus of care is on achieving comfort and ensuring respect for the person nearing death and maximizing quality of life for the patient, family and loved ones.</p> <p>Palliative care addresses different aspects of end-of-life care by:</p> <ul style="list-style-type: none"> ▪ managing pain and other symptoms ▪ providing social, psychological, cultural, emotional, spiritual and practical support ▪ supporting caregivers ▪ providing support for bereavement <p>Palliative care may also be called hospice palliative care or end-of-life care. In some cases, these terms are used interchangeably or in combination. In others, they refer to different types of services or providers. . . . The field of palliative and end-of-life care includes providing care services directly to the patient, family and loved ones. It also includes the education and training of care providers, research, surveillance and advocacy. Individuals, families, communities, the private sector and governments all play important roles in the field of palliative and end-of-life care.</p>

Table 5: The Definitions of Palliative Care (Continued)

WHO (retrieved in 2011)	<p>Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.</p> <p>Palliative care:</p> <ul style="list-style-type: none">▪ provides relief from pain and other distressing symptoms;▪ affirms life and regards dying as a normal process;▪ intends neither to hasten or postpone death;▪ integrates the psychological and spiritual aspects of patient care;▪ offers a support system to help patients live as actively as possible until death;▪ offers a support system to help the family cope during the patient's illness and in their own bereavement;▪ uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;▪ will enhance quality of life, and may also positively influence the course of illness;▪ is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
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The definition of hospice care service is also not universally standardized. For example, the National Hospice and Palliative Care Organization (NHPCO) indicated that hospice care also provides palliative care for patients. According to NHPCO,

[t]he focus of hospice relies on the belief that each of us has the right to die pain free and with dignity, and that our loved ones will receive the necessary support to allow us to do so.

- Hospice focuses on caring, not curing and, in most cases, care is provided in the person's home.
- Hospice care also is provided in freestanding hospice centers, hospitals, and nursing homes and other long-term care facilities.
- Hospice services are available to patients of any age, religion, race, or illness.
- Hospice care is covered under Medicare, Medicaid, most private insurance plans, HMOs, and other managed care organizations (as cited in Kaplan, 2010, p. 42).

According to Canadian Hospice Palliative Care Association (CHPCA, 2002),

[h]ospice palliative care aims to relieve suffering and improve the quality of living and dying. Hospice palliative care strives to help patients and families:

- address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears
- prepare for and manage self-determined life closure and the dying process
- cope with loss and grief during the illness and bereavement.

Hospice palliative care aims to:

- treat all active issues
- prevent new issues from occurring
- promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization.

The distinctions between palliative care and hospice care may vary. For example, the former might be provided in larger health care institutions, and the latter would be provided at home in some European countries. The article, “Choosing Hospices,” posted on the Harvard Medical School’s website (2005), stated, “The philosophy of hospice is that everyone has the right to die free of pain and with dignity, and that families should be supported in helping to make this possible.” However, palliative care in terms of the definition given by the WHO does not exclude any progressive medical treatment that aims to cure the disease or to prolong the patient’s life.

The boundaries between palliative care and hospice care are blurred, and the interchangeable use of the terms in the overlapped health care sectors demonstrate that palliative care and care for the end-of-life share some similar principles, such as the improvement of life quality, and the focus on the dying person’s physical, emotional, social, and spiritual needs. In some circumstances palliative can be part of hospice care, or in other situations, care for the end-of-life is a component of palliative care. The actual

differences between the definitions of hospice care and palliative care are not important since they all tried to identify palliative care from a holistic perspective by addressing various aspects of life, such as symptom control, spiritual supports, and supports for bereavement. However, Deborah & Quill (2006) argued that palliative care should not be a one-size-fits-all approach since people have various personal beliefs and expectations related to death and care for the end of life discussed earlier.

Some scholars indicated that various social barriers have put constraints upon palliative care services. Romanow stated that

there is an ‘inverse care law’ in operation. People in rural communities have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres. (as quoted in Rural Hospital Service Closures, 2009, p. 4)

Previous research showed a tendency internationally that many people living in remote rural areas have struggled with accessing health care services (Evans, Stone, & Elwyn, 2003; White, Wall, & Kristjanson, 2004; Killam & Carter, 2010; Rourke, 2005; Robinson, Pesut, Bottorff, Mowry, Broughton, & Fyles, 2009; Schuurman, Cinnamon, Matzopolous, Fawcett, & Hameed, 2010). Rural families reported difficulties related to the available health care services in the relatively isolated areas, especially during the night-time, weekend, and holidays for people who received palliative care at their own homes (Kelly & Minty, 2007; Evans, et al., 2003; White, et al., 2004;). Other issues identified in various studies include the families’ economic and social distance, such as the lack of transportation, and the unawareness of available local services. Additionally, the lack of counselling, psychological, and ambulatory services were also barriers that affected the establishment of palliative care services in rural areas (Evans, et al., 2003;

White, et al., 2004; Killam & Carter, 2010; Rourke, 2005; Robinson, et al., 2009; Schuurman, et al., 2010; Kelly, 2006).

Some scholars argued that, in fact, the lack of human resources is a common problem shared by people living in both urban and rural areas. Additionally, it causes many pressures for healthcare providers. To illustrate, the increased medicalization of people's bodies and lives (Field, 1994; Williams & Calnan, 1996; Conrad, 2005; Carnevale, 2005) and the development of "death technologies" (Carnevale, 2005, p. 3) or the "technologization of death" (Carnevale, 2005, p. 3) might have become a sugar-coated (modern) "holistic" health care approach which encourages the healthcare providers to medicalize or technologize the patients' social conditions contributing to their illnesses (Williams & Calnan, 1996) to help the patients achieve optimal health.

In this case, the healthcare providers, especially physicians and nurses are expected to be perfect (Weinstein, 2001), meaning the healthcare providers are "required" to focus on their professional developments, to know their patients, to take full charge of the diseases, and to be "the gatekeepers of medical resources" (Weinstein, 2001, p. 268) as emphasized in the cost-efficiency health care system. Weinstein (2001) argued that achieving perfection is impossible because the unrealistic expectations put upon the healthcare providers by the local health care systems, patients, and other people are also their limitations. That is, that like other ordinary people, the healthcare providers are limited by various factors, such as time, knowledge, experiences, and "resource constraints in hospitals and laboratories" (Weinstein, 2001, p. 271).

Therefore, with the increased patient numbers on the waiting lists for treatments,

such as transplant surgeries, more healthcare providers need to be recruited. The National Physician Survey (NPS), the largest survey of physicians in Canada, indicated, according to its 2010 survey, the demands for their time increased due to the complexity of their patient caseload, the needs of patients living in chronic conditions, the increased administrative tasks and paper work, the increased needs of aging patients, and the increased patient expectations (The Royal College of Physicians and Surgeons of Canada, 2011). The demands for more healthcare providers are very obvious across the nation. However, Canada, especially its rural areas (Killam & Carter, 2010; Rourke, 2005), has not been able to meet the needs for healthcare personnel. Additionally, the imbalance between the increasing number of patients and the slow recruitments of healthcare providers have put many staff members, such as physicians and nurses, in a very stressful situation in which time is always a concern (Watson, 2008).

Summary

In the literature and in the communities, differing perceptions and practices surrounding death and care for the dying circulate and are available, and community members and healthcare providers of diverse kinds respond to this passage in life. Biological definitions of death or end-of-life care sit uneasily with various social responses, culturally informed modes of behaviour and proper standards for professionals, and differing individual experience of death and care for dying persons. In the following chapter, I explore these dynamic “regimes of value” (Appadurai, 1986), and beliefs associated with the end of human life in some LGS Mennonite communities.

Chapter Four: Mennonites, Migrations and Communities

This chapter provides a historical background of the LGS Mennonites, and focuses on their beliefs related to life and care embedded in their community lives. Mennonites took their name from Menno Simons, an ex-Roman Catholic priest born in Friesland, a Dutch province (Krahn & Dyck, 1989, para. 2). They became known as Anabaptists, a branch of Christianity, who practice adult baptism or rebaptism (Fretz, 1967). Originally, Mennonite groups were rooted in Switzerland, Germany and the Low Countries, including the Netherlands, Belgium and Luxembourg, and their history goes back to the 16th Century Reformation. Despite this movement's political, social and economic purposes, it aimed at reforming the Catholic Church (Dyck, 1967), which the reformers thought needed to regain purity or virtue.

Migration as a Boundary Marker of Self-Sustaining Communities

Migration became a way to develop self-sustaining communities that respected the rule of Christ. A *Bible* passage emphasized this value: “Adulterers! Do you not know that friendship with the world is enmity with God? Therefore whoever wishes to be a friend of the world becomes an enemy of God” (James 4:4). For this reason, the LGS Mennonites very often purchased isolated land to keep a distance from cities and non-Mennonite villagers. When they could not maintain the boundaries between themselves and others, they changed their localities in search of favourable places where they could maintain a distinctive lifestyle and enjoy religious and educational freedom.

Low German-Speaking Mennonites

Because of religious persecutions, since 1530, many Mennonite people fled their original homeland to seek religious freedom in other places, such as Prussia in the kingdom of Poland (Friesen, 2001). “Over two centuries in Poland, Mennonites came to adopt the local Lower Prussian Low German (*Niederpreußisch*)” (Cox, 2008, p. 22). According to Epp (1993) and Cox (2008), the local Low German dialect combined with the influences of Dutch, Flemish, and Frisian became *Plautdietsch*, referring to Mennonite *Plautdietsch* or Mennonite Low German. It was used as the daily language in people's homes and personal conversations. The church services, such as sermons and hymns, “were generally performed in literary Dutch” (Sawatzky, 2005, p. 40). A number of LGS Mennonite people, for example, the Old Colony Mennonites, kept *Plautdietsch* as their first language, regardless of the frequent resettlements they established in various countries, such as Russia, Canada, the United States, Mexico, Bolivia, Paraguay, and Belize after leaving Prussia.

Settlement in Russia

The LGS Mennonites left Prussia due to a mixture of religious and economic problems. In the later part of the 1770s, Catherine II (Catherine the Great) of Russia invited the Mennonites, who were well-known for being hard workers with excellent agricultural skills, to her territory around Ukraine to cultivate the unproductive land in exchange for the free exercise of religion, military exemption, educational autonomy, and autonomous governance of village affairs (Neff & Richard, 2007, para. 1; Epp, 1974). In 1763, Catherine II issued a manifesto ensuring European immigrant farmers' rights and

privileges in Russia. Krahn, Bender and Friesen (1989) indicated that this manifesto soon attracted the Mennonites of Prussia and Danzig who “were continually encountering restrictions in their economic and religious life. Later the matter of exemption from military service became important” (para. 5). Previous studies showed that from 1787 to 1870, 1,907 families with a total of some 8,000 LGS Mennonites migrated to Russia (Schultz, 1969; Krahn et al., 1989).

The Chortitza Mennonites were the first Mennonite settlers in Russia, and located their colony on the left bank of the Dnieper River between the cities Ekaterinoslav (Dnepropetrovsk) and Alexandrovsk (Zaporizhia) in Ukraine in 1789 (Krahn & Sawatzky, 1990; Dyck, 1967). The term, Old Colony, was used to distinguish the early Chortitza Mennonite migrants from the New Colony established in 1803 (Krahn & Sawatzky, 1990; Dyck, 1967). The Old Colonists, also called Old Colony Mennonites since their resettling in Canada, are perceived as the most conservative members in general. Bowen (2001) stated that the Old Colonists, as a group, “[have] been particularly mobile” (p. 462). This means that very often these people looked for new locations when their own life patterns were threatened by others, including both non-Mennonite people and the “liberal” or “less conservative” Mennonite groups who were open or relatively open to modernity, such as modern technology and public education (Enns, 2009; Urry, 1983; Gilmore, 2000).

The settlement locations were very important for the LGS Mennonites to live like one body, the body of Christ. Those people sought large isolated blocks of land where they could re-establish their agricultural lives, and at the same time, maintain their separations from the state or worldliness (Urry, 1983). Therefore, the big tracts of land

were not only for building houses or for developing large agricultural farms. Instead, Loewen (1993) explained:

Their new homes were to bear many of the marks of their colonies in Russia. Their place names, village and field systems, leadership hierarchy, denominational identity, architecture, language, and mode of production were replicated in the new land. It was as if nothing had changed. (p. 70)

After 1870, many LGS Mennonites were forced to leave Russia because the Russian national government withdrew the LGS Mennonites' special privileges and abolished the promised autonomy, including their educational autonomy and military exemption. They were forced to become "full-fledged Russian citizens with no special favors" (Smith, 1981, p. 440). In addition, the increased population among the Mennonite groups, which was caused by a high birth rate, combined with the newly established governmental restrictions on purchasing and selling land, resulted in an increased landless Mennonite population. These social, educational and economic changes pushed the Mennonite groups, who were no longer able to maintain their self-contained culture in their closed communities (Schultz, 1969), out of this country. In 1870, to escape the threat of military service and economic hardship, as well as to pursue the freedom in education according to their own conscience, some Mennonites in Russia started moving to the United States and Canada (Urry, 1983; Sawatzky, 1971).

Migration to Canada and the United States

In the 1870s and 1880s, approximately 18,000 Mennonites migrated to North American countries (Dyck, 1967; Loewen, 2001). The LGS Mennonite people who migrated to Canada from Russia during this time period were referred as "Kanadiers" (Loewen, 1993) to indicate the Canadian migration. Forty years later, between 1922 and

1930, 21,000 Mennonites arrived in Canada (Krahn, Bender & Friesen, 1989, para. 6; Loewen, 2002). Later, from 1941 to 1943 when Germany occupied the Ukraine, nearly 35,000 Mennonites were evacuated by the German military (Epp, 2000), and many German Mennonites, who had already settled in Russia for a few generations, were identified as alien foreigners and persecuted by the Stalin government (Daller, 2005, pp. 583-584). During World War II, around 12,000 Mennonites escaped to Canada and Paraguay (Epp, 2000).

The Mennonite groups who came in the 1870s and in the 1920s generally were in different economic situations and had different lifestyles. Janzen (2007) described that “the 7000 Mennonites who moved from Russia to Manitoba in the 1870s were poorer and more hesitant about the social changes” (p. 3) than the migrants in the 1920s. Many LGS Mennonites who moved to Canada in the 1920s, in general, were successful farmers, educators and business people in Russia before the Revolution (Smith, 1981) and open to new technology and public education (Smith, 1981).

The LGS Mennonites were welcomed by the Canadian government when they arrived during the 1870s and 1880s. Similar to the previous Russian authority, the Canadian officials also provided the Mennonites with guaranteed privileges and autonomy. Additionally, Mennonite settlers in Manitoba received \$100,000 from the state (Janzen, 2007) that helped them build their own colonies and agricultural systems. Nonetheless, the struggles that those Mennonite people experienced in Prussia and Russia began again when the Canadian government changed its policies in regard to the operation of independent Mennonite schools, and the exemption from military service,

which kept the LGS Mennonites separated from the larger society. Many LGS Mennonites, especially the conservative church members, in general, felt the threats to their lifestyle and religious beliefs. For this reason, several delegations were sent to Latin American countries, such as Paraguay and Mexico, to seek religiously and culturally more accommodating places.

Migration to Latin American Countries

From 1922 to 1927, 7,735 Mennonites migrated from Canada to Mexico (Map 1) and Paraguay (Janzen, 2007). It was estimated that 2,000 Mennonite migrants went to Paraguay (Janzen, 2007), and established the Menno Colony, which was located in the central Chaco, west of Puerto Casado (Smith, 1981). Over 5,500 Mennonites from the Canadian provinces of Manitoba and Saskatchewan moved to Mexico (Dyck, 1967; Peters, 1988; Janzen, 2007; Sawatzky, 1971). These people established the Manitoba colony, near the town of Cuauhtémoc, in the Northern state of Chihuahua, and the Durango colony in the same state (Dyck, 1967; Peters, 1988).

Between the late 1950s and the early 1960s, a large number of LGS Mennonites from Canada, and more than 5,000 Mennonites from Mexico relocated to Belize (previously called British Honduras) (Dyck, 1967; Pauls, 2004) as the result of the Canadian and Mexican governments' enforcements of their own public education among the Mennonite population. The Belize government promised the Mennonite migrants complete control over their own colonies (Pauls, 2004), and later, the LGS Mennonite communities were established in the areas of Corozal, Orange Walk, and Cayo (Gingerich & Breneman, 2008). In Belize there are four major colonies. The Shipyard, in

which generally only horses and buggies are allowed, and Little Belize colonies were considered relatively conservative; the Blue Creek and Spanish Lookout colonies were considered more liberal (Pauls, 2004; Gingerich & Breneman, 2008).

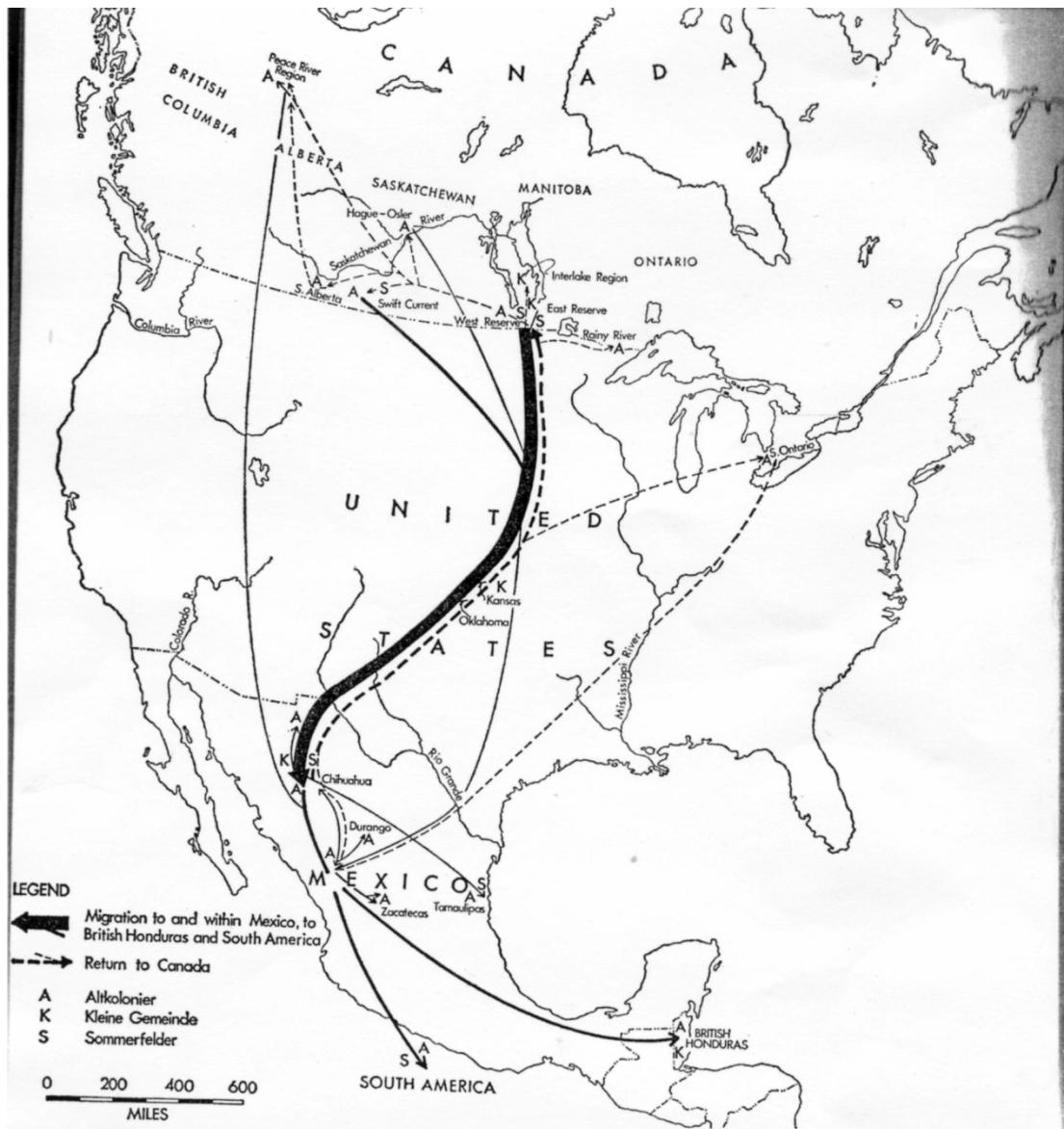
In 1967, 102 Old Colony Mennonites left the Peace River country in the La Crete area, a country site in the province of Alberta in Canada and moved to San Ignacio in Bolivia (Bowen, 2004). The local natural environment and the poor quality of the 2000 acres of land (Bowen, 2004) they purchased led to another resettlement. These LGS Mennonite migrants left their belongings in the desert, and bought another bloc of land even though an unsuccessful negotiation with the local government resulted in a higher price than the LGS Mennonites expected (Bowen, 2004). These early Mennonite pioneers finally created a traditional Mennonite community in a rainforest area, known as Las Piedras, 75 miles northwest of Santa Cruz, (Bowen, 2004; Hiebert, 1987). In 1983, a new Mennonite colony was established as a branch of Las Piedras called Las Piedras II (Bowen, 2004; Hiebert, 1987).

Coming Back to Canada

Redekop (1969) stated that the migrant LGS Mennonites were looking for less dogmatic social regulations and more adventures (as cited in Canas Bottos, 2008b). Canas Bottos (2008b) and Driedger (1988) argued that the LGS Mennonites who migrated to different countries were those who did not accept modernity and acculturation. People who chose not to move were those who were more open to accommodate the mainstream influences (Canas Bottos, 2008b; Loewen, 1993). However, the LGS Mennonites' migration was a complicated interplay of religious

beliefs, kinship ties, economic conditions (Bowen, 2001), social security issues, and educational and health needs as well as the desire to protect cultural autonomy (Loewen, 1993). Various interactions of these factors pushed and pulled the LGS Mennonite families to move from one country to the other.

Map 1: “Mennonite migration to, from, and within Mexico⁷” (Sawatzky, 1971)



⁷ Copyright is obtained from the Regents of the University of California.

The Pushing Forces

The LGS Mennonites' decisions to migrate might be considered "hasty" in the sense that many relocations were not well planned (Bowen, 2001). Fretz, a Mennonite sociologist, commented on the massive migrations as "poorly planned, loosely organized, and sometimes composed of the economically and socially more unstable population of the home community" (as cited in Bowen, 2001). This situation led to more problems and different kinds of hardships, such as poverty and the loss of lives. For example, in Paraguay, the land Mennonites bought in the Chaco area was covered largely by "almost impenetrable growth of scrub trees, spiny shrubs and cacti, with occasional swampy meadows and open *campos* or fields. In a dry season Chaco is hot and dusty, and in a wet season, it is muddy making the roads difficult to travel" (Fretz, 1962, pp. 1-2). This natural environment pushed Mennonite farmers to change their farming strategies, switching from cultivating wheat to producing other crops, such as cotton and peanuts, in exchange for money and other goods. However, it was hard for the LGS Mennonites to sell their products, due to the lack of roads linking to the "outside world" in the Mennonite settlement area (Peters, 1988, pp. 201-202). In 1927, when the typhoid epidemic caused the loss of 200 lives, approximately 355 Mennonites returned to Canada from Paraguay (Fretz, 1953).

Mennonites who moved to San Ignacio in Bolivia from La Crete were also trapped in the non-cultivable and unproductive land they purchased before arriving. The land, "covered with scrub trees and thorn bush, with sandy soils. . . [was weak and poor]" (Bowen, 2004, p. 65). One of the group members in the same study described that his

parents were shocked when they saw the desert land, and emphasized that the isolated nature of the place was obvious. Since all the migrants of this group were not prepared to handle these conditions, the whole group was infected by dysentery. The participant, furthermore, commented that even though the lack of clean drinking water was a significant problem at that time, people had no “opportunity” to worry about it. They were preoccupied as they struggled to plant crops on this piece of land so that they could be self-sufficient. However, after a few months, their first harvest failed, and they, eventually, resettled in the Las Piedras area.

