

**CONSTRUCTING CULTURAL DIVERSITY: A
STUDY OF FRAMING CLIENTS AND CULTURE IN
A COMMUNITY HEALTH CENTRE**

By

Manju Prava Acharya

A Thesis

Submitted to the Faculty of Graduate Studies

In Partial Fulfilment of the Requirements for the Degree

Master of Arts

**Department of Anthropology
The University of Lethbridge
Lethbridge, Alberta Canada T1K 3M4**

© Manju Prava Acharya, 1996

ACKNOWLEDGEMENTS

I wish to express my profound gratitude to my supervisor, Dr. Norman L. Buchignani for his guidance, advice and encouragement during the course of this research, and for his constructive criticisms during the preparation of this manuscript. My sincere thanks are also to my supervisory committee members Dr. David Brown and Dr. Judith Kulig for their help and support all through my MA program. I am thankful to Dr. Brown for his thorough and critical review of an earlier draft of this manuscript.

I extend my sincere thanks to the entire staff of the Lethbridge Community Health Centre, and special gratitude to the community health nurses and their senior managers for their whole hearted cooperation during this research. I thank you all for putting up with me and my numerous questions for nine months.

I was helped by Paul Letkemann, Rumi Graham, Dough Frieble, Craig Walsh and Karen Freeman during the preparation of this manuscript. I hereby great fully acknowledge their help. Dr. Doreen Indra deserves special mention for starting me on this MA program and providing moral and emotional support during the two years.

My sincere thanks are also due to the University of Lethbridge and the Regional Centre for Health Promotion and Community Studies for their financial assistance through the Master's Stipend program. The University of Lethbridge Library staff deserves a special mention in this thesis for their timely support.

I express my loving thanks to my husband Surya who helped me immensely through his support, encouragement and love and my daughters Sheila and Sharmila for their patience and understanding. Finally, I wish to express my gratitude to my parents for their support and encouragement from afar.

TABLE OF CONTENTS

LIST OF TABLES	2
LIST OF FIGURES	3
INTRODUCTION	4
Organization of the Thesis	7
CANADIAN CULTURAL DIVERSITY AND THE HEALTH CARE DELIVERY SYSTEM	9
Increased Cultural Diversity in Canada and Southern Alberta	11
Urban Growth: An Attraction for Canada's Diverse Population	22
Multicultural Policies and Canada's Health Care System	27
Conclusion	41
THEORETICAL FRAMEWORKS FOR THE STUDY OF HEALTH INSTITUTIONS AS CULTURAL SYSTEMS	43
Culture and Institutional Culture	43
Study of Institutional Culture	47
Medical and Health Care Institutions As Interactive Cultural Systems	58
METHODOLOGY	64
Gaining Access	64
Data Collection Methods and Strategies: My Role and Experience	72
CHARTER, STRUCTURE AND EVERYDAY PRACTICE AT A COMMUNITY HEALTH CENTRE	82
The Community Health Centre's 'Identity'	85
Hierarchical Social Structure: the Bureaucratic Reality	107
"Cultural Diversity": Perceived Problem and Organizational Response	131
Conclusion	141
FRAMING CLIENT AND CULTURE	142
Client Identification : Making Cultural Sense	147
"Moral Responsibility": A Criterion for Client Differentiation	157
The Ambiguous Roles of Nurses in the Face of Client Diversity	176
CONCLUSION	179
REFERENCES CITED	185
APPENDICES	203

LIST OF TABLES

Table 1:	Total and Native population of Alberta and Lethbridge in 1971, 1981, 1991.	14
Table 2:	Registered Native Indians on and off-reserves in 1975, 1981, and 1991.....	15
Table 3:	Immigration to Canada by last permanent residence.....	18
Table 4:	Religious affiliation as % of total population in Alberta and Lethbridge - in 1971, 1981 and 1991.....	21
Table 5:	Urban population (%) of top four Canadian provinces from 1951-1986.....	23
Table 6:	Population by ethnic origin in the six largest Alberta cities in 1991.....	25

LIST OF FIGURES

Figure 1.	The informal reporting structure of the public health nursing program.....	111
Figure 2.	Interaction between micro and macro organizations (inter departmental and outside agencies).....	115
Figure 3:	Perceived attributes of the CHC client and the role of the CHC nurse.....	146

INTRODUCTION

The clinical community in Western society has long practised medicine as organized by “two dominant principles: 1) the principle of essentialism which states that there is a fixed “natural” border between disease and health, and 2) the principle of specific treatment which states that having revealed a disease, the doctor can, at least in principle, find the one, correct treatment. These principles have served as the legitimization of the traditional, hierarchical organization of health-care” (Jensen, 1987:19). A main feature of medical practices based on these principles has been to address specific kinds of problems impeding or decaying health. This research is centrally concerned with essentialism and the institutional fixation of problems as two important nodal points of Canada’s biomedical value and belief system. More specifically, I hope to show in an organized way how these principles shape staff knowledge of *client and culture* in a community health centre (CHC) in Lethbridge, Alberta. My analysis is based on four guiding points: 1) that in our polyethnic society health care institutions are massively challenged with actual and perceived cultural diversity and cross-cultural barriers to which their staff feel increasingly obliged to respond with their services; 2) while client cultural diversity is “real”, institutional responses depend primarily on how that diversity is imagined by staff –often as a threat to a health institution’s sociocultural world; 3) that problem-specific, medicalized thinking is central in this community health centre, even though its mandate is health promotion and this problem orientation often combines with medical essentialism to reduce “culturally different” to a set of client labels, some of which are problematic; and 4) while a “lifestyle model” and other models for health promotion are at present widely advocated and are to be found centrally in this institution’s (CHC) charter, they have led to little institutional accommodation to cultural diversity.

In this thesis my aim is to present an ethnographic portrait of a community health centre, where emphasis is given to the distinctive formal and informal “formative processes” (Good 1994) of social construction of certain perceived common core challenges facing the

Canadian biomedical community today—challenges concerning cultural difference and its incorporation into health care perception and practice. I am particularly interested in institutions subscribing to a “health promotion model” of health care, a term I have borrowed from Ewles and Simnett (1992). Ewles and Simnett describe the meaning of “health promotion” as earlier defined by WHO (World Health Organization):

this perspective is derived from a conception of “health” as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities (Ewles & Simnett, 1992:20).

Health is therefore concerned with “a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity” (Ewles and Simnett, 1992:6). I am interested in determining how threats to this definition prevail in a community health centre’s ideology of preventive care, and how that ideology encodes dimensions of diversity. I, however, want to go much further than this by exploring everyday staff discourse and practice, to understand how client cultural diversity is formed and informed by what staff do and say. How, in short, do individuals based in a health promotion organization socially construct their clients as objects of institutional concern? We need, as Young (1982) suggests, “to examine the social condition of knowledge production” in an institutionalized health care service provision subculture.

There are, I believe, also practical reasons for conducting this research. Over the past ten years the Canadian health care system increasingly has had to focus on two potentially contradictory goals: reducing costs, and lessening persistent inequalities in health status among key groups and categories of persons in the Canadian population. Many now argue that one of the most central dimensions of the latter—of persistent health inequalities in Canada—is ethnocultural. Few would seriously argue, for example, that Canadian First Nation health statistics are anything but appalling. Moreover, radical changes in immigration patterns over the past three decades have greatly increased urban Canadian cultural diversity.

Caring "at home" now assumes international dimensions (McAdoo, 1993; Butrin, 1992; Buchignani, 1991; Indra, 1991, 1987; Galanti, 1991; Dobson, 1991; Waxler-Morrison, 1990; Quereshi, 1989).

A growing voiced desire to provide more pluralistic health care and health care promotion has become persistently heard throughout the clinical community in Canada (Krepps and Kunimoto, 1994; Masi, 1993). Even so, for many health professionals cultural difference evidently remains either irrelevant or a threat to the established order of things. Applied research on health care institutions undertaken to investigate how better to meet these challenges nevertheless remains very incomplete and highly concentrated in two broad areas.

One of these is structural factors within the institution that limit cross-cultural access (Herzfeld, 1992; Hanson, 1980). Some of these studies have shown the prevalence of a strictly conservative institutional culture that frequently makes frontline agency workers gate-keepers, who actively (if unconsciously) maintain client-institution stratification (Ervin, 1993; Demain, 1989; Ng, 1987; Murphy, 1987; Indra 1987; Foster-Carter, 1987; de Voc 1981). In addition, extensive research has been conducted on disempowered minority groups. This research has examined the frequency, effectiveness and manner with which ethnic and Native groups make use of medical services.

Some institutional research on cross-cultural issues shows that under appropriate conditions health professionals like nurses have responded effectively to client needs by establishing culturally sensitive hiring and training policies and by restructuring their health care organizations (Terman, 1993; Henderson, 1992; Davis, 1992; Henkle, 1990; Burner, 1990). Though promising, this research remains radically insufficient for learning purposes. In particular, little work has been done on how such institutions come to "think" (Douglas, 1986) about cultural difference, form mandates in response to pressures to better address culturally different populations and work them into the institution's extant sub-cultural ideas and practice (Habarad, 1987; Leininger, 1978), or on how helping institutions categorize key populations such as "Indians" or "Vietnamese" as being culturally different, or assign to each

a suite of institutionally meaningful cultural attributes (as what becomes the institution's working sense of what is, say, "Vietnamese culture"). This is so despite the existence of a long and fruitful ethnographic institutional research tradition, grounded initially in theories of status and role (Frankel, 1988; Taylor, 1970; Parson, 1951), symbolic interactionism (Goffman, 1967, 1963, 1961), ethnomethodology (Garfinkle, 1975), and organizational sub-cultures (Douglas, 1992, 1986, 1982; Abegglen & Stalk, 1985; Ohnuki-Tierney, 1984; Teski, 1981; Blumers, 1969). More recent work on anthropological social exchange theory (Barth, 1981), on institutional and societal discipline (Herzfeld, 1992; Foucault, 1984, 1977), on the institution-client interface (Shield, 1988; Schwartzman, 1987, Ashworth, 1977, 1976, 1975), and on framing the client (Hazan, 1994; Denzin, 1992; Howard, 1991; Goffman, 1974).

I also hope that this study makes a contribution to the study of health care and diversity in southern Alberta. Small city ethnic relations in Canada have been almost systematically ignored by researchers, and similar research has not been conducted in this part of Alberta. Local diversity is significant: three very large Indian reserves are nearby, and the city itself has a diverse ethnic, linguistic and ethno-religious population.¹ Also, significant province-wide restructuring of health care delivery was and is ongoing, offering both the pitfalls and potentials of quick institutional change. Perhaps some of the findings here can contribute to making the future system more responsive to diversity than the present one.

Organization of the Thesis

It is traditional in anthropological research to use a "holistic" approach to the study of the culture of a community, institution, association, or group of people—one that is based on the notion of combining data on history, ideology and social relations. My study of the community health centre's institutional culture subscribes to that approach, and this is reflected in its chapter organization. Chapter One provides a basic contextualizing outline of sociohistorical changes in Canadian society, showing a gradual transformation of the

¹ See relevant tables in Chapter One.

population and of national cultural ideologies from a “monocultural” to a “bicultural” and finally to a “multicultural” base. This chapter also briefly traces the history of the Canadian health care system, highlighting public health initiatives. Chapter Two contextualizes the study theoretically. It discusses a range of social science models and traditions in the study of bureaucratic organizations and their cultures, with an emphasis on the study of health care institutions. Chapter Three outlines the research methods I employed during nine months of participant observation at the health centre that was the empirical focus of my research.

The analysis then shifts to a critical interpretive analysis in the final two chapters. In Chapter Four I investigate a range of institutionalized and subjective meanings of “culture” and “cultural diversity” in centre charters, institutional structure and staff-client relations. I then move from the domain of the formal and general to that of the informal and specific, showing that while staff were constrained by the former, they had great cognitive and instrumental power in the latter. Nevertheless, for reasons outlined there they did not often exercise that power to further facilitate either cross-cultural service delivery or cross-cultural understanding.

Chapter Five is an ethnographically-based analysis of bureaucratic client and problem classification. I demonstrate there how staff imbued with a local institutional culture informed by an essentialist problem orientation and faced with severe resource constraints partitioned their client universe into those who were seen as “responsible” and those who were not. Surprisingly, cultural difference was often used to explain, even to justify, client non-compliance among those so labelled; this lowered the risk that individuals from groups identified by staff as culturally different were considered “irresponsible”. Local First Nations people were *not* often considered to be culturally different in any such explanatory way, and they were repeatedly blamed for their lack of effective participation in centre programs. A brief summary conclusion follows thereafter.

CHAPTER ONE

CANADIAN CULTURAL DIVERSITY AND THE HEALTH CARE DELIVERY SYSTEM

Canadians live in a country of some nine million square kilometers in size occupied by a diverse population.² For a long time, this diversity was primarily identified with Native peoples, French, and the English. The French and the English Canadians were then the only ones referred to as charter members because they were the first Europeans to take possession of the land and to place governing structures there (Buchignani and Indra 1985:vi). In 1867, when a federal union came into existence, the fathers of Confederation proposed a new Canadian society acknowledging a very limited concept of cultural pluralism.³ Although narrow, diversity nevertheless was acknowledged to be an integral part of federal Canadian culture from the beginning. This was further clarified by Sir George Cartier when he wrote, "In our Federation, we shall have Catholic and Protestant, English, and French, Irish and Scotch. They are of different races, not for the purposes of warring against each other, but in order to compete and emulate for the general welfare" (Monet, 1992:21). A minimal concept of multiculturalism pertaining to Canada is thus not new. From the inception it was embedded in Canadian ideology, primarily highlighting the division between British and French. Canadian institutions and communities were chiefly built by the French and English, and there was an expectation that all other Canadians who were nationally, linguistically, and culturally different would and should assimilate to these charter groups.

Up to the 1960s, few Canadian institutions responded to the many service challenges this pluralistic society posed, working instead with a largely invariant, middle-class, gendered

² Please see Burnet and Palmer (1988) for a detailed analysis of Canada's people. They have shown that Canada was always multicultural in its ethnic composition, but that the depth and range of that diversity has increased dramatically in the last thirty years.

³ See Knowles (1992); Burnett and Palmer (1988).

image of their patients, clients and students.⁴ As well, cultural diversity was not an attractive or important topic for research until the 1970s, when issues pertaining to cultural/ethnic difference became more salient among some key Canadian institutions and service providers. Canadian government exemplified, indeed led, these changes by acknowledging and establishing cultural rights and privileges for all Canadians through a series of legislative acts passed from 1971 to the mid 1980s.⁵

Even so, while health care workers in everyday practice now frequently encounter co-workers, clients, and patients that have linguistic, religious, cultural and ethnic differences, the institutions in which they work have been particularly slow to adjust their agendas to more extensively to reflect cultural diversity. Substantial institutional accommodation remains rare. Indeed, this has attracted new anthropological and sociological research to the study of health care bureaucratic organization.⁶ In this light, the primary objectives of this chapter are contextual: to identify and summarize key demographic and political changes in Canadian society over this century and to relate them to changes in health care policy. I have divided my discussion into five sections. In the first two sections my discussion focusses on changes in Canada's population and on the forces that have brought cultural diversity to the forefront of discussion in the last twenty years. In the third section I provide an overview of the rise of Canadian multicultural policies and their implications for the Canadian health care

⁴ There virtually were no such programs in schools (Ashworth, 1975, 1977), immigrant settlement programs were almost non-existent (Indra, 1987; Ng, 1987), and there was very little helpful accommodation in social, police and health services.

⁵ In 1971 the federal government established multicultural policies; the Canadian Human Rights Act was passed in 1977; also in 1977 the Citizenship Act came into effect, a Multiculturalism Act followed in the 1980s. For detailed analysis please see Burnett and Palmer (1988).

⁶ There are number of good sources on health and culture research. See Ralph Masi, Mensah and McLeod (eds.), *Health and Cultures: Exploring Relationships*, vol. 1 and 2. Oakville: Mosaic Press, 1993. Also see B. Singh Bolaria and Rosemary Bolaria, *Racial Minorities, Medicine and Health*. Halifax: Fernwood Publishing, 1994.

system. The fourth section gives a brief history of the development of community-based health care. The final section of this chapter provides a basic overview of the community health center, its history and organizational structure.

Increased Cultural Diversity in Canada and Southern Alberta

Changes in Native Populations

Native peoples are the longest residing people of Canada. This category includes people whose ethnic origins are identified as being one or more of the following three categories: North American Indian (both status and non-status), Inuit and Metis. Among these are in turn peoples of diverse cultures, languages and lifestyles. Until recent decades these people were socially isolated. Even though they are the first inhabitants of Canada, they historically “were pushed to the fringes of Canadian society, and some of them are still isolated on reserves and in yet unexploited parts of the North” (Burnet & Palmer, 1988:4).

Native peoples nevertheless have rebounded strongly. These people on average now are much younger and have higher birth rates than the Canadian population as a whole. A rapid increase in their population, with more of them migrating into the cities and towns, is but one factor that has brought these people into social, demographic and constitutional prominence in Canadian society (Ponting, 1990).

Indeed, the proportion of people belonging to Native groups in the total Canadian population has been on the rise since the 1930s (Shah, 1993:80). According to the 1961 and 1971 census there were approximately 220,121 and 312,760 Native Indian and Inuit (Eskimo) people in

Canada, respectively.⁷ In the 1981 Census, the reporting methods concerning ethnic origin changed, in particular allowing all respondents to indicate multiple ethnic origins. In this Census it was estimated that the North American Indian, Inuit and Metis people constituted 2.0% (486,834) of the total Canadian population. In the 1986 mini-Census, 711,725 persons or 2.8% were identified as having aboriginal origins. According to the 1991 Census 1,002,675 people (3.7%) reported having aboriginal origins, either as their only ancestry or in combination with other origins (Statistics Canada, 1994), from which Statistics Canada estimates that there are 783,980 people of American Indian ancestry, 212,650 Metis and 49,255 Inuit in Canada (Canada Year Book, 1994). This is a remarkable increase of 41% from the 1986 Census.⁸

For the purpose of my study, the provincial Native population distribution is central. Among the Canadian provinces and the territories, the 1991 Canadian Census shows that the highest provincial Native population is in British Columbia, followed by Alberta and Saskatchewan. In Alberta, 158,790 First Nations people were enumerated during the 1991 Census, of whom 99,655 were Indians, 56,310 Metis and 2,825 Inuits (Statistics Canada, 1991 - Cat. No. 93-315:206-207). They constituted a significant 6% of Alberta's population (or one out of every seventeen Albertans) and their proportion evidently is increasing rapidly. With this increase

⁷ Source: Population figures: *Historical Statistics of Canada* (1983). Origins of the population, census dates, 1871 to 1971. Series A125-163. During this period persons whom the Canadian government registered as "Indians" were counted separately from the other aboriginal people who may have had the same ancestry, but were considered as "non-status Indians" because they did not meet the legal definition set out in the *Indian Act*. The same applies to Metis. Also during this period all ethnic origin data related to responses concerning only an individual's father's side. Therefore the population figures presented here may not be very accurate, as they discount native women who married interracially, and under-count native people on reserves and in cities.

⁸ This dramatic increase in aboriginal population could be partly due to changes brought to the *Indian Act* (Bill C-31) in 1985. Also due to the heightened attention that focused on aboriginal issues in the year leading up to the Census (Canada Year Book, 1994), and also because of the earlier undercounting.

a consequent increase in certain forms of cultural diversity can be expected (Samuel, 1986). This increase is not simply to be equated with diversity of identities or home practices. It also brings a different range of challenges to public service institutions, health care service providers in particular.

Lethbridge, a small urban center, is strategically situated near three important Indian reserves, upon which are based the Blood, Peigan and Siksika Indian Nations. Lethbridge has a population of 60,974 (Statistics Canada, 1991. Catalogue No. 95-381). However, services provided by this city are utilized by about 120,000⁹ people in the city and the surrounding area. It is estimated that in 1991 there were 1,490 Native peoples living in this community. But according to both the 1992/93 Aboriginal Peoples of Lethbridge Census and the Lethbridge District Census the total number of Natives residing in Lethbridge and adjacent towns were 1,984 and 3,189, respectively.¹⁰ This disparity in population figures support the generally accepted notion that the actual local Native population is highly uncertain, yet is considerably higher than suggested by figures typically presented by various government and non-government agencies. Urban native lifestyles involving frequent moves, lack of personal telephones or long-term fixed addresses, and refusals to participate in surveys which leads to a severe undercount of these people across the province.¹¹

⁹ Source: 1991 Census.

¹⁰ Source: The Aboriginal Peoples survey was sponsored by Zone 3 and Lethbridge Local 2003 of the Metis Nation of Alberta with the support of Employment Canada, 1994 with evaluation of data by Dr. Brigham Y. Card and Dr. Keith Perry. The Aboriginal population of the City of Lethbridge was surveyed in fall 1992. 18,758 or 74% of all city households were contacted and it was found that there were 1,038 Aboriginal people in the households contacted. Between January and April 1993, a smaller survey team surveyed 23 communities (towns, villages, and hamlets) in the Old Man River Regional Planning Commission, or the Lethbridge district. They also included Taber, Coaldale, Cardston, and Fort Macleod and found that these communities have the largest numbers of Aboriginal among the communities surveyed (pp. 2).

¹¹ The same trend is also found for Alberta's urban Native population. Source: *Native Seniors in Alberta: A Situation Report, 1995*.

The populations of local bands that use Lethbridge as a main service center has increased dramatically. As Table 2 indicates more than four thousand reside off reserve, a high proportion in and around Lethbridge; most of the ten thousand who do not nevertheless use Lethbridge as their major metropole for everything from grocery shopping to surgery.

Table 1: Total and Native population of Alberta and Lethbridge in 1971, 1981, 1991.¹²

Year	Population of Alberta		Population of Lethbridge	
	Total	Native only	Total	Native only
1971	1,627,874	44,545	40,856	145
1981	2,213,650	60,005	54,624	546
1991	2,519,185	158,790	60,940	1,490

¹² Figures are taken from: Lethbridge Urban Study, 1975 and 1985. The Lethbridge Social Planning Department for their publications have used figures from Statistics Canada, Catalogue No. 92-723 for 1971, and Census Canada 1981. 1991 Census figures are from Statistics Canada Catalogue No. 93-315: 206-207.

Table 2: Registered Native Indians on and off-reserves in 1975, 1981, and 1991.¹³

Band	Year	Total	On-Reserve	Off-Reserve	% Off-Reserve
Blood	1975	4,969	4,909	844	17.0
Blackfoot		2,706	1,961	738	27.3
Peigan Nation		1,611	1,334	275	17.1
Blood	1981	5,757	4,700	1,051	18.2
Blackfoot		3,062	2,059	989	32.3
Peigan Nation		1,796	1,340	450	25.1
Blood	1991	7,277	5,817	1,435	19.7
Siksika¹⁴ Nation		4,008	2,348	1,581	39.4
Peigan Nation		2,553	1,676	877	34.3

Change in Immigration Policy and in Local Immigrant-Origin Populations

Immigration has always been an important component of Canada's history. For generations it has allowed certain people from a variety of ethnic and national origins to enter, "bringing many distinctive outlooks, ideas, talents, experiences, and traditions to help shape Canada's response to the challenges of its environment" (Burnet and Palmer, 1988:3). Prior to Confederation, Canada's population grew primarily through immigration from England, Scotland and Ireland (Badet, 1994). Confederation led to the establishment of Canada's first

¹³ Source: Indian and Northern Affairs Canada, 1991 and 1992. The older source: Program Statistics Division, Management Co-ordination Branch, Indian and Eskimo Affairs Program, Department of Indian Affairs and Northern Development, 1975 and 1981.

¹⁴ The name changed from Blackfoot to Siksika Nation in 1990. Source: Indian and Northern Affairs Canada.

Immigration Act in 1869, and successive legislative and administrative changes made to immigration policy resulted in successive waves of immigrants entering Canada, each one from a greater range of countries. This helped first stabilize, then increase the Canadian population. It has also greatly changed the ethnic composition of this country over the last century.

The period 1896 to 1931 was characterized by massive immigration from Great Britain, the United States, Scandinavia, Germany, Holland and some Eastern European countries notably western Ukraine, Poland, and Hungary. This influx of new immigrants, as Knowles (1992) states, temporarily transformed western Canada into a polyglot society -- but one where cultural difference was sanctioned only in the private sphere, as there was little -- almost no -- institutional accommodation of these people in the public sphere. After a long hiatus (1931-1945), early postwar immigration brought hundreds of thousands of displaced persons and refugees from Europe to Canada (1946-1957). This was followed soon after by more Americans, British, Germans, and Dutch (1952 to 1960). Between 1955 and 1970 waves of Italians, Greeks, Hungarians and Portuguese also entered the country as traditional immigration biases against them were relaxed.

A radical restructuring of the immigration regulations took place in the 1960s. The Department of Manpower and Immigration was established in 1966 and with this came the incorporation of the so-called point system into the immigration regulations in 1967. Subsequently, new immigration regulations were introduced and the Immigration Appeal Board was established. Collectively these changes removed all residual racial, ethnic and national barriers, replacing them with a highly class-based set of selection criteria (Knowles, 1992; Burnet and Palmer, 1988; Bolaria, 1983; Basran, 1983). The Canadian immigration policy of the 1970s recognized basically three categories of immigration: 1) a *family class* to reunite families, including the immediate family, children and grandparents; 2) a *humanitarian class*, to provide safe haven for refugees; and 3) an *independent class*, to foster economic development by selecting business immigrants and skilled workers (Badets, 1994; Knowles, 1992).

This colour-blind, economically- and kinship- oriented policy radically shifted immigrant flows from Europe to other regions, especially Asia, the Middle East, and the Caribbean: more recently to Central and South America and some parts of Africa (Badets, 1994). For a couple of decades now family reunification has been central to immigration policy and this has amplified immigration from countries where extended kinship is central. As a result, in recent times, the majority of immigrants are from Asia, particularly from Hong Kong, China, the Indian subcontinent and the Philippines. According to the 1991 Census, it is estimated that “Asians” represented the largest continent-based group among recent arrivals (42%), followed by people of European and West Asian origin who comprise 22% and 8% of recent immigrants, respectively. The people of Caribbean and African origin make 6% and 4%, respectively (Badets, 1994: Catalogue No. 96-311E). This pattern prevailed throughout the 1980s (Logan, 1990:32) and will continue into year 2016 (Kelly, 1995). Kelly states that “the number of visible minority adults is projected by the government of Canada to triple between now and 2016 to just over six million” (1995:8). The same trend may also be seen in Lethbridge.

In the 1991 Census, people said to have British or French ancestry formed the largest ethnic populations in Canadian society. Their proportion is declining, however, with more and more Canadians claiming ethnic “roots” other than French or British. Also, in 1991 nearly eight million people, or 29% of the total population, reported more than one ethnic origin, indicating that they believed themselves to be of some kind of mixed ethnic ancestry (Badets, 1994). Among the Canadian-born, 4,879,340 people listed one or more ethnic origins other than British or French.

Table 3: Immigration to Canada by last permanent residence ¹⁵

Continent	1961		1971		1981		1991	
	Number	%	Number	%	Number	%	Number	%
Europe	52,132	72.7	52,031	43.0	44,784	34.8	46,651	20.2
Africa	1,088	1.5	2,841	2.4	5,901	4.6	16,530	7.2
Asia	2,706	3.8	22,171	18.3	50,759	39.5	122,228	53.0
N & C America	11,663	16.2	25,002	20.7	10,183	7.9	18,899	8.2
Caribbean	1,307	1.9	11,017	9.1	8,797	6.8	13,046	5.7
Australasia	1,432	2.0	2,902	2.4	1,020	0.8	735	0.3
S. America	1,301	1.9	5,058	4.1	6,114	4.8	10,468	4.5
Oceania	n/a ¹⁶		n/a		1,024	0.8	2,213	1.0
Other	60	0.0	878	0.0	36	0.0	11	0.0
Total	71,689	100	121,900	100	128,618	100	230,781	100

This increased diversity in national origins and identity has also changed the linguistic and religious composition of Canadian society. According to the 1991 Census, the percentage of the population who reported a language other than English or French as their mother tongue grew from 11% in 1986 to 13% in 1991, largely due to the growth in the number of recent immigrants with other mother tongues (Badets, 1994). In 1961, 1.3% of Canadians claimed not to know English or French. This figure rose to 1.5% in 1971. In 1981, there was

¹⁵ 1961 and 1971 figures are taken from *Historical Statistics of Canada*, 1983: Series 385-416. 1981 and 1991 figures from *Canada Year Book 1994*. These two monographs are published by Statistics Canada.

¹⁶ Data not available.

a small decline to 1.2%, which again turned around and rose to 1.4% in 1991.¹⁷ Besides the two official languages, there are many other languages spoken by Canadians. According to the 1991 Census, 702,000 speak Italian, 685,000 speak German, 557,000 speak some form of Chinese, and 402,000 speak Spanish. Native peoples alone speak some 50 languages belonging to 11 distinct families (Statistics Canada, 1994). The “home languages” which have grown most in recent years have been Chinese, Spanish and Punjabi while Italian, German and Ukrainian declined (Canada Year Book, 1994). Sensitivity to language diversity probably is one of the important issues that has challenged health care providers in providing culturally appropriate health information and in easing access to their clients.

Although the vast majority of Canadians report that they speak English or French, service providers across Canada consistently report that a very significant proportion of the population lacks basic fluency in either. Moreover, in recent years Canada has been accepting more immigrants from non-English speaking countries. On many occasions these people are the parents, spouses or close relatives of new Canadians from countries like China, Hong Kong, India and South America. The reality is that many of these people find it difficult to access services without additional knowledge of English or French. As a result, they are reported to shy away from accessing a number of public services. When they do try to access such services, language problems sometimes cause miscommunication between health professionals and clients (Kobayashi and Rosenberg, 1993; see Galanti, 1991 on the U.S.). Kobayashi and Rosenberg (1993) and others continue to link language barriers to inequality in health care service overall.

Religion has always played a key role in generating group solidarity and identities and also in establishing many institutional policies in Canadian society. According to the first Canadian Census (1871) the vast majority of the Canadians then had some religious affiliation: 98% of the population were then Christians (Catholic or Protestant), and the

¹⁷ Immigration is the cause of this increase.

number claiming no religious affiliation was negligible (Mori, 1990). Although Christians (Catholics and Protestants) remain the vast majority, their proportion of the population is on a gradual decline (96% in 1961, 89% in 1981, 83.1% in 1991). According to the 1991 Census, there were 45.7% Catholics, 36.2% Protestants, 1.5% Eastern Orthodoxies, 1.2% Jews, and 2.8% "Eastern non-Christians" living in Canada. Today it is estimated that 1 Canadian in 8 has no religion, while 1 in 35 is of a faith that stands outside the Judeo-Christian traditions (Canada Year Book, 1994). Moreover, disguised in the blanket "Christian" figures are now a range of churches and sects of an ethno-religious nature with significant representation in southern Alberta: Hutterite, "Mexican" Mennonites, Mormons, and others.¹⁸

¹⁸ So-called Mexcian Mennonites are primarily immigrants from rural Mexico, but others have come from other Latin American countries. "Mormons" are members of the church, Jesus Christ of the Latter Day Saints.

Table 4: Religious affiliation as % of total population in Alberta and Lethbridge - in 1971, 1981 and 1991. ¹⁹

Religion	1971		1981		1991	
	Alberta	Lethbridge	Alberta	Lethbridge	Alberta	Lethbridge
Catholic ²⁰	26.0	23.5	27.7	26.7	26.4	24.2
Protestant ²¹	59.2	63.1	56.1	60.2	48.3	54.6
Eastern Orthodox	5.3	2.8	2.2	1.1	1.7	-
Jewish	0.4	0.3	0.5	0.3	0.4	-
Non-Religious	6.6	6.1	11.7	9.8	20.0	16.3
Eastern Non-Christian	0.1	1.3	1.7	1.8	3.1	-
Other	2.4	2.9	0.1	0.1	0.1	4.9

With a few key exceptions the Province of Alberta and City of Lethbridge have similar religious denominations to the ones found nationally. Provincially, practitioners of eastern non-Christian religions have substantially increased in the last ten years. This can be attributed to an increase in the number of recent immigrants from non-Christian religious backgrounds, primarily from Asia and the Middle East, virtually all of whom practice their religion in Canada. They have set up temples, mosques, and gurudwaras, across the country,

¹⁹ Source: 1971 Census - Lethbridge Urban Study, 1975 used Statistics Canada, Catalogue No. 92-723; 1981 figures - Lethbridge Urban Study, 1985 which documented statistics from the Alberta Bureau of Statistics; 1991 Census figures for Alberta are taken from the Canada Year Book, 1994 and Lethbridge information from the City of Lethbridge's Economic Development Department.

²⁰ Includes Roman Catholic and Ukrainian Catholic.

²¹ Includes Anglican, Baptist, Jehovah's Witnesses, Latter-day Saints (Mormons), Lutheran, Mennonites, Hutterites, Pentecostal, Presbyterian, Salvation Army, United Church, and Protestant, not otherwise specified.

especially in larger centers like Toronto, Vancouver, Edmonton, Calgary and Winnipeg. Even a small city like Lethbridge now also has a mosque, an Ismaili center and several Buddhist churches. As noted, the Lethbridge region also is a center for several Christian sects and churches whose histories of oppression and outsider status have molded ethno-religious groups. The concentration of Hutterites around Lethbridge is greater than around any other Canadian city, though virtually none live in town. European-origin Mennonite immigrants from rural Mexico and other Latin American countries have come in increasing numbers to several local smaller towns and environs. Key pioneers of the Lethbridge region were Mormons, and perhaps 10 % of the city's population are now practitioners; this reaches over 80% in some local towns and hamlets.

Urban Growth: An Attraction for Canada's Diverse Population

At the time of Confederation Canada was primarily a rural society, and it remained such until this century. It is estimated that in 1851 only 13% of the Canadians lived in urban centers (Canada Year Book, 1994). Subsequently, urbanization has been a persistent feature of Canada's demographic history. A decline in farm-related jobs has generated much migration of rural populations into urban centers; the linked notion was that cities provide greater economic opportunities than the rural areas. By 1981, about 75% of the population was concentrated in urban areas (Michelson, 1988:75). This ratio has not changed in recent years.²² However, all Canadian provinces are not equally urban. Ontario, British Columbia, Alberta and Quebec are more urban than the rest of the provinces, whereas the Atlantic provinces are least so. The province of Alberta, despite a slow rate of urbanization during the mid 1980s, was well ahead of the national average in this regard. During the 1971-1986 period Alberta's economy boomed due to changes in oil and gas prices. Calgary's and

²² In Canada, for a settlement to qualify for 'urban' status requires a population of at least 1,000, and population density of 400 or more per square kilometer. The primary occupations of these people must not be based in farming, fishing, or hunting (see Burke, 1990; Michelson, 1988).

Edmonton's populations increased by 66% and 58% respectively during this time. While outside the main orbit of these industries Lethbridge experienced a steady population growth. The steady population growth of Lethbridge was mainly due to internal migration of farm owners and workers from surrounding areas, and from the development of local service-providing institutions. Lethbridge residents today are disproportionately (to Alberta's population) involved in public services or spin-offs from them: education, health care and old-age services, agricultural research and the like.

Table 5: Urban population (%) of top four Canadian provinces from 1951-1986. ²³

	Percent of urban population				
Province	1951	1961	1971	1981	1986
Canada	62	70	76	76	76
Alberta	48	63	76	77	79
Ontario	73	77	82	82	82
Quebec	67	74	81	78	78
B.C.	69	73	76	78	79

The 1991 Census also suggests that Canadians continue to migrate westward, making Alberta and British Columbia currently the most desirable places to live because of better economic opportunities and in British Columbia's case, milder weather. During the oil boom years (1976-1981) Alberta attracted a net migration of 200,000. While the province became one of the greatest population losers during the 1980s (Ram, 1991), this has reversed subsequently. (Canada Year Book, 1994).

²³ Source: Canadian Social Trend, vol. 1. 1990: Statistics presented in this volume are taken from Statistics Canada, Census of Canada.

Local rural-urban migration within Alberta has also increased significantly. A good transportation system and concentration of specialized services in cities have made rural/urban migration important and both have contributed to a greater concentration of services in cities. People who live in rural communities now routinely commute to access facilities in cities, while local facilities atrophy. This has implications for the health care service providers. They now not only have to serve people from the city, but also from an increasingly large surrounding area. Lethbridge as a small urban center in the southern part of Alberta illustrates this phenomenon well. It is a major regional center which provides special services to people from surrounding communities. Its proximity attracts a diverse population—Natives from the three reserves, Hutterites, Dutch, Mennonites, and others from the farms, as well as other people with linguistic, religious, cultural and ethnic diversity drawn from as far as 200 km away.

Native peoples mostly live in cities and towns

Stereotypes associating Natives with rural living notwithstanding, according to the Department of Indian and Northern Affairs (1991) 40% of registered Indians then resided off reserve and crown land. In fact, it is estimated that only 19% of those with Native origins now live on reserves (Matthews, 1994). In contrast, approximately 50% of Native peoples now live in cities and towns (Matthews, 1994:12). In Alberta, about 68% or 85,065 Native peoples lived off reserve in 1986. (Native Seniors in Alberta, 1994:10). This figure has risen to 110,000 according to the 1991 Census. About half of these people live in the six largest cities of Alberta; Lethbridge is one of these six cities.

Several reasons have been advanced for this large Native population movement to larger urban centers. Native peoples are more mobile than the non-natives and they change residence more often than the general population (Shah, 1993:81). In recent years, when the overall Canadian fertility rate has declined, the birth rate of Native population has remained high. This high birth rate among the Natives has made some reserves overcrowded, reserve jobs prospects are often rare. These factors have forced many to leave the reserve in search

of better living conditions in the cities. Some young Natives believe that in the cities employment and educational opportunities will be better than on the reserves, and so they migrate to urban areas. Finally, the need for facilities and services that are not available on reserve has drawn many Native peoples to the cities. Many Natives move to the city at least in part to access health services like hospitals, dental clinics, and physiotherapy facilities that are not available on reserve.

New Immigrants Settle Almost Exclusively in Urban Centers

New immigrants almost always settle in urban centers, and thus contribute significantly to increases in the size and diversity of these communities. In the early years of Canadian Confederation immigrants primarily settled in rural communities and hinterlands in response to policy efforts of the Canadian government to develop rural areas (Badets, 1994:28). After World War II Canadian economic diversification spurred a demand for skilled and unskilled industrial and construction workers, which contributed to the current urban pattern. Later, the point system adopted for selecting immigrants to Canada favored applicants with skills suited to “high-tech” urban settings rather than rural environments (Burke, 1990:39).

Immigrants during the last two decades have not evenly dispersed throughout the country. They now almost all live in Ontario, Quebec, British Columbia and Alberta, and almost exclusively in urban centers. This trend if anything has increased. According to the 1991 Census, 94% of new immigrants then settled in just four provinces; 81% of the Canadian-born population live in these provinces (Badets, 1994:28). This is primarily due to availability of jobs, chain migration, and also the opportunity to live close to their own ethnic communities. Ontario has always been the main center of attraction for postwar immigrants and this is reflected in the 1991 Census. In 1991, 52% of new immigrants moved there (Canada Year Book, 1994). The same Census reflects one consequence: about 40% of Ontario’s population reported ethnic origins other than British or French. Quebec received an estimated 22% of immigrants, followed by British Columbia with about 14%. Alberta

ranked fourth (7.5%) in receiving immigrants in 1991. This is a slight drop from 1990 when 8.8% or 18,944 immigrants entered this province. In 1992, 17,310 people entered this province with landed immigrant status (Statistic Canada, 1991 Census: Catalogue No. 93-332). In recent years those immigrants who came to Alberta have concentrated in major Alberta cities.²⁴ Secondary inter-provincial migration to Alberta cities has been extensive.

Table 6: Population by ethnic origin in the six largest Alberta cities in 1991. ²⁵

Single Origin(s)	Edmonton	Calgary	Leth-bridge	Red Deer	Fort McMurry	Medicine Hat
British	139,125	164,380	12,805	13,245	10,095	6,885
French	27,240	16,215	890	1,360	1,705	750
German	53,330	42,095	4,455	3,720	905	10,230
Ukrainian	52,610	14,970	n/a	1,340	650	760
Chinese	32,960	32,515	1,405	740	750	360
Canadian	30,550	28,085	1,300	2,010	1,190	1,435
Aboriginal	16,585	n/a	1,490	605	1,795	335
Other	137,985	118,680	10,760	5,920	2,920	3,810
Mult. Origin	341,780	316,325	26,435	27,735	14,655	18,360

Table 6 provides a snapshot of the changing ethnic composition of Alberta and Lethbridge.

Changing social, political, and economic conditions both in Canada and in the rest of the world have had an impact on Canadian immigration. As mentioned earlier in the chapter,

²⁴ According to the 1991 Census, immigrants make 18%, 20% and 15% of Edmonton, Calgary and Lethbridge populations, respectively.

²⁵ Source: Statistics Canada, 1991 (Catalogue No. 95-375, 95-378, and 95-373).

Canada since the 1970s has begun to accept more immigrants from non-European nations and war-stricken countries and their neighbors. Many of these “new” immigrant groups (like Chinese, Vietnamese and El Salvadorians) have settled in Alberta and in Lethbridge. There are also other long-established local ethnic groups like Hutterites who still maintain their own distinctive cultural practices. This has also brought increased ethnic diversity in the local area.