The natural, economic and social hardships might have been a shared experience for many LGS Mennonites in Latin American countries. The fertility of the land that Mennonites bought in Mexico is from average to unfertile (Peters, 1988). Sawatzky (1971) stated, “although more fertile lands occur in smaller tracts benefitted from run off and consequent addition of soil and organic matter . . . erosion has already taken its toll of the top soil” (pp. 104-106). The poor quality of the farming land the LGS Mennonite people bought from the government of Mexico, together with natural disasters, such as the unexpected long drought in the early 1950s, made some LGS Mennonites’ agricultural lives very difficult.

Additionally, the rapid growth of the population led to an increased need for land (Enns, 2009, p. 4). Because of their prohibition against practicing birth control and a high birth rate, the LGS Mennonites very often had large families. It led to the need for more agricultural land (Janzen, 2004), especially for the young people. However, it was not available because of the Mexican government’s policy at that time, which restricted the Mennonites from purchasing more land from the government when they needed it

(Castro, 2004). As a consequence of this unmet need, a landless class was “generated” and “developed” in some LGS Mennonite colonies (Sawatzky, 1971; Friesen, 1990), and some community members without land were pushed into the cheap labour market.

Many Mennonites in Mexico also lost their savings because of the local banks’ unstable situation (Janzen, 2004). The economic conditions became more serious during the drought at the beginning of 1950s. Additional economic pressures were caused by the devaluation of the peso and free trade agreements. Nonetheless, the conservative congregations refused to change their agricultural practices to improve their economic situations, such as setting up an electricity system. Villagers who made changes were excommunicated by their churches (Janzen, 2004; Enns, 2009), so others who wanted to seed and farm their lands with new technology to improve their economic wellbeing were pressured to leave their own colonies (Enns, 2009; Janzen, 2004; Quiring, 1997).

The rejection of new technology, which represents modernity and “worldliness,” assumedly protected the LGS Mennonites’ group identity as the true followers of God. Canas Bottos (2008b) explained that the “acceptance of pick-up trucks, cars, electricity and other aspects of modern life...breached the practice of separation from the world” (p. 220). Owning a car was not sinful itself (Canas Bottos, 2008b; Quiring, 1997), but it would lead to constant travelling to the neighbour towns, which consequently would bring the outsiders’ influences, such as drinking and dancing, back to the Mennonite communities (Canas Bottos, 2008b; Quiring, 1997). Additionally, there was a fear that if the ministers did not punish individuals who violated the regulations, other members would follow the bad models, which eventually could weaken the community’s integrity (Roessingh & Plasil, 2006). Moreover, owning a car represented personal wealth,

individuality, competition (Canas Bottos, 2008b), and pride (Loewen, 1993), which were against the essential Christian values of simplicity, humility, integrity, and conformity (Canas Bottos, 2008b; Fast, 2004; Arthur, 1997; Arthur, 1998). These concerns for modern technology, in fact, were also applied to change in other life aspects, such as dress code (Canas Bottos, 2008b).

In addition to preserving an isolated agricultural lifestyle, another important goal for the LGS Mennonites' resettlements in Latin American countries was to maintain the control of education, including teaching in German that was seen as an inalienable feature of their faith (Smith, 1981; Janzen, 2007; Pauls, 2004) by many conservative Mennonites. However, a few years after the LGS Mennonites' arriving, the Mexican government started pressing those people to accept public education by replacing Mennonite teachers with Mexican teachers (Smith, 1981; Pauls, 2004). Later, the Mennonite schools were closed (Janzen, 2004; Pauls, 2004). Additionally, the national government "[enforced] a Social Security System throughout the nation. This meant the building of hospitals, schools, sport and recreational facilities, [and] public institutions that were contrary to the religious convictions of the Mennonite communities" (Pauls, 2004, p. 168). When these events happened, some people felt threatened again. As mentioned earlier, a group of people resettled in Belize. Some LGS Mennonites wanted to come back to Canada, but they had no resources (Janzen, 2004), such as money and transportation, for their trips.

In other countries, the LGS Mennonites also faced many social problems. For instance, in 1961, a young Mennonite boy was killed in Belize, which shocked many community members (Pauls, 2004). "People were worried about their health. Over there, we were strangers and Canada was our home. That could've been a reason we came back

to Canada” (Koop, as cited in Pauls, 2004, p. 168). In the middle of the 1980s, some LGS Mennonites in Belize moved back to Canada and settled in Nova Scotia because they could not stop their neighbours in Belize from “stealing their possessions and terrorizing the families” (Pauls, 2004, p. 168). In recent years, kidnappings, armed robberies, and carjackings have threatened the LGS Mennonites in Mexico. Other social issues, such as alcohol or drug abuse, and the lack of proper medical care, also have made the unstable living situation even more difficult.

Castro (2004) argued that another reason for the LGS Mennonites’ resettlements in Canada was their educational needs. Many conservative Mennonites were not allowed to read and study the *Bible* themselves. Some LGS Mennonites studied the Scriptures or organized *Bible* study groups themselves, and were accused of being disobedient to God’s will (Roessingh & Plasil, 2006; Bowen, 2001) as represented by the churches’ regulations. The reason for this accusation was that those people challenged the authority of their church leaders (Roessingh & Plasil, 2006, p. 64), who were perceived as the spokesmen for God. Moreover, people who gained public education or were interested in using modern technology might also be banned since they were becoming worldly.

The Pulling Forces

The land shortage combined with other difficulties, such as the devaluation of the Mexican peso during the economic crisis, the dry weather (Bowen, 2001), unstable living environments, and other social problems pushed some LGS Mennonites out of Latin American countries. Simultaneously, some people, who were looking for places with safe social environments where they still could maintain their religious and agricultural

practices, saw the opportunities in Canada. For instance, in Canada, LGS Mennonites are able to work in various occupations in addition to being farmers.

Castro (2004) indicated that although many preachers in the conservative LGS Mennonite churches did not teach their members about the possible negative effects of the low level of education on their lives, such as being economically marginalized, the ordinary people still learned it from others. Mennonite people living in the Quellen Colony, close to Cuauhtémoc, who had relatively loose rules related to public education, became a model for some LGS Mennonites (Castro, 2004) in this area. Additionally, various educational programs related to agriculture, *Bible* study, and language skills were established in the areas where the conservative LGS Mennonites lived. As the result of these influences, some conservative church members wanted to gain some public education (Castro, 2004). Returning to Canada became an approach not only to cope with social changes (Driedger, 1988), but also to negotiate the pastoral emphasis on the cultural, spatial and physical boundaries between congregation members and “outsiders.”

As a result of these pushing and pulling forces, the LGS Mennonites who maintained their Canadian citizenships returned to Canada. Some people who could not move to Canada immediately would come to this country as seasonal labourers, and when winter arrived, they would return to Mexico when it was cold (Enns, 2009; Janzen, 2004; Basok, 2002). Many of these people eventually became permanent Canadian residents, and during the last three or four decades, about 40,000 Mennonites resettled in Canada (Enns, 2009; Janzen, 2004). Some LGS Mennonite groups have also moved to the United States from Mexico since 1976. Cyndi Treaster, the director of the Farmworker,

Immigrant and Refugee Health Section in the Office of Local and Rural Health in Kansas

indicated that during the last few decades, about 4,000 to 5,000 LGS Mennonites from Mexico migrated to Southwest Kansas (Green, 2007). Some LGS Mennonite families moved to Texas and Oklahoma to look for working opportunities (Green, 2007).

New Challenges in Canada

Some LGS Mennonite people perceived Canada or the United States as relatively good places for them to stay in that they could still practice their religious lifestyles within their own communities. However, for others, moving back to Canada meant that they had to face new challenges to preserving traditions while trying to adapt to a new social environment. For example, living in an isolated area, as the LGS Mennonites' practice of living (Bourdieu, 1977; Winland, 1993), would allow them to gain a sense of the past, which in turn helped these people establish a sense of self (Epp, 1987). Van Dyke (1972) in his study indicates that the reason for some LGS Mennonites' migration to Bolivia from Canada was to regain a true disciple's life after they arrived at the new place. The participants in this study believed that

[i]n Bolivia we will use horses and wagons again as it was in the early days here. We can have our own . . . schools again and our children will have a chance to grow up in our way, speaking Low German instead of English. (p. 120)

This ideal living style, in fact, has been perpetuated by some LGS Mennonite groups since it reemphasizes their religious identity. After coming to Canada, however, their intention of not being affiliated with the state was challenged by Canadian immigration laws and citizenship laws. Moreover, Janzen (2010) explained that these laws have been changed during the last several years, which means that gaining their Canadian citizenship might have become difficult for some LGS Mennonites who were

not born in Canada. At the same time, it is also important for the LGS Mennonites to provide proper and up-to-date documents to apply for their citizenships or to become permanent Canadian residents, but some families have not kept those documents.

Another challenge the LGS Mennonites faced was that the resettlements themselves were costly. Bowen (2001) indicated that many people who moved twice between Bolivia and La Crete exhausted all their money for the constant migration, and some of them had to rely on their relatives' or others' financial supports. In fact, some LGS Mennonites, who wanted to return to Bolivia where they could maintain their traditions, could not manage their trips again since they could not afford the journey (Bowen, 2001). It might also have been hard for some LGS Mennonites who returned to Canada for work to find good jobs because they tended to have a low level of education (Castro, 2004) and might not speak English. However, learning English might be seen as being prone to accommodate (Driedger, 1988) to the mainstream value.

To meet the need for education, some LGS Mennonites built their own schools that used their own curriculum and teachers. Many LGS Mennonite children have been sent to public schools. In southern Alberta, 8-900 children went to such schools (Banman & Epp, 2010, MCC Networking Minutes Mexico). About 500 children were in home schools, many of which had very low standards (Banman & Epp, 2010, MCC Networking Minutes Mexico). There are also about 400 children not in school at all (Banman & Epp, 2010, MCC Networking Minutes Mexico) for reasons of distance, cost, or religious beliefs. These examples illustrated some challenges LGS Mennonites faced after returning to Canada. Some of them might have felt that they were in the situation of

betwixt and between, meaning “[torn] between commitments to both their traditional communities and the outside world. . .” (Epp, 2004, p. 223).

Inter-church Boundaries

Winland (1993) argued that schisms among the “Mennonite communities have traditionally developed precisely from differences in biblically-inspired convictions” (p. 117). Some conservative church leaders tried to safeguard the social boundaries (Loewen, 1992; Loewen, 1993; Guenther, 2004) by using different approaches, such as the excommunication (Quiring, 1997; Loewen, 1992; Loewen, 1993) of an insider who transgressed, so the person became an “outsider.” There are various reasons for excommunication, meaning people could be banned for any unacceptable and sinful behaviours, such as the violation of the dress code, or the acceptance of evangelicalism (Winland, 1993; Regehr, 1996; Guenther, 2004). Previously, excommunication was used massively as a mechanism to protect the community’s “communal value,” and solidarity, but it eventually led to splits in churches.

For example, the use of rubber tires was a major factor that caused the LGS Mennonite churches’ separations in different countries, such as in Mexico and Canada (Canas Bottos, 2008a; Canas Bottos, 2008b; Quiring, 1997). Some LGS Mennonites were afraid that their own congregations would ban them if they used rubber tires on their tractors, so they used the steel tires instead. Driving the steel-tired tractors allowed people to reconfirm their traditional agricultural practices, and to maintain their connections with a bigger farmer market at the same time (Canas Bottos, 2008a; Canas Bottos, 2008b; Quiring, 1997). The conservative churches also banned the use of other technology, such

as trucks, electricity, and telephones since some technology provided direct connections with the world (Quiring, 1997; Regehr, 1996; Loewen, 1993) and were perceived as threatening to the distinctiveness of a believers' community (Yoder, 1986), meaning God's true believers are "in" but not "of" the world (Kaufman, 1979).

However, some restrictive rules were adjusted gradually in many churches (Canas Bottos, 2008a; Canas Bottos, 2008b). Some churches banned the ownership of cars or trucks, but allowed their members to travel in them only when necessary (Quiring, 1997; Canas Bottos, 2008b). For example, the church members were allowed to sit in the back of other people's trucks (Quiring, 1997) when going to the hospital (Canas Bottos, 2008b). The adjustments allowed the LGS Mennonites to use some new technology and to redefine the boundaries between "insiders" and "outsiders" (Canas Bottos, 2008a; Canas Bottos, 2008b) at the same time.

Many newly built Mennonite churches that accepted people who were excommunicated by their original churches (Quiring, 1997; Loewen, 1993) also contributed to the churches' schisms. For example, Darrell Kelher, an Evangelical Mennonite Mission Conference (EMMC) church leader, explained that many LGS Mennonites in the Pailon colony in Bolivia were excommunicated (as cited Lockhart, 2006) from their congregations in Mexico because they wanted to change the traditional agricultural practices. Many of those people joined other Mennonite churches after moving to Bolivia. For another example, some LGS Mennonites switched to the less conservative churches because they were excommunicated by their original churches for accepting evangelical theory or "questioning" the preachers, the speakers for God's word.

However, at the same time, some church members insisted on maintaining their traditions. In some cases, the LGS Mennonites started new conservative churches. In one case, some church members believed that their bishops would eventually lead their congregations to become worldly since the church leaders were promoting modernity by using a microphone during church service (Regehr, 1996).

The Sense of Community

John O'Neill (1985) believes that how people perceive their bodies reflects how they think about their societies. For example, the scientific health model has treated the body as a complicated machine that consists of various interconnected parts. Every body is composed of various vibrating machines whose speed, rhythm, timing, and quality have to be controlled by the scientific regime to protect the health of the person (Synnott, 1992; Baumgartner, 2006). Therefore, a person's health or a nation's health is determined by the functional ability of each component and the quality of the predetermined relations between these parts.

The LGS Mennonites' health, death, and care related beliefs and practices cannot be separated from their understandings of community as the body of Christ. Their communities, according to Mary Douglas' (1970) grid group model adapted by Bruce Malina (1986), consist of Low Individualism-High Community groups. One of the features of this type of community is that personal satisfaction cannot be satisfied by either the individual's or the community's achievements (Snyder, 1995). Instead, a person's satisfaction is derived from his or her membership. For example, some people from the *Rheinlander* Mennonite churches believed that

[s]alvation was perceived as a corporate reality by the villagers. God had called them to faith in Jesus Christ, and the response to this call was properly expressed by committing themselves to the believing community. This commitment meant subjecting individual desires and wishes to the good of the whole group. (Friesen, 2001, p. 12)

Community and the *Bible*

Religion consists of convictions, symbols and practices that are based on the idea of the sacred, rather than on a set of scientific evidence (Scott & Marshall, 2009). As a belief system, religion has played an important role in LGS Mennonite people's lives. Mennonites focus on the New Testament, highlighting the teaching of Jesus. According to Fretz (1967), in general, Mennonites gain their voluntary church memberships through their conversion to Christianity, which means people acknowledge and publicly accept the only truth, God, and the idea that God's word, the *Bible*, is the only rule for faith and life (Miller, 1989; Riesen & Urry, 1998).

In general, the LGS Mennonite people believe in a literal interpretation of the *Bible*, meaning many LGS Mennonites' lives are directed by their ministers' "teachings" of the *Bible* (Enns, 2009), which are in general the surface meanings of the verses. For example, the ministers from some conservative churches dress like soldiers to follow the biblical meaning of the "armour of God." The meanings of the Scriptures are "always the power, certainty, truth, the reality of [Christianity] itself, of which the recitation is an exemplification and an affirmation rather than a description" (Lambek, 1990, p. 27).

Ministers in general are the "rule protectors" since they are believed to be the spokespersons for God (Guenther, 1994, p. 6). Some LGS Mennonites were taught it was inappropriate for them to learn the *Bible* themselves since they would interpret the

Scriptures inaccurately. As the only “authentic” resource for the LGS Mennonites to know God, the ministers, in turn, gained people’s respect, and power, which was used to separate individuals from the community through actions such as excommunication. However, this social stratification may not be seen as a form of inequality. Rather, some LGS Mennonites may identify it as a protection or necessity of the group’s identity.

Adult-baptism and “Living Like Jesus”

Menno Simons, one of the iconic figures in the Anabaptist Movement, believed that following God, being a Christian, or becoming a member of God's kingdom, is a conscious and voluntary decision, which separates the believers from non-believers. Infant baptism, therefore, is perceived as a force against religious freedom (Snyder, 1995) since babies are not capable of making a voluntary commitment to God based on their understandings of the Lord (Bender, 1944).

Penner (2005, p. 10) stated, “Baptism is for those who understand its meaning, are able to be accountable to Christ and the church, and voluntarily request it on the basis of their faith response to Jesus Christ.” The book, *Confession of Faith in a Mennonite Perspective* (Mennonite Church, 1995), stated:

Christian baptism is for those who confess their sins, repent, accept Jesus Christ as Savior and Lord, and commit themselves to follow Christ in obedience as members of his body, both giving and receiving care and counsel in the church. Baptism is for those who are of the age of accountability and who freely request baptism on the basis of their response to Jesus Christ in faith. (p. 46)

Being baptized by water⁸ not only symbolizes an awareness of the need to repent the sins, but also indicates that the baptized person is ready to live in the way that Jesus Christ did. In other words, to be baptized, it is very important, according to the Scriptures, for people to be aware that they have sinned. Menno Simons stated, “We must all acknowledge, whoever we are, that we are sinners in thought, word, and deed” (as quoted in Wenger, 1961, p. 40). Adult-baptism represents believers’ acknowledgments of their sins (Veen, 2005), their willingness to make a life-long commitment to follow God. Additionally, Miller (1991) says, “God’s grace is expressed not only in a declaration of forgiveness but primarily as a creative and transforming power which regenerates and renews sinful human beings” (p. 47). When people are baptized, their sins are forgiven, and they enter a new life by receiving the Holy Spirit. However, they must keep a strong faith in God whose mercy and grace will help them face different kinds of temptations, and avoid sinful ways.

The idea of the godly incarnation of Christ promoted by Menno Simons and his followers implies that Jesus, the son of God, was free from original sin. However, Jesus still faced many temptations while living in the physical world, and never tried to escape the physical or spiritual suffering. “Living like Jesus,” therefore, cannot be understood as only living in a non-sinful way. It also means to be called and used by God to spread the gospel and to live in union with Him because obedience leads to peace and healing. A biblical statement related to this idea in Proverbs stated that

⁸ The ritual process of baptism is not the focus of the study, so it will not be discussed in this thesis.

My child, be attentive to my words; incline your ear to my sayings. Do not let them escape from your sight; keep them within your heart. For they are life to those who find them, and healing to all their flesh. (4:20-22)

Community, Church and Body

The Mennonites, “especially for the 1920s Mennonites, the congregation, or *Gemeinde*⁹, formed the centre of Mennonite life and the source of everything that defined a Mennonite” (Taves, 1995, p. 2). The church is the centre of a Mennonite community that helps all Mennonites provide better services to God. The church, Harold Bender said, is “a voluntary, separated fellowship” (as cited in Snyder, 1995, p. 107) that should not be controlled by and affiliated with the states. Indeed, as Dyck described, “the immaculate church is [God's] body on earth” (as cited in Angulo, 2004, p. 35). Mennonites are “members of a body who derive their identity and existence from that body” (Snyder, 1995, p. 13). According to 1 Corinthians in the *Bible*,

For just as the body is one and has many members, and all the members of the body, though many, are one body, so it is with Christ. For in the one Spirit we were all baptized into one body—Jews or Greeks, slaves or free and we were all made to drink of one Spirit. (12:12-13)

Additionally, what is said about the church is also about a Mennonite individual’s body. From a Christian standpoint, the disciples’ bodies are the temples of God. “Do you not know that you are God's temple and that God's Spirit dwells in you? If anyone destroys God's temple, God will destroy that person. For God's temple is holy, and you are that temple” (1 Corinthians 3:16-17). The temple of God either represented as church or human body is

⁹ *Gemeinde* means *church* in English.

built upon the foundation of the apostles and prophets, with Christ Jesus himself as the cornerstone. In him the whole structure is joined together and grows into a holy temple in the Lord; in whom you also are built together spiritually into a dwelling place for God. (Ephesians 2: 20-22)

Confession of Faith in a Mennonite Perspective (Mennonite Church, 1995)

indicates that through confession and baptism, adult Mennonites voluntarily become a part of the united body through which they demonstrate their acceptance of God's guidelines. Accepting disciplines leads the Lord's followers to establish "a new relationship with God through Christ. In God's love, our whole life is freed, transformed, reordered, and renewed" (Mennonite Church, 1995, p. 69).

Community and Belonging

The sense of belonging refers to the embodiment of the congregational relationship and people's relationship with God. Snyder (1995) articulated, "One is somebody (and therefore an individual) simply by belonging" (p. 21); a person has to live in Christ's way. Obtaining membership in God's world requires all disciples to avoid worldliness, because Jesus, in the New Testament said so:

Jesus answered, "My kingdom is not from this world. If my kingdom were from this world, my followers would be fighting to keep me from being handed over to the Jews. But as it is, my kingdom is not from here." (John 18:36)

In other words, the LGS Mennonites are living in the physical world, but they emphasize that they are members of the kingdom of Christ, not that of the state (Hegel, 1991, p. 295). Therefore, those people promoted conformity and nonconformity at the same time in the sense that they obeyed the only truth, God's, and would not follow the social norms and institutional laws when they contradicted God's word, which was the law for the LGS Mennonites.

Community and the Practice of Living

The LGS Mennonites demonstrated their faith in God by maintaining a certain lifestyle, such as refusing to swear oaths, which were part of the belief that concrete obedient acts confirm their faith (Veen, 2005). Menno Simons stated in his article, *Reasons for Teaching and Writing*, translated by John Funk (1871),

For true evangelical faith is of such a nature that it cannot lay dormant; but manifests itself in all righteousness and works of love; it dies unto flesh and blood; destroys all forbidden lusts and desires; cordially seeks, serves and fears God; clothes the naked; feeds the hungry; consoles the afflicted; shelters the miserable; aids and consoles all the oppressed; returns good for evil; serves those that injure it; prays for those that persecute it; teaches, admonishes and re-proves with the Word of the Lord; seeks that which is lost; binds up that which is wounded; heals that which is diseased and saves that which is sound. The persecution, suffering and anxiety which befalls it for the sake of the truth of the Lord, is to it a glorious joy and consolation. (p. 246)

Pacifism and Nonconformity

The LGS Mennonites also identified themselves as pacifists, who committed to a simple and nonviolent lifestyle. By separating church from state, and being distant from the dominant society, they declared their nonconformity to the world. Stated differently, the LGS Mennonite congregations, especially the conservative groups, did not want to associate themselves with governments, but they did not take violent actions against the states' regulations, such as the forced cultural assimilation, since it contradicted their beliefs in pacifism and non-resistance. The tension between being a good citizen and not being affiliated with the political authorities might be resolved in two ways. On one hand, the LGS Mennonites were trying to maintain a "good relationship" with the state, meaning that they obeyed the laws, paid taxes, and substituted other services, such as

sewing, for military services. On the other hand, they were required to be close to their communities and to follow the authority of the Scriptures, taught by their ministers.

Obedience and Conformity

Generally, the LGS Mennonites are the embodiment of their spiritual beliefs. Their bodies are permeated by spiritual “rules” and “guidelines,” which are consciously acknowledged. To illustrate, the LGS Mennonites were well-known for their plain dress. They preferred dark colours, such as dark blue and dark black. Traditionally, the male conservative Mennonites in Mexico “wear blue bib overalls . . . and button shirts. Straw cowboy hats, particularly white ones were commonly worn, although some wear caps” (Quiring, 1997, p. 56). The regulated dress code, which represented the sense of uniformity, was seen as essential to protect their faith because the *Bible* (Romans, 12: 4-5) indicated that “For as in one body we have many members, and not all the members have the same function, so we, who are many, are one body in Christ, and individually we are members one of another.”

However, this cultural practice has been challenged continuously through the last few decades. For example, the young generation today are wearing jeans instead of the overalls. The modern dress codes may have been seen as a sign of cultural assimilation against the belief of nonconformity by some conservative Mennonite congregations, who believe that T-shirts, belts, white collars, neckties, beards, and rings, including the wedding ring, should not be worn (Quiring, 1997) to demonstrate their obedience to God's will.