During the last three decades, Canada’s social, economic, and political profile has certainly changed a great deal. An awareness of cultural diversity is now widely felt in every part of the country. Lethbridge reflects these changes in microcosm, and also shows the changing trend in the ethnic profile. In 1991 there were an estimated 1,495 Native people, and 1,405 Chinese (this includes both Canadian-born and new immigrants). Similarly, many groups reflecting religion, language and ethnic differences now contribute to the economic, political, social and cultural diversity of the community. The individuals involved certainly do not reflect the large numbers found in major Canadian urban centers like Vancouver, Toronto or Calgary. Still, they are significant proportionally, and are an integral part of the community’s everyday life.

Multicultural Policies and Canada’s Health Care System

The changing Canadian population structure throughout this century has resulted in an increasingly culturally diverse society. The nation’s national institutions, however, have been built chiefly on the British model (Burnet and Palmer, 1988) and historically there was little felt need for institutions to accommodate this diversity. “Anglo-conformity” was the overall agenda for both immigrants and Natives. To combat this practice, Native and ethnic Canadians used increasingly effective formal and informal methods to change existing policies (Boldt, 1993). This eventually gave birth to federal multicultural policy and its provincial counterparts.

Canada as a Cultural Mosaic

In the 1960s heightened concern about human rights, the emergence of ethnicity as a dominant theme internationally and rise of nationalist sentiment in Quebec attracted the attention of the federal government. In 1963, to address Quebec nationalistic sentiment a Royal Commission on Bicultural and Bilingualism was established. As a result, in 1969 the Bicultural and Bilingual Act was implemented.

Introduction of this Act (indeed, the establishment of the Royal Commission) attracted vocal dissatisfaction from non-English and non-French Canadians. People of Ukrainian and German origin who viewed themselves as part of a third force in building western Canada, in particular felt excluded from this formal acknowledgment of diversity. Disenchanted western Canadian ethnic associations and spokespersons saw this federal policy as reflecting undue favoritism toward Anglo and French Canadians, and as reflecting total ignorance of the western historical experience (Burnet and Palmer, 1988). The leaders of First Nations who collectively were excluded from discussions by the 1963 Royal Commission on Bilingualism and Biculturalism, were also disgruntled and became increasingly politically active. In addition, the liberalization of immigration policies in 1966 already had increased ethnic diversity in Ontario, especially in Toronto, and group spokespersons quickly arose to challenge the thesis of biculturalism. This dissatisfaction helped bring an alternative multiculturalism agenda to the forefront (Knowles, 1992). In 1971, Prime Minister Pierre Trudeau announced support for a multicultural policy in the House of Commons, stating that "The policy I am announcing today accepts the contention of the other cultural communities that they, too, are essential elements in Canada and deserve government assistance in order to contribute to regional and national life in ways that derive from their heritage and yet are distinctly Canadian".²⁶ This federal multicultural policy emerged within the framework of bilingualism.

²⁶ This quote is taken from *Strangers at our gates*, by Valerie Knowles, 1992, pp. 168. Ms. Knowles cited this quote from Canada, House of Commons, *Debates*, 8 October 1971, 8545-46.

Between 1971 and 1985 a Multiculturalism Directorate was founded and grew within the Department of the Secretary of State, and a new more liberal Citizenship Act was passed, followed by the Canadian Human Rights Act and the Constitution Act of 1982. Finally, in 1988, the Canadian Multiculturalism Act (Bill C-93-Canada, House of Commons) was passed, with a vision of enhancing and preserving the multicultural nature of Canada (Fleras and Elliott, 1992; Dobson, 1991). Critically, this act: “acknowledges the contributions of Canadians of all origins and their communities to the building of Canada. It denies the notion that everyone must fit into a set mold. It affirms that Canadians of all origins have contributed to cultural, economic, and social benefits we all enjoy”. It states that federal institutions “must ensure that government policies and programs respond to the needs of all Canadians, and the government services are delivered in a way that makes them accessible to everyone” (Stevens, 1993:4).

From the 1970s on, the federal government’s implementation of multicultural policy within the bilingual framework spurred most provinces to introduce similar programs and the three prairie provinces and Ontario took the lead in this regard (Burnet and Palmer, 1988:176). They all established various advisory councils to generate information from the community for the formulation of relevant policies. In June 1987, the Alberta government changed the name of the relevant department from Alberta Culture to Alberta Culture and Multiculturalism. Though often stereotyped as “red neck” and reactionary, Alberta in fact became the first Canadian province to have such a department committed in a major way to multicultural development (Alberta Culture and Multiculturalism, 1989:20). The vision of this department was to: “foster an environment conducive to the expression and preservation of cultural heritage in the areas of artistic, historical, heritage, language, education, economic, and social development; to encourage ethno-cultural groups in Alberta to share their traditions with others; and to recognize and endorse the cultural heritage of Alberta”.²⁷

²⁷ Ibid.

The Alberta government also introduced its first Human Rights Code (Statutes) in 1980 that subsequently was revised in July, 1990 as *The Individual Rights Protection Act*. The objective of this act is to see that all Albertans are free from specific types of discrimination; these included ethnic, racial and national discrimination, among others.

The introduction of multicultural programs and policies across the country have generated powerful ideologies that have led Canadians increasingly to look at Canada as a polyethnic society. Also, Canadians who are not from French or English backgrounds no longer have either to hide or forget about their heritage and languages (which in the early 1900s many Ukrainian and German people did in order to integrate into Canadian society). Instead, it is now easier for them to see themselves as Canadians regardless of their ethnicity. Central to this research, these new policies also have made many Canadian institutions and organizations reevaluate their traditional policies and practices, especially those concerning hiring and service provision. In this regard many health organizations across the country now claim that they wish to provide more “multicultural” health care services. What is “multicultural health care”? What implications might it have for community-oriented health professionals?

Ethnic Diversity, Multiculturalism, and the Health Care System: An Overview

The origins of our contemporary health care system can be traced back to nineteenth century Canada (Clarke, 1992). Until 1912 the Canadian government allowed a wide variety of practitioners to offer their services and sell their wares in a virtually open market. Homeopathic doctors and eclectic practitioners of all sorts worked alongside allopathic doctors. Midwifery flourished. The Canadian government, the allopathic physicians' association and allied interest groups for a long time had wanted to see an end to this kind of unregulated free market medicine. Eventually, they were successful. The Canada Medical Act, passed in 1912, the Canadian National Association of Trained Nurses established in

1908,²⁸ and the Flexner Report of 1910 mark important changes in the Canadian health care system. For the first time, the Medical Act standardized licensing procedures across Canada, starting Canadian medicine on the road to being a closed shop. The Flexner Report changed medical education and practice in the United States and Canada. It established orthodox biological science as the axiomatic basis of clinical practice, of which the individual patient became increasingly the main focus (Jensen, 1987). By the 1920s, the hospital-based, curatively oriented, technologically sophisticated health care system which Canadians know today was firmly established (Clarke, 1992).

The Canadian health care system began by utilizing mainly private and voluntary organizations and institutions. Physicians were financed primarily on a so-called user-pay basis (Northcott, 1988) and the employment of nurses and others was largely dependant on physician practice. The concept "Medicare", referring to a universal form of medical insurance, was first coined in 1919 by Mackenzie King as a federal Liberal Party platform. After a decade or so of indecision several political and social factors influenced the Canadian government and reluctantly, a range of medical organizations, to seriously consider this concept. During the 1930s the federal government identified a range of health and social service disparities in different regions of Canada. Also, during the Great Depression years (1930s), financially disadvantaged Canadians like the elderly, the unemployed and individuals in low socioeconomic strata increasingly were unable to access extant services (Clarke, 1992; Crichton and Hsu, 1990). Other factors in the development of a universal health care system were political: 1) the widespread movement in Western industrialized nations toward societal rationalization and bureaucratization in the context of monopoly capitalism; 2) the establishment of a social welfare philosophy reflected in programs like public education, old age pensions, family allowances, unemployment benefits, and medical care insurance in western Europe; 3) the profit-making interests of the life and health

²⁸ This organization then led to the recognition of nurses as professionals in all nine Canadian provinces between 1910 to 1922 (Wotherspoon, 1988).

insurance companies; and, critically, 4) increasingly effective pressure from labor unions, farm cooperatives and the CCF to establish equitable social and health programs for all Canadians.

To address gathering dissent, in 1957 the federal government introduced a limited national health insurance scheme under the Hospital Insurance and Diagnostic Services Act. This was a cost-sharing health insurance arrangement between the provinces and federal government (Northcott, 1988:39). But this insurance plan was not in any way as successful as was initially expected. There were several problems identified in this scheme, including lack of funding for the construction of hospitals, inadequate provision of public and mental health services and a general lack of adequate coverage for basic medical services.

In 1961, a Royal Commission on Health Services was set up by the federal government. Under the leadership of Supreme Court Justice Emmett Hall, this commission recommended that a state-financed system of health insurance be introduced through which every Canadian would be eligible to receive “free” necessary medical and hospital services (Clarke, 1992; Northcott, 1988; Dickinson, 1988). Despite strong opposition from the Canadian Medical Association, the federal government introduced the Medical Care Act in 1968, which was finally implemented in 1972 with the cost of the program to be shared 50/50 by the federal and provincial governments. Although threatened now, the four basic objectives of this insurance remain:

- 1) universality: all residents of Canada are eligible to receive equal, uniform and insured health service;
- 2) portability: the health benefit is portable from province to province;
- 3) comprehensive coverage: the benefits were to include all medically necessary health services provided by hospitals, medical practitioners or dentists and others where permitted.
- 4) no fees for immediate service: the plan was to be run on a nonprofit basis and is subject to public administration audit.

The universal health care system that has evolved since is strongly grounded on a “medical

model” of fighting disease through curative or restorative intervention. Retrospectively, funding determinants over the years have if anything bolstered this orientation. This may now be changing for several reasons. First, there has been a dramatic change in disease profiles among the residents of Canada. Canadian mortality and morbidity rates have become very low, but this and other factors have resulted in an aging population in which chronic illness related to old age is on the rise. To address this health issue more effectively there has been an attempt by the Canadian government and some health organizations to move away from the “medical model” of health service provision and partially replace it with a “health promotion model” or as Clarke (1992) calls it a “lifestyle model”. The central objective in this model then shifts from treating disease to maintaining health.

A second force for change is an increased sensitivity to Canadian societal diversity, including the first glimmers of awareness of a range of multicultural issues by health professionals (Masi, 1993). The rise in the women’s movement, and the organization of effective political activist groups representing First Nations populations and immigrant groups have made a major contribution here. Much more is now said about the risks of not addressing diversity perpetuating disparities in health status and/or the availability of health services (Grant, 1988; Frieder, 1988). Third, the traditional emphasis of the health services on identification of “problems” and the treatment of diseases has inappropriately medicalized many social problems, like family violence (Ahluwalia and MacLean, 1988), anorexia (Currie, 1988) and women’s health (Trypuc, 1988). This also is changing. Lastly, its medical orientation has made the Canadian scheme increasingly expensive. For example, in 1965 the federal government alone spent 475 million dollars in health care. By 1992, this had risen to 7,134 million dollars. (Finance Canada, Statistics Canada, 1993).

Social, cultural, political and economic issues and criticisms have together prompted funders and some Canadian health care service providers to seek more ways to address health issues using a “lifestyle” model where illness is attributed to an individual’s lifestyle, behavior, and consumption patterns (Bolaria and Bolaria, 1994) and where more effort is placed upon

promoting health through changed lifestyles. In 1974, the federal health minister Marc Lalonde anticipated this trend. The suggestions Lalonde made in, "*A New Perspective on Health of Canadians*", have had a tremendous impact on the establishment of subsequent Canadian government health policies; it also influenced the World Health Organization, and the policies of numerous other nation-states. In 1986, the federal minister of health, Jack Epp, published a follow-up document entitled, "*Achieving Health for All: A Framework for Health Promotion*". This report suggested even more strongly that this mission can be achieved through self-care, mutual aid and the development of healthy environments. The report suggested three basic ways to implement this new approach: increased public participation, strengthening community health services, and coordinating public health policy. This shift toward a health promotion model has made multicultural health care delivery something Canadian health care institutions have increasingly had to consider - especially in the light of significantly increased client diversity and the range of multicultural and human rights policies now in place across the country.

But, what is multicultural health? Masi characterizes multicultural health as:

Health care which is culturally, racially and linguistically sensitive and responsive. The definition includes concepts of ethnic and race relations, cross-cultural or transcultural health care; it also includes issues related to human rights and to equity (Masi, 1993:7).

It obviously is not something quite so easy to implement -- evinced among other things by a century of neglect by the Canadian health care establishment. For one thing, the Canadian health system, based as it is primarily on western biomedical culture, has until recently mainly focused on mechanical, technological and pharmacological treatments or "fixes". This has led health professionals' medical gaze to look primarily at the physiological and

medical knowledge - the individual as an organism (often, a male organism) in this context.²⁹ There was little room in such conceptions for patient personality, let alone patient diversity where that diversity ranged beyond the physiological. But the shift to a "health promotion model" in a pluralistic society like Canada has made multicultural health care increasingly problematic and spoken about even if not yet crucial (Lynam, 1993; Todd, 1991; Leininger, 1989; Nolde and Smillie, 1987) to health professionals. If taken seriously, in order to provide "lifestyle" oriented services effectively health professionals clearly will have to acknowledge cultural and other differences among service recipients and respond to them appropriately (Masi, 1993; Lynam, 1993; Anderson, 1990). Leininger contends that when a professional, "... seeks to involve the patient in his or her own care, nothing can be more important than understanding the patient's heritage and traditions (Leininger, 1989:251)".

There is no guarantee, however, that the combined forces identified so far in this Chapter will produce a future health care system that meaningfully addresses actual diversity in the context of a lifestyle model. This will depend in large part on how and whether specific institutions incorporate cultural diversity into their formal mandate, and how (and again, whether) such mandates are reflected in everyday practice. To discover how these have developed in one such institution--a community-based health care centre--is of course the central objective of this thesis. Kleinman (1980) has said that any effective understanding of the medical system requires that one:

Start with the appreciation of health care as a system that is social and cultural in origin, structure, function, and significance. In the same sense in which we speak of religion, language or kinship as cultural systems, we can view medicine as cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal arrangements (Kleinman, 1980:24).

²⁹ The male body continues to be the paradigm in many respects. Note recent activist complaints that those who research and treat AIDS systematically have ignored the rather different symptoms and disease trajectories of infected women.

As a final necessary bit of contextualization, let me conclude this Chapter with a brief account of a key domain in the overall Canadian health care system that for a long time *has* been concerned with a range of community-based factors: community-based public health and its institutional subculture.³⁰ I then briefly describe the community health centre that is the context for my research.

The Canadian Community Health Care

The main stated objective of *public health care*, or as Jensen (1987) calls it, "*community medicine*", has historically been to provide preventive treatment directed toward populations and whole communities. Researchers believe that community-oriented practice in Europe goes back to the end of the seventeenth century. In Canada, Ontario was the first province to implement a Public Health Act in 1882, the essential points of which were soon adopted in the rest of the country (Clarke, 1992). Also, from the 19th century through the early part of this century new immigrants entering Canada were seen (not always accurately) to have initiated epidemics of flu and cholera which killed many people. In order to protect the general health of Canadians, the federal government for the first time passed laws to protect the lives of its citizens through quarantine and sanitation measures coordinated by community health centres. Immunization programs soon followed. Recognition of the limitations in disease-specific approaches encouraged community medicine in the 1960s to explore new diagnostic techniques for the prospect of mass screening. This introduced the increase in use of a *statistical approach and case documentation* which were instrumental in recognizing that certain lower socioeconomic groups and Native populations have higher morbidity and mortality rates than other groups. The statistical model fitted well with the trend that was used by other health professions in identifying the causes of health inequalities in large populations.

³⁰ More historical detail on the rise of community-based public health in Alberta is given at the beginning of Chapter Four.

Over the period between 1950 and 1960 the community health organization also then got involved increasingly with other programs: post-natal services, dental health, support services for chronically sick, disabled, and the elderly living at home, and diet to name only a few. In the 1970s certain home care programs also came under the jurisdiction of community health.

Today, such institutions face the possibility of a complete reformation of their traditional duties as community health care providers. Although expected to provide a range of disease prevention and traditional health promotion programs as before, more and more they have to do this under a new institutional and cultural framework following a more contemporary health promotion or lifestyle model.³¹ Historically community health organizations have geared their programs toward what they have identified as high risk groups, like mothers with young children and school children (Crichton and Hsu, 1990:99). The lifestyle model suggests similar potential exists for promoting the health of those historically deemed normal and not at high risk through both education and intervention. They also give further legitimacy to calls to address more seriously both barriers to, and potential for improved health that may have a cultural basis. Qureshi suggests that “health professionals and GPs should concern themselves with ethnicity, religion and culture as much as with the age, sex and social class of their patients” (1989:vii). Such demands are rather new in the health care system and as mentioned, do not fit well with the older medical model. Moreover, there is little by way of strong formal-institutional guidance or policies concerning these issues to inform or constrain local institutions. Each community health organization across the country now essentially addresses issues of cultural diversity differently, achieving and

³¹ The principle of this model is “that a person’s health is significantly affected by many complex interactions between the individual and his or her particular family, community and culture” (Lee and Herrera, 1993:63).

understanding such issues in its own terms.³² Many such health organizations have not yet seriously come to terms with these issues. Others consider cultural diversity in terms of special projects instead of incorporating them into their everyday discourse (Kulig, 1994; Feather, 1993; Edwards, 1992; Brunt, 1992). Many, like the Centre I investigated, have moved forward informally in complex and not always consistent ways.

Community Health Centres in Alberta

Community health programs in western Canada were first established with the appointment of a Territorial Board of Health in 1870 (Schartner, 1982). This was done to address a smallpox epidemic that had spread among the Indian tribes. With the growth of Edmonton and Calgary, these two cities formed their own health services on a municipal level. In 1905 Alberta became a province and the public's health became a provincial matter. A Provincial Board of Health was formed in 1907 (Schartner, 1982:11).

To address the health concerns of rural communities, in 1919 district nursing stations were established across Alberta. Shortly after that travel clinics were organized to serve rural areas lacking other medical facilities. By the 1920s it was apparent that community health provision as then organized was unable to provide effective health services to the smaller communities, and that there was a growing gap in available health services between cities and smaller communities. Therefore, in 1929 the Alberta government established as a basic health service a range of immunization and child care programs for people living in rural areas. After the Second World War, Albertans saw community health centres constructed in all parts of the province (Schartner, 1982).

³² The city of Toronto Department of Public Health has adopted the Mandala of Health as the model. The city's Department of Health articulated its' first formal commitment to multicultural policy in 1978. For further details see Lee and Herrera (1993).

The Community Health Centre in Question Here ³³

The origins of this urban-based community health centre (CHC) dates back to initiatives in 1891. First a Standing Committee of Municipal Council was created called the Committee on Health and Relief. In 1897, the town of Lethbridge created a Board of Health. After Lethbridge became a city in 1907, it passed an extensive public health bylaw, which evidently served as a model for later provincial legislation.

In early years the main focus of public health in Lethbridge was the control of communicable disease, the provision of clean water and healthy food, and control of general sanitation and disposal of waste. Public health staff also ran an isolation hospital, which was handed over to the Municipal Hospital in 1952.

In April 1958 a community health centre finally was established in the city with financial support of the provincial government. The functions of this community health centre thereafter became increasingly complex. It began providing services that were managed previously by the Health Board, a Nursing Mission (which held a baby clinic and milk station, health education and home visits) and School Health Services. As time went on, more community health services were added to the existing ones. These included certain dental services and speech therapy (in the 1970s). During the early 1980s there was an extensive expansion of services, including Home Care, Alberta Aids to Daily Living, Sexual Health, an Early Intervention Hereditary Disease Program, and the Preschool Assessment and Treatment Center. The latter two programs were provided as regional services in collaboration with two other health centres in the region. In summary, the Health Centre operated fifteen distinct formally-named programs. They were: Alberta Aids to Daily Living, Audiology, Communicable Disease Control and Epidemiology, Community Nutrition, Dental Health, Early Intervention, Environmental Health, Hereditary Diseases, Home Care,

³³ Source: CHC Handbook, Revised: June 1994.

the Preschool Assessment Treatment Center, Public Health Nursing, Sexual Health, and Speech-Language Pathology.

Prior to 1973, funding for the CHC was shared by the Province and the Municipality on a two thirds, one third basis. In 1973 the Province amended the Public Health Act which established such centres as autonomous bodies and assumed full responsibility for funding their programs.

The stated overall goal of the CHC is now to enable people to live healthy lives within a healthy community.³⁴ The CHC handbook proclaims,

All Health Center programs utilize health promotion strategies in accomplishing their goals. This includes the provision of the information to the general public to increase their knowledge about possible health problems, increasing peoples coping abilities, etc. The strategies are intended to empower individuals and families to make healthy choices and take responsibility for their own health (CHC Handbook, 1994:17).

At the time my data collection ended, the CHC employed approximately 114 staff representing a wide range of health professionals, support, technical and clerical staff. It provided service primarily to City of Lethbridge residents and its official geographical service boundaries are coterminous with that of the city. This institution also provides some additional services in conjunction with other neighboring health centres.