The membership in an LGS Mennonite church indicated a Mennonite's identity as a faithful follower of God who depends on God and on His disciples, but is independent in the physical world. Because of these dependent and independent relationships, it is essential for the LGS Mennonites to protect their relations with His "true" disciples, and community integrity, which reflects their relationship with God. They believe that their stewardships with God will have a significant influence on their afterlives. Putting it differently, the damage to the uniformity and cohesiveness of the group not only implies the deconstruction of LGS Mennonite people's current lives, but also the group's betrayal of God as a whole.

Community solidarity was maintained by the church membership and kinship systems. Driedger (1988) and Loewen (1993) suggested that the early LGS Mennonites' migration to North America, and to Latin America indicated the processes of chain migration in which a few families move to a new place, and some families will follow (Fretz, 1944). Their migration was described as a "family trend" (Fretz, 1944, p. 9) in that social relationships played an important role. Regehr (1996) explained, "Community, congregational, and family life and activities were integral and interrelated aspects of Christian living" (p. 219). Therefore, the migration process was an enforcement of an individual's submission to the community, and the groups' identity. Dr. Heinrich Loewen has explained, "We [Mennonites] see ourselves as a family . . . and the concern I have is that we will lose this biblical aspect of the kingdom, the kingdom of God is a family" (as cited in Neufeld, 2004, para. 4).

The Future of the Community and the Control of Knowledge

According to Fretz (as cited in Quiring, 1997), the priority of the LGS Mennonite children's education was to learn biblical knowledge, which was also taught and reinforced in churches. Ideally, in the LGS Mennonite colonies no one should know more than others (Urry, 1983, p. 314). For the LGS Mennonites, their children did not have to demonstrate they knew more than others. In fact, community members who demonstrated that they obtained more 'modern knowledge' than others might have been criticized by the ministers and other community members. The reason was the LGS Mennonites' belief that salvation is achieved through their faith, and not by knowing more about the outside world. Indeed, salvation is God's decision.

LGS Mennonite boys, in addition to learning biblical knowledge, also needed to gain some essential agricultural skills. Girls had to learn how to be good housewives. Traditionally, LGS Mennonites' children went to school until grades six to eight. Boys sometimes would have one or two more years of schooling than girls because they needed more skills to be good farmers. Children went to school according to the agrarian calendar, so the classes would not interrupt their daily agricultural lives.

The desire to raise their children in an undisturbed traditional way, or in a pure world, was embedded in Mennonites' daily practices. For example, some LGS Mennonite parents removed their children from school because of the "sensitive" questions the children asked, such as how eggs become chickens (Angulo, 2004), and where the dinosaurs come from. The parents were "deeply unhappy about such questions, [and] reacted by promptly withdrawing the child from school" (Angulo, 2004, p. 65-66).

Another example in a previous study was related to a rumour, spread in La Crete, Alberta, about the teaching of sexuality in public schools that were replacing the Mennonite private school (Bowen, 2001). Bowen (2001) said that the sex education in the public elementary class was believed by local Mennonites to be taught through exposing children to realistic films that portrayed sexual acts. This rumour became one of the factors that pushed some parents to move to other places since they wanted their children to have an “innocent” and “pure” childhood.

Public education has always been a challenge the conservative LGS Mennonites faced. Many conservative LGS Mennonites perceived education as a threatening factor because a higher level of education would lead to a feeling of pride or of superiority. Moreover, being educated and critical could cause uncertainty and anxiety among the LGS Mennonite population because knowledge “bridges” the community members and the physical world. In other words, the public education was “dangerous” because it was changing the known world, which was presented by the ministers, to the knowable world, which can be challenged or questioned by science and philosophy (Urry, 1983). Knowledge leads to differences, and encourages people to “test” God by challenging the church leaders’ power (Urry, 1983). Katharine Enns (2009) stated that “Education and sophistication are signs of apostasy, which explains why the presence of enlightened, educated members in the community is generally not welcome” (p. 4).

The Closed Religious Community

The idea of the closed religious community is adopted from Eric Wolf (1957), who named two farmer groups in Mesoamerica and central Java as closed corporate

peasant communities. In this study, the features Wolf used to define these communities are applied in identifying the two groups of LGS Mennonites in southern Alberta and southern Manitoba with some adjustments. First, Wolf (1955) demonstrated, “The corporate peasant community is composed primarily of one subculture, the peasantry” (p. 462). The two Mennonite groups have been defined as closed religious communities since they are a single subculture of Anabaptist congregations who practice voluntary church membership.

Second, Wolf (1957) described that the peasant communities “are corporate organization[s], maintaining a perpetuity of rights and membership; and they are closed corporations, because they limit these privileges to insiders, and discourage close participation of members in the social relations of the larger society” (p. 2). These social practices, indeed, emphasized equality among villagers. Equality among the LGS Mennonites was protected in several ways. Historically, many LGS Mennonite villages used an open field agricultural system, which ensured the villagers equal access to poor and rich soil (Sawatzky, 2005) and the equal division of labour (Longhofer, 1993). Additionally, some farmland was used for communal pasture (Sawatzky, 2005). Although the open strip field system was abandoned by many Mennonite colonies, other common properties have been maintained, such as churches, the representation of God’s kingdom on earth, and schools operated by the colonies. Another communal “resource” shared by the LGS Mennonites was their collective identity as “God’s chosen people” (Bowen, 2001, p. 463), who through faith, reflected in their behaviours and communications, may be saved, and defined their colonies as “the community of discipleship” (Snyder, 1995, p. 12).

Third, “[t]he corporate community emphasizes resistance to influences from without which might threaten its integrity” (Wolf, 1955, p. 462). For the LGS Mennonite people, life may be “created by formation within community, and satisfactory life requires an acceptable level of group participation. Otherwise illness in some form will occur” (Snyder, 1995, p. 46). Therefore, being God’s followers requires the LGS Mennonites to separate themselves from the outsiders who do not believe or follow God in the same way as they do. For instance, the symbolic meaning of sending children to their own schools was that of being separated from the mainstream and modernity.

The LGS Mennonites also believed that living in Jesus’ way of life required them to submit themselves to the community for the common good to show their compliance to God’s will. People who did not behave in the required way or follow the ““do’s and don’ts”” (Roessingh, 2004, p. 70) set by their churches were perceived as showing their pride, which is prohibited in the *Bible* (Kollmorgen, 1943; Canas Bottos, 2008b). For example, obtaining more knowledge than other community members would damage the “family relations” by creating inequalities within their colonies. This should be banned because of their belief in the old way of life as the reinforcement of the “family tie,” and the discipleship with God, which held the members of God’s family together.

The variations of the practices and prohibitions marked the cultural boundaries that protected the community solidarity and reproduced the collective identity. For example, some churches did not allow their members to use modern transportation or equipment, such as motor vehicles and electronic farming machines. Simultaneously, few conservative Mennonite church members might be allowed to use approved technology,

such as a radio. Although the lack of modern transportation and agricultural equipment caused many inconveniences for the LGS Mennonites, Hoover argued that "This whole culture of families working together, communities working together as a unit, would be in danger of disappearing" (as quoted in Raffaele, 2006, p. 10A) if modern technology were employed. Additionally, the acquisition of modern material possessions would lead to more desires, proscribed in the Scriptures, and should be regulated to keep a simple lifestyle (Canas Bottos, 2008b; Fast, 2004).

Public education was also controlled since it was a challenge for some ministers whose interpretations of the *Bible* were the primary resources of knowledge for many LGS Mennonites and could result in creating anxiety as well as inequality among the colony members. The development of public education potentially threatened the LGS Mennonites' identity by encouraging people to be curious and critical, which was perceived as challenging the LGS Mennonites' relationship with God.

Fourth, "[t]he corporate community frowns on individual accumulation and display of wealth and strives to reduce the effects of such accumulation on the communal structure. It resists reshaping of relationships; it defends the traditional equilibrium" (Wolf, 1955, p. 462). The LGS Mennonites are allowed to have personal wealth and property, but they have to, according to Redekop, Ainlay and Siemens (1995), "reconcile the accumulation of personal wealth with responsibilities to the collective good" (as quoted in Roessingh & Schoonderwoerd, 2004, p. 66) by, for example, bringing food to families in need. In addition, the practice of brotherhood and mutual aid are strategies used by the LGS Mennonite groups to keep equilibrium within the communities.

The idea of common good is also applied to the accumulation of spiritual wealth. LGS Mennonites, like other faith groups, follow a set of rules or regulations, which control almost every single aspect of their lives. The Scriptures are seen as the knowledge of God, but not of the intellectual world. Ideally, biblical knowledge is not something secret. Rather, all disciples should share it since knowing and believing in God is the only way to achieve their salvation and to maintain their hope to be saved (Urry, 1983, pp. 311-312). However, as mentioned earlier in this chapter, the meanings of the Scriptures are highly controlled by the church leaders in some LGS Mennonite churches. In these cases, biblical knowledge may have become a form of personal wealth that can be “converted into prestige” (Wolf, 1986, p. 327). In addition, prestige “is convertible into authority, and . . . authority can be wielded with the external world” (Wolf, 1986, p. 327). In short, the control of the biblical meanings as communal property, on one hand, protects the social solidarity. On the other hand, it creates inter-church splits and tensions as mentioned previously.

Community, Caring and Healing

The LGS Mennonites’ idea of caring places the notion of health, illness and disease into a broader cultural and theological context that “include[s] the church community and its witness to the Kingdom of God, the pervasive power of sin, and Christian stewardship” (Kotva, 2002, p. 3). Care is a collective action that cannot be accomplished by individuals themselves since the LGS Mennonites are different parts of the same body (Kotva, 2002, p. 2) and share the common good. For the LGS Mennonite people, life may reflect the “limited independence of personal existence [which is] rooted

in creaturely interdependence and ultimately in dependence on God” (Buller, 1989, p. 84).

Caring is a process through which people reconcile with God. This is based on their faith rather than on medical treatment solely. Sinful behaviours can damage the peace of Christ, which leads to sickness and illness. Therefore, to have good health, people need to maintain good relationships with God and others, including their enemies because God loves those who love him as well as others who do not.

Care is also a process through which the LGS Mennonites prepare themselves to meet God. The use of the blue ribbon, a traditional funeral practice, indicated the life-long preparation for a person’s reunion with God. Previous studies described that some LGS Mennonites were buried in a white shroud adorned with blue ribbons at the neck and the wrists (Blue Ribbon Faith, n.d.; Faith and Culture, 2005). The white shroud symbolizes the adornment of the saints (Blue Ribbon Faith, n.d.; Faith and Culture, 2005; Buller, 1996), the purity of the virgin, and “the wedding garment and that the deceased had gone forth to meet her/his Lord” (Faith and Culture, 2005, p. 20).

The dress code is based on a story in Matthew 22:1-14

Once more Jesus spoke to them in parables, saying: “The kingdom of heaven may be compared to a king who gave a wedding banquet for his son. He sent his slaves to call those who had been invited to the wedding banquet, but they would not come. Again he sent other slaves, saying, ‘Tell those who have been invited: Look, I have prepared my dinner, my oxen and my fat calves have been slaughtered, and everything is ready; come to the wedding banquet.’ But they made light of it and went away, one to his farm, another to his business, while the rest seized his slaves, mistreated them, and killed them. The king was enraged. He sent his troops, destroyed those murderers, and burned their city. Then he said to his slaves, ‘The wedding is ready, but those invited were not worthy. Go therefore into the main streets, and invite everyone you find to the wedding banquet.’ Those slaves went out into the streets and gathered all whom they found, both good and

bad; so the wedding hall was filled with guests. But when the king came in to see the guests, he noticed a man there who was not wearing a wedding robe, and he said to him, ‘Friend, how did you get in here without a wedding robe?’ And he was speechless. Then the king said to the attendants, ‘Bind him hand and foot, and throw him into the outer darkness, where there will be weeping and gnashing of teeth.’ For many are called, but few are chosen.”

The blue ribbon symbolizes “the commandments of Christ [that] were inscribed in the hearts of His disciples” (Faith and Culture, 2005, p. 15), which was also based on the biblical teaching (Blue Ribbon Faith, n.d.; Faith and Culture, 2005). Numbers 15: 37-40 stated,

The Lord said to Moses: “Speak to the Israelites, and tell them to make fringes on the corners of their garments throughout their generations and to put a blue cord on the fringe at each corner. You have the fringe so that, when you see it, you will remember all the commandments of the Lord and do them, and not follow the lust of your own heart and your own eyes. So you shall remember and do all my commandments, and you shall be holy to your God.”

However, Bulher (1996) explained that the blue ribbon tradition was used in Sommerfelder churches, a relatively less conservative branch of the LGS Mennonite church. Additionally, they would use black ribbons to decorate the coffin, and around cuff and neckline, but other churches, such as the Old Colony Church, might only have used a white ribbon, or no ribbon at all.

Summary

The LGS Mennonites’ migration history indicated their acknowledgment of the differences in beliefs and behaviours as boundary markers, separating them from the rest of the world, and the awareness of the various forms of embodiments of God, and of interdependency. For example, Matthew (5: 9) stated, "Blessed are the peacemakers, for they will be called children of God." God is represented by churches, as the body of

Christ, and by Mennonites themselves as the moving temples. Snyder indicated, “[a]lienation from the community brings dishonor, isolation, and illness. Peace with the community brings honor, satisfaction, and health” (1995, p. 135). Migrations and excommunications were used to protect peace in the LGS Mennonites’ commitments in God and in being peacemakers by some conservative churches.

The LGS Mennonites are encouraged and required to follow the true faith (Epp, 2000) that prepares them to be with God. However, in some social environments, it became hard for them to follow the churches’ rules that taught them how to “live . . . a God-fearing life” (Schroeder, 2001, p. 33). For example, The LGS Mennonites’ resettlements in Canada are different from their early migrations to North American, and Latin American countries in that the current resettlements are the results of personal choices to improve their social, economic and health well-being instead of churches’ decisions.

For the LGS Mennonites, caring is more than the various medical treatments for their health conditions. In fact, caring is a community action, and reconciliation is part of the caring process. It focuses not only on the LGS Mennonites’ current physical and social conditions, but also on the factors that challenged their peaceful relationship with God, which in turn threatened their “future,” salvation, and reunion with God.

The first section from chapter one to chapter four provides some background information about this project, the LGS Mennonites, and the “closed religious communities”. Indeed, it focuses on the ideologies related to death, dying, and palliative care from different perspectives. In the following section, from chapter five to chapter

eight, I will focus on the practices related to death and palliative care in three LGS Mennonite communities. The practices and beliefs can overlap, or can be different, and it is important to know how the LGS Mennonite communities have looked after their own people when the public health services cannot meet their needs. In chapter five, I will explore the diverse health care services in three LGS Mennonite communities, which may explain why some health services seem available for local people, but they may not be accessible for everyone.

Chapter Five: Local Health Care System(s)

Kleinman (1988) described three overlapping sectors of a health care system. The professional sector, also called the formal sector, generally refers to the system in which the healthcare providers have specialized trainings and accredited knowledge and may be licensed. In Western societies, generally, physicians, and licensed nurses or health care assistants are in this sector. The folk sector, also called the informal sector, includes “non-bureaucratic healthcare providers,” who are not trained in the conventional medical educational system. The popular sector is an area in which people can obtain medical or health care related information and knowledge, such as the patients’ own experiences, and families’ or friends’ suggestions associated with different kinds of health issues or concerns. The boundaries of these sectors in this study were blurred and shifted constantly during the LGS Mennonites’ interactions with “outsiders”; for example, when the LGS Mennonites visited Mexican physicians, and when the Mexicans used the addiction centre run by the LGS Mennonites in Mexico.

Health Care Services in Three Locations

Health Care Services in Cuauhtémoc, Mexico

The three sectors of a health care system that consists of both public health care institutions and various faith-based facilities in the Cuauhtémoc area where the Mennonite colonies are located cannot be separated clearly. For example, *Luz en mi Camino* (Light on My Way), near Cuauhtémoc, is a community project, a cooperative work of various Mennonite churches that has been supported by MCC Canada. It used to

be the “only Low German addictions centre¹⁰ in the world” (Friesen & Schmidt, 2008, p. 4) that uses the Twelve-Step program with three-month residency treatment to help people, both Mennonites and Mexicans, with addiction issues. Additionally, it supports the family members.

When visiting this rehabilitation centre with the MCC employees and volunteers, our group of women visited the section that is the female residential area. The housework facilities, such as the kitchen and laundry machines are also part of the building. In the kitchen area, we met some wives who accompanied their husbands to this centre and were preparing lunch for the residents. One of the wives who came to visit her husband was from another Latin American country.

The employees and volunteers working with this centre have a range of educational backgrounds that include people who are master’s degree holders, trained pastors, social workers, and self-taught “nurses.” For example, “Helmut [was] a pastor and Eve [was] a social worker and chaplain” (Friesen & Schmidt, 2008, p. 4) at this centre. Some Mennonite people from different countries also have worked as healthcare providers. The staff members also included those who successfully overcame their addiction issues with the help of the Twelve-Step program provided by this centre, and came back to help other service users. They work generally by relying on their own experiences.

¹⁰ In 2001, near Pailon, 60 kilometres east of Santa Cruz, in Bolivia, a Mennonite church-supported shelter for women opened with the help of MCC Bolivia, and a Low German rehabilitation centre, under construction on the 7.5 hectares of land, would offer treatment programs for men who have been struggling with alcohol and drug addictions (Terichow, 2010).

Although this organization has been very successful in helping its residents with coping with their addiction issues, several concerns related to the employees in this centre were raised in my conversations with MCC employees, healthcare providers, and local people. First, the “counsellors” in this centre generally do not have professional training in addiction counselling service, or social work, and they are not required to have these backgrounds to work with the residents. Therefore, there is a concern that those people may provide wrong instructions or information to the service users. Second, considering the local social environment, some people predicted that this facility would encounter more difficulties related to recruiting well-trained healthcare providers. The third concern was related to whether or not the non-Mennonite social workers, nurses, or counsellors could work in this centre when considering the language barriers, and cultural safety issues.

Other facilities, such as *Hoffungsheim*, a facility run by a couple for people with disabilities, and *Friedens Platz*, an orphanage with a safe house, and local schools, also indicate the local people’s efforts to establish a self-sustaining community by helping each other to meet their physical, mental, economic, and spiritual needs. For example, *Altenheim*, a home for aged people or elders, built in 1986, is also managed by local LGS Mennonites. This “home” opens its kitchen as a restaurant every Saturday afternoon to the public, and the income is used to support this facility. Additionally, there are some “folk” healthcare providers, who look after dying people, or provide medical treatments to people with burn injuries.

Personal Experience of Medical Pluralism in Winkler, Manitoba, Canada

In this section, I am using my own experience to illustrate the health care diversity in this area, and to give a broad picture of what an ordinary (non-western) person may feel like when she or he is sick in a rural area, especially during the night-time or weekends.

I went back to Winkler for my research in the middle of May 2010 after staying in Mexico for three weeks. I arrived in Winnipeg with *Wintpocke* (chickenpox) without knowing it. My home-stay auntie and uncle, who picked me up at the airport, took me to a walk-in clinic in Winkler. Before the physician diagnosed me, my auntie, a retired healthcare provider, warned me that the blisters on my neck looked like chickenpox. Her “guess” contradicted the diagnosis of the physician I visited before arriving in Winkler. She said they were fever blisters, and that since I had already had the disease and been vaccinated for it, it could not be chickenpox. However, I was diagnosed with chickenpox by the physician in the walk-in clinic in Winkler, and was required, of course, to stay at “home” for at least five to seven days before continuing my research.

A few days after the diagnosis, I felt achy, restless, and itchy. Because it was a Sunday afternoon, and no walk-in clinic was open, my auntie decided to take me to the emergency service in the local hospital. The receptionist was very nice and put me into a wheelchair in the waiting area after she took my information. A few minutes later, I was called by a nurse, and my auntie pushed me into a room. A firefighter paramedic-in-training walked in and told me that she would take my blood pressure, pulse, and body temperature while a nurse, the mentor of the paramedic-in-training, was watching her

during the process. A few minutes after they left the room, the nurse came back and did all the tests again and told me that the physician would be with me shortly. The physician came and stated that I had a high fever, and I needed a blood test to check if I had an infection. Fifty minutes later, my auntie and I left with the physician's suggestion that I should take extra strength Tylenol, and his prescription for antibiotic pills.

There is no pharmacy open on Sunday in Winkler. My auntie suggested bringing me home, and she would pick up the medicine in Morden. I did not want to travel for 15 minutes on the gravel road again and sit at home for another 40 minutes waiting for the pills, so we decided to go together. On the way to Morden, the only question in my mind was: Why can it not be easier for consumers who need to access services?

The second time I went to the emergency service department was an early morning around 2:00 a.m., a week after my diagnosis. I had a dreadful headache and vomited constantly. A very experienced physician who also had a good reputation in the local community examined me. My headache was getting worse, and he decided to add a little amount of morphine into my Intravenous Therapy (IV). Next morning, the physician asked me how I felt, and suggested that I have a good rest at "home," and find a family doctor in Winkler.

I picked a family physician that I believed would help me to handle the complications of my chickenpox, such as chest pain and headache. He was a very nice person. However, I still felt very disappointed when he honestly told me that he could do nothing for my pain, and the only suggestion he could give was that I take the Tylenol with me, so that I could have it when the pain came back. I asked my home-stay auntie

and uncle if they knew other physicians, such as herbalists or homeopaths, in this area since I did not want to rely on Tylenol.

I started seeing a Chinese acupuncturist, Hao, who treated her clients at her own home. She treated me with the acupuncture needles and cupping. Additionally, she gave me some suggestions related to healing the scars on my face after learning I was looking for treatments for them. A few days later, I went to a local health food store where I learned some aromatherapy recipes for pain relief, body relaxation, and skin care from a staff member who knew different kinds of “alternative” or “informal” treatments, such as herbal remedies and aromatherapy.

A Mennonite friend asked if I had tried *Wunderoel* or *Wunder Oil* (Wonder Oil), one of their traditional medicines. The friend said, “You know... Wonder Oil treats everything.” I heard this expression used by some Mennonite people and others who worked with them while I was involved in this project. While talking about Wonder Oil, some LGS Mennonites taught me how to take it orally. “You put a teaspoon of sugar in it, and mix it with a bit of water, or you just swallow it like that,” a Mennonite participant said. Some Mennonites, in contrast, indicated that Wonder Oil¹¹ should be used externally only, for example, for pain relief. People should not drink it because its ingredients include alcohol. An LGS Mennonite participant living in the Taber area, my

¹¹Wonder Oil has been used in various ways. For example, Cormier (1998) stated that it “can be warmed and rubbed on a fussy baby’s stomach or on a nursing mother’s breast” (p. 29). Also, it was discussed in *Health and Illness Beliefs Among the Southern Alberta Kanadier Mennonite Immigrants*, by Kulig and Hall (2004), and *Childbearing knowledge, Beliefs and Practices Among Kanadier Mennonite Women* (2004), by Kulig and her co-authors.

third fieldwork location, explained, “We are not allowed to drink, but Wonder Oil is a medicine. It is not toxic. It is different from alcohol.”

Taber, southern Alberta, Canada

I moved to the Taber area at the end of August 2010 after living in Winkler for three and a half months. The person who worked in the tourist information centre gave me very specific information about the local health care services that include one hospital and two clinics. There are 3 dentists, 13 physicians, and 3 chiropractors serving this community. Additionally, ambulance, mental health and public health services are also available in town. Unlike the long-term care homes I visited in the Cuauhtémoc area, and in the Winkler area, the continuing care unit in Taber was a public health facility managed by the provincial health services.

When I was conversing with some local healthcare practitioners, they stated that they did not have enough information related to providing palliative care to the LGS Mennonites in this area, and only one resident in the long-term care unit might have some LGS Mennonite background. Additionally, “the LGS Mennonites did not actively use this long-term care unit.... The palliative care nurse and physician did not come every day because they also had offices in Lethbridge. A lot of palliative care services were done in Lethbridge,” a local healthcare provider said.