CHC Formal Organizational Structure ³⁵

At the time I did fieldwork there, the formal organizational chart of this CHC showed four administrative levels (see Appendix A), with a policy Board at the top. The Chief Executive Officer (CEO) was the administrative head of the institution, and was a medical doctor, as

³⁴ See Chapter Four for further details.

³⁵ Again, see Chapter Four for more details.

specified by the Provincial legislation. The CEO was responsible for all administrative duties and had an extremely influential role in CHC policy and program formulation. The CEO sat on the Board on behalf of CHC staff, where the CEO's role was as a mediator between the Board and the staff. The CEO was directly responsible for implementing the Board's wishes. The third management level encompassed the Directors of different programs offered at this CHC. These Directors were responsible for their respective programs and were an important liaison between the CEO and staff. Directors oversaw programs, did hiring, and wrote proposals for outside funding. There were at the time four Directors in this Health Center, and one Assistant Director. The Assistant Director was located in the Public Health Nursing Program.

The front line workers composed the last level in this organizational chart. They included about one hundred individuals: community health nurses, a nutritionist, speech pathologists, health inspectors, geneticists, dental hygienists, and audiologists.

Conclusion

The structure of Canadian society in the last three decades has changed generally; notably relevant here is a great increase in cultural diversity and acknowledgment of that diversity. Canada has become the leader in formally recognizing itself as a multicultural nation. These changes have begun to impact upon Canadian institutions in general, and Canadian health care institutions in particular. Cultural diversity's initial impact upon health care provision now comes at a time when increased advocacy for a "health promotion model" for health care services is also generating many new challenges to and potential for our health care system. In a fundamental way, calls for more attention to cultural diversity and to human lifestyles are based on highly congruent, core philosophies and are potentially mutually supportive. In an institutional world long guided by other ways of seeing and now faced with resource reductions, however, increased demands, and little guidance, how things actually

evolve will depend much on local factors. Central among such factors is how individual institutions encode cultural difference in belief and practice; this is the subject of Chapters Four and Five. The following chapter first analyzes a range of relevant theories that anthropologists and social scientists have used to understand the bureaucratic cultures of health organizations. In particular, my discussion emphasizes those theories which subsequently contribute to my analysis of the community health centre's culture.

CHAPTER TWO

THEORETICAL FRAMEWORKS FOR THE STUDY OF HEALTH INSTITUTIONS AS CULTURAL SYSTEMS

The previous chapter presented a brief sociohistorical analysis of the growth of Canadian cultural diversity and of its impact on health institutions and service delivery. As noted there, an awareness of this rapidly changing population is necessary for our health care system to provide appropriate service, especially in the area of health promotion. Utility or necessity notwithstanding, powerful critics have argued that the Canadian government and other interested parties are still not doing enough to reduce the “racial” and ethnic health care inequalities (Ramsey, 1995; Ujimoto, 1994; Hall, 1994; Ervin, 1993; Bolaria, 1994, 1988; Dhruvarajan, 1994; Clark, 1992; Indra, 1991; Frideres, 1988). This study focuses on one key dimension of this issue: how client cultural difference is inscribed into the everyday practice of health service institutions. In this light, the goals of this chapter are twofold. First, I focus on key theoretical aspects of the study of institutional culture, a literature to which I hope to have made some contribution through this research. I start by addressing a series of operational definitions of culture axiomatic to an understanding of institutional culture and the culture of health care institutions. Then I critically appraise three theoretical approaches that have been used to discuss the everyday practice and discourse of bureaucratic organizations, focusing particularly on issues of medical knowledge construction. I conclude the chapter with a brief reiteration of my research problem, as contextualized by this theoretical discussion.

Culture and Institutional Culture

Mainstream definitions of the word “culture” have changed many times since its first significant anthropological use in 1871 (Kroeber, 1952). According to early social theorists like Durkheim, Radcliffe-Brown, Kroeber, and Benedict, society and culture were immortal

and transcendental; individuals were born into their culture and through socialization processes became a member of that society or social group. Their philosophy of culture could not be described as the straightforward product of individual persons (Stein, 1990). Instead people were characterized primarily as products of their culture, rather than its makers. Today, when one opens an introductory anthropological text, culture is typically defined archaically, reflecting this earlier view: “as a learned system of beliefs, feelings and rules for living around, which a group of people organize their lives. It is a way of life for a particular society” (Crapo, 1993:5).

In as much as anthropological discourse on culture and on modern nationalism have been massively interpenetrated, this term with archaic meaning attached is often used informally in folk discourse to identify large social groupings or categories of people based on shared national origins. For example, Canadian, Japanese, or Polish culture in folk discourse usually refer to a normative set of lifeways identified with an ethnic or national group; sometimes it is used to refer to people who are “Native” to these respective countries. This folk notion of culture is described by Kreps (1994) as a “*national culture*” whose frame of reference is to geographical and historical space, and which, in Benedict’s (1984) terms, is often an integral part of their ideologies of imagined national communities.

In complex modern societies like Canada there are in fact many nodes of actual significant diversity—many distinguishable “subcultures” within the boundaries of the state. Many of these are personally salient, and are the focus of social groups. Thus people may not only identify themselves as “Canadian”, but also as participants in ethnic, professional, class, and regional subcultures. One individual may identify him/herself in many different ways in social space and time, and with a number of cultural frames. Moreover, contemporary anthropological research has shown that such individuals are not at all the passive recipients of cultural notions such as found in these contexts. They individually synthesize and make meaningful elements selected out of a wide range of traditions and trends, and integrate these elements into personal systems of belief that help them make sense out of the social situations in which they participate.

The best way one can then start to approach defining culture in reference to a complex society that would be relevant to this study is as “a complex and multifaceted social phenomenon that has powerful influences on all aspects of modern life. Culture refers to collective sense making of members of social groups, the shared ways they make sense of reality” (Kreps, 1994:1). Culture consists of constantly reinterpreted shared beliefs, values, and attitudes that guide the behaviours of group members (Krep, 1990a; Geertz, 1973; Arensberg and Kimball, 1965). But this alone is insufficient, as in this analysis I am not studying the culture of an ethnic or national group, but that of a small public institution where people are recruited from different ethnic, political and social backgrounds. These people are explicitly trained for membership in the institutionally-linked groups and categories of person that have found themselves there. They come from the “outside”, yet the sense of overlapping membership is strong; people identify themselves with these groups. I acknowledge this by using Stein’s inter-actionally and identity-oriented definition of culture, in which he sees cultures:

... as a shared and constantly renegotiated sense of definitional affiliation with a particular group or groups and the action that derives from and validates this self-definition. A sense of shared identity, of overlapping meanings and their associated symbols and rituals, becomes expressed in the fantasy of ‘we-nes’. ‘I am’ becomes ‘we are’, and vice versa. Further, what ‘we do’ follows from what ‘we are’ (Stein, 1990:1).

Institutions and Culture

Like communities, associations, ethnic groups, and religious congregations and institutions are both social and cultural productions (Herzfeld, 1992; Buchignani, 1991; Douglas, 1986; Cohen 1985), even if the individuals who participate in them do not always see them as such. In this regard, Berger and Luckmann, in *The Social Construction of Reality* state that:

The objectivity of the institutional world, however massive it may appear to the individual, is a humanly produced, constructed objectivity. The process by which the externalized products of human activity attain the character of objectivity is

objectivation. The institutional world is objectivated human activity, and so is every single institution. In other words, despite the objectivity that marks the social world in human experience, it does not thereby acquire an ontological status apart from the human activity that produced it (Burger and Luckmann, 1966: 60-61).

Institutions are human products. So, therefore, are the cultures and subcultures of institutions. As much as culture is general, the bureaucratic culture can be evoked by Geertz's words, "man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs" (1973:5).³⁶ Members of an institution have both formal and informal goals that are strongly grounded in their bureaucratic culture. It is crucial therefore, to have first an understanding of how a health care organization maintains its institutional legitimacy and sense of solidarity (ideology). A second analytical requirement is to conceptualize institutional social processes of knowledge production. Community health organizations established in late nineteenth century were founded on an ideology of community-oriented preventive treatment practices. Since their inception such organizations have introduced and integrated many new health programs and services, yet continue to identify themselves as community-based health service providers. As Douglas notes, "to achieve this objective institutions [subtly] shift process where something is admitted, something rejected and something supplemented to make the [new] event cognizable" (Douglas 1982:1). She further suggests that this process is largely cultural where a host of individual choices become catalogued and constrained and where overall mandates and process structure individual consciousness (Ibid). A central point of my study is to understand those forces that help institutions sustain their identities yet change to respond to internal and external determinants and constraints—in particular determinants and constraints involving notions and realities of cultural difference.

³⁶ As an institution is both a social and ideological production, Douglas (1986) contends that an understanding of both cognition and environment is needed for a cultural analysis. Her assumption is that these two concepts are connected. For example, in *Purity and Danger*, Douglas (1975) asserts that "each tribal wisdom invests the physical world it knows with a powerful backlash on moral disorder" (1975:5).

Study of Institutional Culture

To help understand the CHC's organizational structure and culture in the most general sense I use primarily an interactional anthropological approach, tempered by some earlier conflict theory and functionalist ideas. It is interactional in part because institutions "do not have minds of their own" (Douglas 1986). They are human constructs maintained by conscious, interpretive individuals, whose rules and practices are always in the process of being legitimated and renegotiated. This approach usefully highlights logical pattern construction and legitimization within small scale social organizations. My study of a CHC as an example of one institution in a modern health care system is specifically intended to provide a conceptual understanding of the interactional processes through which its members are constantly creating, negotiating, revising, internalizing, and externalizing their culture. It also seeks to show the degree to which CHC staff in these instances are far from passive individuals caught in an invariant institutional matrix. I would note parenthetically that this goal in turn led to my committing to the use of long term participant observation as a supplement to interviewing as I have sought from the first to encompass both the conceptual and behavioural sides of this institution's culture. An interactionist orientations well suits this challenge.

Today's increasing concern to provide culturally sensitive health care has made the study of relevant health care institutional cultures important (Kreps, and Kunimoto, 1994; Muecke, 1992; Herzfeld, 1992; Henderson, et al., 1992; Johnston, 1991; Stein, 1990; Osborne, 1990; Leininger, 1989). Many such studies were done prior to this one. It is important to examine the ways in which social scientists have approached bureaucratic cultural analysis, both in order to make sense of what they have discovered, and in order to apply a sense of their insight here. The following section reviews three major perspectives of this sort: structuralist, conflict, and interactional approaches to the empirical and conceptual understanding of the western bureaucratic cultures. I focus selectively on elements of these theories that I have

deemed more useful for my cultural analysis of CHC everyday practice. In this regard, I also highlight findings about how medical knowledge systems extended to include new information while maintaining continuity with “problem-specific” thinking. A few weaknesses of these theoretical approaches will also be briefly discussed.

Western Medical and Health Care Institutions As Curers of Illness and Disease

Classical structural-functionalist approaches to the analysis of institutions typically focus on the acknowledged, beneficial consequences such institutions have for society in its totality (Thompson et al., 1990). As a result they often concentrate either on the functional requisites for the survival (Parson, 1966) of such institutions, or on them as a cultural systems (Good, 1994; Young, 1993; Rhodes, 1993; Jensen, 1987) operating as agent in treating illness, preventing disease and promoting health in the larger society (Jensen, 1987). But there is a fundamental weakness in this approach which has led to its current unpopularity. Functionalists are not often particularly careful about how they identify the functional problem or need which they postulate the institution should address. Secondly, these theorists rarely address Dukkheim’s maxim that to establish a function for something does not automatically account for its existence.

This is not to suggest that functionalism did not historically make significant gains here. Merton’s contribution to functional theory and the analysis of a society at various levels has helped immensely in the study of institutional culture (Douglas, 1992, 1975; Bell, 1992, Turner, 1979) especially by well defining manifest and latent functions. The simplest definition of manifest functions are those that are planned and in many situations explicitly presented, whereas latent functions are unvoiced and unintended (Ritzer, 1992:115). The manifestation of the principle of essentialism and prevention of disease and illness, for example, is central to the CHC’s everyday practice, as shown in Chapter Four. This objective is presented as an institutional mandate, and is presented in other forms like the organizational handbook, brochures, and advertisements informing the community of their

presence and overt objectives. But, as will also be shown, the biomedical model has a strong latent function of participating in the generation of patient/client categories and perhaps, in maintaining health inequality (Clark, 1992). As Rhodes suggests, both in its manifest and latent forms the ideology of “biomedicine” participates in a cultural separation of mind and body, nature and culture, in ways that may produce a sense of dissonance expressed in increasing criticism and doubt (Rhodes, 1993:164). More generally, distinctions between manifest and latent charters and agendas have helped facilitate important contributions to the study of bureaucratic and organizational culture (Indra, 1987; Ng 1987; Teski, 1981; De Voe 1981).

Merton (and others) also have further disaggregated latent functions suggesting that there are two types of unanticipated consequences worthy of study. One type is where the consequence is dysfunctional for a designated system, (and comprise latent disfunctions) and the other is irrelevant to the system (having neither functional or dysfunctional consequences).³⁷

Allied structuralists have also made an important contribution. According to Weber’s theory of bureaucracy, institutional stratification constitutes and defines stable patterns of relationships and activities (Zhou, 1993) essential for the avoidance of disfunction in organizations (Foner, 1995; Herzfeld, 1992; Douglas, 1992; Cohen, 1982; Townshed, 1971).

Structural anthropologists in more recent times who have used decision-making theory to study social institutions have gone further in focusing on the means used by individuals to achieve a given end, but have rarely asked how people come to prefer one end over some

³⁷ See also Ritzer, 1992:115. Merton’s contribution on latent functions is addressed later, where I show instead how CHC staff latently develop new categories of clients and medical problems in the process of maintaining their institutional cultural identity. This has been shown also by Young (1993) in his study of a psychiatric unit that was part of the U.S. Veterans Administration medical system.

other end (Thompson et al. 1990:55). They also primarily have focused on the social system as a whole rather than on taking a person-centred approach. For example, Taylor (1970) in her ethnographic study of a hospital culture identified the two most important characteristics of this institution as: the function of the institution, and the role relationships between its members. She said of American institutions more generally that they are:

Separated [by function] into two categories: those that produce goods and services and those that process people. I call the institutions that do things to people, people-processing plants; and I identify three kinds of people-processing plants: launching plants—schools, colleges, and other institutions that prepare people to become working members of society; fall-out plants—institutions that do something to and for people when they are temporarily unable to function in society (hospitals and prisons fall into this category); and scrap institutions—the institutions in which we store human rejects (homes for the retarded and nursing homes for the aged are both excellent examples). (Taylor, 1970:141-142).

In this description Taylor shows what Weber and Parsons (1951) have emphasized: how “society” accomplishes specific tasks through functional institutions. She points out that:

When we organize things to and for people—educate them, cure them, care for them, and so forth—we tend to use what I think of as conveyer-belt logic. An excellent approach to the task of producing nuts, bolts, sausages, and other inanimate objects, but one with obvious pitfalls when the object to be processed is animate and human. Consequently, our people-processing systems tend to expect more conveyor-belt behaviour than is absolutely necessary, and those persons being processed characteristically draw attention to this fact by sporadic refusal to conform to particular demands (Ibid).

This conveyor-belt analogy evoked here is in some ways very archaic. Still, it does begin to touch upon the asymmetrical role relationships possible between service provider and client, as for example, between physicians and patients. The pecking-order analogy Taylor uses elsewhere to characterize role relationships in this hospital also evokes a view of a hierarchical system that unequally distributes power and privileges according to roles with a minimum amount of conflict. The most obvious weakness of this approach is that in focusing only on one relevant dimension of the institution, it ignores many others that are relevant—especially those of a more fluid or person-centred nature.

Others have expanded these earlier structural approaches by taking a less naive and literal view of institutional functions and with this a more dynamic approach to institutional structure. They have done so in part by shifting from the study of only literal institutional functions to research on mechanisms of institutional legitimacy and world view.

Fisher (1981), for example, explains how bureaucratic structure influences both health policy and program decision-making in Nepal:

In the world of international health, donor agencies are caught in their own bureaucracies--by the organizational structure, by their planning and funding procedures which must adhere to a rigid time schedule, and by organizational and personal goals which influence perceptions of planning and the evaluation of programs such as ICHP. Such bureaucratic demands lead donor agencies to a course of action which has more to do with their own needs than the beneficiaries of Nepal's health services (Fisher, 1981:202-203).

Fisher's analysis of institutional behaviour confirms what may others have shown: that legitimacy concerns and conformity pressures often predominate over what the clients need. Murphy (1987) presents a similar picture concerning power and authority within the discourse of the hospital, in *The Body Silent*. He compares this institution with Goffman's "total institution" (Goffman, 1961), institutions like prisons or asylums where both patients and staff are forced to conform to the institution's discourse.

Ethnographic research on inter-group relations in health contexts has frequently investigated the interface between health service providers and service users (Murphy, 1987; Taylor, 1970; Goffman, 1974, 1963, 1961)³⁸ which as Frankenberg (1993) calls the relationship between "sufferers and healers". A generic label (provider-user) and associated approach,

³⁸ See also allied works that focus on understanding the culturally-based and health practices of different ethnic and racial groups (Kulig, 1994; Muecke, 1992; Galanti, 1991; Winn, 1990; Dobson, 1991; Brosnan, 1990; Peters, 1987; Fox, 1987).

however, is still often used to account for the social structure, function, and maintenance of the social stability of such organization. Most treat the institution in question in a too abstract and general way to contribute much to understanding the situational and sub-institutional process whereby a community health centre constructs specific categories of person: not a simply "good" or "bad" client, but say an "El Salvadoran" client. Most attempts so far fail to integrate sufficiently the social and cultural factors that contribute on an ongoing basis to continuity and change in diverse, and not always consistent ways. Instead, the primary focus is on how as overall institutional preferences are structured to become manifest in the general way of life of the institution,³⁹ and processes of differentiation often are neglected (Thompson et al. 1990). As Barth (1981) chides in respect to this form of anthropological analysis:

The most dominant and most indispensable ...[relevant approaches]... is *structuralism*. I believe it to be fundamental to the conceptualization of any kind of complex reality. But the way it has been adapted to anthropological materials has entailed a predominant focus on 'systems of thought', even when avowedly speaking about the connections of social interaction and people's relationship to their environment. It has also focussed strongly on the macro-level of forms, institutions, and customs, ignoring the micro-level of the distribution and interconnections of concrete acts and activities; or else it has confounded the two as if the acts of individuals were a simple homologue or 'expression', of collective macro-structures. As a method, it has tended to achieve clarity - indeed often brilliance - in the depiction of patterns by a high degree of selectivity: by backgrounding and eliminating variation and abstracting the norm, thereby ignoring increasingly more of what seems to me real and vital in people's lives on

³⁹ Alternatively, many medical anthropologists involved in analyzing cross-cultural health care provision have spent much time generating literature about the symbolic and epistemological dimensions of sickness or illness, healing, and health in various cultural groups (Reid, 1994; Lindenbaum and Lock, 1993; Dhruvarajan, 1994; Good, 1990; Nichter, 1989; Peter, 1987; Guilmet and Whited, 1987; Fox, 1987; Scheper-Hughes, 1984). However, as Good (1990) describes this sort of research also avoids coming to grips with institution-based ways of seeing: "this knowledge is only developed to help the public health specialists convince people to act more rationally - to use preventive services, obey doctors' orders, or utilize medical services "appropriately" - such theories evaluate health beliefs for their proximity to empirically correct knowledge concerning the serious".

the operation of backgrounding in the construction of shared understandings (see Douglas, 1975:3-4) (Barth, 1981:4)

To summarize, despite their limitations structural-functional perspectives definitely have some positive implications for this research. The CHC does function as a formal bureaucratic organization with an explicit, predefined mandate grounded in medical models of illness prevention and health promotion (Good, 1994; Stein, 1990; Todd, 1989). This problem-specific overall cultural orientation of the CHC gives unequal power to key bureaucrats to control institutional space, time and knowledge (Foner, 1995; Herzfeld, 1992). In addition, the Centre has a well-defined formal hierarchical structure where decision-making power is at least said to be located at the top of a traditional pyramid. In terms of service, it provides programs that are strongly informed by the Community Health Act of Alberta.

In these and other ways I *have* used structuralist strategies to approach an understanding of the centre. In particular, I have paid considerable attention in the earlier parts of Chapter Four in mapping out the formal charter and organization of the institution. I see this as only a starting point, however, as my main focus is on CHC staff everyday discourse and practice relating to cultural difference. I concentrate on the influence of cognition and interaction on CHC staff perceptions relating to their construction of their medical object, the client. Most structuralist social scientific research on medical institutions is done from an “etic” perspective. In this thesis, however, I want to focus primarily on “emic” data and use it to construct “etic” theory about the CHC and bureaucratic culture more generally. To do so requires the use of additional theoretical approaches.

Medical and Health Care Institutions as Arenas of Cultural Conflict

The development of conflict-oriented theory generally can be attributed to increased skepticism about the explanatory power of functionalism as a paradigm of social analysis (Farganis, 1993). My purpose here is not to provide a historical background of the

development of this widely-based theoretical approach. Instead, my focus is on some of the contributions this perspective has made to cultural theory, and to research on health and cultural diversity. Finally, I also briefly identify some the limitations of this theory as applied to my study.

Conflict theory analysis of bureaucratic organizations can be contrasted with functionalist approaches in several ways. Structural-Functional theory sees society as quite static, or in a state of moving equilibrium; such stability often is seen to be “natural” not in need of explanation. Functionalists emphasize the orderliness of the social system, and seek to identify broad-based elements like norms that contribute to an institution’s stability and cohesion.⁴⁰ A central thesis of more conflict-oriented sociological studies of medical organization is that a differential distribution of decision-making power generates health inequality of many sorts (Findlay, and Miller, 1994; Frieder, 1988). Findlay and Miller (1994), for example, have demonstrated how power differentials have allowed the contemporary health system to medicalize women’s lives and even women’s own understandings of their own bodies.

A number of ethnographic studies of biomedical culture conducted from a conflict perspective view western medicine as not being in accord with its functional charter. Instead, they highlight the coercive dynamics of medical organizations and stress that all structures are subject to processes of change (Dobson, 1991; Leininger, 1989). This is best exemplified by the work of Leininger (1989; 1978) on transcultural nursing. Her primary focus in these studies has been to show how the nursing profession expands its medical and health care knowledge to adjust to societal changes through what de Certau (1984) calls organizational “strategies”.

That dissension and conflict are central to a community’s, or a social organization’s

⁴⁰ See Parsons (1951) as a classical example, and analyses of it by Farganis (1993).

continuity, disintegration and change (Stein, 1990; Todd, 1989; Cohen, 1985; Foucault, 1979) is likewise well documented in Stein's *Medicine Culture in America*. Stein has primarily focused on how medical culture has come to reflect changing American value systems. In short, it is his thesis that the biomedical model underlying our health care delivery system is maintained through coercion and through a high concentration of power and authority. What earlier researches may have viewed as a functional division of labour is here viewed as a form of professional domination. Authority in this context does not lie with individuals, but depends on position; positions and the power of positions are maintained through struggle. Not surprisingly, many conflict theorists argue colonialism, racism and sexism as reflected in the Canadian health care system have produced many significant health inequalities affecting different groups of comparatively disempowered people (Clark, 1992; Knudsen, 1991; Trypuc, 1988; Pollock, 1988; Frideres, 1988).

Another development relates not so much to contextuality as to perception. A strong sense of the authority of medical and health care knowledge and self-promoting medical organizational values may have made the physician and some other health care professionals perceive themselves to be gatekeepers and guardians who rightfully act to sustain social order and maintain coherent control of the health care subculture (Malone, 1993; Harrison, 1993; Lowenstein and Glanville, 1991; Henkle and Kennerly, 1990). Some more literally inclined analysts still support this view. For example, Shah (1990) suggests in *Public Health and Preventive Medicine in Canada*, that primary care staff must serve three essential functions: guardian, gatekeeper and chronicler.

Few conflict theorists would take such perceptions at face value—neither would they automatically accept traditional paternalistic assertions that physicians and nurses neutrally and altruistically adopt new medical and health care knowledge and approaches for the

benefit of the poor and the disadvantaged groups.⁴¹

For the purpose of my analysis of the CHC as a cultural system this theoretical orientation makes several significant contributions. I do not believe that we can characterize current transformations of health practices and beliefs without understanding the linked roles of integration and conflict, consensus and coercion--especially when as in this case one wants to contrast formal structures with informal ones, and beliefs with actual behavior. A key relevant strength of conflict theory is that it allows one to understand how a way of life coheres by working "behind the back" of individuals to form preferences and ways of seeing (Thompson et al., 1990:152). Moreover, recent attempts to assert the priority of "lifestyle" modes encompassing multicultural health care in a regime of decreased funding has severely challenged Canadian health care delivery professionals, leading to much conflict and uncertainty and rapid institutional change. Structural-functional approaches have limited applicability here. The conflict approach helps one highlight ongoing everyday struggles between frontline CHC nurses and management, how frontline nurses have conceptual formation and practical power, and how they try to use and extend that power.⁴²

Non-Marxist Conflict theory has been criticized on a variety of grounds some of which are relevant here. One drawback of this theory is that it never has succeeded in divorcing itself

⁴¹ In contrast, Todd (1989) shows how the cultural discourse of health professionals generates new categories of women's health problems and maintains relationships between doctors and female patients. de Certau (1984) more generally describes "strategies" used by members of a dominant group to flexibly respond to external pressure, and to sustain their authority in that cultural context. Cohen (1985) in *Vision of Control* elaborates on this subject in a study of institutions and deviants.

⁴² Sacks (1988) in *Caring by the hour: women, work, and organizing at Duke Medical Center* has demonstrated the power of subordinates on a medical institution very nicely. Her focus was to show how clerical, service, and technical workers almost succeeded in unionizing Duke University Medical Centre. She also shows the contribution of African American women in the movement's leadership. This is a significant contribution by groups like women activists, and interest groups to the medical bureaucracy culture.

entirely from its structural-functional roots (Ritzer, 1992: 123). Thus, many conflict theorists still concentrate either on how conflict maintains the institutional *status quo* or leads to beneficial change.⁴³ The approach continues also to suffer from some of the same conceptual and logical problems (for example, vague concepts, tautologies) as did structural functionalism (Ritzer, 1992:127).

This theoretical tradition over-emphasizes the institution's maintenance of a highly generalized dominant position and of the *status quo*. While the approach highlights systematic discrimination against certain types of service users, there remain a tendency to over generalize, (indeed to almost stereotype) about how institutions label or frame patients. Ng (1988) in *The Politics of Community Services* asserts to her that, the term "immigrant women":

Conjures up the image of a woman who does not speak English or who speaks English with an accent; who is from the Third World or a member of a visible minority group; and who has a certain type of job (eg. a sewing machine operator or a cleaning lady). Thus, "immigrant women" is socially constructed category presupposing among other things, a labour market relation (Ng, 1988:15)

Actual immigrant women are in fact highly variable and no institution would stereotype them so narrowly as this. A fine level of detail is required here as my focus is not on client discrimination, as in Kogan and Kotelchuck's (1994) *Racial Disparities in Reported Prenatal Care Advice from Health Care Provide*. Rather, it seeks to use various explanatory strategies to show how a CHC staff culture generates a full range of client categories and subcategories pertaining in some fashion to cultural difference.

A final qualification I have concerns the conflict approach treatment of history. To their

⁴³ Shah (1990) in his discussion of the Canadian health care system for example stresses the evolutionary concerns of social conflict. The same approach is also found in Crichton and Hsu's (1990) description of the Canadian health care system and of the evolution of public funding for health services in Canada.

credit, conflict theorists often use historical modes of explanation to show why health care delivery addresses various health needs and clients the way it does. In doing so, however, researchers often remain too close to the view that social facts (or social change) are the immediate products of chronologically previous events. This downplays the roles of both everyday practice and the contemporary constraints and contexts of health institutions and the country.

Medical and Health Care Institutions As Interactive Cultural Systems

In the late 1970s Arthur Kleinman (who seemed to be influenced strongly by Goffman's analyses of group behaviour) pioneered a new approach to the study of institutionalized medical systems and disease. In doing so, he centered on the medical system as a cultural system and argued that such studies require a new type of highly anthropological analysis. This is now called the "meaning centered" tradition in which, for example, disease is not a fixed, external, objective entity, but an explanatory model; Kleinman argued that disease belongs to a cultural frame, that particular to the specialized subculture of medicine (Good, 1990:53). My objectives for this study do not have anything to do directly with disease, health, or illness practices *per se*. My focus is on studying institutional health care culture as an ongoing construct—how community health centre staff construct the notions of cultural differences in their daily discourse and practice, and in so doing, how they construct culturally different clients. This cultural approach is therefore highly congruent with my needs. The cultural object here is the client.

More generally, the concept of a culturally-based *object* is now an important pillar in the study of both social interactions and culture. As Blumer (1969:69) suggests, an "object is constituted by the meaning it has for the individual or groups for whom it is an object ... this meaning is not intrinsic to the object but arises from how the person is initially prepared to act toward it". In this view, meaning associated with objects are fluid and change in different

social situations. Another point Blumer makes is that all objects are social productions in that they are formed and transformed by defining processes that take place in ongoing social interaction. Blumer also notes that since an object is something that is designated, one can organize one's action toward it, instead of responding immediately to it; when they act, people act toward objects on the basis of the meaning the objects have for them.

It is in this specific context that I hope to make a contribution, for while recent anthropological and sociological studies of medical institutions and medical practice demonstrate considerable cultural diversity within the current medical system, much current work still concentrates on issues of efficacy - on how bureaucracy does or does not function in this regard. Herzfeld notes that "in so doing, researchers address the success or failure of particular bureaucracies in terms of bureaucracy itself: service of citizens' needs, immunity to patronage, efficiency" (1992:2). There also has been much debate among social scientists as to whether institutions' organizational structures primarily cause culture (defined as shared values and beliefs, i.e., mental products) or whether culture primarily generates structure. Few studies integrate both processes, and as Thompson et al. (1990) frames it,

in recent decades, the social sciences have witnessed a dissociation between studies of values, symbols, and ideologies and studies of social relations, modes of organizing, and institutions. Cultural studies proceed as if mental products were manufactured in an institutional vacuum, while studies of social relations ignore how people justify to themselves and to others the way in which they live. One of the most important contributions of our cultural theory, we believe, is bringing these two aspects of human life together. ... institutional arrangements do, as methodological collectivists contend, constrain individual behaviour, but it is also true, as methodological individualists insist, that institutional arrangements are held together and modified by an institutional setting not for their making. As Marx says, it is individuals who create, sustain, and transform that setting. It is the individual (and not the behaviourist's rats) that shapes the maze while running it (Thompson et al., 1990:22).

This forms the basis of my approach to CHC culture and organization. The cultural theorists similarly work with the assumption that change is essential, even to the stability and

maintenance of cultural patterns. As Eckstein points out, "stability without change is like trying to balance oneself on a bicycle without turning the pedals. Just as turning the pedals of a bike is essential to stabilizing the rider, so change is essential to the maintenance of cultural patterns"(Thompson et al., 1990:80). I would agree with Thompson here that change is "(1) ubiquitous and endogenous, (2) necessary to stability, and (3) neither unilinear nor unidirectional"(Thompson et al., 1990:83). I hope to illustrate the dynamic dimensions of potential agents of stability and change throughout this study.

Cultural theorists also seek to explain why individuals or groups in institutions want what they want, and how do they go about trying to get it. Thus, some work in this tradition focuses on preference formation; it has shown that both preference and perception are socially constructed, often in such a way as to justify particular role relations, statuses and patterns of social relations. Douglas (1986) uses this approach to show how latent groups survive, and on "how a thought world constructs the thought style that controls its experience" (1986:43). As she and others stress, there is constant negotiation taking place between the signifier and the signified in institutional contexts, particularly I would say because often the signified are also signifiers: clients and other actually and symbolically potent types of individuals.

Another aspect of cultural approaches I have found useful is that they bring institutional rankings of preference into high relief. This, Douglas (1990) argues, arises centrally from people's involvement with other institutional contexts. Social relations are the great teachers of human life (Thompson et al., 1990) and the key means through which institutional preferences are socially constructed and produced (Herzfeld, 1992). Cultural theorists stress that such preferences are never just randomly assembled, but rather are patterned, both within and between individuals (Thompson et al., 1990). In what follows I have paid particular attention to how notions of advocacy, care, client responsibility, categories of client and the like hang together as aspects of staff world views and also to show how staff align social action and collective belief.

Although I depend heavily on cultural orientations in what follows, there are several pertinent weaknesses with this approach which Douglas (1982) has identified. In particular, in its more static manifestations it has little to say about people's choices between social forms, or local folk theories of choice; neither does it sufficiently place the individual actor at center stage.

Interactional Approaches to Knowledge Construction

Interactional approaches provide a connective here. Speaking broadly, Ritzer suggests that "*interaction* is the process in which the ability to think is both developed and expressed, and knowledge is constructed" (1992:102). It is here that the individual or group becomes social objects to one another. It is also a process where people learn symbols as well as meanings in social interaction. As Barth notes, much social science work including his own has "focused on the task of developing a perspective on the subjective and goal-pursuing actor. This has entailed taking up the questions of what place considerations of value and utility have in canalizing the behaviour of persons; the variation exhibited in behaviour and the factors generating this variation; and what it is that propels and constrains individual actors and thus shapes their behaviour and their lives" (1981:2). This is exactly what I try to do in ensuing chapters, where I have tried throughout to bring two potentially paradoxical dimensions of institutions together: bureaucratic social and cultural constraints; and individual consciousness and volition.

Interactionally oriented theorists would concur with cultural theorists in asserting that institutions in our society tend to hang together less due to their objective qualities than because of a tendency of people to perceive them in that way. This tradition focuses on how human personal and collective knowledge is developed through social action. This social action involves not only the individual actor, but also other person or persons. As Charon (1992) puts this:

Social action tells people who we are and what we think - our ideas, perspectives, wants, motives, intentions, morals, background, strengths, and dislikes. Social action therefore means that other people are very important to what we do (Charon, 1992:145).

Social interaction has many dimensions—far more than could be appropriately itemized here. Social interaction is mutual and symbolic (Charon, 1992). It involves personal identity, role taking, labeling others and influence of other's identities; presentation of self are of course central.

This approach is now extensively used in studies of institutions (Wood, 1994; Rhodes, 1993; Thompson et al., 1990; Stein, 1990; Ohnuki-Tierney, 1984; Teski, 1981; Goode, 1990; Murphy, 1987; De Voe, 1981; Goffman, 1975, 1967, 1963, 1961; Cowie and Roebuck, 1975), bureaucratic behavior (Golander, 1995; Herzfeld, 1992; Fisher, 1981; Townsend, 1971) ethnic, and group study (Verkuyten, Jong and Masson, 1995; Sprott, 1994; Merleau-Ponty and Stanner, 1994; Hazan, 1994; Keefe, 1992; Indra, 1991; Buchignani, 1991, 1988; De Vos, 1975; Barth, 1981; 1969), and community structure (Cohen, 1986).

One of the aims of the interactional approach is to explain the “inner or experiential aspect of human behaviors” as these relate to human social behavior (Chenitz and Swanson, 1986). This focus is especially important to my research in that it helps me better address some of the discourse used by CHC staff that have their roots in experiential reality. As Morse and Johnson suggest in *Understanding the Illness Experience*, “perceptions of reality are fluid and constantly created according to the definitions and meanings attributed to the situation and according to the negotiated response of the self and others within the situation. Therefore, people make use of symbols, interpreting and eliciting meanings rather than simply reacting to them” (Morse and Johnson, 1991:5). While I do not often use classical Symbolic Interactionist terminology, I do embed related theory at several key points. This is particularly true of my attempts to characterize staff behavior in context—especially nurse-patient interaction during the more than fifty home visits I observed.

In the following chapter I outline the methodological approaches employed in this research project, ranging from those involved in site selection and data collection to modes of analysis.

CHAPTER THREE

METHODOLOGY

This chapter highlights three broad methodological issues. First, I focus on issues relating to gaining access to an appropriate research site, and in an appropriate fashion. Second, I outline my data collection strategies. Third, I discuss my role as a researcher during data collection. The entire chapter is primarily descriptive in nature and sets the stage for the analysis that follows in the two subsequent chapters (Maykut and Morehouse, 1994; Dietz, Prus and Shaffir, 1994; Bernard, 1988).

Gaining Access

Site Selection

A major challenge facing every field researcher is to select a research site that is conducive to the descriptive and explanatory goals at hand. The nature of my research objectives, along with my institutional connections, made this task simpler for me than it might otherwise have been. Since my project and I were associated with the Regional Centre for Health Promotion and Community Studies at the University of Lethbridge, selection of and access to an institution was negotiated with the assistance of my thesis supervisory team,⁴⁴ and appropriate practice was followed concerning relevant ethical guidelines.⁴⁵ My major role in this process was to choose a topic for my research study which was academically rigorous

⁴⁴ I would like to thank my supervisory team members, Dr. N. Buchignani, Dr. D. Brown, and Dr. J. Kulig for their support and cooperation in the negotiation process with the community health centre's Chief Medical Officer and the Director of Nursing involving my placement at their institution.

⁴⁵ This thesis and associated activities subscribes fully to both the University of Lethbridge and SSHRC ethical guidelines. The proposed research agenda was submitted to the University of Lethbridge Arts and Science Human Subjects Research Committee after receiving approval by the health centre in question.

and “doable”. The selection of the CHC (as opposed to another institution) involved several factors: being sufficiently nearby to avoid access barriers involving long distance travel; accessing an institution involved in health promotion which was staffed primarily by health professionals; working in an institution that was large enough to offer a variety of programs and guarantee a degree of individual anonymity, yet small enough to be researched by one individual with the available resources. The CHC met all these criteria.

Specificity and Anonymity

Dealing with ethical issues like confidentiality, privacy and anonymity for the protection of communities and informants have always been a major challenge and point of discussion among anthropologists and other social scientists who conduct research with human subjects in small-scale contexts (Fluehr-Lobban, 1991; Sacks, 1988; Bernard, 1988). It is very common practice for anthropologists in particular to use fictitious names or pseudonyms for communities and other groups under investigation as well as informants. In the preliminary stage of this investigation the most central queries I had to face from the CHC management and staff were related to confidentiality and anonymity. Extensive discussion of these issues was required, as some of the particular constraints involved posed significant challenges. In the end there was consensus that total anonymity could only be achieved at the cost of serious negative consequences for the study, and a partial anonymity was selected as a compromise. Disguising the names of staff individuals in itself was not difficult and was done throughout. I used fictitious names (alphabetical referents in sequential order) consistently. To gain access and to obtain reasonably good data from an institution or within a group, it is crucial to develop confidence between the researcher and the researched (Shaffir, Dietz and Stebbins, 1994; Bagg, 1992; Babbie, 1992; Barnard, 1988; Chuchryk, 1984). In any case, I wanted to develop a congenial relationship with the CHC staff and to respect their wishes concerning my research activities. Success in data collection heavily depended on their cooperation. I explained to them that all my notes, my interviews and my thesis would not contain any of their names. I did, have to point out, however, that there would always be some risk that a person intimately familiar with the CHC’s organization and

staffing at that particular time might be able to gain a sense of who some individuals were due to staff position data I would have to present there. This was well understood.

My second challenge was to decide whether to keep the name of the city and the institution anonymous. At the outset, the focus of my study was to do a critical examination of how the professional employees of a health care institution in Lethbridge construct notions of clients, particularly those that are seen by them to be culturally diverse. The subjects of my study were envisioned from the start to be the staff of a community health centre. The attempt here from day one was to develop an interpretation based strongly on employees' perspectives through what Geertz calls the *verstehen* approach, or **emic analysis** as interpreted through **etic theory** (1973:14). This is not and never was intended as social science research aimed at the evaluation of service provided by the CHC— a point I made repeatedly in my initial proposal and thereafter, to all Centre staff. Neither had I any wish to assess the efficacy of treatment for specific illnesses or attempt a description of related folk beliefs. The maintenance of complete anonymity regarding geographic location and institution were therefore not as much an issue here as it might have been if I were operating in a more evaluative mode. A decision to maintain complete institutional and geographical anonymity would have had, as Sacks argues, “the ironic consequence of forestalling some of the most potentially involved and informed political and scholarly dialogue” (1988:9). To maintain authenticity and add credibility to this largely ethnographic study, I have made extensive use of sociohistorical information about Lethbridge, and about the CHC itself. All I have done is to alter the name of this institution. Throughout my thesis, this institution is referred to as the “*community health centre*”, “*CHC*” or “*the Centre*”. No reader at all knowledgeable about the region will fail to know to which institution I refer—a point I also impressed upon staff. I should note that because I have employed a strategy of only partial anonymity I refrained from collecting or reporting information potentially injurious to any individuals. Also my topical focus and near total lack of knowledge related to the medical and health care field have both led to a bare minimum of data collection and discussion of treatment and disease issues.

Research Setting: the Community Health Centre

Through the cooperation of senior managers I gained long-term access to a community health centre which provides a wide range of public health service to Lethbridge's 60,000 people, as well as a similar number of people from outlying areas. At the time of my research the CHC had approximately 114 employees.⁴⁶ All of them were Euro-Canadian women, with the exception of three Euro-Canadian men, and three Japanese Canadian women. This institution was then a medium sized organization by local standards with a primary focus on community visits: chiefly post-natal and to some extent involving the ill and the elderly. On a daily basis, the staff interacted with clients from a wide range of socioeconomic and cultural backgrounds—on a typical day, dealing with a hundred clients, and with another 250 to 300 people by telephone.