However, my participant observation work in this area provided more information that may also be related to the LGS Mennonites’ reluctance to use the “formal” health care system. For example, I noticed that the healthcare providers in a local long-term care centre have planned and organized many social activities, such as birthday celebrations,

and Christmas parties for their residents. However, some volunteers who were helping the residents and entertaining them on this unit were from Catholic churches. Moreover, the Catholic rituals, such as saying the rosary, on the unit were led by different Catholic groups.

For another example, two days before Halloween, I conducted an interview with an LGS Mennonite volunteer, which took place in the cafeteria area of the local hospital. Walking down the hallway, I noticed that the offices and the long-term care unit were already decorated with Halloween crafts from pumpkin crafts and stickers to Halloween skeletons and spiders. One of the most “unforgettable” decorations was a big plastic spider web, with 3 big spiders on top, which was taped on the door and covered most of this door to the rehab medicine area. Next to the door was a Halloween skeleton “sitting” on a stainless steel I.V. pole, and the skeleton seemed to be taller than I was while “sitting” there. Two general explanations, given by some healthcare providers, for the decorations of the hospital and long-term care unit were: “That is our culture.” “It is fun.” “It is fun to do something different. My kids (children) picked their Halloween costumes already. It is going be fun,” a staff member working for the local hospital said.

Some healthcare providers may perceive Halloween as a “harmless festival” in which children and sometimes adults will dress up and have fun. However, Halloween is not “fun” for the LGS Mennonites in general. In fact, some of the LGS Mennonite participants indicated that they do not celebrate this festival since it is “a celebration of evil and death,” or “the celebration of people’s fear of evil,” the LGS Mennonite participants said. Moreover, becoming involved in the celebration of Halloween

represents disobedience to God. Halloween symbolizes the cultural practices and beliefs of death, witchcraft, and demonic forces, which are clearly proscribed in the *Bible* (Berry, 1998). Therefore, the LGS Mennonites may not feel comfortable when they are in the local hospital since the celebration of Halloween runs contrary to their religious beliefs.

The informal sector of the local health care system includes different agents. Some LGS Mennonite individuals have provided private palliative care for their church members at the sick people's homes. Indeed, under some circumstances, the caregivers would let the sick persons move into their houses. As an example, an LGS Mennonite woman allowed a female church member, diagnosed with a terminal disease, to live with her until she died. The healthcare provider explained to me, "her [the deceased's] children did not live with her, but they helped when she needed to go to the hospital. Her son came to help; he drove her to the doctor's office." During my stay in Taber, the same healthcare provider had another female church member, diagnosed with chronic diseases, living with her.

Different kinds of support groups in the LGS Mennonite churches also provide health care to their members. For example, there are support groups for people with addiction issues. The LGS Mennonites in women's groups also help each other in various ways, including delivering meals, such as chicken noodle soup, to church members who are sick. An LGS Mennonite told me, "we give them (the sick people) chicken-noodle soup" when I asked what the sick people eat at home. Two other church members explained, "I do not know why; we just did it," and "Maybe because it is healthy and has nutrition." The chicken noodle soup also can be purchased in the Mennonite restaurant

close to a Mennonite store selling some Christian CDs, books, and Mennonite food that the LGS Mennonites eat in Mexico.

The ladies' or men's breakfast and *Bible* studies are also informal health care services through which people reproduce their social relationships and receive emotional supports from others. For example, some women might share their concerns, worries, or stress that could not be shared with their families. During the *Bible* studies, some people would ask the class leader to lead a prayer to God for various difficulties and concerns, such as their family or health issues, their concerns over relatives' missionary trips to other countries, and for the newborn babies.

The Taber area not only has diverse Christian church branches, but also produces and reproduces some mainstream culture, in terms of body shape and life style, in general. For example, these are Herbal Magic, a business selling herbs and diet programs to help people lose weight, and Curves, a business providing exercise machines and diet plans to help women to build good body shapes. A dance studio is also available in downtown Taber, but the conservative Mennonites may not be use this facility because the recreational dance, such as ballroom dance or couple dance, "is a 'sugar-coated evil.'" Sairs (1997, p. 94). Indeed, "no truly born-again person will ever want to defile or degrade himself by going to a dance" (Buckwalter, quoted in Sairs, 1997, p. 94).

Summary

Some people have argued that the services provided by the LGS Mennonites' own health care facilities are not different from the services offered by the bureaucratic (public) or private health care organizations, such as local public hospitals, clinics, and

long-term care units in terms of treating patients with pills, and providing counselling services by experts. However, what the community based health care centres, supported by various Mennonite groups, have represented are the social networks, or social relations, an important social and cultural value in the LGS Mennonites' lives. Indeed, some of the "professional" institutions' services are based on the clients' "agreements" to being separated from their own cultural contexts and practices, such as languages, religious rituals, and holidays. For this reason, accessing the public health care services itself can be a barrier for some local people.

However, Mennonites' own health care centres generally protect their residents' cultural values when they receive medical or spiritual treatments and care. For example, the church services in the long-term care home I worked with in Winkler were provided by different Mennonite churches in *Plautdietsch*, and sometimes they were in High-German. Additionally, the pastors and pastoral care people working with this organization normally could talk to the LGS Mennonite residents in *Plautdietsch*, which made it easier for the residents and their family members to express their concerns and to ask questions. The next chapter explores how the LGS Mennonites looked after their own community members.

Chapter Six: Mutual Aid

For the LGS Mennonites, palliative care may not be different from other forms of care and supports that they provide for each other in their daily lives. The non-stop care and supports practiced among the LGS Mennonites have been called “*mutual aid*,” which, in fact, is a manifestation of their stewardship and the reflection of their voluntary conviction. The LGS Mennonite population have seen themselves as God’s chosen people, and have tried to live like Jesus in the physical world. An LGS Mennonite, who switched from the Old Colony Mennonite Church to a more liberal one, also stated in a *Bible* study group, “We always want to live like Jesus. When he was in the physical world, he was facing a lot of temptations and struggles, but he lived holy. . . . We receive God’s love through him. We know that we need each other, need to look after each other. We should love each other just like God loves us.” This statement confirmed Bender’s idea that being a voluntary member of the faith community requires individuals to practice mutuality and accountability (as cited in Toews, 1996), meaning community members can trust and rely on each other for their physical, spiritual and cultural needs.

Mutuality

Brotherhood

The practice of mutual aid is rooted in the idea of brotherhood, which helps God’s people live as a whole community. It is also an important factor in the church members’ involvements in palliative care because “people learn to give and receive love and care through helping their brothers and sisters,” a pastor said. This idea of brotherhood is emphasized and reinforced through reciting the Scriptures during church service. For

example, in Proverbs 17:17, Solomon's son David stated, "A friend loves at all times, and kinsfolk are born to share adversity." John 13:34-35 stated,

I give you a new commandment, that you love one another. Just as I have loved you, you also should love one another. By this everyone will know that you are my disciples, if you have love for one another.

1 John 4:20-21 reemphasizes this:

Those who say, "I love God," and hate their brothers or sisters, are liars; for those who do not love a brother or sister whom they have seen, cannot love God whom they have not seen. The commandment we have from him is this: those who love God must love their brothers and sisters also.

Therefore, it may be reasonable to say that Mennonites identify themselves as sisters and brothers in Christ. They may not take the care, the representation of God's love, they received through their brothers and sisters for granted since, a pastor explained, "We always do things we are not supposed to. We have to remember that we are rebellious against God" (see Romans 3:10-12). Additionally, a *Bible* study group facilitator, also a pastoral care provider, said that

We do not deserve God's love. We only deserve His judgment. It is so true, but God loves us. He wants us to share His love. . . . You care for others to show it; you are sharing His love with others¹².

However, the LGS Mennonites may take "giving" for granted in the sense that it is God's requirement.

Love and Care: God's Love and His Care

The practice of mutuality is an extension of God's love (Nolt, 1998, p. 74). God's love described in the *New Testament* is what people believe. This is stated in 1

¹²See 1 John 4:16.

Corinthians:

If I give away all my possessions, and if I hand over my body so that I may boast, but do not have love, I gain nothing. Love is patient; love is kind; love is not envious or boastful or arrogant or rude. It does not insist on its own way; it is not irritable or resentful; it does not rejoice in wrongdoing, but rejoices in the truth. It bears all things, believes all things, hopes all things, endures all things. Love never ends. But as for prophecies, they will come to an end; as for tongues, they will cease; as for knowledge, it will come to an end. For we know only in part, and we prophesy only in part; but when the complete comes, the partial will come to an end. When I was a child, I spoke like a child, I thought like a child, I reasoned like a child; when I became an adult, I put an end to childish ways. For now we see in a mirror, dimly, but then we will see face to face. Now I know only in part; then I will know fully, even as I have been fully known. And now faith, hope, and love abide, these three; and the greatest of these is love. (13: 3-13)

Caring, for Mennonite community, is a reflection of the mutual love (*agape*) (Snyder, 1995; Driedger, 2000) which exists in three ways: God gives love to people; disciples give their love to God; disciples love each other in the same way as Jesus loves people (Snyder, 1995). The mutual love happens at the same time (Snyder, 1995).

God's love is also an action, which saves people. Many events I observed in the communities were examples of God's love in action, such as baby sitting for others, and helping a grieving family prepare the funeral. In addition to that, I suggest that for some conservative LGS Mennonites, the selected rejection of some modern technology was also a way to share God's love with others, for example, their children. For instance, there are no televisions, computers, or access to the internet in some LGS Mennonites' houses. The reason, I suspect, is to protect the "nature" of the LGS Mennonites' social relations, which may be changed from place-bounded (the kingdom of God) to space-bounded (an imagined global village or an exotic world) (Kauffman & Driedger, 1991; Driedger, 2000).

A gathering is very important cultural activity for the LGS Mennonites to associate with or to relate to each other. The gathering events, such as *Bible* study groups, Sunday school studies, family reunions, youth gatherings, ladies' breakfasts, and communions that I participated in and observed in the three communities, indicated that people perceived themselves as members of their communities in general. They reconfirmed and reproduced their identities through the constant in-person interactions with other members. Visiting my Mennonite "relatives" and friends with my "family" members in the communities, and cracking sunflower seeds ("Mennonites' secret seeds," as my youngest brother, Di, in Mexico, told me they are called) with them allowed me to share a sense of the "past time" or the history of Mennonite life with them.

An important point, in addition to sharing the history, is that their "traditional" lifestyle has been practiced by many generations "in the Kingdom of God on earth [they] have tried to build through decades. . . . They (the conservative LGS Mennonites) do not say this explicitly, but they know what they are doing" a healthcare provider said. In other words, the LGS Mennonites' social relationships are a form of social capital, one of a very few resources for them to live in difficult situations, and their social relations generated and reproduced "in the Kingdom of God on earth" (according to the same provider) are against the personal or individual "kingdom" built in the material world.

It is undeniable that fear and uncertainties may be involved in some of their social behaviours. For example, some conservative LGS Mennonites who had neighbours from less conservative churches when living in Canada were afraid that they would be criticized by their friends or fellows in other Latin American countries "if they knew [we]

had contacts with outsiders,” an LGS woman said. “But,” she continued, “I think Canada is the best country to live in. I do not have to worry about [having] no food, and the dusty floor. I am here to help others, and no one criticizes me for talking to others.” The woman additionally said, “I think no one should die for their beliefs.” The conflict between this woman’s feeling towards Canada and her fear of being criticized by others may be a shared experience among many conservative LGS Mennonites in Canada, as mentioned in the literature review.

However, protecting the future generations from anything that will lead them out of God’s kingdom by means such as the abandoning of modern technology may not necessarily mean that “they [have] no idea about what a true discipleship is;” “their thinking is backward,” or “they [do] not really understand God’s word,” according to people with and without Mennonite backgrounds. In contrast, it demonstrates those people’s faith in God through protecting the community-oriented culture, including care and love. Stated differently, the LGS Mennonites’ social relations are culturally, historically, and “geographically” defended (Innis, 1954; Driedger, 2000), meaning people paid attention to, and showed their concerns with traditions, history, communities, and the future generations of their communities.

Expressing Love and Care

Some Mennonite churches are relatively less conservative than others, and people from these churches may express their love towards family members, friends, and children more explicitly than people from more traditional congregations in general. When attending the less conservative churches, it is not uncommon to see the couples,

especially the younger couples, holding hands. Another example was found in a less conservative LGS Mennonite family; the expression, “I love you” was used very often in the family. In one case, the mother went to her sick child’s room to see if the boy was still sleeping or not. When she found out he was awake, she asked him if he wanted to have dinner with the family or eat in his own room. The boy was still not feeling very well, and went back to sleep. The mother touched his forehead to see if he had a fever. Before she left his room, she said, “OK, *schlop scheen* (have a good sleep). I love you,” and hugged her boy. The boy responded, “I love you, too.”

While asking healthcare providers how the LGS Mennonite people express their emotions and feelings towards their sick family members, the common answers are: “They would ask the sick person how he or she feels today”; “in some families, moms may ask the sick children what they [would] like to eat or what they want to do”; “they may cook some good meals for the sick person, or make chicken noodle soup for them”; “they pray and sing for the patients.” Additionally, some healthcare providers have stated that they have not seen a range of body languages, such as giving a hug and kissing the forehead, used by some LGS Mennonites when visiting their family members in hospitals or long-term care homes. Therefore, it may be reasonable to say that for the LGS Mennonites, especially the conservative ones, love is often in their actions as a way to follow their role model, Jesus Christ, instead of in their verbal or body language expressions explicitly.

Mutual Aid as a Lifestyle

The LGS Mennonites demonstrated their faith in God by maintaining a certain lifestyle, such as refusing to swear oaths, which is part of the belief that concrete obedient acts confirm their faith (Veen, 2005). Menno Simons stated in his article, *Reasons for Teaching and Writing*, translated by John Funk (1871),

For true evangelical faith is of such a nature that it cannot lay dormant; but manifests itself in all righteousness and works of love; it dies unto flesh and blood; destroys all forbidden lusts and desires; cordially seeks, serves and fears God; clothes the naked; feeds the hungry; consoles the afflicted; shelters the miserable; aids and consoles all the oppressed; returns good for evil; serves those that injure it; prays for those that persecute it; teaches, admonishes and re-proves with the Word of the Lord; seeks that which is lost; binds up that which is wounded; heals that which is diseased and saves that which is sound. The persecution, suffering and anxiety which befalls it for the sake of the truth of the Lord, is to it a glorious joy and consolation. (p. 246)

The Communities' Involvements in Palliative Care

The communities, and congregations' involvement in the palliative care is a reciprocity of love. Some LGS Mennonite women both in Mexico and in Canada indicated that they had the experiences of cooking or baking for their community members who were sick. A woman, who used to provide care for her colony members in Mexico, gave an example about the involvement of the community. She said, "When the child was suffering badly from [the illness], [the] grandma called all ladies from the village to pray together for the child." Another example is indicated that mutual care is illustrated through people's prayers. When the church members are sick, hospitalized, or dying, normally, the pastors will make announcements during their church services on Sunday morning, and pray for the sick or deceased people, and their family members, together with other church members.

Mutual aid and supportive networks are intertwined in these communities generally, and they produce, and reproduce each other. Not only are the networks established between patients and the formal healthcare providers, they also include informal healthcare providers, such as community members. To illustrate, the teenagers may help young parents babysit their children and cook meals. People also provide other supports, such as making donations to meet the patient's and the family's financial needs. One ordinary event I experienced consisted of different elements, including food, prayer, and daily care, which are very important for palliative care services. Indeed, it explained how the networks were developed.

One early evening, a pastor and his wife from the congregation that the individual belonged to visited the ward. I saw them when they were talking down the hallway. I had met this pastor a few months ago, so I tried to say "hello" to him and his wife. He did not notice me standing against the wall in the hallway. I followed them from behind and tried to find another chance to greet them. However, it seemed that they did not realize that somebody was following them. The wife was in a traditional long dress made from a piece of dark blue cloth, and wore a black headscarf on her head. She was holding a hymnbook, not the *Bible* in her right hand and walked quietly beside and slightly behind her husband. The pastor did not have anything in his hands, but did have a pen in his breast pocket. They both looked very serious. Although I knew that the LGS Mennonite people, especially those from the conservative churches, generally did not express their sadness or happiness through facial expressions, I was still trying to find out the reasons for their seriousness. I wondered if the person they would see was in a declining situation, or whether they just looked that way all the time.

On the way to the ward, there was no verbal communication between this couple. They walked into the patient's room and greeted the patient and other visitors in *Plautdietsch*. At the same time, the pastor shook hands with two men in the unit, and said, "How are you" in Low German again. One of the men moved from the couch in which he was sitting, and let the pastor sit there. A woman in the room pulled up a chair for the pastor's wife. This is a small ward with its own bathroom, so when there were six people, including the patient, the space seemed very crowded. I was standing across the hallway, and watching what they were doing inside the room. All the visitors were facing or partially facing the patient's bed. A man and a woman stood next to the window sometimes looked outside and made several eye contacts with me. I nodded my head to greet them. However, no one reacted to me regardless of the fact that I met this family a few days ago. After talking for several minutes, the pastor led the people in prayer. They kept their heads down and eyes closed during the prayer. After the prayer, the wife handed the hymnbook to her husband, and the pastor started singing in High German. They sang four songs together, and prayed again after the pastor closed the book.

A healthcare assistant came in to check the patient's intravenous fluids, and talked to the patient and visitors in *Plautdietsch*. Suddenly, I heard the assistant laugh. When she came out, I asked her what they were talking about. She answered, "Oh, I just asked [the patient], 'how do you feel today?' and 'Did you see your grandchildren today?' Nothing special really." I asked if the grandchildren were here to visit. The assistant responded, "No, the mom said that they were in their cousins' home since yesterday afternoon. They will probably go to the Sunday school together, and go home after the church service." I wanted to know what they were laughing at, and the lady answered,

“[the patient] missed *Rollkuchen* (a kind of deep fried pastry eaten with watermelon and syrup), and people cooked all kinds of food for them (the patient and the family), but no one brought *Rollkuchen* yet. . . Well, I [guessed] because she had some [swelling] issues, so they just did not bring it.”

It became obvious through this example that the patient and the family both had physical, emotional and spiritual needs. The community in which they belong had tried to meet their needs. It was possible that family and friends thought the patient’s mind was not very clear, so they did not take the person’s words seriously, or the patient never told people to bring “*Rollkuchen*.” There is also a possibility that considering the patient’s medical condition, people did not bring *Rollkuchen* in, but they cooked other kinds of food for them. The family members, especially the women who were the caregivers in general, also needed helpers to look after their own children and houses. One LGS Mennonite lady said, “Going to the church service is very important, so we help each other.” It was also common in both Mexico and Canada that when the parents could not take their children to churches for the Sunday school or youth group activities, their relatives or people from the same congregation normally would assist the parents who were asking for help.

In this sense, the sick person or the patient in hospital may not be seen as being separated from the community to which she or he belongs. Rather when a person is sick, asking for help and accepting others’ care or supports reinforces the idea of brotherhood (Fretz, as cited in Regehr, 1994; Epp, 1982) or sisterhood. Simultaneously, it reproduces LGS Mennonite people’s identity as God’s followers.

“Being there” or “being with the person through the difficult time” is always important for the LGS Mennonite population and is part of mutual aid. Difficult times are a challenge for people, and it may weaken their beliefs and trust in God. “Being there” is not only about keeping company with the people in need or suffering. Joseph J. Kotva Jr. in his work “Religious Beliefs and Healthcare Decisions” explained that

Remaining present with the sick is a shared responsibility of the entire community, not just the responsibility of pastors and deacons or elders. This responsibility is expressed in ways ranging from sitting at the bedside to providing meals for the sick individual’s family. (p. 4)

In other words, the idea of mutual aid is embedded in the community’s action, which simultaneously enhances the community coherence, and reinforces their beliefs, their trust in God, through working collectively.

The Continuity of Care

Some healthcare providers, especially the home care nurses, mentioned the continuity of care for palliative patients and their families. A non-Mennonite nurse in Mexico stated, “Sometimes they do not understand why they should do such things [after they are released from the hospital]. For example, the diabetic mother did not change their diet after going back to their communities. . . . They (women) need translators to explain to them because they do not speak Spanish, but their husbands sometimes do not want to do it.” In Canada, a home care nurse also gave an example. She said,

A lot of the LGS Mennonite patients and their family members are really good. They would follow what the doctor said. They might not know why it’s necessary to check the diabetic patient’s blood sugar several times a day, or they thought as long as they do not have sugar, they do not need to check it. We had to explain to them, so they will do it.

A mental health nurse also highlighted the continuum of care. She indicated, “After the

patients were discharged from the hospital, their physicians might refer them to me, so that they would receive the mental health care continually.”

The idea of continuity of care has been emphasized in primary care (Hennen, 1975; Haggerty et al., 2003). It not only implies a longitudinal relationship between patients and their care providers, but also requires the patient’s collaboration (Haggerty et al., 2003; Munday, 2007). Moreover, it extensively focuses on the relationship between a single patient and his or her healthcare providers. Haggerty et al. (2003) listed “[t]hree types of continuity which include

- Informational continuity—The use of information on past events and personal circumstances to make current care appropriate for each individual
- Management continuity—A consistent and coherent approach to the management of a health condition that is responsive to a patient’s changing needs
- Relational continuity—An ongoing therapeutic relationship between a patient and one or more providers (p. 1220)

Munday (2007) described the main challenge to achieve the continuity of care for patients is “their complex needs and the wide range of professionals involved in their management” (p. 27).

More than “Continuity”

There was little emphasis on the continuity of care from the medical perspective among the LGS Mennonite individuals as revealed through my fieldwork. Instead, there is a preference for the family members or the communities themselves to look after the sick person as “*mutual aid*” or “*supporting each other*” although people admit that the healthcare providers are more knowledgeable than they are.

A wife who moved to Canada from Mexico with her husband, who had been diagnosed with a severe mental disease, refused to send her husband to a long-term care centre. The woman was taking care of this man by herself and accepted help from other people, including physicians, her relatives, and the pastor of the church, which is similar to the one she went to in Mexico. She felt it was good to find a church that had similar beliefs and practices as the one she had attended in Mexico. With a physician, I visited this couple. They lived in an old house borrowed from one of their relatives living in Canada. An open kitchen area was the first thing I saw when I came into the house. Like many other LGS Mennonite houses, this was a very clean house. There was no dust on the stove or counter, and kitchenware was put into the cabinets beside a stainless steel kettle and hot water pot on the stove. There was a double bed in the middle of the room and a small fridge was on the right side against the wall. A couch faced the bed; there was enough space for one person to walk between the two. An old European style, tall triangular cabinet was in the left corner next to the bedroom door. There were many pictures of the couple, their families, and friends displayed on the shelves of the cabinet. On the right side of the door was a table around which there were two foldable stools.

She told me that, “she had a conversation with this pastor and agreed with the suggestion that if one day she could not look after the patient by herself anymore, she would send him to a long-term care facility.” While we were talking, one of her relatives walked in to visit her. This visiting lady is a farmer living in Canada with her own families and has helped the wife with housekeeping, cooking, and other things since they arrived. I asked her how often she came to visit, and they both told me that she came almost every day. I assumed that they knew each other very well, or had a close

relationship before the couple arrived in Canada, but they told me that they rarely saw each other or talked to each other since they originally did not live in the same country. The visitor lady immediately said, “We just help each other.”

This case reflects several issues. On one hand, taking care of the sick person by the family is a traditional practice among the LGS Mennonite population. They may consider it as a task or a test of faith given by God. The wife’s behaviour expressed her concerns not only for her husband’s emotional and physical needs, but also for the cultural idea of making a lifetime commitment to one single marriage. The lady demonstrated her loyalty and love to her husband through caring for him every day by herself. One the other hand, the wife’s rejection of advice to send the dying husband to a care centre was associated with how the long-term care home was perceived. In other words, sending relatives, especially spouses and children to long-term care centres may be seen as abandoning those who are dying. The pictures on the shelves reflected close family ties, which might also become loose if the husband was sent to the nursing home.