Preliminary Explorations

On June 15, 1994, I visited the community health centre with my supervisory committee members and met the Chief Medical Officer and the Director of Nursing. After my preliminary introduction to the research site,⁴⁷ it was clear to me that this institution was too large and complex for my research project, if investigated in its totality. As Taylor suggests, "to have a better understanding of the whole institution, a satisfactory start is concentrating on one part of it" (1970:7). Focusing on a single, or several programs or activities seemed to be appropriate. To decide on which program or programs to select, during the first three weeks I visited various programs and observed a range of services provided by this organization. During that period I met the managers, coordinators of the programs and other

⁴⁶ Staff from the Home Care unit are counted in this statistic, but they are physically located outside this institution. Therefore, daily activities of this sub-organization are not counted in the Health Centre's daily service figures.

⁴⁷ I thank the assistant director of public health nursing unit who gave me a tour of this organization and provided me with key information needed to initiate my data collection.

staff members of various programs and discussed in general terms their notions of and program support for cultural diversity, and how they had worked this into their institution's health priorities and everyday practices. The following are some samples of comments and questions I recorded during this initial stage in regard to the term "cultural diversity":

This is very useful for our organization to see how staff transform the notion of cultural diversity in their everyday practices.

So where have you come from? We don't have very many people of your nationality in this community.

I can say that we do not have established programs dealing with cultural diversity in [this] small community. There are good programs in Calgary and bigger cities.

Three to five years ago they⁴⁸ under the supervision of the Director of Nursing had a program established. They hired two staff to work with their community and the community health centre. But, it did not work. Right now we⁴⁹ are trying to set up a program with [a] Mennonite group, but it is so far not working out.

Have you gone to the local small town clinic? They have programs for Hutterites, Mexican Mennonites. We do not have so many programs.

When you say cultural diversity, do you mean the Natives?

It was clear to me very soon that "cultural difference" was an idea of which everyone was aware, but seemed to be thought of as associated primarily with programming challenges in other places, perhaps Natives excepted. The Centre had no staff explicitly involved in coordinating multicultural issues, and no programs in place that targeted specific "ethnic" or Native populations.

⁴⁸ Here "they" refers to the community health centre administration and the local Latin American association.

⁴⁹ This person's job responsibilities encompass three community health centres in southern Alberta. "We" here refers to one of the other community health centres.

Public Health Nursing Program (PHNP)

The main charter objective of this CHC is to prevent disease and promote health at an individual and community level. The Public Health Nursing Program is the key locus of CHC service delivery.⁵⁰ In financial terms Public Health Nursing is the second largest program in the CHC after Home Care. This umbrella program organizes a wide range of services: immunization, a baby clinic, various types of home visits, school programs, and post-natal and prenatal programs. I found the Public Health Nursing Program to be a very appropriate locale for my research given their diverse clientele. Many of this unit's programs used strong universal service mandates: immunizing all local children, providing postnatal services to all new local mothers, etc.

The Public Health Nursing Program (PHNP) then employed sixteen nurses and two nursing assistants. There were two managers (the director of nursing and the assistant director), two senior nurses, and fourteen public health nurses. Out of these latter fourteen, four were part-time, one casual, and nine full-time. The services provided by this unit were classed under two sub-programs. The *maternal and child health program* concentrated on prenatal classes, post-natal classes, newborn home visits, development screening, school health, hospital liaison, nutrition counseling, bereavement visits, and general health promotion. The *communicable disease control program* focused on infant and preschool information. The nurses involved in these two sub-programs were physically located in one area, which enabled them to work closely with each other. Indeed, this was necessary, as many of the duties in each sub-program were carried out by all the nurses. For example, the immunization clinic, newborn home visits, school programs, infant and preschool information, development screening, school health and bereavement visits were distributed among all the public health nurses in the PHNP.

⁵⁰ For a detailed description of Alberta's Public Health Programs see Schartner (1982).

During my subsequent nine months of episodic fieldwork at this institution I became an active participant and spent virtually all my time with the PHNP staff. I soon attempted to focus exclusively on one category of service among those listed above: newborn and other home visits. There were several reasons for this. First, institutional discourse can be best understood by intensive observational research done among relatively few people (Verkuyten, Jong and Masson, 1995). Second, I soon became aware that several formal procedures for client categorization and evaluation had been developed both by the Alberta Health Department and CHC management that were relevant to newborn visits. It was clear to me that there were also informal bracketing practices taking place as well. This well suited my needs. Third, selection of the home visit program allowed me to accompany the nurses and actually observe the client identification, evaluation and categorization as an active process. Finally, nurses involved in such visits interacted with each other constantly and I had the opportunity to overhear and participate in nurses' conversations with each other about their clients; in other words, I had an opportunity to participate and collect data both in the "front stage" and "backstage" (Goffman, 1959) of this interactional process.

Getting in at a Time of Turmoil and Change

In the spring of 1994 the Alberta government made an announcement that it would eventually and dramatically change the province's health care system. One of the strategies this government undertook was to eliminate its provincial budget deficit by slashing government funding to all the government departments and programs including health. At this politically sensitive time a major challenge was to get the health centre staff to talk comfortably with me about cultural diversity when they were greatly worried about personally critical things such as job security and impending organizational restructuring. In order to facilitate this, I considered my entry into the field carefully.⁵¹ I was, for example,

⁵¹ The literature indicates that cultural and ascriptive differences and similarities between the field researcher and the researched may constrain or enhance access to a research setting (Shaffir, Dietz and Stebbins, 1994:36)

conscious of problems or sensitivities that might arise because of my physical appearance as a South Asian. I was also aware that my "East Indian" background might itself activate actions and ideas involving the topical frame under investigation. I was also a university-based outsider and in spite of my best efforts, initially I was seen as a researcher who was there to evaluate the staff's performance. To enhance my access to the world of the public health nurse, I decided to develop the limitations of the initial role and position allotted to me in a positive way. For example, I offered to help the nursing staff in any way I could in relation to culturally different clients. This and other entry strategies confirmed to me that in order to maintain a positive relationship with long term subjects, much ongoing reciprocity is required.

Another thing that made my initial access easier was the entirely coincidental presence of four nurses whom I knew quite well prior to my field research. Their presence also helped me immensely, first in regard to the alleviation of some of my initial worries and frustrations, and then during the entire nine months of fieldwork. I soon developed two key informants, who assisted me greatly during the whole data collection period. Both of my key informants⁵² had all the qualities that a key informant ideally might have in order to assist me in understanding the native perspective (Bernard, 1988).

Retrospectively, another factor which helped me to enhance my rapport with the nursing staff in particular was my willingness to do a presentation to staff regarding my research objectives. I was asked to be specific in that presentation and to include information about the length of my stay at this research site, the number of days and hours a week that I was to spend with them, the number of visits with each nurse I anticipated, and the area of activity I would be observing. The request came from the public health nursing program director, who was designated as my on site supervisor. As she explained it to me:

⁵² I thank both nurses here, sadly, in anonymous fashion. Initially when I began my research I was cautioned by one of the nurses not to participate in any conversation relating to clients because of the fact that I have limited knowledge related to the health care delivery.

We in nursing have to exactly know how many home visits you want. Your length of stay, type of families. For example: are you interested in white middle class families? Your research methodology. You have to remember that the nurses have to worry about you. You are a researcher, so you have to tell us what you are trying to observe.

I was confronted with these sorts of questions time after time. On September 12, 1994, I did my presentation and made myself available for further questions and inquiries in relation to my study. Many nurses wanted to know if I would be using a tape recorder during my interviews, showing discomfort with this possibility. I emphasized that I would use a tape recorder only as a backup tool for my notes and only during formal interviews, and one would only be used if the participant had no objection to it. This met with general agreement. I was also careful to reemphasize the complex issue of personal confidentiality and anonymity.

Data Collection Methods and Strategies: My Role and Experience

My fieldwork began on June 15, 1994 and was completed on April 5, 1995. During this period, my methods of data collection were those conventionally associated with an ethnographic study in a contemporary applied context:⁵³ observation, participant observation, and open-ended as well as semi-structured interviews (with the office staff of the community health centre, administrative director, nursing director, and community health nurses), and the compilation of extensive field notes. Considerable literature-based and statistical data were also used for contextual and descriptive purposes. In the following section a detailed description of each strategy of inquiry is presented.

Ethnography

When social scientists speak of ethnography, Prus suggests that “they assume the tasks of thoroughly examining the life-worlds and practices of those whose situations are being

⁵³ I applied a methodological “multimodal framework” (MMF) as suggested by Samuel (1990).

studied" (1994:17). This refers "in part to the detailed description and interpretation of a group's way of life, beliefs, values, expectations, rules, conscious and unconscious levels of meaning, attitudes, roles and the consequences of these for behaviour" (Stein, 1990:4-5). This methodology (actually, a linked set of methodologies) is the hallmark of cultural and social anthropology (Maykut and Morehouse, 1994; Bernard, 1988; Spradely, 1980; Geertz, 1973). It is often described as the science of cultural description, interpretation and formulation of theories (Wilcox, 1980; Spradely, 1980; Geertz, 1973). Stein, in *American Medicine as Culture*, asserts that:

Ethnographic work is to help build a corpus of rich, intensive emic studies that further permit one to develop a comprehensive cross-cultural ethnological etic theory, not only about the individual group one studied but about commonalities and variations in being human. Ideally, these methods and models help us to know what is culture or era specific and what is species specific, that is, universal (Stein, 1990:5)

A "good" ethnographer can integrate both or use alternatively the "insider" and "outsider" experience to gain an appreciation of the actor's perspective (Bernard, 1988; Spradley, 1980)- which was important, even critical to my interpretation of this CHC's culture.

Observation

In order to support and further develop my hypotheses that CHC discourse concerning clients is grounded in principles of medical essentialism and is socially constructed, my research approach extensively involved what Geertz (1973) calls the "thick description" of the social discourse and behavioural setting of the CHC. My first domain of inquiry was to discern the nodal points (in beliefs, values and practices) that are played out in the form of symbol, sign, ritual, and language. Many suggest that this can be done best, at least initially, by being an astute listener and observer (Stein, 1990; Bernard, 1988; Wilcox, 1980). For instance, the poster I found in the lobby area of the community health centre which displayed the various types of services available and made use of pictures meant clearly to involve different race/ethnic, gender and age categories, conveys an unspoken message of the institution's acknowledgment of cultural diversity.

Taking this rather passive “wide-angle lens” approach (Spradely, 1980) frequently helped me throughout to gather macro-level information about the CHC as a cultural organization. Also, observations made of micro-level interaction involved in the everyday activities of the CHC can be best described as the recording of extensive descriptive details about the “imponderabilia of actual life and everyday behaviour”.⁵⁴ As Bernard (1988) suggests, spending time and getting to know the physical and social layout is a significant part of successful ethnography. It in particular reduces problems of reactivity. He further argues, “low reactivity means higher validity” (1988:150).

I attempted to make my observations in a structured manner. Initial observations began in the lobby area of the CHC. This was located on the main floor and was the main entry point for every individual that came to the institution. Spending much time in the lobby gave me the opportunity unobtrusively to study the physical layout of the CHC. In order to make it easier for the staff and myself, this strategy involved passively attaining an *intimate familiarity* with a sector of social life (Shaffir, Dietz, and Stebbins, 1994). I also attempted to minimize staff discomfort and threat by initially maintaining a presence, yet also considerable social distance from staff.

Observations of a wide range of verbal and nonverbal presentations were made, many in interactional contexts. Literature on cross-cultural or multicultural health care delivery suggested that the observation of “front stage” interaction would contribute much insight into the role of the health institution in caring for culturally diverse groups. This was the rationale for my extensive commitment to observing home visits (see below). I observed many other contexts of interaction among staff and between staff and clients: appointment procedures for all services; activities in the clinics and staff meetings.

⁵⁴ This quotation of Malinowski (1922:22) is taken from Kathleen Wilcox’s *The Ethnography Of Schooling: Implication For Educational Policy-Making*.

Clinics (baby well clinics, adult/travel clinics, and immunization clinics) were held routinely in the morning, afternoon and evening of each workday. As these clinics drew in different types of clients, they were potentially valuable sites for dramaturgical analysis (Charon, 1992) and I made repeated observations of them. Observations were made during all three times of the day on a random basis⁵⁵.

Secondary Documents

As Prus suggests, observational technique:

encompasses not only those things that one witnesses through one's visual and audio senses, but also any documents, diaries, records, and the like that one may be able to obtain in [a] particular setting ... Observational material on its own is an inadequate basis on which to build an ethnographic study because one would have to make extensive inferences regarding people's meanings and intentions (Prus, 1994:21).

Secondary documents can provide significant contextual information (Bell, 1994); it certainly did so here. A sample of the community health centre's philosophy statement was obtained which outlined the charter of the institution and its stated roles and procedures in practicing preventive treatment in a diverse community. Other pertinent written documents including health information brochures, blank child health records, information packages for new mothers, postpartum visit documents, translation sheets, blank notice of a live birth (prepared by Alberta Health), the nurses' weekly activities reports, and early postpartum

⁵⁵ A drop-in clinic for babies operates every Thursday afternoon from 1:30-3:00 p.m. The travel clinic was on Monday morning, and Wednesday and Friday afternoons; the baby clinic was held all day Monday through Wednesday, on Thursday morning and Friday afternoon. An extended hour baby clinic was held on Thursday afternoons from 3:55 to 5:30. The baby clinic was used by parents with appointments mainly for immunizations, but also to assess the baby's motor development and to weigh the child. Health or illness related concerns of the parent in relation to the child were also discussed. The drop-in clinic was informal, appointments being made by the parents after they arrived at the CHC. The main focus of this clinic was to visually assess and weigh babies and discuss any problems parents may be having.

discharge routines and report were assiduously collected for subsequent interpretive analysis. I made a point, however, to collect no documents nor CHC materials pertaining to specific clients.

Participant Observation

Participant observation potentially adds a different and vital dimension to research (Prus, 1994). It allows the researcher to get closer to the lived experience of the participant than does observation alone. I should note that my commitment to an interactionist approach was of course limited by my lack of medical credentials, which restricted how participatory I could be during nurse visits to new mothers. As with many ethnographic case studies, much of my “participation” in my participant role was limited (see below): physically being there, occupying a specific role and status, verbally communicating, and providing some minor assistance. I volunteered to work as the nurse’s assistant. I helped nurses in carrying their equipment and official documents. I also got involved in recording information that the nurse would call out to me during our home visits. I helped set up post-partum classes. Extensive notes were taken; after the fact for home visits at the request of nurses.⁵⁶

In summary, professional barriers made it impossible for me to participate in many activities as would a nurse and, therefore, my objective was to do the next best thing: to look over the shoulder of the administration, nurses and other staff while they performed their duties, to be helpful and to ask many questions in a range of contexts. This in particular involved the sensitive monitoring and recording of the delivery of services in the clinic setting, home visits and while visiting the hospital; and of the internal structure and the decision-making processes of this institution illustrated by one general staff meeting, two public health nursing staff meetings, and other workshops and events.

⁵⁶ See the section on field notes below.

All of my participant observation activities were conducted while accompanied by CHC staff. During the nine months I was there, I made 52 new born home visits with ten nurses. As a general practice, nurses made at least two home visits to each new mother giving birth in Lethbridge. The first visit was called the "initial visit" and the second the "follow-up". Each nurse was initially to take me along to six home visits (including both first and second visits), but I eventually had to be flexible about this number⁵⁷. Due to various practical difficulties my number of visits made with each nurse in the end was different and I did not achieve my initial tentative target of 100 home visits during the time I had available.⁵⁸ My initial target number of 100 was based upon knowledge that CHC nurses make on an average 150 home visits in a month. The completion date for my field data collection was set at December 15, 1994, but as securing home visits took much longer than I had anticipated, I extended my data collection efforts to April 1995.

In addition, I had the opportunity to take part in nine post-natal classes (every Tuesday afternoon from 1:30-3:30 p.m, plus one evening class). I also made five visits to the baby clinic, three random visits to the adult immunization clinic (which is also known as the travel clinic).⁵⁹ I spent one day with the hospital liaison nurse who took me to the hospital where she visits various departments on a weekly basis (radiology, the outpatient area where she collected X-rays, the maternal unit, the intensive care unit, the pediatric unit, and the infectious disease unit). She was responsible for making arrangements for CHC nurses to

⁵⁷ The six visit quota had been developed after finding out the total number of visits that each nurse made on average in one month. Also, a request came from the nurses that I should be exact in my number of visits required with each nurse.

⁵⁸ A few nurses were unable to take me on home visits because of timing conflicts. Some were busy with other special projects, and small number just did not want me there when they made home visits.

⁵⁹ All these participant observations were carried out after receiving permission from participating clients in person or over the telephone.

contact all new mothers discharged from the hospital, who were seen to require high-risk health instruction or observation in the home. This nurse was the senior nurse in charge of the maternal child assessment program. Every year in the month of October the CHC Public Nursing Program organized a "mobile flu clinic" for people who were over the age of sixty-five and had chronic and respiratory disease. I was invited to observe the operation of this clinic by the senior nurse of the communicable disease control program and accepted. I was also invited by the director of nursing to attend a workshop with the nurses on Native Awareness (December 9 and 16, 1994) and an Advisory Council Meeting of Streets Alive Family Support Association programs on March 22, 1995.

Further, I visited the staff coffee room every afternoon. In this setting, informal communication and exchange of personal and professional information constantly took place among staff. By the third month of my fieldwork I had physically moved into the Public Health Nursing Programs section of the CHC. I used two office spaces alternately to do my journal writing while waiting for the nurses to invite me to go on home visits with them. This facilitated my access to "backstage" data, while making data recording easier. Throughout, direct quotations were recorded verbatim where possible.

In-depth Interviews with the Community Health Staff

The third method of data collection used extensively was interviewing. My participant observation included a great deal of informal conversation, especially after we left clients' homes. I also conducted sporadic interviews of the CHC's clerical and professional staff. These usually took place when I was waiting for the public health nurses to return from their lunch breaks, or from outside appointments. This type of unstructured or informal interview is of course common in ethnographic research and often takes place during the course of participant observation (Maykut and Morehouse, 1994; Bernard, 1988; Spradely, 1980). Usually I made use of many open-ended questions here as the purpose of these interviews was to elicit the informant's "story" with as few prompts as possible (Morse and Johnson, 1991:7)

More extensive open-ended interviews are particularly valuable when a researcher is interested in gaining a participant's perspective. This allow a greater range of possibilities for meanings to be constructed by the individual subject (Maykut and Morehouse, 1994:82) and not just by the interviewer. As Prus (1994) suggests:

... letting the participant "talk back" to the researcher is fundamental in achieving a more viable sense of intersubjectivity. Indeed, without this opportunity to uncover, ascertain, and qualify the meanings that others hold for objects in their life-worlds and the ways in which people go about accomplishing their activities in practice, it would make little sense to talk about studying human lived experience (Prus, 1994:22).

To achieve these ends I also did extensive semi-structured interviews with staff. These interviews were conducted with the director of each administrative unit, director and assistant director of the public health nursing programs, and fourteen CHC nurses. The director of administration was also interviewed to collect data on decision-making processes, and organization structure. He was also the secretary and treasurer of this health institution's Board, which is responsible for allocating funds for its operation. My original plan was to interview the chief medical officer and some members from the local Health Board to explore their perception of multicultural health care and how they worked this concept into their CHC mandate. Unfortunately, provincial government health care reforms had by that time made the local board of the CHC disfunctional as a prelude to its disbandment, and I was unable to observe a board meeting or interview board members. The director and assistant director of nursing were interviewed primarily to understand how they thought health policies were established and implemented in various programs offered under their supervision. Finally, frontline nurses were interviewed about their roles in the actual implementation of the health care delivery programs, and their perception and experiences relating to the culture and cultural diversity of clients.

It is the responsibility of the researcher to establish and maintain a positive interviewing climate (Maykut and Morehouse, 1994; Bernard, 1988; Spradely, 1980). In this regard, I first

prepared a preliminary set of interview questions and pretested them on two of my informants. I divided my questions into four broad areas: participant demographic or biographical information; their understanding of health and health promotion; their sense of culture and cultural diversity; and finally issues relating to services and programs. Some revisions were made to the question format and questions based upon suggestions made by my two informants.

Formal appointments were then made with individual staff to guarantee that I had an opportunity to speak to each of them privately and without interruption. As mentioned earlier, I had assured everybody personal anonymity, and no one refused to make an appointment to speak with me. In every interview I took along my tape recorder, but used it only after getting permission from the participant, and only as a backup to my notes. All the interviews except one took place in the community health centre itself. To maintain complete privacy the office door was shut and front desk staff were asked to take messages for that particular nurse for the duration of the interview.

At the beginning of each interview, individuals were told that it was with the help of each of them that I was learning about their institution's culture. Anything they shared with me would remain anonymous. To make the interview non-threatening and supportive, I explained at the onset the structure of the interview and the anticipated time span (which was completely under the participant's control), and I requested them to reflect centrally upon their own experiences. I attempted to begin the interview moving from the general to the specific which Chuchryk (1984) calls "concrete information". Every interview closed with the two following questions (associated follow up questions) and a note of thanks to acknowledge the participant's cooperation:

Do you have any other additional information that you would like to share with me?