Moreover, the wife’s loyalty to her husband might have also reflected an important belief in the spiritual nature of marriage (Guenther, 1994; Redekop, 1985; Fast, 2004; Riesen & Urry, 1998): The union of two people, which can be dissolved by death only (Redekop, 1985; Peters, 1992). Redekop (1985) indicated, “As conversion is a union with Christ” (as cited in Peters, 1992, p. 119). Therefore, this wife’s care for her husband reconfirmed her loyalty to God, and indicated the connection between body (the couple) and mind (Jesus/God). More than that, the true disciples, such as the lady visitor, are called or used by God to spread the gospel by helping each other, and others. To be self-

contained and independent from outsiders, but be dependent on God, people have to commit their spirit into God's hands, which Jesus Christ did when he was dying.

Summary

Generally, the LGS Mennonites believe that they are responsible for looking after each other, and bear brothers' and sisters' burdens (Kotva, 2002, p. 3). Paul, in Romans 12:3-6 stated,

For by the grace given to me I say to everyone among you not to think of yourself more highly than you ought to think, but to think with sober judgment, each according to the measure of faith that God has assigned. For as in one body we have many members, and not all the members have the same function, so we, who are many, are one body in Christ, and individually we are members one of another.

Therefore, from the LGS Mennonite' perspective, their practices of mutual aid are an expression of God's love. As the family members of God's kingdom, it is their responsibility to look after each other, because, for them, living like Jesus is to become "the persons of love" (Snyder, 1995, p. 80).

To share God's love with others, the community members have become caregivers in addition to the healthcare providers working in the formal sector of the health care system, and family members related by blood ties or kinships. Various actions have been taken by the LGS Mennonites from a range of congregations to share God's love with other people on the basis of their own interpretations of the Scriptures, but some social actions and people who conducted them might have been stigmatized. If the church is the embodiment of the Kingdom of God, and practicing mutual aid reconfirms people's relationships with God in that they are in the same body, then it may be time to think about how harmful it can be to the body when its "parts" are hurt in different ways.

In the following chapter is an example of how the LGS Mennonites adjust the regulations created and reinforced by their churches; how the boundaries between insiders and outsiders are blurred, and how mutual aid is practiced in a funeral as a community event in an LGS Mennonite village.

Chapter Seven: A Funeral in a Conservative Mennonite Village

When I was in Mexico, one day, Mei unexpectedly asked me if I would like to go to a funeral in a conservative Mennonite village the next day. I was curious about how she knew that there was a funeral, or where she got her information. Her response reminded me of a phrase I heard in some of our interviews: “by word of mouth from one person to another.” The following morning, before we left home, Mei kindly suggested that I not bring the *Bible* with me since people would use *Geistreiches Gesangbuch*, a hymn book in High German, instead of the *Bible* during the service.

We arrived around 10 o’clock, and many cars and trucks were already parked in or beside the schoolyard. As soon as we got out of the car, a grey and blue pickup truck passed us. Eight or nine Mennonite women and men sat on the edge of the truck box that contained a plain wooden coffin covered by a white blanket (Buhler, 1995; Buhler, 1996, Buhler, 1997). It was obvious that two women in the truck were crying and drying their tears, and others held onto the coffin. Walking on the unpaved road with other Mennonite mourners, Mei and I attracted many people’s attention because of my Asian face, and our “outsiders” outfit differentiating us from other ladies. In fact, I noticed through the whole funeral process, there were only three women, including Mei and me, who were in black blouses, skirts, and moderately high-heeled shoes.

Most of the women dressed in customary LGS Mennonite clothing: a long black dress with black hosiery underneath. Many aging women and some who were younger wore the handmade black *haube*, a kind of head covering, covered by a black handkerchief. Generally, the less conservative women and those who were unmarried,

including some elementary-school-age girls, only wore on their heads the black handkerchiefs, some of which were embroidered in colourful floral patterns at the back. Flats or low-heeled shoes and sandals seemed to be standard footwear.

The different dress codes among those LGS Mennonite men attracted my attention, too. A group of what looked like “military men” in dark grey “military uniforms” walked in front of us. Their visor caps were the same colour as their uniforms. There were no collar tabs or epaulettes on their suits, but they all wore the same kind of tall, black boots without zippers or ties. Mei explained, “They are the pastors of the church which the deceased person went to.” Other LGS Mennonite men, mostly, wore dark blue or black button shirts and suits without ties. A few of them wore bright blue, striped, button shirts and blue bib overalls, or jeans. The white straw cowboy hats were very common for men, but caps were also worn.

The funeral was for a lady over 80 years old, who had been very sick for several years before she died. I was amazed by the size of group that attended this event, and wondered if they all knew the deceased person or her family members. In fact, I discovered that not everyone coming to the funeral had relationships with the dead woman or her family. The funeral was more like a public event; people did not need official invitations and were free to come.

The funeral took place in a quonset building, like a big hall or garage, instead of in the colony church. I was told that the church in that community was not able to hold that many people, so they used this building. However, according to Buhler (1996), it was possible that there was no church in this village, so people used the quonset building.

Hundreds of people, including men, women, elders, children and babies, entered the quonset building in which the family and their helpers had already set many long wooden benches with no backs. Men sat on the left side, and women with their children were on the right side. No obituary or funeral programs were given to the participants. When Mei and I walked into the hall, the back rows were almost full. We sat in the second row behind the immediate female family members of the deceased. Two little girls sitting three persons away from Mei were sobbing. As soon as the taller girl made eye contact with me, she stopped crying. That was one of the most embarrassing and difficult situations I encountered in my fieldwork because I suddenly did not know how to react to her, especially under this kind of circumstance. I felt it would be inappropriate to greet her with a smile, but it would also be rude if I ignored her by moving my eyes away. I nodded my head, but we were still looking at each other until a young lady sitting beside her touched the girl's left shoulder. The little girl turned around, and a few minutes later, she started crying again.

The coffin was in the middle of the hall, and the dead woman was facing the entry, the east. Behind the coffin was the pulpit in the middle, with the ministers sitting on both sides. For me, this was a very practical way to manage the space in terms of setting the benches for hundreds of people, and simultaneously, it emphasized the importance of this ritual, which signified the last stage of a disciple's life in the physical world. Some people walked around the coffin as soon as they were in the hall, but many Mennonites sat down on the benches and bowed their heads, signifying their humility. I looked around to see what others were doing. Only a few ladies in the very back rows were whispering, and the whole quonset was very quiet. I had some eye contact with

some women and men who had not bowed their heads; there were no discernible expressions on their faces.

The dead woman was in a white “dress,” covered by a piece of white fabric, the shroud, tucked into the edges of the coffin, and a white *haube* covered her head. “The shroud is always white,” some LGS Mennonite participants later indicated, and “either the female family members or friends, or those from her church made her gown,” Mei explained. There was no makeup on her face. She looked like a waxwork statue lying in the unpainted wood coffin. A villager made this tapered coffin that was wider at the head than at the foot. The sides of the coffin were not very high, so people could view the body from the right or left side. A piece of white cloth from the coffin lining was draped to cover the edges of the coffin from the top to the bottom. In addition to the unpainted coffin, the lack of black ribbons on her cuffs and neckline also indicated her membership in a very conservative LGS Mennonite church. This information was provided by an LGS Mennonite couple in an interview, and was confirmed in the article, “Mennonite Burial Customs,” written by Linda Buhler (1996). Her hands were arranged on her chest, the right hand was on top of the left one. It seemed as if she was worshipping.

The two hour indoor service consisted of a sermon and occasional singing and silent prayers. It was conducted in High German, and the pastor who led the service made some comments in *Plautdietsch*. The leading pastor read from a notebook that he had almost completely filled with information about the deceased and the sermon he wanted to give. He indicated that the dead woman was a good role model for her children, who, in turn, like their mother, were followers of God. He also said that the lady always taught

her children in the way of God, a requirement of being a good wife and a good mother. He suggested that her children follow the mother to live in a faithful way. The preacher never stated whether or not the deceased was with God, or was in heaven already. Instead, according to Mei's translation, he said, "I hope we would see each other in heaven."

During the silent prayer, people bowed their heads, and the whole building was relatively quiet, except a little child cried once, and her mother took her out. I realized, later through my research, that the LGS Mennonites in Mexico and in Canada interpreted the reasons for silent prayer differently. A retired pastor from a less conservative church said that was a time "for personal confession, and for you to recognize that you sinned." He explained, "We encouraged people to come to funerals People should recognize their sins. Talk to God faithfully. When the judgment day comes, we will be judged. You got to think how you present yourself in front of God." However, an LGS Mennonite lady born in Canada, also from a less conservative church said, "I think silent prayer is very important. It is not like we are afraid to pray to God (in front of others), or to admit we are Christians, but we use the mouth to swear, to lie, or to say something we should not I practice silent prayer."

During the service, no musical instruments were used. People sang on three occasions, two or three songs each time. Each song lasted at least five to six minutes, and it was hard follow what they were singing although Mei shared her hymnbook with me. My language was not the only reason causing problems. In fact, the tempo was extremely slow, and I felt that all the songs had the same melody and pitches. During the later

consversations with Mei and other LGS Mennonites, I discovered a common explanation for this singing style was that people used it to confuse others, as a way to protect themselves from being persecuted in Europe because no one could understand what they were singing. However, according to Wesley Berg's (1996) explanation, variation in melody and pitches might be perceived as a "way of expressing individuality in a culture stressing conformity" (p. 65), which is similar to the violation of the dress code, such as wearing a skirt instead of a dress. Moreover, the author stated that many LGS Mennonites traditionally learned to sing according to their "notes," the transcriptions of different music factors (Berg, 1996), for example, ornamental tones, and melody, to control the singing process (Berg, 1996) so that no one would sing differently from another.

It was almost impossible for me to observe the women sitting behind me, but easier to see the men's behaviours through the service. About 20 Mennonite men from the deceased person's family, including one man in the pastor's uniform, were sitting in the front row. A few of them cried relatively loudly in that they sobbed, and I could hear their whimpers. Two of them constantly took their handkerchiefs out of their pockets to dry their tears and to wipe their running noses. Other people sitting behind them remained very calm. Indeed, there were no facial expressions on their faces.

When the sermon was finished, the coffin, which was left open during the indoor service, was taken to the yard for viewing before going to the cemetery. Men and women walked on different sides of the coffin, and again, the dead woman was still facing east. When I was viewing the body, I realized that the coffin was not only plain and undecorated, but also did not have handles or hinges. After all the people had viewed the

body, the family members placed the lid on the coffin. The male family members lifted up the coffin and put it in the truck's box again. The truck crossed the only main street, and drove on a dusty side trail between two farmers' yards heading towards the cemetery. Other people who wanted to see the burial would follow the truck. Men were ahead of women walking towards the graveyard. Some people did not go, and stayed for *faspa*, a small meal, including the *Kringle* (twisted bun), coffee, sugar cubes, milk, and water.

The graveyard was also "plain" in that there were only two or three gravestones for people who died recently. Some graves were marked with a flat "gravestone," a fist-sized rock, on which the dead person's name was "carved," shallowly. The most popular burial marker at this site was the wooden stick. Two sticks with no names identifying the head end and the bottom end marked a grave. The lady's coffin was opened again in the cemetery before the burial, and the deceased still faced east, because "Jesus will come from the east," some Mennonite participants stated. The LGS Mennonite men stood closer to the grave, hand dug by male community members or family friends, than many women did. By chance, Mei and I stood close to some ministers. Apparently they were not comfortable with the appearance of two female "strangers." When they were walking towards the fence of the cemetery to keep a distance from us, the leading minister started talking, which stopped those ministers from moving away. Mei and I could not hear the minister's words clearly until he led a silent prayer. After the prayer, the minister asked if people would like to make more comments, but nobody responded.

Just before some Mennonite men closed the coffin again, a lady, who seemed to be the oldest child in the family, ran up to the coffin and firmly grasped it. She cried loudly while holding the coffin. Her behaviour shocked everyone at the gravesite. People

suddenly became very quiet, and the sobbing ladies next to us also stopped. I observed the shocked expressions on some men's and women's faces, although they disappeared very quickly. The lady's brother or brother-in-law, who was in the pastor's uniform and sitting with other male family members, walked briskly to her, grasped her arm, and with an air of authority, led her away from the coffin. It seemed that he was embarrassed by her "irrational" behaviour. While the lady was still crying, I was afraid that she would faint. Other women were holding her arms, and let her find comfort in their physical closeness. Some men closed the coffin, and put it into the grave. They filled the grave by hand with other male helpers, and set two wooden sticks one on each end of the grave. After that the pastor made some comments about the deceased woman as a good wife and good mother again. Another silent prayer followed his words, and then people went back to the quonset for *faspa*, which was prepared and served by female relatives, friends or church members. During the meal, men and women still sat separately. People left after having the *faspa*, and some women stayed to help with cleaning.

More than That

My first impression of the funeral itself was that it was "plain," which symbolized obedience, conformity and social control, the basic elements of a traditional social or religious system (Roessingh & Plasil, 2006). Additionally, as many theorists have argued, funerals are rituals used to reinforce and reproduce social boundaries and people's identities. In this case, the LGS Mennonites identified their willingness to submit themselves to their communities for a "collective salvation" (Scheler, 1973, p. 554) by controlling their bodies and behaviours. For example, the way that the pastors dressed

was based on a passage, the Armor of God, in the *Bible*. Paul in Ephesians 6:10-18 stated,

Finally, be strong in the Lord and in the strength of his power. Put on the whole armor of God, so that you may be able to stand against the wiles of the devil. For our struggle is not against enemies of blood and flesh, but against the rulers, against the authorities, against the cosmic powers of this present darkness, against the spiritual forces of evil in the heavenly places. Therefore take up the whole armor of God, so that you may be able to withstand on that evil day, and having done everything, to stand firm. Stand therefore, and fasten the belt of truth around your waist, and put on the breastplate of righteousness. As shoes for your feet put on whatever will make you ready to proclaim the gospel of peace. With all of these, take the shield of faith, with which you will be able to quench all the flaming arrows of the evil one. Take the helmet of salvation, and the sword of the Spirit, which is the word of God. Pray in the Spirit at all times in every prayer and supplication. To that end keep alert and always persevere in supplication for all the saints.

This particular dress code represented the ministers' pilgrim status, and their preparations for leaving the physical world, and for being with God (Redekop, 1969). However, the ministers' bodies could no longer be seen as "a template for social organization" (Lock, 1993, p. 136) or as part of the mind-body dichotomy. Rather, they were the bodies of social order (Lock, 1993), and the embodied Knowledge of God (Lock, 1993).

For another example, there were no adornments, such as ribbon, flowers, and pictures used for decorating the body, coffin, and the quonset building. Additionally, the participants in the funeral, in general, behaved in the same ways, in that they dressed according to the cultural rules and controlled their emotions properly by not allowing themselves to show sadness in their faces. The backless benches implied a cultural "ideology of a hard life" (Roessingh & Plasil, 2006, p. 60), so sitting on the backless benches was "hard on the body and grave on the mind" (Roessingh & Plasil, 2006, p. 60), an act that expressed that they were following Jesus or embracing God's word with their

hearts (Roessingh & Plasil, 2006). This idea was in line with what the *Bible* said: “Share in suffering like a good soldier of Christ Jesus (2 Timothy 2:3).

Based on the idea of sharing emphasized in the Scriptures, I suspected that the differing dress codes and my looking different from them might not be the main reason causing some LGS Mennonites and their pastors to feel uncomfortable. I thought this because, before I went to the funeral, I had heard some stories about some LGS Mennonites adopting Mexican or Native people’s children who might not look like other members of the village. Instead, the symbolic cultural meanings embedded in clothing might lead some members to think that Mei and I did not believe in the same things they did, such as the importance of being a member of a faith community rather than being a faithful individual (Redekop, 1969; Berg, 1996; Snyder, 1995). In other words, “outsiders” behaviours of choosing to wear certain clothing that is different implied their unwillingness to “take the biblical injunctions as seriously as [the conservative LGS Mennonites] did” (Ens, 1974, p. 37).

The Normalization of Death as Part of Life

The funeral actually illustrated more expectations for the faith community members or moral community members (Durkheim, 1995) than enforcements. For example, when talking about bowing their heads, more than one Mennonite participant in our conversations stated that the conservative LGS Mennonites take the surface meanings of God’s words, “but they are faithful and humble people.” A healthcare provider said, “They are humble people.” He said that one of his clients told him, “We are low.” The term, “low,” he explained, meant, “I am utterly bowed down and prostrate” (Psalm 38:6).

“You put your head down. You bow down in front of God. You listen to your ministers. That is what you should do, and you should not question it.”

Another example was related to “crying.” In my later interviews, some LGS Mennonites, especially those who had moved back from Latin American Countries, stated, “No, the conservative men did not cry in the funerals . . . Women were allowed to cry. It was normal; it is natural, but they need to control themselves, too.” Another one said, “They [men] should not cry like that. It is not my responsibility to judge, but I have not seen one [man] crying like a child in my church,” while talking about men’s proper behaviours in a funeral. A pastor, furthermore, stated, “Yes, I saw men crying in funerals, but not very often. Because they needed help, they cried for God’s help; for example, they had a lot of children who needed to be fed . . . We know that God has His own plan.” However, a Mennonite healthcare provider indicated that “grief has its place, as even God has grief over our mistakes. At the same time death is accepted as part of God’s plan and a stepping stone to what God has for us after death.”

Their statements might have referred to two ideal purposes for people’s crying. First, ideally, people should not cry for the dead person because they did not live together anymore. Instead they should trust God that they would (or might) meet again in their eternal home if they were faithful disciples. This first kind of crying might not be acceptable and might be seen as a violation of social “norms” since it symbolizes their distrust in God. Another kind of crying, “On one hand, is asking –pleading. On the other hand, it is an emotional expression of faith that God is there and cares,” the Mennonite healthcare provider explained.

The funeral also illustrated the communal nature of the community. I lived in big or small cities for almost 30 years before becoming involved with the LGS Mennonite communities, but I could not recall any funeral for an ordinary person that had as big a group of supporters as the LGS Mennonite family had. Moreover, the funerals I attended for people from mainstream society generally were held on Saturday or Sunday when people did not have to work, and had time. In contrast, the LGS Mennonite lady's funeral was on a regular working day. It meant, perhaps, when people came to help the grieving family, or to give the family some emotional supports, they had to leave their farming and housework behind. As an "outsider," I perceived attending the funeral as an important commitment people made for other disciples living in the same body as they did. It was for the communal good. However, for the LGS Mennonites, according to my observation and interviews, a large attendance for the funeral, and putting personal interests aside were "normal" because it was "the nature of a believer's life" as a pastor said in his sermon.

The funeral was a social lesson that showed what a community "could do," and what an individual "could not do." This practice, in a way, contrasted the highly valued exercise of an individual's own interests promoted in some mainstream cultures. In addition to obeying the ministers' interpretations of the Scriptures, which, in general, directs the LGS Mennonites' lives, the social network is another most important resource for the LGS Mennonites to maintain to reproduce their collective identity as God's followers. As mentioned earlier, women from the dead lady's family, church or village made her gown. The coffin was handmade, and the grave was dug by hand. The practice of mutual aid indicated the development of a self-sustaining community as well as the

trust relationships and mutual recognitions established among the conservative LGS Mennonites. Therefore, it may be reasonable to say that “outsiders” included not only those who had different cultural practices and beliefs, but also people that community members could not count on.

Additionally, the funeral was an example of “the lifelong preparation for death” (Bryer, 1979, p. 257). There were some children at the funeral who were exposed to death by viewing the body with their mothers and listening to people’s conversations related to the dead person. For example, a lesson the children might have learned was how to be a good role model like the dead person who taught her children about God’s requirements, and was still faithful when she was very sick. In addition, making the coffin and gown for the deceased woman formally informed her family members and friends that the physical death was real, meaning that the dead person finished all her life stages on the earth, and was ready to start a new life. Finally, the white gown, *haube*, and shroud indicated the deceased’s purity, which was an essential personal “quality” for the believers to meet God.

Summary

The funeral in the conservative LGS Mennonite village clearly showed cultural richness. It made “daily life and Christian ideal one and the same” (Sawatzky, 2005, p. 3). Indeed, it showed a kind of care, the care for the community members’ future by preparing people to face death, and to reconfirm their hope, which was God’s promise. Moreover, the funeral indicated that the LGS Mennonites, in terms of Christian formation, were not “inducted” (Schroeder, 2001, p. 33) into God’s world, and “were

made to see that this is the way the world is, and it is not any other way”(Schroeder, 2001, p. 33). Rather, they learned it in their everyday lives. It highlighted the sense of a faithful community by promoting mutual aid, mutual recognition, and mutual trust. These practices may be seen as social norms, “common sense,” and God’s will instead of as their pastors’ requirements.

This is not denying the internal power control, reflected in the control of the biblical knowledge and discouraging the questioning of a minister’s interpretations of the *Bible*, within an LGS Mennonite congregation. It is also not dismissing the fact that the social control, power, and structure were reproduced through the ritual. However, the LGS Mennonites’ belief in the community of faith is based on their understandings of God, who does not need to show his existence through a series of laboratory experiments, but requires his followers to have a faith in him, and to trust him and his promise, which will happen eventually, but not yet (Davis, 1976). This fundamental belief was identified as one of the main forces that led some LGS Mennonites to reject life insurance in their history. Nolt (1998) indicated that some conservative LGS Mennonite church leaders denounced life insurance for its “lack of trust in God and the care of the church” (p. 216).

Moreover, the funeral might have partially indicated that the LGS Mennonites’ ideology of the separation between church and state, or between the colonies and the outside world was not the only factor that caused the conservative LGS Mennonites’ “separation” from the mainstream and from other Mennonite groups because, as Ens (1974) and Schroeder (2001) stated, those people also encountered rejections from the mainstream. In fact, the rejection was one of the reasons pushing the LGS Mennonites to resettle constantly.

More than that, the funeral contained practices that for some outsiders may have seemed “backward,” “naïve” or “ignorant” (these terms were used by some participants in the interviews or conversations). For example, people from mainstream society may have questioned the presence of children, who were supposed to be in school, at the funeral. They may also have been puzzled by the singing style, which might be “one of the most effective barriers to intrusions from the outside into their congregational life: strange to hear and even more difficult to learn” (Berg, 1996, p. 112). Both practices illustrate separations, and different separations “may have been God’s will but one wonders if all of them were” (Janzen, 2010, p. 10). In the next chapter, I describe and analyze more practices and their associated beliefs related to death and palliative care among the LGS Mennonites.

Chapter Eight: Palliative Care

This chapter uses various examples to explore and to explain some beliefs and practices associated with death, dying, and palliative care among the LGS Mennonites. It does not attempt to address all aspects related to care for the end-of-life. Instead, it provides a larger picture of the diversity and complexity of “palliative care services” provided by and for the LGS Mennonites.

Definitions Offered by Participants

The term palliative care is used interchangeably with another one, hospice care, in Canada. The patients I encountered in palliative care programs in Canada generally were diagnosed with incurable terminal diseases with six months or less to live. According to the definition given in the literature review chapter, what they were receiving probably should be identified as hospice palliative care. The interchangeable use of the terms led to a certain degree of confusion, not only for the LGS Mennonite individuals, but also for the healthcare providers.

Constantly, the healthcare providers would tell me that there were no palliative care patients in their hospitals or long-term care centres, or they did not directly provide palliative care services to the patients. Sometimes, people would wonder why I spent time in the long-term care centres, or wanted to interview nutritionists who were perceived as having nothing to do with palliative care. These questions were hard to answer since I did not want to impose my own ideas of palliative care, death, and dying upon others, or to make them feel that their perceptions or understandings were wrong.

Different Interpretations of Palliative Care

There is no universal definition of palliative care that spans all cultures. In addition to its overlapping meanings with hospice care, and hospice palliative care, some LGS Mennonites had their own interpretations for this kind of service that contradicted the general purposes for providing palliative care services: managing the patients' pain, providing comfort, helping the patients find strengths in their lives, and supporting the patients, their families as well as healthcare providers. Additionally, it aims at preventing suicide.

However, some LGS Mennonites believed that there was a connection between palliative care and suicide or assisted dying, meaning palliative care or hospice palliative care was perceived as “legalized” ways to assist the dying people to commit suicide, or these services promoted the employment of euthanasia. According to a registered nurse with a Mennonite background, the reason for people’s associating palliative care with euthanasia was that they lacked knowledge about palliative care, and they thought that the physicians and nurses encouraged them to deliberately end the life of the dying people or family members living with terminal diseases. An LGS Mennonite visiting some relatives in Canada said, “I do not know this (palliative care). Life is in God’s hand. I do not understand why people want to use medicine to help them die.” I asked him to explain his statement, and he said, “I do not think it is right. It is sinful if you kill yourself, or you help others to kill themselves.”

The second interpretation provided by some LGS Mennonites was associated with the idea of “hope.” Palliative care, which is designed to help the service users to gain or

to maintain the sense of hope (Holt & Reeves, 2001), has been interpreted as a suggestion of “no hope” by some LGS Mennonites. They might not have labelled the dying person as “*hopeless*” directly. Instead, they might have labelled some palliative care providers as representatives of “*death*,” meaning those people just went to the patient’s family to make the “*hopeless*” announcement. For example, a family asked the palliative care physician and nurse to leave their houses, and told them, “We had enough bad news already.” In another case, the palliative care providers were identified as the “representatives of commercial funeral houses,” who tried to help the families prepare the funerals while the dying people were still alive. The family asked the palliative care nurse why she was there, and told her, “He has not died yet.” “*No hope*” or “*hopeless*” in this case may be closely related to a belief that healthcare providers are responsible for controlling, curing or treating the diseases, and for changing the patients’ physical conditions. “*No hope*” or “*hopeless*” in this case may also refer to the failure of modern medical technology or the technologization of diseases, which “promised” their “magical” functions of changing people’s lives. However, the failures of medicine or technology were perceived as the failures of healthcare providers. Moreover, the disappointments with medicalization may, in a way, indicate an acceptance and denial of death at the same time, meaning a realization that the physical death is inevitable, but an unwillingness to see it happen.

The third interpretation was related to the fear of being separated from the family members, especially from children. To give an example, the LGS Mennonite parents who refused to use palliative care services believed that “if they were on palliative care, the (Canadian) government would take their children away,” according to one of the

community nurses in Canada. The parents, who both were diagnosed with terminal diseases, refused to use this service, and moved out of the town where they used to live to “prevent” the government from taking their children away. When they moved back, they were very close to death already. After talking to the healthcare providers, they agreed to be placed on palliative care and made arrangements for their children with their relatives.

Dying as a Way to Live: Brain Death and Organ Donations

It was surprising that many LGS Mennonite individuals involved in this study accepted brain death as a sign of “*no hope*.” They indicated that when the physicians announced the patients’ brain deaths, the life support machines could be removed. From an LGS Mennonite perspective, “*no hope*,” meant that the person would not be able to go back to “normal” life, which not only consisted of enjoying social life and doing physical work, but also included completing the spiritual work, such as praying and worshipping. Since being able to work is a significant value in the LGS Mennonite people’s lives, the loss of ability to hold this important personal value can be an important reason for their decisions to withdraw from various medical supports and treatments.

Generally, working, for the LGS Mennonites, is not only about doing a job and earning money, but also associated with self-expression in that they are able to act according to God’s word, and to maintain their self-sustained communities, a reconfirmation of an important belief in being independent from “outsiders.” Having life that is supported by machines, for many LGS Mennonites, is not acceptable in that it is against the idea that life is natural and given by God. A machine-supported life, in a way,

also challenges their belief that disciples should rely on each other, and work together as one body. Therefore, I suspect that achieving a long life expectancy through the medicalization and technologization of diseases and death without regaining the ability to work again may be perceived as damage to the community as a whole. This is to say that a machine-supported life may “contaminate” or “damage” the whole body, the body of Christ, which is supposed to depend on God, and to be self-sustained. Additionally, a machine-supported life may reflect a person’s inability to confront the temptations in the physical world, and reluctance to become a true believer. For the true believers, “*no hope*,” in this case, meant it was the time for the dying person to leave the physical world.

Although the LGS Mennonite population, in general, considered death as part of living, organ donation was not perceived as an intention to “extend” the donor’s life. Instead, it was an expression of love for God. However, in my research, most LGS Mennonites indicated that they never thought about whether or not they would donate their organs to others. A pastoral care person said, “I do not believe they talk about it,” in terms of the conservative LGS Mennonites’ perceptions of organ donation because “really our bodies are given by God. I think some of them may believe that they should not make the decisions themselves, or they do not know about organ donation at all. I am not sure. I am fine with that.”

Nonetheless, a small group of people, including some pastors, disagreed with the idea that brain death was a sufficient criterion for a real death. One person argued, “I have concerns over the organ donations because I am not too sure about how much life is left in the person’s body after his brain dies.” He went on to state, “In order to use the

organs or tissues, there must be life in it. If a life still exists in the organ, taking the parts out is accelerating the death speed.” Other pastors from different congregations also stated that generally the churches do not promote or encourage their members to donate their organs, but they did not criticize people who made or would make the donations either. “This is a personal choice,” a pastor indicated.

The Fear of Death

It was undeniable that some LGS Mennonite people did not accept their deaths as easily as the religious ideology had suggested. Also, very often the family members were more afraid of the feeling of separation than the dying person was. Additionally, the families may have expressed their denial of dying by refusing to open discussions about death with the patients, although sometimes, the persons on palliative care wanted to talk more about their lives, including their death. “There are fears about death, because they do not want to give up the physical world,” an LGS Mennonite moving back from Paraguay stated. The same person also indicated that he was ready to talk about his death with his children, but he did not think that the family members were ready.

“Death,” a pastor explained, “is not a punishment, but a reward for the person to be close to God. Good death is to have peace with God. People ask for forgiveness, and accept death as the beginning of a new life.” “Death is a natural process just like living, a process through which you continually show your faith in God. The followers’ souls will be cleaned of their sins, and the deceased will continually live with our Saviour in heaven. We will have everything we need,” an LGS Mennonite woman described.

Another fear was not related to death directly, but it was associated with the

process of dying itself. A significant cultural value in the LGS Mennonites' beliefs is being independent. However, being sick, dying, and losing the ability to work may cause some emotional suffering for the LGS Mennonite individuals. It was common that the LGS Mennonite people involved in this study indicated that they would not want to use any life support machines at the end of their lives, or in other situations, such as if they fell into a coma. One of the reasons, in addition to following God's decision, was expressed by one LGS Mennonite woman who had moved back to Canada from Mexico: "I do not want to be a burden for my family."

The Descriptions of Pain

From a medical perspective, pain management is a very important part of palliative care. Recently, an idea of applying a holistic approach to "relief" for different kinds of emotional, spiritual, and physical pain as a whole has been promoted through various healthcare sectors. This method aims at relieving the patients from the needless suffering by using medical and non-medical treatments, such as the combined utilization of morphine and counselling service.

Sometimes, the patients were asked to evaluate the severity of their pain on a scale from 1 to 10. This scientific scale was used for healthcare providers to provide an immediate response to the patient's medical or health condition, such as the injection of narcotics, or to diagnose what has happened to the patient's organs. However, the descriptions of pain vary from one LGS Mennonite individual to another, and are hard to measure. Pain was interpreted according to where it came from, such as "*back pain*" and "*headache*," or when it happened, such as "*sudden pain*." Other terms the LGS

Mennonites used during the fieldwork included “*aching*” and “*intensive*.” Some of them were more descriptive, such as “*burning*” and “*beating*.” In some cases, the patients would depict their suffering or aching in accordance with their life experiences. For example, a lady who had broken bones told the physicians and nurses that she felt she was in labour. In another situation, a patient who had some skin allergies described, “I feel I have a lot of bugs on my body . . . chewing my skin.” In the formal interviews, the interviewees used another term, *nerva krankhiet* (nerve pain) to describe their physical and emotional suffering.

A Good Death

Professor Benita C. Martocchio (1983), at the Case Western Reserve University, stated, “In a society which views life and death as separate entities, the period of life or living after the diagnosis of a usually fatal illness is often seen as part of dying rather than living” (p. 26). How to die, rather than how to live, has been the focus of people’s attention when talking about palliative care. Palliative care in this sense may address more about how to prepare for the closing point of life than how to live with an approaching death and how to prepare for the beginning of a new life.

For the LGS Mennonite population, death or dying is the end of physical existence on earth as well as a transitional process, through which the dying person leaves the current known world and goes into a future unknown world: “heaven.” This transferring process exists not only in people’s imaginations, but also in their current experiences. To go to the “indescribable” world, heaven, people have to truly give their hearts to God, and believe that they will not be saved by what they do or say in the

physical world. Instead, they are saved by faith because “salvation is not an achievement. It is God’s mercy,” some LGS Mennonites stated.

Dying was also seen as a reconciliation process through which people would reconcile their relationships with the Lord by repairing their relationships with others around them. They, additionally, should not question God’s power, or become uncertain about their faith in God in any situation, including in the process of death. Asking for and giving forgiveness are not only interactions between people, but also processes through which people reaffirm their faith by repenting of their sins. People who were able to do it were perceived as having a *“good death.”* However, LGS Mennonite people described how to reconcile differently. For example, some LGS Mennonites demonstrated that it is very important for the dying person *“to make things right”* before they leave the physical world. In this case, death signifies the end of the conflicts between people with whom the dying person may continuously live with in heaven. Confession before death implies people’s awareness of their status as sinners, which is the condition of human beings’ lives, and their needs for God to purify their sins, and to *“save”* them.

For another example, some LGS Mennonites stated that living their lives according to God’s word would allow them to have a good death without sins. These LGS Mennonite individuals believed that a good death should also include *“no regret.”* An LGS Mennonite woman said in an interview,

I do not understand why it is so important for some people that the dying people have to say, “God please forgive me.” For me, if you wronged others, you should ask for forgiveness from that person; if others wronged you, you should forgive them. You do not have to wait until the last moment when you have to go, and then realize that those things have to be done. I do not know what God has to do with that . . . You treat people well, follow God’s word, and forgive others, you

will not regret when people close to you pass away although you are not around when the person died or when you die.

Different explanations about a “good death” indicated that there was no “universal” definition of death and dying among the LGS Mennonites. A good death could mean to make time and to create opportunities to ask for God’s forgiveness as a way to repent of their sins. Repenting is important in the sense that the dying people can be accepted to live in the Kingdom of God. However, for others, people should recognize and confess their sins in their everyday lives. “Reconciling their relationships with God is not a one-time thing,” a pastor said.

A Baby’s Death

Some pastors do not provide spiritual care to dying children directly. One pastor said, “In our church, we talk to the child if he or she is seriously sick, or dying, but normally we talk to the parents.” The reason why the pastors or ministers were not actively involved with children was not very clear. One suspicion is that children are too young to understand God, so they may not be able to comprehend the pastors’ messages. Another thought is children are innocents and do not have sins. Because of this, after they die they will go back to God directly. It seemed that there were more considerations related to providing emotional and spiritual supports for the parents than for dying babies or children, but the practice of spiritual care for dying children varied from one church to another.

Having interactions with dying children is hard for both families and healthcare providers. Some physicians found it was really challenging for them to talk to children who were dying. They tried to stay with the truth, but when children asked why they were

suffering, the physicians indicated that they really did not know what to say to their little patients. In some cases, the physicians might even have felt “helpless,” meaning they felt that they did not receive enough supports from the dying children’s parents. To give a recent example, a child from a conservative church had major surgery, and the mother was with the little patient in the hospital. Because of the language issue (the LGS Mennonite woman did not speak English), they called a translator also working in the health care field for help. After the surgery, the physicians and nurses encouraged the mother to have more physical and emotional interactions, such as talking or telling a story to the child. However, the mother refused to do so unless the physicians could assure her that the child would recover from the surgery. The healthcare providers, on one hand, felt very frustrated that the woman “did not want to” provide more supports for her own child. On the other hand, the lady wanted to know whether or not it was the time for her child to go, and if it was, she did not want to do anything to encourage the child to stay alive against God’s will.

Another case was also in Canada. An LGS Mennonite person prayed with a dying relative to God that God could take the patient suffering from severe pain to be with Him. She explained that they prayed to God for “*Thy love*” and “*Thy gift*,” but not “for relieving the suffering of the person,” she said, “or for giving my relative an easy life.” Similar practices happened in other places, too, such as in Mexico. An LGS Mennonite lady who looked after some sick children in her colony said, as translated by a healthcare provider, “they did not do things [that would] extend the baby’s life if they (the sick children) had to go. A grandma asked other women to pray with her for her sick grandchild for letting the kid be with God.”

In Mexico, people were allowed to see stillborn babies and to take the children with them. A healthcare provider indicated, “Some families felt sorrow, and asked why God let this happen, but generally, they did not blame women for the miscarriages or stillborns.” Normally, “in Mexico, there were no funeral services for stillborn or miscarriage babies,” the healthcare provider said. Some LGS Mennonite ladies, furthermore, stated that babies who survived for more than 24 hours, “*a full circle*,” might have “funerals.” According to an LGS Mennonite, and two healthcare providers, in Canada, some churches provided short services for the deceased children in the graveyards of their churches. Upon the families’ requests, some churches also gave full funeral services for children who had died.

A very “atypical” statement, made by a Mennonite couple that worked with the LGS Mennonites in some Latin American countries, was “people (mainly women) might have secretly prayed for their aborted babies.”¹³ The wife explained,

They prayed for their (the mothers’) own salvation. I had a lady come to me because she was very depressed, and could not handle it anymore. She said that she lost her baby. She did not tell me what happened, but she said she prayed to God for forgiveness . . . It is just hard to listen to the stories like that.

When I asked the couple how the woman’s family reacted to it, the wife said, “I do not think her husband knew it.” “Her husband was an alcoholic, as were two of her brothers. We worked together for a few months, but he (her husband) went back to the old situation shortly after we left,” the husband said.

¹³ Judith C. Kulig and her co-authors discussed the LGS Mennonite women’s beliefs and practices related to pregnancy, family planning, and miscarriages in *Growing Up as a Woman: The Health Perspectives of Low-German-Speaking Mennonite Women*.

Living Will and Life Directive

Kevin Davidson (2011), a stewardship consultant working in the office of the Mennonite Foundation of Canada (MFC), was glad that his father had a will, which ensured that proper arrangements were made for the family members. This officer wrote that “If my dad had not understood the value of a will, it would have meant higher stress, more time away from my family and work, unnecessary legal and court costs, and even the real possibility of despising Dad for not being properly prepared” (p. 13). He additionally stated that “everyone has a will: Either the one you or your lawyer complete, or the one the court completes for you” (Davidson, 2011, p. 13).

However, for some of the LGS Mennonites, the will may only be made by the Lord. My research shows that Advanced Life Directive (ALD), Living Will, and Will are still new ideas, and some of the LGS Mennonites stated that they have not heard those terms. After explaining what those documents were, and the general purposes for making them, some LGS Mennonite individuals indicated that it might be good for them to have living wills, and they would take it into consideration. At the same time, a small group of individuals agreed with the idea that having a living will is good, but they indicated, “I will not make one for myself.”

When asked about the reasons for not having a living will, mostly people would be quiet. A registered nurse with a Christian background explained, “They believe that they and their family members are self-conscious people, and they would follow God’s will. God has his own plan about how and when this person will die, and people should obey God’s decision.” An LGS Mennonite lady believed that after the person’s death, the

property left by the deceased would be equally distributed to the children, and “they (children) would not fight each other for properties. There [were] no arguments,” she said.

In Canada, I visited some LGS Mennonite patients who were involved in palliative care programs, and receiving the services at their own homes with homecare or palliative care nurses and physicians. I was told that those people all had their written Advance Care Planning, Health Care Directives, and Do Not Resuscitate (DNT) orders. In addition, the LGS Mennonite residents in the long term care centres where I worked were required to fill out healthcare directive forms regarding the use of life-sustaining treatments, such as cardiopulmonary resuscitation (CPR), artificial ventilation, or intravenous therapy when they were accepted by the organizations. The family members mentioned that because of the patients’ life directives, there were fewer family arguments about how the person should be cared for when he or she was dying. Additionally, the patient’s life directives allowed the families to make choices that respected the dying people’s decisions, especially when they knew that the patients did not want their lives to be prolonged or maintained by medical means. However, for some LGS Mennonite individuals, a person making a living will may be seen as an action against God’s will.

Sin or Judgment: Suicide

Suicide is considered as a sinful behaviour among many LGS Mennonite people. Committing suicide will damage the person’s eternity and brings sins to the family members. The topic of suicide for some LGS Mennonite individuals was taboo, about which they were reluctant to make comments. Stated differently, commenting on the person who committed suicide would be seen as making a judgment, which was

prohibited in the *Bible*. Generally, the LGS Mennonites believe that life is a gift given by God who also has his own plans for his children. When asking a woman who looked after some dying women from her churches about what would happen to a church member if the person committed suicide, she simply answered, “That’s . . . we should not talk about.” When asking her about what will happen to the family members of the person who committed suicide, she gave the same answer.

However, being non-judgmental may be an idea rather than an action taken by every church person. A pastoral care provider told a story about a client who was struggling with accepting the fact that one of the family members committed suicide several years ago. The young person later told the pastoral care person that losing a very close family member was only one of the reasons causing the emotional distress. Another factor was that a church leader told the client that the deceased person would go “straight to hell.”

However how people who chose suicide were treated also varies from one church to another. Additionally, people indicated that some churches would bury the deceased excommunicated persons in the same way as they did those who killed themselves. Normally, the LGS Mennonite people are buried with their heads facing east and feet pointing west, so that “people can see the second come of Jesus. Some churches have buried the persons who committed suicide or excommunicated individuals in the opposite direction, which may indicate that the person would not be raised again on the resurrection day. Some LGS Mennonite participants and healthcare providers with Christian backgrounds expressed their disagreements with the practice of burying a

“sinner” facing west during my interviews. For example, one healthcare provider with a Mennonite background stated, “the judgment was made by people, and not by God Jesus just has to make a U-turn if the dead person is buried facing west.” There were also churches that placed the gravestones at the foot of the persons who conducted “self-murder” and were excommunicated instead of putting them at their heads as if these individuals were buried in the opposite direction.

Another practice described during the interviews was that the suicide or the excommunicated person would be buried one foot deeper. The reason for the extra foot was not very clear either, but one explanation given by the LGS Mennonites was that the deceased person would be closer to hell. One of the Mennonite participants who gave that answer stated, “because we only have two places to go after we die: heaven or hell. In heaven you are enjoying your eternal life with God, but you will not be accepted if you do things God does not like, so we have to listen to God’s word.” I asked him if he could give me a passage in the *Bible* associated with what he said; he answered, “I could not remember. But if we do not listen to God, we will be punished.” An interesting point revealed through these descriptions was that the deceased people are remembered in terms of not only who they were, but also their relationships with God represented in what the person did and said in the physical world.

A Baby’s Grave

In Mexico, I asked Mei to show me the graveyards or cemeteries in different colonies. After seeing five or six graveyards, I was shocked to see a baby’s grave facing WEST instead of east in a conservative LGS Mennonite church cemetery. A general

explanation from some LGS Mennonites was that the grave might contain a baby born out of wedlock. This practice apparently contradicted the information in my interviews.

In fact, people who participated in my interviews never indicated that the children born out-of-wedlock would be buried in this way.

In general, both LGS Mennonite men and women indicated that children were innocents, and they went to God directly. One Mennonite pastor, who used to live in Mexico, stated, “Babies and children do not consciously sin or act against God . . . They are innocents.” I asked about the baby’s grave in the conservative church’s cemetery, and why the grave faced west. He said, “I do not think that is a common practice from my own knowledge and experience. Well, in Mexico, there are some very conservative Mennonites, and they believe in punishment. They believe the punishment is from God. It is not. It is from people . . . The *Bible* said, ‘we were by nature children of wrath’ (Ephesians 2:3) . . .” He started reading the *Bible*:

But God, who is rich in mercy, out of the great love with which he loved us even when we were dead through our trespasses, made us alive together with Christ—by grace you have been saved—and raised us up with him and seated us with him in the heavenly places in Christ Jesus, so that in the ages to come he might show the immeasurable riches of his grace in kindness toward us in Christ Jesus.
(Ephesians 2: 4-7)

The pastor, furthermore, said, “You know, we should receive God’s mercy like children.” I asked him if this statement was from Mark (10:15): “Truly I tell you, whoever does not receive the kingdom of God as a little child will never enter it.” The answer was “Yes,” and he explained, “Do you know why the little children were set as role models? They do not question the power of God. They trust Him, but adults,

sometimes, would ask for God to give them this or that . . . They test God. We should not do that.”

The Healer and His Healing Place: Death and Dying

When talking about death, only one LGS Mennonite mentioned, “Death is God’s plan.” The same person also said, “We cannot avoid death, but we can have a new life in our eternal home (heaven) if we are faithful.” Many other LGS Mennonite people described the physical death as the nonexistence of people’s physical bodies. Additionally, death was also a consequence of sickness, accidents, or the lack of care for themselves, which were also the reasons for people’s illnesses and diseases. Although the discussions about sin and faith were very common in the *Bible* study groups, Sunday schools, and church services, people did not indicate that sin and being unfaithful caused death. In contrast, people who experienced some death, especially unexpected death, as through car accidents, might have become unfaithful in that they may have questioned God’s love and power to save or protect people. An LGS Mennonite said, “some people would ask ‘why did He let this (a car accident) happen to my [family],’ or ‘He promised His people the protection of His power. Why did he not do it?’”

Their loss of faith may be seen as being defeated by the enemies that are against God and God’s people. A pastor described death, in addition to the nonexistence of the physical body, as “our last enemy.” The reason he gave was that “it can destroy people’s faith. People will not be saved if they do not have faith in God.” I asked the pastor to explain the relations between the body, people, death and heaven to me. He referred to the passage in Philippians (3:20-21):

But our citizenship is in heaven, and it is from there that we are expecting a Savior, the Lord Jesus Christ. He will transform the body of our humiliation that it may be conformed to the body of his glory, by the power that also enables him to make all things subject to himself.

God Is the Healer

A naïve question I asked some LGS Mennonites, which unexpectedly revealed some of their understanding of curing and healing, was: Why can diseases, accidents, and the lack of care cause death? And some of the probes of this question included: Can all diseases be cured or treated? What diseases have been cured or treated? Why can some diseases not be cured or treated? Who cures or treats diseases? (Some of their facial expressions indicated that they thought that there was something wrong with this woman who was asking these questions.) Normally, the LGS Mennonites, especially those from the conservative churches, were quiet after hearing this question, and then offered these responses: “Our bodies do not work anymore; the brain cannot work. I do not know; it is nature. I do not know; that is how we are created by God.”

Nonetheless, a young LGS Mennonite man from a conservative church said, “Because our lives are from God. When we are called, we have to go.” In terms of the medical treatments for various diseases, the man said, “The physicians and nurses help us when we are still alive.” Moreover, he said, “They only can treat our diseases, but they are nice people.” Another question I asked him was: “What will happen to people after they die?” He said, “If you are healed, let’s say saved, then you go to heaven.” I wondered what would happen to those who will not be healed. He said, “I do not know. God knows everything; the *Bible* knows everything, too.... Do you know [that] God has a cell phone number you can call?” I was not sure whether or not this young person was

frustrated with my questions, or with the “fact” that I am not a Christian, and therefore, I knew nothing about the *Bible* and God. I stopped our conversation since his voice became louder, and I sensed the frustration in his answers. However, his answers revealed an important point which was that God heals people, and healthcare providers cure diseases. Moreover, healthcare providers, regardless of their occupations as physicians, nurses, or pastors, have limited knowledge and abilities compared to God, who knows everything. Healthcare providers also have no control over people’s afterlives. In other words, God uses the healthcare providers to show His curing and healing power.