Was this interview threatening in any way?

Field notes

Field notes are critical to compiling an effective ethnographic record. Maykut & Morehouse describes their ideal qualities: “the qualitative researcher’s field notes contain what has been seen and heard by the researcher, without interpretation” (1994:73). Bell (1994) likewise sees field notes as a source of description, and also as a site of reflection. Much of the data collected took the form of field note descriptions made immediately following observations or during the interview process. I maintained four types of field notes. The first type of notes related to my research methods and techniques. Here, I recorded such things as the number of home visits I made, the preliminary questions for the interviews, and new ideas regarding my field research. All home visit data were recorded in detail in my field notes that were first inscribed in a condensed form and expanded later on. This material was placed in what I called my descriptive notebook. In a third notebook I expanded my field observations in order to provide a contextualized description of these events. Throughout, wherever it was possible I recorded direct quotations from the nurses’ discourse. This sometimes was a difficult challenge, as I was barred from carrying my field notebook with me when actually visiting client homes. I also had another notebook and tape recorder to directly record data from my personal interviews with each staff member. Tape recorded information was used later to fill in the missing gaps in my note taking.

CHAPTER FOUR

CHARTER, STRUCTURE AND EVERYDAY PRACTICE AT A COMMUNITY HEALTH CENTRE

In this chapter I look at the everyday operation of the community health centre (CHC). I begin my discussion by grounding in the premise that when the staff of the community health centre are interacting with their clients they do not think and perceive themselves in terms that most of the social scientific literature has stressed: not as “guardian”, “gatekeeper”, or “authority” figures.⁶⁰ Instead, they think of themselves more centrally in roles of “correction” (Foucault, 1979)—correction of “specific-problems” that are integral to this public health institution’s mandate and practices. The following generalizing discussion of the business (the physical and social space) of the institution, or as Foucault calls it, the “capillary network”, is based on my interaction with the staff and my ongoing observations of inter-group and intra-group relationships. I had the opportunity to spend a considerable amount of time with the nurses and the managers of the Centre’s public health nursing program, and as a result the following discussion is grounded in, and primarily presented from these actors’ perspectives.⁶¹ In doing this, I hope to evoke the basic negotiation processes involved in the actual provision of multicultural preventive health service in this local health centre. Then I attempt to interpret the surface statements and the deeper structures of some of the

⁶⁰ See Edelman, Murray (1974) *The Political Language of the Helping Professions* (Politics and Society, Vol. 3(4):295-310)).

⁶¹ During my nine months of fieldwork at the Community health centre, staff specifically discussed with me a variety of relevant topics: personal biographical information and life history, the meaning of health and health promotion, culture and cultural diversity, and the development and future of cross-cultural and multicultural health care. The quotations presented below are drawn from notes I took while participating in conversations with individual nurses or in group sessions with public health nurses and managers, or from other data collected directly from observations, participant observations or extended interviews.

narrative stories I present in order to highlight associated everyday process⁶² and bureaucratic decision-making/rationality. I begin to explore relationships between the perceptions of the staff (as subject) and their (subjective) experiences of the culturally different client (as object) and the concepts developed to explain and address it; these themes are considered more centrally in Chapter Five. Most importantly, my focus is on the use of symbols, language, metaphor and the social order or “structures of social action” (Cohen, 1985) incorporated in the inside workings of the community health centre. These are seen as important for privileging and maintaining social bonds (Scheff, 1990)-- which are in turn seen as key underlying motives for action within any social organization.

Douglas (1973) argues that a deep knowledge of institutions rests on an understanding of social boundaries and systems of accountability; these constitute and reflect the world we witness and experience and the sets of rules, codes and obligations with which we are aligned.⁶³ For example, Hazan (1994) in *Old Age: Constructions and Deconstructions* argues:

Generally speaking, knowledge, rather than consisting of the data at our disposal, is shaped by perceptions, beliefs, rationalizations and other non-rational forms of imagery. When we speak of knowledge, then what we have in mind is in effect images of knowledge. ... Most of the professional literature on ageing is aimed at the know-how-oriented reader, whose interest is in information about the state of the elderly as an object. Only a smattering of research is dedicated to deciphering the world of old people as subjects, and even less of this work attempts to understand the ways in which knowledge about ageing is produced and reproduced (1994, pp. 3).

This chapter then begins with three objectives, one of which is to investigate the discourses

⁶² During this period the health board of this institution (which was formally the backbone of the institution’s decision-making process) was rendered dysfunctional because of health care reforms that were taking place at that time. The Centre’s control was amalgamated under a regional board, and its local board has since ceased to exist

⁶³ This paraphrase is taken from Haim Hazan’s (1994) *Old Age: Constructions and Deconstructions*, pp. 2.

that account for "the positions and viewpoints" from which the Community health centre's staff speak of cultural diversity and "the institutions which prompt people to speak ... and which store and distribute the things that are said".⁶⁴ This then sets the stage for detailing what I term the community health centre's "theory of essentialism" involved in promoting effective involvement in the development of services and programs, cross-cultural and otherwise. This is cast in such a way that part of this ethnography contributes to our understanding of general knowledge construction processes as they take place at the micro-level, within the Public Health Nursing Program specifically, and the community health centre more generally.

I first turn to a discussion of what my fieldwork data on preventive treatment practices and talk indicate about the role political and economic forces play when staff attempt to control illness by intervening against specific health threats specified within the Public Nursing Program. In Community Health, the Public Health Nursing Program has been (theoretically at least) the scene of a series of significant health care reforms involving cross-cultural difference.⁶⁵ The third objective is to trace relevant connections of institutional power from one of its key sources: from where medical knowledge and ideology are developed that have implications for the assertion of institutional identity and legitimacy (Good and Good, 1993). This is exemplified by constructing a basic understanding of essentialist definitions underlying staff practice, which in turn also helps us to analyse the role that the seamless

⁶⁴ Diane Macdonell's *Theories of Discourse: An Introduction* quotes Foucault work (1976, trans. 1979, p.11). on p.2.

⁶⁵ According to the recent literature in medicine, clinical practice and epidemiology there are many examples which illustrates a series of adaptation strategies with regard to multicultural health. For detailed information on cross-cultural care see Brosnan (1990), Leininger (1989), Kaufert, O'Neil and Koolage (1985), Tripp-Reimer and Afifi (1989); on cross-cultural research see Mueck (1992), Henderson, Sampelle, Mayes and Oakley (1992); on administration and cross-cultural issues see Lowenstein and Glanvill (1991), Burner, Cunningham and Hattar (1990), and Teram and White (1993).

relationships among language, knowledge, ideology and practice (Ibid.) have in the transformation or development and application of multicultural health care.

The Community Health Centre's 'Identity'

As a Public Health Service Provider

The Canadian public health services draw their charter from the societal objective of protecting and improving the health of populations (Crichton and Hsu, 1990). Contemporary health care service providers⁶⁶ and public health services in Canada began in the early nineteenth century supported by government funds. Historians generally argue that this service was established by the precursors to the federal Canadian government as a reaction to the advance of cholera and to prevent the spread of other water and food borne diseases in the country.⁶⁷ Gradually, the rise of discussion of other health-related problems and on societal health disparities⁶⁸ further bolstered support for the public health service as an essential societal service; an incorporated philosophy was that every Canadian might access

⁶⁶ In Canada during the nineteenth and first half of the twentieth century, people with means were expected to pay for services like accessing doctors, hospitals, and pharmacists. For an in-depth analysis on Canada's health care system see Crichton and Hsu (1990).

⁶⁷ Canada's first Board of Health was established in the 1800s to coordinate society's defence against epidemic outbreaks. See Scharner (1982) for detailed historical information on the development of health centres in Alberta.

⁶⁸ At the beginning of twentieth century the introduction of statistical methods to analyse the causes of unequal health status among various groups in the Canadian population was an additional factor that influenced political decisions supportive of a government-funded public health program. Jensen (1987) describes in detail the development of statistical approaches in Western medicine.

it essentially free of direct financial cost.⁶⁹ Without stretching the definition too much, it would be fair also to say that such institutions have always been community-based.⁷⁰ The institutions that resulted have helped protect millions of Canadians from the spread of communicable disease, and have greatly reduced morbidity and mortality rates among a wide range of key groups and types of people.

This set of institutions continues to operate in 1995 in every part of the country with many of its original objectives intact. It is true that a wide range of pressures have either affected or strongly suggested that these objectives be modified to more effectively address Canada's increasingly diverse people. Actual and asserted barriers to full access (social, political, cultural, economic, situational, etc.) in particular have resulted in the continuous expansion and re-formulation of new programs and services. Even so, the basic charter remains the same: to provide all residents of Canada an equal opportunity for health.

This very general charter is implemented differently however in every such institution. Again, my intention in this research as mentioned earlier is not to lump all community health centres together in my substantive discussion. It would be as inappropriate to make global generalization about all the health centres in the country, or even the Province, based on my research findings dealing with one such centre as it would be to generalize all culturally and racially different clients. As a case in point, there is a considerable variability among the three community health centres in this region alone. They differ in the size, efficiency, quality, atmosphere, organization of staff, administrators and program priorities. In certain

⁶⁹ According to Crichton and Hsu (1990:96) the public health services "were not means tested but supplied on the principle of universality as a contribution to the community development." This viewpoint can be dated back to eighteenth century Europe, when the state or monarch (at least in principle) took the full responsibility in looking after their subjects (Jensen, 1987).

⁷⁰ The explicit notion of community based care was borrowed from European countries (Clark, 1992; Jensen, 1987), yet was formally established in Canada by the 1890s.

important ways each health centre poses a unique situation (Townshed, 1971). Linked parallels with others deriving in part because all community health centres in the country abide by the same set of rules implemented in Canada's Public Health Act, employ similarly socialized service workers, and are government funded.

The CHC as a Bureaucratic Organization

Although the community health centre addressed here received its community health mandate in 1958, the impetus for its founding can be traced to Canadian health services principles of the nineteenth century. The central underlying institutional objective here as elsewhere continues to be the provision of "preventive treatment" to the local community. Very recently, social pressures have required this institution to unpack "community" in several ways: most particularly for this study, to give attention to multicultural primary health programming, in order to ameliorate disease and ill-health among "culturally-different" members of the community. The result is that this health centre now claims to demonstrate an active interest in the cultural norms and practices of "other" cultures. This should not suggest of course, that the concept of cultural diversity is a new phenomenon on the cultural scene.⁷¹ Instead, using Foucault's "production of knowledge" approach it can be argued that in this case the classic "medical gaze" locally has begun the extension of the old code of medical knowledge in a very specific way: "the gaze" has included yet another way of seeing things by categorizing it chiefly as a medical/health concern. This process nevertheless has rather suddenly led community health staff to look at and articulate a range of "problems" through reference to client cultural and "racial" characteristics. At this initial stage of what presumably will be a long process of integration of notions of cultural difference, this has been done so far chiefly by incorporating relevant issues into the extant medical paradigm of curing or preventing illness through reference to fairly immediate causes. As Rhodes (1990) puts it:

⁷¹ See Buchignani (1991); Burnet and Palmer (1985); Buchignani, Indra and Srivastava (1985) for more detailed analysis on the subject of Canadian multicultural society.

Medicine rather than functioning to delineate a reality that exists independently of its description, are techniques for the shaping of reality that create patients as individuals susceptible to a particular kind of judgment. Thus, people are profoundly shaped by disciplinary mechanisms that permeate our society, with medicine primary among them (Rhodes, 1990:163).

“Illness prevention” clearly remains the basic ideology organizing what public health professionals do and how they present their “reality” in a distinct manner. In this respect, it can be argued that it is more institutional practice (Good, 1994) than axiomatic theory that has helped them extend their medical knowledge into this comparatively new domain; in order to respond effectively to a perceived new set of challenges, it has approached the concept of cultural diversity as a problematic object of concern. More generally, Lowenstein and Glanville (1991) further delineate this assertion concerning “cross-cultural concepts” in practice by pointing out the importance of adaptation and expansion to most medical and health care organizations’ survival.

This is not to say that the processes through which ideas concerning cultural diversity become institutionalized do not involve the wish to provide better service to a diverse population. Such processes are recognized as having the potential to, and if integrated adequately, facilitating the recognition of “racial”, cultural and class differences as important to institutional goal attainment. Malone (1993) argues, the integration of cultural diversity concepts reflects the institution’s commitment through their guiding principles regarding cultural and racial sensitivity. This is however hardly automatic. Like any set of ‘foreign’ ideas deriving initially from outside the institution’s frame of reference, there is always a significant risk that notions of cultural diversity simply will be reconfigured to conform to extant institutional ideologies, charters and practice.

In the following section the meaning of “cultural difference” to Centre staff will be further elucidated. An attempt is made to demonstrate that the concept of “cultural diversity” as a perceived risk (Douglas, 1992), was discussed simultaneously in two different institutional contexts. One in the framework of the institution’s formal mandate, where I argue that the

concept is highly camouflaged. Again it is discussed primarily in the terminology of “a problem” of institutional legitimacy.

The following section begins with an analysis and exploration of the strategies, or “social inventions” (Scheper-Hughes, 1992) that are manifested by the community health centre in its various processes of staff and institutional self-presentation (Goffman, 1959)—both in the community health centre’s social structure and everyday practice. I seek to do this by concentrating on common themes and meanings of cross-cultural care as narrated and explained by the staff of this local public health institution, as well as from my observations drawn from participant observation. What is the best place to initiate an analysis of an organizational culture? Critical initial questions here are: what helps the health professional come to believe that their practice represents adequate multicultural health care service? In this context, how do members of the community health centre perceive that what they do constitutes health promotion? How do they distinguish themselves as health promotion workers from those in other health organizations?

I spent several weeks deciding where to start to find the answers to these and related questions. Taylor (1970:7) says that “a satisfactory start could be from any part of a complex organization”, but I shall retrospectively attempt to initiate my discussion here beginning with an analysis of Centre’s overall institutional-cultural expectations. I of course am dealing here with both an organizational subculture and an ongoing organization which is addressing certain health issues and concerns⁷² as a central goal. These goals are part of all public health staff’s experiential realities. They also serve to highlight the difference between themselves

⁷² The primary objective of the institution is to provide health education and illness prevention. It also acts as a liaison between health professionals like doctors, social service agencies, and the client. The main focus of this organization is preventing illness rather than responding reactively after the onset of disease and injury.

and other social organizations.⁷³

The form and centrality of *hospital* goals has of course been extensively discussed (see Todd, 1989; Murphy, 1987), albeit typically in a rather static fashion. Murphy (1987) explores the role of hospitals using a Parsonian framework, and while his focus is on the objective of curing or attempts to cure, he also shows how strongly the institution's objectives remain conceptually grounded in the now traditional, essentialist biomedical model.⁷⁴ It is however argued by many anthropologists and sociologists (Hazan, 1994; Good, 1994; Abu-Lughod and Lutz, 1990) that institutions are always forming and reforming their ways of seeing. Attention to an institution's everyday life in particular allows one the possibility to explore the role of language in explaining the context-specific currency of various ideological threads concerning cultural diversity in the community health realm of discourse. Gumperz and Cook-Gumperz (1982) for example, wrote:

We customarily take gender, ethnicity, and class as given parameters and boundaries within which we create our own social identities. The study of language as interactional discourse demonstrates that these parameters are not constants that can be taken for granted but are communicatively produced. Therefore to understand issues of identity and how they affect and are affected by social, political, and ethnic divisions we need to gain insights into the communicative processes by which they arise. (Gumperz and Cook-Gumperz, 1982:1).

⁷³ See institutional studies of Cohen (1985); Taski (1981); Cowie and Roebuck (1975); Taylor (1970); Goffman (1961). Each study presents the special tasks addressed by each of these social organization.

⁷⁴ Thompson et al.(1990:104) defined essentialism as practices and views "in which the consequences of some behaviour or social arrangement are essential elements of the causes of that behaviour"—in this case as applied to the challenge of fighting disease.

Healthy Albertans Live in Healthy Alberta: The Language of Identity

Unlike communities⁷⁵ where kinship is an important indicator of community membership and guide for action, institutions are organized under formal and informal charters which assign roles and statuses and offer participants a range of goals, explanations, rewards and punishments.⁷⁶

Like most other bureaucratized institutions, the community health centre has a symbolic macro-objective which is explicitly displayed in their institution's boardroom, main entrance, and organizational handbook. As a result, the logical point of entry for the analysis is the institution's written role statement. The "corporate"⁷⁷ mission stated there is as follows:

The Health Centre's mission is the promotion of optimum health for the people of Lethbridge (community health centre's handbook, 1994:10).

This statement of mandate was revised in June 1994 in response to the health care reforms then being undertaken by the Alberta Government. It includes both the "vision" and "mission" of the health centre and follows nine primary objectives set out by the Alberta's Public Health Act to fulfil the vision of "Healthy Albertans Living in a Healthy Alberta". All

⁷⁵ Bradfield's (1973) *A Natural History of Associations* analyses the meaning of communities and association. He has used ethnographic works of earlier anthropologists like Evans-Pritchard, Forde and Harris.

⁷⁶ Galanti emphasises that "one way to asses cultural value is to observe how an individual member of a group is punished. To understand people's values is key to understanding their behaviour... (1991:4)."

⁷⁷ The institution constantly uses business metaphors in its charter documents. It thus identifies itself as a "business organization" where staff provide effective and efficient services to its "customers"—the public. They however also present themselves as professionals who command special knowledge and have the ability to provide critical information when needs arise.

these broad provincial mandates are incorporated by this community health centre in its mission documents. Therefore we can say that formally this organization's nine major objective stated in its mandate are:

1. To increase the number of years of good health by reducing illnesses, injuries and premature deaths and improving well being.
2. To make decisions based on good information and research.
3. To include a health perspective on public policy.
4. To have appropriate, accessible and affordable health services.
5. To live in strong, supportive and healthy families and communities.
6. To live in a healthy physical environment.
7. To recognize and maximize individual potential in spite of biological differences.
8. To choose healthy behaviours.
9. To develop and maintain skills for facing the challenges of life in a healthy way.

The changing health care reform environment has made all health organizations struggle for extremely limited government funding. As a result, each health institution is trying vigorously to justify its existence by demonstrating that the services they provide are unique, special, or irreplaceable. The underlying ideology of CHC is clear: to continue to develop distinctive preventive health service and programs that distinguish them from other health care organizations and also justify their budget, staff and service provision as a unique organization at this time when avoidance of duplication is a major slogan of the government.

Broadly speaking, it is easy to see that the biomedical essentialist philosophy of the Canada Public Health Act derived from the nineteenth century continues to be reflected in this formal institutional role statement. Intentionally or not, the resulting asserted mandate identifies

immediate environmental, social, and economic obstacles to health and to assess the physical condition of individuals. This is also documented in a 1994 public health mission statement where it clearly asserts that, "how healthy Albertans are and will be in the future, is determined as much by our social, economical and educational policies as it is by our health care delivery system" (Community Health Centre: Role Statement, 1994:3). Not surprisingly, the central intervention programs supported by the Centre are mainly in the areas of health promotion, prevention, protection and community care. From the institution's stated point of view, it is important to provide such services, and the mandate of community health is to meet the health needs of all the people of Lethbridge.

But how do they do it? How are these broad policy goals implemented? I argue that this appears largely to be determined by the institution's everyday bureaucratic practice. I say this in part because the chief medical officer⁷⁸ (like many other institution directors who are similarly placed) traditionally has been given great authority to decide on implementation of services. (Prior to reorganization this was subject only to periodic Board review.) It is primarily the chief medical officer who also decides on the cultural images and terms the institution should use to present itself publicly as a distinctive and necessary organization.

But the daily practice of "frontline" staff also provides powerful inputs into the institution's self-definition. In this Centre, as in public health practice generally, the main type of interaction that takes place is "conversation" and "assessment" through which "information" is collected from clients and given out to them. Out of context, this nurse-client cultural interface was often eloquently interpreted by the community health nurses as something providing a service primarily "*through health education*"—a claim much in accord with the formal institutional philosophy. But during participant observation and informal conversation carried on with individual nurses during home visits and baby clinics I recorded

⁷⁸ According to the Canada Public Health Act all the directors of Public Health Centre have to be medical doctors.

the following rather different comments and observations made by nurses:

In our home visits basically we are doing the physical assessment of the mother and the baby. "W" and I are preparing the chart for the new nurses and other staff who are here for long time and are set in their own ways.

[During a subsequent home visit.] First, "I" gave me a brief background information about the mother, the newborn baby, and her family. This included the marital status, number of children, and the employment status of the husband. All this information was provided to me prior to us arriving in this particular home. As soon as we arrived there, the nurse had a brief chat with the lady of the house and then proceeded to a physical evaluation. Lastly, she gave her an information package and went over this very briefly with the new mom.