The LGS Mennonites may perceive the healthcare providers as caregivers and supporters, who bear God’s love, instead of as healers. This is not to deny the power embedded in the modern medical treatments and technology, and the authority or knowledge of healthcare providers. In contrast, Egnew (2005) when discussing the relation between medicine, high technology and physicians wrote, “The marriage of science and medicine has empowered physicians to intervene actively in the course of disease, to effect cures, to prevent illness, and to eradicate disease” (p. 255). However, some LGS Mennonites still believed the only power that could handle everything and heal people both physically and spiritually was God. For example, an LGS Mennonite woman who had surgery said, “I prayed for God’s mercy,” and she appreciated that God sent a really good physician to her. The idea that God is the only one that has healing power indicates that healing does not simply refer to the medicalization and technologization of diseases and death, or to pain relieving (Browning, 2004). It may also embrace a sense of satisfaction and confidence in what people have done for others, in

what others have done for them, and in what they believe. In the LGS Mennonite woman's case, her satisfaction and confidence might have been in her relationship with God. In a church service, the pastor cited a verse, Isaiah (58:11): "The Lord will guide you continually, and satisfy your needs in parched places, and make your bones strong; and you shall be like a watered garden, like a spring of water, whose waters never fail," to indicate that God heals people, and gives what they need.

After Death

Some LGS Mennonites used metaphors to describe what would happen to people after they die. Some people believed that if the dead people were accepted by God, their souls would go into heaven with the Lord immediately. They also would receive new bodies from the Lord on the resurrection day, and they would be alive again. Another explanation was that after death, people's bodies would go to sleep. On the resurrection day, God would come to wake them up. The souls would rejoin the new bodies and become glorified.

Cremation is not accepted and encouraged by LGS Mennonite churches generally. Moreover, it seems that the LGS Mennonites were very concerned about how the dead bodies would be buried. Some people believed in the idea of "ashes to ashes; dust to dust," which was recorded in the *Book of Common Prayer*. The biblical idea is based on Genesis (3: 19) that "By the sweat of your face you shall eat bread until you return to the ground, for out of it you were taken; you are dust, and to dust you shall return." This idea was also associated with concerns related to the physical resurrection, the raising of a perfected body. The LGS Mennonite participants in the study demonstrated a belief that

the body that would be raised was spiritual. It would be different from the physical ones we have now. An LGS Mennonite believed, “The new body will not be sick, or become rotten.”

It was not clear whether or not burying the physical body signified the disappearance of the physical world, or if it indicated that without having a physical body buried properly, on the judgment day, the person’s soul would not be able to join the new body. However, one quote referred to in the study is 1 Corinthians (15:42-44), which stated,

So it is with the resurrection of the dead. What is sown is perishable, what is raised is imperishable. It is sown in dishonor, it is raised in glory. It is sown in weakness, it is raised in power. It is sown a physical body, it is raised a spiritual body. If there is a physical body, there is also a spiritual body.

In this case, it may be reasonable to interpret LGS Mennonites’ burying practice as a reflection of the idea that physical bodies are means for their spiritual goals. In other words, “being spiritual does not mean non-physical,” a healthcare provider said, meaning spirit and physical body are inalienable.

The Healing Home

Heaven, described as eternal home by the LGS Mennonites, is a place where the relation between some LGS Mennonites and God continues after their physical death. According to some participants’ descriptions, heaven is also a place where people would be healed. A pastor asked people in the church service, “Are you ready to go to heaven?” No one answered him. He continued,

I am, but I am not ready to give up my physical body yet. God wants me to be here . . . It is God’s test . . . Jesus was tested, too. My life is to finish God’s

work. When I die, I can say that I have showed my love to God . . . Why do we want to go to heaven? Not for the golden streets and pearl gates. Because we can be with God. He healed us; he saved us.

An LGS Mennonite healthcare provider said, “There is no pain, no suffering, no tear in heaven.”

Some people believed that the entertainment that they enjoyed in the physical world was meaningless compared to the joy they would receive in their eternal home where everyone is equal, and they happily live together with God and saints. An LGS Mennonite said, “I know we still will recognize each other, but we will not relate to each other like wife and husband, or parents and children.” It seems that social relations still exist in heaven but not social relationships, or people maintain their social relationships without physical intimacy. This idea may be reflected in how the LGS Mennonites address other church members, who are not their spouses in the physical world, as brothers and sisters, which allows the two parties to stay close without having intimate relationships.

One relationship remains constant. God is with people always. “When people are ‘sleeping,’ they are still with God,” a female LGS Mennonite stated. She also pointed out several passages in the *Bible* that describe the metaphorical relation between death and sleep. In 1 Thessalonians 4:13-14 Paul said,

But we do not want you to be uninformed, brothers and sisters, about those who have died, so that you may not grieve as others do who have no hope. For since we believe that Jesus died and rose again, even so, through Jesus, God will bring with him those who have died.

Additionally, 1 Thessalonians 5:9-11 described,

For God has destined us not for wrath but for obtaining salvation through our

Lord Jesus Christ, who died for us, so that whether we are awake or asleep we may live with him. Therefore encourage one another and build up each other, as indeed you are doing.

Going to heaven and living with God are the spiritual goals for the LGS Mennonite people. Many of them in the study expressed their hope of going to heaven, but the term, “hope” was interpreted differently. On one hand, some LGS Mennonites from the evangelized churches were sure that they would go to heaven, if they followed God’s words, but they could not speak for God. Therefore, an LGS Mennonite explained, “we say we hope that we can go to heaven. It is God’s decision, but we know we will be accepted.” On the other hand, “hope” reflected a desire to maintain a strong faith and trust in God for the rest of their lives that He is going to accept them into heaven when they die (Friesen, 2004). This belief is held by the LGS Mennonites from some non-evangelical or traditional churches. John Friesen (2004) indicated, “Their hope in eternal salvation was seen as a lifelong process that continued after baptism. They lived in the hope that God's grace would be sufficient to sustain them as faithful followers of Christ” (p. 136).

Healing and Wholeness

“Heaven is the home for all the redeemed,” a pastor said during a funeral in a less conservative church. This pastor and a person providing social services to some LGS Mennonites shared a similar idea that people would be healed if they were faithful, but “people cannot heal themselves,” the pastor stated. The social service provider said that the healing strategies used by the LGS Mennonites include singing, praying, and repenting their sins.

The word, *healing*, is from the Greek word, *sozo*, which also means heal, be whole, and to make whole. The *Bible* described healing as an essential action Jesus took to present the gospel. Snyder (1995) indicated that it is the disciples' duty to heal the sick and to form a faith community in the way that Jesus demonstrated, including practices of mutuality and discipline (Kotva, Jr., 1989; Buller, 1989). Therefore, through the healing process the LGS Mennonites experienced not only the mutual supports, "ongoing forgiveness and reconciliation" (Miller, 1991, p. 57), but the correction, which reinforced the disciples' relationship with God (Miller, 1991; Snyder, 1995; Schroeder, 2001). In short, the reconciliation of relationships is also part of a healing process that brings people back to God.

If healing means to regain the sense of wholeness, then God represents the healing process because of his appearance as "the Self-same Spirit" (Heywood, as cited in Jacobsen, 2003, p. 209). The *Bible* is a history of "separation." It "recorded" how and why people, human beings, in general, are not like God who represents wholeness, the oneness of spirit, soul and body. The reason is people sinned, and God heals sinners. The *Bible*, therefore, directs people to follow and to serve God, and provides solutions for the difficulties people have encountered, in this case, how to achieve the sense of wholeness.

Healing While Moving

The previous discussions of the LGS Mennonites' resettlements in this thesis indicated that their frequent moving led to various difficulties in maintaining a simple lifestyle and in following God's will. Indeed, moving and migration, for the LGS Mennonites, especially the conservative groups, became "inevitable" strategies to

maintain the meaning of being Mennonites or being God's followers. Stated differently, migration was a practice of Jesus' lifestyle, which reconfirmed their relationship with God, who is the true healer, and the only saviour. Therefore, I would interpret the migration as a process of collective healing (Kirmayer, Simpson & Cargo, 2003) in that the maintaining and the restoration of their own language, religious and communal practices can be seen as their making the efforts of healing (Kirmayer, Simpson & Cargo, 2003). Through this process the LGS Mennonites demonstrated their faith in God, and reproduced their collective identity as the body of Christ by expressing their disagreement with the "outsiders" living in the world as fragment parts, individuals or enemies.

The LGS Mennonites' avoidance of "outsiders" and modernity made them appear to want to be isolated (Schroeder, 2001), as if to suggest that the resettlements reflected their awareness that living in the physical world, they had to face many conflicts, challenges, or temptations which could lead them to disobey God's word, and to become unfaithful (Schroeder, 2001; Friesen, 2004). Therefore, for the conservative LGS Mennonites, in general, minimizing the interactions with "others" who did not believe, follow or behave in the same way as they did became a way to protect their relationship with God. It was also a way to protect their sense of wholeness, the oneness of Spirit, Soul and Body, which could only be "achieved" by being accepted to live with God.

The struggles between maintaining the conservative traditions, and the real difficulties in real lives reflected the LGS Mennonites' desire to be with God, who is the real healer, in heaven. Additionally, the struggles in the physical world reflected heaven

as the only place where there would be no boundaries and “*differences*”, and in which people would not be identified as “*You Are That*” (Gangaji, 2007). People in heaven probably also would not be identified as Mennonites and non-Mennonites. This, in turn, indicated not only the LGS Mennonites’ awareness of the separations and loss caused by some restricted orthodoxies and the constant resettlements, but also their objections to dualism: insider versus outsider; following God’s will versus being “made” (Schroeder, 2001, p. 33) to follow God; churches (the body of Jesus) versus heaven; political states versus God’s kingdom.

Knowledge Control and Health Education: Teaching but Not Teaching

As discussed in the historical review, the *Bible* is very important for LGS Mennonites. However, it is hard to ignore the fact that some congregations do not encourage their members, especially the females, to read or to study the *Bible*. Additionally, some LGS Mennonite people also believed and were taught that teaching the *Bible* is a sinful behaviour. A male volunteer in a health care institution, who used to live in a Latin American country with his family, referred me to this following passage to explain why people should not teach the *Bible*. Later, surprisingly, I found that the same passage and similar interpretation was used in some less conservative churches, too.

The passage is James (3: 1-10):

Not many of you should become teachers, my brothers and sisters, for you know that we who teach will be judged with greater strictness. For all of us make many mistakes. Anyone who makes no mistakes in speaking is perfect, able to keep the whole body in check with a bridle. If we put bits into the mouths of horses to make them obey us, we guide their whole bodies. Or look at ships: though they are so large that it takes strong winds to drive them, yet a very small rudder guides them wherever the will of the pilot directs. So also the tongue is a small member, yet it boasts of great exploits. How great a forest is set ablaze by a small

fire! And the tongue is a fire. The tongue is placed among our members as a world of iniquity; it stains the whole body, sets on fire the cycle of nature, and is itself set on fire by hell. For every species of beast and bird, of reptile and sea creature, can be tamed and has been tamed by the human species, but no one can tame the tongue—a restless evil, full of deadly poison. With it we bless the Lord and Father, and with it we curse those who are made in the likeness of God. From the same mouth come blessing and cursing. My brothers and sisters, this ought not to be so.

Another reason for the objection to the independent study of the *Bible* might have been related to the fear that what was known would be questioned and challenged; additionally, it would be transferred into something unknown (Urry, 1983). In other words, when people have gained more knowledge they may become curious about what they do not know, and start questioning what they have known (Peters, 1988; Redekop, 1984). This fear was also reflected in the health care education among some churches.

Body Knows Everything

Normally, there was no health science education curriculum that taught how men's and women's bodies work biologically in the LGS Mennonites' private schools. In addition, being sick and suffering might be seen as a faith test given by the Lord, or as part of God's plan (Kulig & Fan, 2011). One physician in Mexico indicated that

some women believe that God makes them different, and that is why they always have physical problems, such as the lower back pain. They do not associate the pain with their living style They work harder than men. They help their husbands in their farms, and look after their families. The back pain is so common among them, because they do a lot of heavy lifting They are taught to obey their husband[s], so they have to do whatever their husbands said.

Honouring a husband reflected a significant component of the LGS Mennonites' cultural ideology and practice, which is living a peaceful life. However, this physician indicated that many people actually suppressed their emotional pain and suffering instead

of coping with the real issues in their lives, such as domestic violence “because they are pacifists and peacemakers. They believe they should not argue with their husbands; they cannot,” he stated.

Some healthcare providers indicated that they encountered some LGS Mennonite people who were unaware that their physical problems, such as a lower back pain or headache, might have reflected their emotional stress. A registered healthcare assistant in Canada also indicated the lack of health-related knowledge among some LGS Mennonites by saying, “They do not know their bodies. We know that chronic pain very often goes together with emotional or psychological issues, such as worries, depression, and the lack of sleep, but they do not. No one tells them that.” A physician with a Mennonite background explained, “Some of them did not really understand health. Others might have misinformed them about how to maintain good health.” One of the examples the physician gave was a patient who was suffering from some chronic infections, and the pastor from the person’s church told the family that they did not pray enough, and that was why the person was not recovering.

Biblical Knowledge and Facial Expressions

Moreover, when talking about health education in terms of death, dying, and grief, most of the LGS Mennonite participants in my study indicated their acceptance of death as a natural phenomenon. “We sing together” was a way for the grieving family and the community members to handle their sadness. However, after participating in several funerals conducted for deceased people from both conservative and less conservative churches, I asked some participants about the reasons for some LGS

Mennonites' lack of facial expressions of sadness or unhappiness in some funerals. An LGS Mennonite from a conservative church said, "That is God's rule," and others from the conservative churches likely would answer, "I do not know."

Their responses seemed very confusing, but they were actually based on the belief of *Gelassenheit*, "meaning submission and yielding to one another. Other words that help translate and explain *Gelassenheit* are humility, servanthood, tolerance, and patience" (Peters, as cited in Bauman, 2003, p. 7). A pastoral care person, furthermore, explained, "It means to let it go. You can understand it like 'moving on.' You cannot move on if you always look back, right?" A passage that explained this "letting go" idea, according to this participant was in Luke (9: 59-62):

To another he said, "Follow me." But he said, "Lord, first let me go and bury my father." But Jesus said to him, "Let the dead bury their own dead; but as for you, go and proclaim the kingdom of God." Another said, "I will follow you, Lord; but let me first say farewell to those at my home." Jesus said to him, "No one who puts a hand to the plow and looks back is fit for the kingdom of God."

A Good Patient Model

A type of ideal good patient living with terminal disease, in general, is "passively compliant with societal norms, family wishes, or health providers' recommendations," (Proulx & Jacelon, 2004, p. 118) and religious regulations. A good patient also does not "burden others nor . . . drain economic and medical resources that could be put to better use in the service of individuals who are economically productive" (Proulx & Jacelon, 2004, p. 118). Additionally, some healthcare providers believe that a good patient, who does not complain and accepts death, is a positive thinking person. One non-Mennonite person who worked with some LGS Mennonites stated, "They (the LGS Mennonites) are

good patients. They do not complain, and they will follow whatever the physicians tell them to do. I think we should learn something from them. Be positive. Do not complain every day.” I asked the person to explain the idea of “be positive,” and he said, “Stop complaining. It is about if the glass is half full or half empty.”

The idea of not complaining means being positive and appreciative, according to my observation, and was reproduced in different social sectors among both healthcare providers and LGS Mennonites. For example, when I told my chickenpox story to the participants, some of them would interpret my ‘why’ question (Why can it not be easier for the service users?) as a complaint. “I cannot believe you are complaining about that,” a healthcare provider with a Mennonite background said. An LGS Mennonite individual responded, “We have everything in Canada.” I asked the healthcare provider the reason for taking my words as a complaint rather than looking at it as a suggestion or a question. I continued, “I wondered if some things could be done to make people’s, especially the service users’, lives easier.” He was quiet for a while, and said, “I think people sometimes forget about what they have. Life is not only about being easier.” I also asked the LGS Mennonite participant the same question, and the answer was that “our minister said, ‘people who complain do not have clean hearts. They need to pray more.’”

A Good Model of Palliative Care

Unfortunately, it seemed that there were more restrictions on complaining than suggestions for people to express their emotional, physical, cultural, and spiritual needs in proper ways. The non-complaining rule may have put some pressure on both the health care service users and healthcare providers. A non-Mennonite nurse said, “It is hard,

sometimes; unless you are born in their culture, you just do not know how to help them. They do not tell you what they **need**.” It is undeniable that the cultural and language issues might have led to some distrust or miscommunication between the two parties. However, the cultural rules related to emotional control and not complaining might also have played an important role, because they have prevented the patients from expressing their unmet needs, and felt dissatisfactions. In other words, social and cultural norms have put pressure on people in that they should not experience certain kind of emotions, especially the negative ones (Tice & Bratslavsky, 2000; Burkitt, 1997).

To provide a good palliative care service, according to some experienced healthcare providers, is “to know your patients; to know what they NEED.” People generally only focus on how people die when they are thinking of palliative care. However, one of the palliative care nurses in this study said that

palliative care is not all about death. It is about living as well . . . How the person can live with the terminal illness and face the approaching death is important. It is not only about the medicalization of the death, but also about **care**; how they want to be treated. I have patients who called me simply because they **wanted** to talk to somebody.

Moreover, this nurse stated, “it takes time for them to **share** their feelings and thoughts with you.” Another nurse working with the LGS Mennonites also stated, “Sometimes, you need to cite the *Bible*, so that they will **know** that it is ‘OK’ to **express** their emotions or to **say** what they need.”

Summary

Palliative care is an abstract term for some LGS Mennonites, and its interchangeability with other terms, such as hospice care, and palliative hospice care, has

led to some confusion among the healthcare providers as well. Palliative care, as a multi-dimensional service, was given different meanings by people from the local communities that contradicted its ultimate goal, which was to improve the quality of life. The data gathered in three field sites revealed some of the LGS Mennonites' understandings of palliative care based on their practices of life instead of the "*practices of death*."

The way that the LGS Mennonites care for dying people indicated that a holistic approach to palliative care is more than looking after the sum total of different aspects of life. A life's fulfillment and satisfaction may come from a hope, which is a promise that one will be treated as a whole through a healing process. The LGS Mennonites' resettlements in different countries may be examples of collective healing processes. The LGS Mennonites generally believe in the Christ-like lifestyle and try to live in that way to witness the larger society quietly (Snyder, 1995; Schroeder, 2001). This is God's demand regardless of "whether the outcome will mean success or whether they have persuaded others to line up with them" (Snyder, 1995, p. xi).

The LGS Mennonites, especially the conservative ones, may not actively approach and persuade "outsiders" to become Christians. However, their practices of certain lifestyles have showed the "outsiders" when they moved from one place to another that the relationship¹⁴ between God and people is real. This is to say that the relationship between people and God exists in the physical world, and is reflected in people's daily experiences, and performances of their social roles, as mothers, fathers, and "brothers" or "sisters." It is a belief among the LGS Mennonites that there is only

¹⁴ See the discussion about the relationship between God and the deepest self provided by Charles Davis in *Body as Spirit: The Nature of Religious Feeling*.

one world, which is God's world (Schroeder, 2001). This is an absolute fact, truth, and reality; therefore, people should behave according to what God says unless they want to be "outside" of His world.

The ethnographic data also revealed some issues related to care for the end-of-life among the LGS Mennonites. The power control within the communities, and the lack of information on alternative strategies for coping with death and dying, in addition to the idea of accepting death "without complaining," may have prevented the LGS Mennonites from expressing their physical, emotional, and cultural needs to healthcare providers. However, meeting the service users' needs is the fundamental rule for setting up a good palliative care model. In the following chapter, I summarized the major lessons I learned from the LGS Mennonites and healthcare providers. In addition, I provided some suggestions that may help to improve the palliative care services for the LGS Mennonites.

Chapter Nine: Lessons Learned and Suggestions

It has been almost two years of working with the LGS Mennonites and healthcare providers who provide different kinds of services to this group of people. From Mexico to Canada, I have encountered healthcare providers whose good intention of providing help has been ignored, and who have been criticized for not being helpful. I also have talked to LGS Mennonites who are looking for help from health care practitioners, and whose fear of asking for help from outsiders has been ignored. In this chapter, I provide some lessons I have learned, such as a short reflection on the “gap” between palliative care in official definitions and in the LGS Mennonites’ daily lives, which aims to give a general review of how the dying persons can easily be excluded from the mainstream health care system when they are using the palliative services. I have also offered some suggestions, and I hope they are useful for both the ordinary LGS Mennonites and healthcare providers.

Lessons Learned

Lesson 1: Religion Is Part of Life

It is not a secret that the LGS Mennonite people believe in Christianity, but I became cautious about calling Christianity their religious belief after working with them for a few months in the communities. I realized that following God, serving Him, and being with God through Jesus Christ were part of their lives. It is similar to the First Nations people’s worship of the sun, and the secret mountains, or the fishermen’s worship of the ocean. “For Mennonites, religion was more than a set of beliefs; it was life itself” (Taves, 1995, p. 2). Some people do not value biblical knowledge and treat it as

“superstitious,” but the LGS Mennonites believe in the *Bible* as the absolute and the only truth, which should not be questioned, challenged, or doubted.

Lesson Two: The Sense of Hope

There were two kinds of hope involved in the discourse of caring and healing. The first one was God’s promise. For the LGS Mennonites, God is a healer who promises them a future, and that promise will happen eventually, but not yet. Another hope is from the modern technology and biomedicine represented by the healthcare providers working in the formal sector. This hope, in contrast, does not provide the sense of certainty because no one can be sure if it can become a reality before some medical experiments or procedures are conducted. According to Mellor and Shilling (1993), to a certain degree, many religious practices have provided a sense of security to the believers when coping with death and dying, and that is also the main reason why religious beliefs cannot be replaced by scientific knowledge in which the sense of uncertainty is embedded.

Lesson Three: The Gap between Official Definitions and Practices of Palliative Care

As with many other anthropologists and ethnographers, my first primary data are from the participants in this project and nearly eight months of community life in two countries. In addition, I have collected my secondary data for this project by reading the *Bible*, and by reviewing different types of literature related to Mennonites, especially the LGS Mennonites’ concepts of death, dying, religion and palliative care. I have tried to relate all the core elements represented in different palliative care-related articles to the LGS Mennonites’ lives I have observed. It has been a great and rewarding opportunity for me to see how different elements, such as economic, cultural, and religious factors

have played out in their everyday lives in terms of palliative care giving and receiving. Early in the study, I felt that something was missing between various palliative care instructions or guidelines and the LGS Mennonites' social lives, such as addressing a dying person's dignity as emphasized in some definitions, but avoiding discussion about dignity among the LGS Mennonites.

I was confused and could not identify what was missing exactly until one LGS Mennonite participant, a friend of mine as well, asked me, "LingLing, which part of our culture do you like the best?" I asked him to explain his question, and he said, "Do you like our food, beliefs or, you know . . . lifestyle, maybe?" His question made me realize that in the definitions of palliative care there were no **agents**, identified clearly. This is to say that according to the definitions given in the literature review, palliative care services are supposed to be **provided by caregivers, or are identified as teamwork performed by caregivers.**

However, in some definitions, such as the one given by the WHO (2002), the term *palliative care* has replaced the term *caregiver*. This seems to remove the human element from the term palliative care, and makes it a cold, neutral program without the human capacity to care. Through shifting definitions, it has become a commodity that on its own does nothing. It relies on the capacities of the healthcare providers who are involved in different palliative care programs to become the real caregivers. No matter how well designed the programs may be, if we do not consider the agents who provide the care as part of their definition, the term *palliative care services* will be meaningless.

Additionally, palliative care is "an approach" (WHO, 2002; Health Canada, 2009;

EACP, 2009), and “a form of care” (CMMS, 2008) used to “address” different aspects of a dying person’s life, or to “[affirm] life and regards dying as a normal process” (WHO, 2002). In this case, the role of palliative care is switched from the “caregiver” to a controlling force, which reflects a great value placed on “controlling” various aspects of life as a way to normalize the dying person.

There is nothing wrong with the good intentions of providing care for the dying people and their family members. However, problems arise from the ideology behind these definitions. For example, in these definitions, dying people are categorized into the group of passive palliative care receivers by not being identified as active agents working with other healthcare providers to provide care for themselves. To make my point clear, I also will use the definition of palliative care given by WHO to illustrate how the dying people are excluded from the group of active caregivers. Moreover, in this definition, I bolded and italicized the “*agents*” that “*provide*” palliative care (who does what). The definition of palliative care (WHO, 2002) is:

Palliative care is an approach ***that*** improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by ***means*** of early identification and impeccable ***assessment*** and ***treatment*** of pain and other problems, physical, psychosocial and spiritual. **Palliative care:**

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient’s illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;

- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

If we replace the black dots with the omitted phrase, palliative care, at the beginning of each sentence in the listed, then it should look like this:

- Palliative care** provides relief from pain and other distressing symptoms;
- Palliative care** affirms life and regards dying as a normal process;
- Palliative care** intends neither to hasten nor to postpone death;
- Palliative care** integrates the psychological and spiritual aspects of patient care;
- Palliative care** offers a support system to help patients live as actively as possible until death;
- Palliative care** offers a support system to help the family cope during the patient's illness and in their own bereavement;
- Palliative care** uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- Palliative care** will enhance quality of life, and may also positively influence the course of illness;
- Palliative care** is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

The lack of agents and the exclusion of dying people were the main reasons why I could not see all the important aspects addressed in some palliative care definitions and guidelines in the LGS Mennonite communities. The definitions are information that the service users need to know about palliative care. In other words, whom the dying persons and their families are **working with**, and how they will work together are not clearly stated in the definitions. This definition, in a way, is certain about what the palliative care can **give to** people who use it. However, it fails to address how the dying persons or

people living with terminal diseases, and their family members can be included into this service¹⁵ as active agents.

In the LGS Mennonite communities, generally palliative care, or care for the-end-of-life, was provided through the community members' performances of mutuality, including "mutuality of recognition; regular and mutual affirmation and certification" (Driedger, 2000, p. 72), and mutual aid (Buller, 1998) as well as mutual love (Snyder, 1995). The most important point is that generally the dying persons are in their cultural contexts, meaning they not only identify each other as brothers and sisters, but also include each other in care for the end-of-life, such as praying together as a family.

The LGS Mennonites' beliefs are embedded in the way they care for their dying family members. The rituals, such as funeral services, family reunions, and church services, involved in care giving reinforced people's identity as God's followers, as well as the integrity of the LGS Mennonite communities. However, the rituals themselves do not control people's lives. For example, instead of saying palliative care protects a patient's dignity, the LGS Mennonites said, "God is a God not of disorder but of peace" (1 Corinthians 14:33), and the conservative members did not talk about dignity in terms of personal choices. Rather, it is closely associated with God's mercy and glory since

¹⁵ This is not a critique of the writers' style, or an exploration of written English linguistic issues. It is a reminder that many non-English speakers, such as some LGS Mennonites, want to know what palliative care is before using it. Excluding service providers and receivers in the definitions can objectify palliative care services, which risks objectifying the service users and "blaming the victims." In other words, it is people's own faults if they feel the services have not met their needs because the definition or definitions clearly state what the services **give**, such as enhancing the quality of life of its users regardless of whether or not the quality of life is defined from the dying person's perspective.

God is the creator who “gives us lives and promised us a future,” an LGS Mennonite said.

Lesson Four: The Individual and the Community

How the LGS Mennonites regulate their communities, in a way, contradicted how the nation, for example Canada, has been controlled. For the LGS Mennonites, in general, the ideology is that what is good for the community (God’s kingdom, or the body of Christ) is good for the individual (a disciple), and the national development strategy used in Canada is based on the idea that what is good for some of the individuals (oil-gas industry) is good for the community (the nation).

Lesson Five: Death as a Social Lesson

Death is a private process through which people reconcile their relationships, but it is also a community affair. Communities’ involvements can be found in every aspect of people’s lives, from accompanying a dying person and helping with housework to financial aids, and reflect the importance of social relationships and social networks in the LGS Mennonites’ cultural practices. More than that, a funeral is a significant social event for the LGS Mennonites, too. Children from conservative families, in general, were encouraged to participate in the funerals regardless of the causes of the death. When I asked a lady why the parents did not stop children from seeing the deceased bodies, which might have been severely damaged due to accidents, the lady said, “So they can show the kids what God can do in a second.” Therefore, it is reasonable to say that palliative care is a socially learned knowledge among the LGS Mennonites.

Lesson Six: Palliative Care as Part of Life

Palliative care is not merely about how to die. Instead, it is about how to **live meaningfully** in the present life as an ordinary person does even at the end of life. This care process, regardless if it is called dying or living in the final stage of life, may be seen as a healing ritual. Simultaneously, the LGS Mennonites regain their identity and the sense of wholeness by reconfirming their faith and trust in God and in other disciples before they die. Through the ritual, the dying people repent their sins, reconciling their relationship with God, and ask or give forgiveness, which leads them to be close to God. Finally, they leave God's kingdom on earth with the hope that they can go to heaven. If God accepts them, their bodies re-join their souls and minds on the resurrection day, which is a sense of completeness in contrast to living in the broken physical world as sinners. However, as Zahourek (2009) indicated,

Healing takes time, but that time is relative. Healing may take seconds or decades. Healing is like pain in that it is defined by the individual and is therefore dependent on the person's recognition of a change or shift. (p. 17)

Lesson Seven: A Culturally Constructed Respectful (Good) Death

The research data indicated that a respectful (good) death is a personal and community "plan" in that people have to be ready or prepared to meet God. It takes time to "plan" for the end of life, and actions have been taken on both personal and community levels. For example, going to church services helps people accept physical death as inevitable, and praying for God's mercy is associated with getting into an eternal world after death. A "well planned death," in a way, helps the individuals to be ready to face their death, which may create a peaceful environment for both the dying people and

others around them. This is not to suggest that healthcare providers train their patients to be “good patients,” who should accept death without expressing their dissatisfactions.

Lesson Eight: Cultural Knowledge and Misrepresentation

Some healthcare providers perceived the LGS Mennonites’ non-complaint principle as a positive thinking style, which confirmed a cultural norm of emotional expression or emotional control (Srivastava, 2007; Kowalski, 2002). I did not analyze how the promotion of non-complaint has affected the cross-cultural communication between healthcare providers and the LGS Mennonites since I did not have sufficient data related to this topic. However, equating non-complaint with positive thinking instead of looking at it as a form of emotional control may create or impose some pressure on the LGS Mennonites to explain themselves, and to express their needs. The reason was that some Mennonites perceive some behaviours, such as making suggestions, articulating their needs, and asking questions, as forms of complaining, which violate their belief in non-complaining. Therefore, the healthcare providers’ endorsement of non-complaint may result in the LGS Mennonites’ reluctance to raise their concerns and questions. This, in turn, can create more obstacles for the healthcare providers to understand their LGS Mennonite patients.

Lesson Nine: Need for Attention

A growing concern about and attention to the increased ethnic population and cultural diversity within Western societies “is essential in developing equity of access to service provision in palliative care” (McGrath, Vun, & McLeod, 2001, p. 305).

Lesson Ten: Dying at Home

“Wanting to die at home” is not only a wish to stay at home, a familiar social place, and being surrounded by family members, friends, and loved ones, but also an expression of how some dying people want to spend the rest of their lives. This wish is closely related to their beliefs of how to live well (Park, 2010), or to live meaningfully. An example was a handmade thank-you card a healthcare provider who provided palliative care services to people dying at home received from a patient’s family. The front picture of this card was the patient lying on a comfortable bed, looking out the window at the farm on which the person spent an entire life. At the same time, the patient was petting the dog, “Miss Will,” sitting next to the bed. Inside the card, the family wrote, “This is what dying at home is all about! We wouldn’t have wanted it any other way. . . . Thanks!” The healthcare provider said, “I was so glad that I could help [the patient] to live in the way [the person] wanted. . . . For the patient, and for the family, that was the best way to live for the rest of [that person’s life].”

Suggestions

I hope the following suggestions are useful and helpful for healthcare providers and different health care organizations that provide health-related care to the LGS Mennonite population.

Suggestion One: The Biblical Knowledge

To help the LGS Mennonites, especially the conservative ones, it may be useful if the healthcare providers can gain a general understanding of God’s word. Additionally, it is not reasonable to blame people, especially the new immigrants, for what they do not

know, meaning if they do not know and understand what palliative care is, they may not be able to use it. It is the health care organizations' and providers' responsibilities to provide them the information related to the alternative options that can help them to improve their well-being. However, it is understandable that in some locations, there are more obstacles to approaching these people than there are in other locations for various reasons.

Suggestion Two: Respect and Consideration

Some public health institutions (there are different health care institutions) may place more emphasis on the mainstream cultures and less emphasis on the needs of minority groups. People may argue that their main clients are from the majority who do not have restrictive religious rules. However, regardless of the restrictions imposed upon some LGS Mennonites, especially the conservative ones, the hospitals or healthcare centres should respect their clients' cultural practices, especially in a multi-cultural country, such as Canada. This respect is not only from the healthcare providers as individuals, but also from the administration level. The interior designs or decorations of health care organizations, in a way, may reflect the institutions' attitudes towards, and considerations for local minority groups' social, cultural and physical needs.

Suggestion Three: Workshops

Low German language and cultural workshops can be given to non-LGS Mennonite healthcare providers, so that they can have a basic understanding of this specific group. In addition, training in cultural diversity can be organized and given, by minority leaders (the ethnic leadership), which can help healthcare practitioners, patients,

and the family members reduce emotional stress and avoid misunderstandings. Some “academic terms” do not make any sense to the LGS Mennonites, especially those who do not speak English, so it may be useful to explain the services instead of making generalizations.

Suggestion Four: Developing Caring Networks

Paying attention to dying people’s various needs is a way to support them to “live their dying” (Home Hospice, 2008, para. 1). The development of caring networks in which the healthcare providers, such as physicians and palliative care nurses, should be included is essential to meet these needs. For example, the caring networks should be able to provide healthcare-related guidance, advice, and supports (Home Hospice, 2008) for people who are looking after their dying family members at home.

Suggestion Five: Mutual Aid

A mutual understanding between the health care providers and LGS Mennonites has to be promoted. Sometimes the patients and their families respond to the physicians and other healthcare practitioners with fear, which may be a result of their negative experiences, and not with understanding, in the sense that some patients expect the clinicians to know everything and to take complete charge of their diseases. However, healthcare providers are also limited to their knowledge and experiences. It is an ideal or an expectation that the health care providers should know their patients, the patients’ diseases and the patients’ needs. Therefore, it is necessary for the patients to recognize the limitations of the physicians and respect them in terms of the efforts they are making or their willingness to help the patients to pursue their well-being in new routes.

Some people have argued that it is not the patients' responsibility to tell the healthcare practitioners their cultural beliefs and practices. Nonetheless, the question, "How can the healthcare providers have a better understanding of their patients' needs if their clients refuse to provide some relevant information?" remains unanswered. Therefore, it is necessary to encourage the LGS Mennonites to express themselves.

Suggestion Six: Be Aware: Betwixt and Between

The interconnection between people's understandings of caring and healing and their interpretations of the role healthcare providers play in palliative care services can be challenging (Dane, 2004). That is to say that the healthcare providers have to be aware that like their LGS Mennonite patients, they are also in a betwixt and between situation. They are betwixt: on one hand, the healthcare providers represent the state, authority and control, but they may be seen as being called by God to cure His people's diseases. On the other hand, the healthcare providers are seen as the representations of God's love, promise, and magical power, but their work, in general, is based on scientific knowledge and logic. Indeed, healthcare providers have to obey various institutional regulations. They are in between: on one hand many healthcare providers have tried to provide a "holistic" health care to patients by addressing their social and cultural conditions related to the patients' diseases. On the other hand, people may believe that healthcare providers are in charge of the diseases only. Therefore, the healthcare providers may need to reflect on their roles and positions during the process of providing palliative care.

Suggestion Seven: The Acknowledgement of Hope

Holt (2000), in one of his studies of the concept of hope among the Dominican

people, stated, “Hope is an essential but dynamic life force that grows out of faith in God, is supported by relationships, resources and work, and results in the energy necessary to work for a desired future. Hope gives meaning and happiness” (p. 1116). It is necessary to encourage the LGS Mennonite service users to recognize **hope** in palliative care, and to perceive palliative care as “a source of hope” (Woelk, 2008, p. 1243). The healthcare providers should inform their patients or clients that through using this service, they will work together. In addition, the healthcare providers should clearly indicate that their roles as assistants to help the service users “look at the situation openly, acknowledging hope or confronting feelings of hopelessness” (Holt & Reeves, 2001, p. 125).

Suggestion Eight: A Program Is a Program

Palliative care services are particularly valuable when they assist the dying people to maximize their ability to perform their social roles, or to adjust their social roles to be “more compatible with their life-styles” (Martocchio, 1982, p. 141). Palliative care intends to help people to achieve their dignity, the sense of wholeness. Therefore, it is important to include the dying person (and other support people) in this process. Death acceptance and death denying can exist at the same time; anxiety or uncertainty and “recovering” can exist at the same time, too. People can only have social and emotional supports and help when they are included in social networks and relations. Also, there is no program that can replace people to provide care to others in need. Therefore, I suggest that the partnership between service users and healthcare providers should be identified in the definitions of palliative care. For example, instead of saying palliative care will enhance quality of life, it may be reasonable to say that palliative care providers work

with and help the service users, and their family members to protect and enhance the quality of life.

Suggestion Nine: Being Patient

Sometimes, the LGS Mennonites do not ask questions related to their health conditions for the reasons of language barriers, the lack of health and medicine-related knowledge, uncertainties associated with social policies, and fears of discrimination, of being accused of complaining, or of having contacts with “outsiders.” However, this does not mean they do not want to know. It is important to be patient, because sometimes it takes much effort for them to express themselves.

Summary

“Who am I if I am not you?” John Alderton, (as cited in Actor's Date with Family History, 2003. Para. 10).

In this final chapter, I have provided some of the main lessons I have learned, and some recommendations based on the data collected during the last two years. Certainly, I have learned more than I expected, and more than I can write in this thesis. The LGS Mennonites’ cultural emphases on community, the body of Christ, one of the most valuable lessons I have learned, is also reflected in their care for people who are dying and the families suffering from losing loved ones. However, no LGS Mennonite individuals I talked to indicated that they intended to provide supports to sick people and the families from a “holistic” perspective. Instead, there were many concerns about what the dying person and the family needed. The LGS Mennonite participants taught me that people who were involved in care for the-end-of life are caregivers and not the churches

or health services institutions themselves. Additionally, the care the LGS Mennonites provided generally was based on what the dying person and his or her family needed.

There were two general attitudes I encountered during my research with healthcare providers. The first one was that “we should approach these people (the LGS Mennonites) instead of sitting in the office and waiting for them to find us if we really want to help,” said a staff member from MCC Canada. The second one was that

They are nice people, but they need to be educated. This is Canada. You know, you have to obey the laws; you have to send your kids to school; you cannot abuse your children . . . They do not understand that it has nothing to do with the *Bible*. I mean you cannot use the *Bible* against the law. They are not comparable. Frustrating sometimes, but they are very, very nice. (A healthcare provider with no Christian background)

An interesting, but unfortunate point this person made was that the *Bible* is a book whose power is based on people’s beliefs, and the law itself is an authority, which has to be followed by everyone in this society. This is not arguing that people do not have to obey the law. Rather, it provides an insight into how an “insider’s” knowledge was degraded and separated from daily life, and how that person might have been pushed away by making an assumption that the LGS Mennonites are “obsessed with the *Bible*,” as the same person stated.

Overall, health care programs do not provide any care or supports, but people who are involved in these programs do, so it is not necessary to define the term, palliative care from a neutral or objective perspective. In contrast, admitting that palliative care services are cultural products, and healthcare providers have their own limitations may be a way to make some improvements. Additionally, the healthcare providers and the LGS Mennonites are facing different challenges when working with each other, and being

aware of these challenges may be the first step to making a change or to setting up social networks between caregivers and care receivers.

Epilogue: From Strangers to Friends

I list several “episodes” that happened during my research, and I hope these small details can help future researchers to pay more attention to the details in people’s lives since cultural meanings come from social interactions.

- (1) “No, the *Bible* knows everything; Mom helps!” --My youngest brother, Di, in Mexico.
- (2) “God knows everything . . . Do you know He has a cell phone, too? Call Him!” --An LGS Mennonite participant
- (3) “Did you pray before coming to Canada? Do you pray now? Are you still going to pray after you finish your homework (the research)? --An LGS Mennonite participant
- (4) Mei asked, “Do you have books and CDs for learning Low German?”
“For what?” the LGS Mennonite staff member asked while looking at me, and asked again, “You want to learn High German, right?”
“No. *Plautdietsch*, Low German,” I answered.
“High German? They are different.”
“I know, but I want to learn *Plautdietsch*.”
“Low German? Are you crazy? It leads you to nowhere.”
“But my family here speaks Low German. I want to talk to them, right?”
- (5) “LingLing, you did a lot in three weeks, but one thing you have not done, yet,” an LGS Mennonite friend, Mr. Fast, said.
“What is that?” I asked.
“You have not criticized us yet; I have not heard you criticizing Mexico, yet.”
“Criticizing? For what?”
“I do not know; that is what people from Canada and the United States do. You got to find some reasons.”
“No, no . . . LingLing does not do that. She likes here,” Di said.
“Really? That is unusual!”
“En....Why do I have to criticize a place I feel is similar to the countryside of Beijing? Besides, I got all the attention I needed in three weeks. No, I would not criticize people who treated me as a superstar! Mei, too; she got a lot of attention, too” (laughing)

together).

Mei, "Oh, yes . . . in the funeral and in the graveyards; nobody knows what we were doing." (Laughing again).

(6) "We do not provide palliative care directly. Sometimes, we do, but it is usually just a few minutes; you know, then the patient died . . . I think you just want to hang out with cool guys."--A Healthcare provider participant, who became a good friend of mine.

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Appendices

Appendix A Ethical Approval (University of Lethbridge Human Subject Research Committee)

University of
Lethbridge



Office of
Research Services

4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2431
Fax 403.382.7185

www.uleth.ca/rch

CERTIFICATE OF HUMAN SUBJECT RESEARCH University of Lethbridge Human Subject Research Committee

PRINCIPAL INVESTIGATOR: HaiYan (LingLing) Fan

ADDRESS: Department of Anthropology
University of Lethbridge
4401 University Drive
Lethbridge, AB
T1K 3M4

PROJECT TITLE: Medical Encounters in "Closed Religious Communities":
Palliative Care for Mennonite People
(Protocol #901)

FUNDING SOURCE: Canadian Institutes for Health Research

The Human Subject Research Committee, having reviewed the above-named proposal on matters relating to the ethics of human subject research, approves the procedures proposed and certifies that the treatment of human subjects will be in accordance with the Tri-Council Policy Statement, and University policy.

may mckee
Human Subject Research Committee

February 24/10
Date

Appendix B

Ethical Approval (Regional Health Authority Central Manitoba Inc.)



March 4, 2010

LingLing Fan
37 Berkely Place
Lethbridge, Alberta
T1K 4G9

CORPORATE OFFICE
180 Centennaire Drive
Southport MB R0H 1N0
Tel.: (204) 428-2744
Fax.: (204) 428-2774
Email: info@rha-central.mb.ca
Web Site: www.rha-central.mb.ca

BUREAU CENTRAL
180, rue Centennaire
Southport MB R0H 1N0
Tél.: (204) 428-2744
Téléc.: (204) 428-2774
Courriel : info@rha-central.mb.ca
Site web: www.rha-central.mb.ca

Dear LingLing,

Thank you for your request to conduct research in the Regional Health Authority – Central Manitoba. Your research proposal titled "**Medical Encounters in Closed Religious Communities: Palliative Care for Mennonite People**" has been reviewed by the region.

After careful consideration, it has been determined that this research proposal meets the requirements to conduct research in the region between March to the end of August, 2010.

Central Region is unable to accommodate your request to live in Boundary Trails Health Centre for 3 weeks. You are encouraged to explore accommodations in the local area.

Linda Buhr, Director of Health Services, will be your primary contact at Boundary Trails Health Centre. Linda can be reached at (204) 331-8800.

We wish you good luck in your study and look forward to receiving the results. Please forward a copy of the results to myself at khannah@rha-central.mb.ca.

Kindest Regards,

A handwritten signature of Kristine Hannah is enclosed in a small rectangular box.

Kristine Hannah
Regional Ethics Chair/Regional Program Director Quality Improvement & Risk Management
Regional Health Authority – Central Manitoba Inc.

cc: Linda Buhr, Director of Health Services, Boundary Trails Health Centre
Dr. Ockie Persson, Chief of Staff, Boundary Trails Health Centre
Dr. Cornelius Woelk, Regional Medical Director of Palliative Care
Paulette Goossen, Regional Director Seniors & Palliative Care
Ardith Rothwell, Vice President Programs & South Services
Dr. Denis Fortier, Vice President Medical

Appendix C Ethical Approval (Alberta Health Services)



Chinook Health Regional Research Committee
Attn: Trudi Jersak, Admin. Support
960 – 19th Street South
Lethbridge, AB T1J 1W5

June 2, 2010

LingLing Fan
601 – 37 Berkely Place
Lethbridge, AB
T1K 4G9

lingling.fan@uleth.ca

Dear Ms. Fan:

Re: Research Study Proposal / File # 2010-03
Medical Encounters in "Closed Religious Communities": Palliative Care for
Mennonite People

The above-noted proposal was presented to the Chinook Health Regional Research Committee on March 24, 2010. The following recommendations were provided by the committee:

1. As a student, please have supervisor sign the following statement: "I have read this application and I deem it satisfactory to submit to the Human Subject Research Committee for review."

As the Research Committee has received the above recommendation, approval is hereby provided for this study.

Yours truly,

A handwritten signature in black ink, appearing to read "Paul A. Easton".

Paul A. Easton, MD, PhD, FACP, FCCP, FRCPC, ABSM
Chairman – Chinook Health Regional Research Committee

PE/tj

cc: File

Appendix D

Interview Questions

1. What is your current position in this organization? What are your main duties within this position? Do you work as part of a team or do you work independently?
2. What does health mean to you? What does the care for the end-of-life or palliative care mean to you? How do you feel when someone is talking with you about death and dying? What does death and dying mean to you? What is your greatest fear about death?
3. What causes illness? Why do people become ill? Is illness different for women and men? The young and the old?
4. What is suffering? Why do people experience suffering? What causes suffering? Is it God's will if people suffer? Are we expected to suffer while on earth? Is illness a kind of suffering? Is death a kind of suffering?
5. Who provides care for a sick family member or a dying person? Are there any other organizations or individuals (for example, churches, and counsellors) involved in the care for the end-of-life?
6. What kinds of medications are used to help people who are receiving palliative care to deal with the pain? With other problems, such as nausea or vomiting? Are these biomedicines or ethnic medicines? Do you buy the medications over the counter? What types of Canadian medications are used?
7. What types of services are available as palliative care in this centre/ hospital? What are the hardest things for caregivers to do when providing the palliative care for dying people? Have you experienced any difficulties or issues when providing health services/social services for Mennonite people?
8. How do you "introduce" or explain suffering, death, and dying to your child patients who are receiving palliative care/the care for the end-of-life?
9. If a dying person is in hospital, what type of care do you expect? What type of care do you expect if the person is dying at home?
10. How do you perceive the doctor-patient-family relationships? Are these relationships marked by conflicts, cooperation, or other characteristics?
11. Are there any special supports provided for patients who want to die at home? If "yes", then what kind of social and medical supports will the patient receive if he or she wants to die at home?
12. How do you prepare the families to face the prospect of unplugging a loved one from a life support system? Are you/your patients familiar with end-of-life directives? What will their families do when patients do not have a plan for how

they will be cared for if they become seriously hurt or ill? Would it be all right for you or your patients to make one?

13. Do you help the family make decisions about things that may prevent death (surgery or transplant)? Are there any individuals or organizations other than family members (e.g. churches and ministers) involved in decision making?
14. What suggestions would you give to change the way the care was delivered to better meet your needs? What suggestions would you give to your patients and their family members in terms of how to improve the quality and quantity of life when somebody is seriously ill?