After we returned from our home visit one time "Q", the community health nurse, explained in detail the tasks she believed all public health nurses must carry out in the Early Postpartum Program. The following is their daily ritual, as she sees it—one primarily oriented and organized by forms and an overt regime of accountability:

In our assessment program every community health nurse is assigned to make two home visits after the new mom is discharged from the hospital. In our [first] home visit our immediate concern is the mom because of early discharge. Since the hospital discharges mothers within twenty-four to forty-eight hours, in our visit we look for comparative evaluation in regard to change in health. We focus on baby's weight, head circumference, temperature and other physical assessments. In our second home visit we don't repeat [this task] if anything is not pertinent to health. [Otherwise] we basically check weight of the baby, and that's all we do.

This green form is a recent form that has been developed to keep track of what is the type of visit. Is it under twenty-four hours visit, or forty-eight hours visit? The name of the mother. The type of delivery. As you see, we have all this information to check. This form is primarily for statistical purposes. This will then tell us how many of certain kinds of visits we do; the type of delivery. You see, this also helps us to show our accountability of our time and work to management here, and also to Edmonton. (See Appendix B)

The second form that we have with us when we go on home visit is the early

discharge form. In this form as you see we have a section for mom and a section for the baby. We are to check all the things that is written here. (See Appendix C)

Then we have an information package. This is the package that all new mothers receive during the first home visit. In this package we have information about breast feeding, a passport. This passport which we give out in the second home visit was originated by Alberta Health. We took it as a pilot project and modified it, and we continue to use it. It is called a "Health Passport".

You see we have also another type of form. This is the referral form. This form has to be filled out after our visit. Then we fax [it] to the doctor's office before the mother goes to see her physician. (See Appendix D)

We have this form which comes from the hospital. From this we get all the information about the new mom. They gather these [this information] at the time of admission. The chart information is from the hospital's [form]. (See Appendix E)

The senior manager during my interview pointed out an instance where resource allocation considerations primarily determined a shift in practice:

One of the things we did was the scoliosis screening. The thing about scoliosis screening was really ... It was labour intensive. So we cut it out. We weren't getting enough *referrals* so we stopped doing this *screening*. We stopped doing the intense developmental screening for a year and half, because really the most significant was the *speech assessment*. So those sort of things in public health we do. You really have to be a chameleon. You have to be aware of what is happening with [the] data and population. You have to [be] very much aware of trends. So you have to be willing to say, you may have done something for fifty years, and if it is not working [now] then you have to quit doing it because it is not practical. You don't have endless *resources* at hand. So you have to *justify* what you are doing and you tend to be a chameleon because society changes. When society changes its needs change with it. [my italics]

The above narratives suggest that the primary entry method used in service provision at the

community health centre is to first identify “the problem”⁷⁹ which must be addressed; while health promotion discourse often stresses the positive vision of building and maintaining good health, practical programming at the Centre usually starts with a *negative vision*: the world is awash with actual and potential impediments to health, and their first obligation is to identify, categorize and address these. Thus, much practice is spoken of in the disciplinary language of the “assessment”, “monitoring”, “charting”, “screening” or “evaluation” of a particular physical, social or environmental condition. Most such assessment takes place during client and professional interaction—for example, in home visits, the well baby clinic, the immunization clinics, and the school programs. These are sites where knowledge about possible health “problems” are identified by a community health nurse. Stein (1990:52) contends that “cultural metaphors objectify shared inner worlds and at the same time make claims about the nature of the world held in common”. Here, the problemization of health does just that.

For instance, in one home visit I observed the following procedures carried out by the nurse and this basically features all the (largely medical and accounting) practices that the community health nurses comply with when they do their home visits. The nurse first walked into the house and introduced herself and me. She seemed very calm and in control of the situation. Like other nurses she also had two black bags. One contained the scale to weigh the baby. The second bag carried all the information sheets, a tape to measure the baby’s head, a note pad which had relevant medical information, an information package, a stethoscope, a blood pressure measuring instrument and a questionnaire sheet for the survey that was being conducted. This was a survey to find out if the fee the clients were paying for prenatal service was reasonable or not. The nurse had told me earlier that each home visit took her about an hour to hour and half. Since the baby was sleeping the nurse first did the mother’s physical assessment. She checked her temperature, blood pressure and fundus⁸⁰.

⁷⁹ This problem can be individual, community or societal.

⁸⁰ The large upper end of the uterus.

There were some verbal assessments done by asking questions about the mother's appetite, feelings of discomfort, breast feeding, rest, emotional condition and support systems. Then she did a physical checkup of the baby and asked questions relating to the baby's daily routine: eating, sleeping patterns and bowel movements. Finally, she gave the mother an information package and basically listed what each included item was about. She was very particular in suggesting that the mother attend the post-natal class offered by the health centre.

After accompanying nurses on fifty-two home visits, I would say that nurses spent roughly eighty percent of their time on the physical assessment of their clients, and the rest of the time dealing with such things as socioeconomic, cultural, environmental and educational evaluation. The latter typically found an eventual role as "background" information: explanatory, but not often to be acted upon. Only a very small amount of time was devoted to non-evaluative practice, such as the provision of information (rather than its collection). This well illustrates the centrality of an implicit message: that "evaluation" is essential and is an effective first step in preventing or combatting illness and disease. It also rationalizes institutional hegemony over its clients; ethnographers observing institutions as social control agents have often interpreted "assessment" activities as important rituals of domination (Lock and Scheper-Hughes, 1990; Cohen, 1985; Schneider and Conrad, 1980) and a nodal point of western medical culture.

When it became clear how central the classical medical paradigm of problematizing health was in this context, I decided to ask nurses more frequently about their perceptions of "life style"-based, or "holistic" care. I also included a question on this subject in my extended interview of all nurses: "*Do you think your organization incorporates all the aspect of "holistic care" in your everyday work?*" Following are representative responses I collected:

"L" said: Some yes and some no. One thing that I know with respect to our nursing department is if something ever happened to my child or to my husband, I could walk out the door with no problem. You know in that way it is very family

oriented. ... Considering we have a public health inspector department we don't have an occupational health and safety program in our health centre. ... We should be practising more what we preach. This is just my personal opinion. But our medical officer of health who is going to be probably the medical officer for the district or region #1, once regionalisation happens is a heavy smoker. You know, what message does that send? And some of our management you can tell don't lead a healthy lifestyle. So ... but I think, that they could encourage us more to do programs in certain areas than in other times. I think some of the programs they put a lot of focus on aren't accomplishing what they want. I don't know if there is enough evaluation, like in the program . . .

"K" with what I thought was a very uncooperative voice and with uncertainty said; "Yes".

"F" commented: To a degree, you know there is [are] only two degree[s] that they certainly focus on - the physical problems of the disease entity. I would think that is most. And certainly, I guess diet, nutrition that they would focus on that to a lesser degree, but certainly to a degree. I think we really miss out on the emotional, on the mental part of it. We are ... I don't think we are trained [in] that aspect either. The only times we have really touch[ed] on that I would say, sort of postnatal classes. When we were doing the postpartum depression part. And you know when we do follow up people [they have] those type of problems. But there are lots other problems out there that I don't think staff wise we can possibly meet. We are not trained that way, we do not have enough staff, we don't have enough background. We don't address that part very well.

"X" smiled and said: I guess the body would come first. We also at the health centre do the environment as well. Immunization clinic, [in] our home visit we examine the baby that kind of thing, It is more [the] physical part. But there is also the teaching that goes along as you are doing the physical like doing the immunization, or weighing the baby, we [also] discuss them. The physical and teaching go hand in hand. We are lacking in the spiritual ones. I don't do much on one to one. Your like someone else guiding you. I think that is more of an individual task. I think the mental health [services] covers that. Checking people, feeling themselves, if there is a concern that if I can help them with just by talking through it or giving them more education, and cohesion. If we are not able to, then we refer them to other specialists who will be able to help them in [this] relationship--or whether they are needing more counselling.

"O" after few moments of silence said: I would say we spent about seventy-five percent of our time in doing a physical evaluation. We would like to spend more time in other aspects as well, but we just don't have the time for it.

Although modern health care is evolving to make health promotion ideologies more central, the old medical model still predominates. Nurses continue to focus on body imagery (Lock and Scheper-Hughes, 1990) grounded in a biomedical cultural construction of medicine.

A Strong Shared Sense of Membership

In the world of the CHC and its daily activities every staff member identifies themselves as a full, active member of that small community; the heterogeneous nature of the overall client population is after all absent during related professional presentations of self. All staff have a shared sense of symbolic community membership. Individually and collectively they perceive the health centre as a place whose charter is to prevent diseases and promote health. Moreover, there is general consensus among staff that the Centre is doing its job well in most cases. This world of shared meaning and reciprocally-accepted presentations of self unites the staff and builds a sense of commonality and solidarity (Teski, 1981; Cowie and Roebuck, 1975).

A core part of those shared assertions is consensus about what the Centre is about: “health promotion” and “disease prevention”, pure and simple, and usually stated in exactly these words. When asked to describe the objectives of health centre, “M”, who is one of the senior managers with a background in finance employed there for fourteen years, summarized the role of this organization in the following words:

The community health centre at the present has a mission statement which has all those lofty things [in it], rather than [just] saying “to promote health and prevent disease”. The original idea of [the] mission statement was something that you could share with the community and they would receive it and understand it. You could even remember it. Then staff got involved and started diddling with it like *a horse designed by a committee as a camel*. A mission statement that includes everyone’s input ends up saying nothing—because it has far too much garbage and nobody could remember it. Then we end up with a mission statement which does not mean anything to anybody. [my italics]

The [real] vision is the one which you read on the Boardroom wall. This has been replaced. Otherwise, you couldn't put it on the wall. It is basically saying that the community is a collection of families. Our objective is to promoting health and preventing disease. Even in our home care program well we try to prevent disease and institutionalization. There is always prevention. There is actually no program [that] actually offers cures ... Our health inspectors are protecting health, but based on regulations. But the purpose behind it is to prevent disease [or you can say, to] protect health and prevent disease.

Another such statement is taken from one of the senior managers of public health nursing program, who is identified as "N":

[Our goal is] to change attitude and lifestyle of the people [to have] optimal health. We educate the family to be responsible for their own health. This starts in prenatal period.

"A", who works in the reception desk and in the main office area said:

Our organization is service oriented, we provide programs to prevent, and protect disease, injury and promote health.

"B", a maternal and child assessment program manager explained very briefly the Centre's objective in the following words:

Injury prevention, protection, providing health related information, and health promotion. We do a lot of physical and environmental assessment.

"X", a community health nurse, asserted that:

To promote healthy lifestyle is the basic mandate. This means disease prevention and health promotion. We do this with education. For example, with going out on a new baby visit, [we] discuss the feeding practices, and the immunization schedules. We discuss the mother's health and make sure that she is looked after well. It involves the whole family. Just whoever is at home. Or you may ask how other members in the family are doing or if there is any concerns with the other children, and how are they adjusting to the new baby. The new baby visit is usually a very good time to contact the family, because often they are very receptive to new information. And at that point particularly with the postnatal class, it is important you remind them that you have a new member in the family and if they are having any bad eating habits then let them know that is not such a good thing

to do. But to start with the whole family the healthy lifestyle.

“W”, one of the senior nurses summed up the Centre’s objectives by saying:

Well, our whole mandate is prevention, protection and promotion of health and illness. Like, prevention is making sure that people are aware that there are certain things that you have to do to remain safe, that you have to eat properly, keep up the immunization. You have to watch what communicable diseases [are], [and be] aware of the things that cause [them]. And mostly educating the public and how they can keep themselves healthy. At that, maybe they have to alter their lifestyle to do it.

These personal accounts of the Centre’s objectives illustrate one dimension of this institution: a strong and consistent internal value and belief system, which is a common feature of bureaucratic cultures (Douglas, 1992, 1986; Herzfeld, 1992; Payer, 1989). To the CHC staff, the institution exists to achieve a single goal—to provide “*an optimum health program*”. This example allows one to begin to comprehend the local cultural construction of health care itself, its related division of labour, and bureaucratic efforts made by specific institutions to differentiate and legitimate themselves. My emerging conclusion is that this everyday “folk” mission statement—to promote health and prevent disease— is (among other things) both a vehicle for staff to demonstrate positive shared meanings among themselves and a key means to distinguish themselves from others involved in the provision of health care. Not only does it support a cultural identity that separates CHC from other local health organizations, but also helps the institution’s staff present themselves as significant competitors for resources and legitimizes control of a particular health care domain. It establishes a boundary by institutionalizing a sense of “us” and “them”, cultivating self-interested differences (Lemont, 1992) among institutions, communities and groups.

Many other key words and images support the same set of institutional distinctions. For example, on one occasion an office staff member remarked on the use of separate terminology in this institution. I also found that the staff used some terms consistently at the Centre where they served as institutional markers:

People who stay in a hospital for a temporary period are called “patients”, but as we provide a service, people who come here are called “clients”.

Similarly, staff often made invidious distinctions between themselves and the orientations and skill levels of staff at other health care institutions. As an illustration, “N” asserted the following separation between the professional abilities and level of awareness of their organization’s nursing staff and those of hospital nurses:

In public health we really like [to hire nurses who are] university graduates. Because university graduation, particularly for the nurses, takes the blinkers off. You know nurses with a R.N. tend to be like this [use of body language]. They are focused. They [are] like horses with blinkers on. You know they know where they are going. So long as [you] keep their blinkers on, [and] you give them a tunnel they will perform their job very well. They will do an excellent job for you, and not deviate right or to left. If you get a public health nurse, because of their much broader education she has likely taken her blinkers off. [And] that pony and asking her to become totally aware of its environment and to go where it’s needed to go. The pony with blinders can only go where it’s taken or where it’s sent. Take the blinders off and the pony can’t respond to the needs and what the facets are in society. So it can go wherever and do whatever. And that is the difference [between R.N. nurses and public health nurses]. Public health nurses have been exposed usually a lot more, challenged a lot more in social science and should be able to respond and pick up names and deal with [things]. I mean, we should be able to accommodate the extremely well educated and the very poorly educated within a very quick paradigm, because you recognize the needs of one versus the other...

In my interview with “O”, a community health nurse, she stressed another ideologically distinguishing boundary marker of the Centre. As they deal with “clients” rather than “patients”, the CHC staff are “service providers” rather than medical operators.⁸¹ A key distinguishing range of services involve the provision of “information”:

... in public health we promote health, promote healthy lifestyles, prevent or attempt to prevent diseases. That is basically through immunization programs and

⁸¹ “Medical operators” is my term.

maintaining healthy patterns of living. As well as post-natal care of both mom and infant, and school age care, it also involves seniors and general adult population. So it encompass the entire life span.

To us, health promotion means to prevent injury, just a healthy life style, adequate standard of living, nutritional recommendations. Our service has an educational, spiritual and emotional component [involving] lifestyle. It is not just the physical aspect. We are not physically always caring for the people, but we offer a lot of information, options and [also] discuss [options] with them. And hopefully they will select the healthier.

We do it in every opportunity we get. We are often caught talking. We started in the beginning; we start right immediately following our postnatal visits. Information is offered on nutrition, breast feeding, rest and safety. Then we continue on through our immunization schedule, dental health, nutritional recommendations. As the child grows older [we do] developmental milestone discussions and things like that. And we are also discussing it as well with parents at that time. We discuss smoking cessation, weight control, physical activity, mental rest and relaxation. We do that on a one to one basis, and as well on a group basis. We do go out and provide information to groups or interested parties within the city of Lethbridge, [but only] upon request.

We are to offer as much information [as we can] and encourage them [clients] to select an appropriate alternative for themselves. Like, we want to be fostering independence and self-reliance; we don't want to be doing rescue work. We want to just help them. Giving information, outlining alternatives for them to select that are appropriate for them. Because, what we perceive is appropriate for our beliefs is not necessarily appropriate for the client.

As is well illustrated above, "information" is said to be provided to "clients" for the latter to consider, accept or reject. This reflects yet another ideological distinction between the institution and those more clearly identified as providing medical care: CHC staff say they work "with" clients rather than "on" them. The CHC staff also project a strong sense of "responsibility" in delivering their various health promotion programs. As will be shown in the next chapter, they also expect clients to demonstrate personal responsibility and envision whole categories of clients who are seen to fail to fulfill this expectation.

Maintaining an Institutional Culture

Many such distinctions in all probability have arisen over time in reciprocal presentations of self—of people's "personal front"—in everyday institutional practice; many studies have shown this to be the central force in the generation and maintenance of institutional cultures. "Impression management" of the sort early identified by Goffman⁸² is without question clearly a key to the "*collaborative manufacture of selves*" (Charon, 1992) involved here, which simultaneously supports an institutional identity and establishes barriers and distinctions between "hosts" and "guests", service providers and clients. As Charon (1992:187) suggests, "we must dramatically convince others that we are who and what we want them to consider us to be". One dimension of such practice is to build and reinforce a strong sense of "us", which as other social theorists (Good, 1994; Young, 1994; Good and Good, 1993; Herzfeld, 1992; Cohen, 1985; De Voe, 1981 and Schneider and Conrad, 1980) have noted, can act as a kind of "kinship"-based symbolism.

Similarly, Douglas (1992) working from a theory of risk perspective shows that every institution uses risk analysis to assess the dangers ahead. She then further explains that "risk, danger, and sin are used around the world to legitimate policy or discredit it, to protect individuals from predatory institutions or to protect institutions from predatory individuals" (1992:26). Douglas uses this approach to discuss situations of institutions interfacing with individuals. However, as illustrated above, CHC staff use such strategies to maintain their identity against other health services as well. These personal narratives are constantly shared by the managers and nurses of the community health centre, and can be read as both self-supporting and collectively legitimating: it is important for all bureaucratic service-based organizations to make their services appear socially acceptable so that they can retain

⁸² For a detailed analysis see Goffman (1959) *Presentation of Self*, where he called this dramaturgical analysis; also see Stein's (1983) analysis of American medicine culture; Barth (1981) describes this form of social behaviour through "game theory".

clientele.⁸³

Both through action and speech similar messages are sent by staff in the context of dealing with clients; client-staff contexts differ in one key respect in that such contexts are much like the prisons Foucault addressed. They are at once “an instrument and operator of power, and [the] site of the production and application of knowledge” (Foucault, 1979:112). Following Foucault, many students of institutions now argue (Herzfeld, 1992; Scheper-Hughes, 1992; Douglas, 1992, 1986; Thompson et al., 1990) that *intervention* is used as a medium by staff to define, express and legitimate institutional cultural identity.⁸⁴ This is certainly the case here, where both staff observations about their charter and actual client-staff practice constantly express the Foucauldian metaphor of “discipline” in attempts to extend their institutional world view to others. In the following discussion, these points will be made clearer.

In certain ways this organization has some of the characteristics of a “total institution” (Goffman, 1961). The totality is of course not as great as the prison, asylum or psychiatric institutions, hospitals or military, because clients are not so effectively “captured” as are inmates or soldiers, and staff all have a life external to the institution. Institutions like prisons or the military can totally control new inductees (Murphy, 1987), even to the point of altering their interactional practice and visible bodily markers. They can completely restrain a person in time and space, and eventually, in world view. For what are thought of as “normal”

⁸³ Baum and Oliver (1992) in *Institutional Embeddedness and the Dynamics of Organizational Populations* have analysed the impact of population density on institutional ecology. Also see Douglas (1992) for her insight on the maintenance of bureaucratic culture. Stein (1990) in *American Medicine As Culture* suggests that compartmentalization is one of the primary cultural functions of biomedicine.

⁸⁴ Berger and Luckmann (1966:93) define legitimation as a process of “explaining” and “justifying” to an institution’s objectivated meanings and its practical imperatives.

clients, potential dissonance that might arise from clients and staff having divergent world views is reduced by a radical simplification on the part of staff: “normal”, “well-disciplined” clients who fulfil staff interactional expectations are assumed (without much evidence) largely to already embrace the institution’s basic values and beliefs. Through their attentiveness and lack of contradictory talk and behaviour clients deemed normal signal to staff confirmations of their institution-based world view.

But what of clients who are not so “patient”, not so “disciplined”? Such clients are categorized explicitly as deviant—as “high risk”. In “Q’s” account:

We have a category called ‘high risk’, and any clients who we think needs to have more than two visits we consider ‘high risk’. They get a blue sticker on their record. There is a chart put out by the Alberta Health Care which codes types of patients. There are two broad categories [that are used to categorize a visit to be high risk]. One is the physical assessment where the baby is less than 2500 grams birth weight; is less than thirty-four weeks gestation; or has a persistent neurological deficit [i.e., spina bifida, long term seizures, etc.]

The second category is the socioeconomic background: the mother is less than eighteen years of age; parents with mental illness, mental deficit like depression, speech or developmental delay in older siblings; poor home situations.

These are some of the examples from the big list we have been given to follow. It is up to the nurse’s judgement if this is a physical, emotional or financial problem. You want the child to receive particular attention [i.e., physical/developmental assessment]. So you write the reason for the blue sticker very briefly on the cardboard part of the record. You see, just being a single mother is at high risk, and so is a premature baby.

Nurses’ use of blue sticker criteria “bracket” (Rhodes, 1990) clients into special categories where they are stereotyped as deviant—not here meant necessarily as a negative term except in the sense that there is something out of the ordinary and problematic to do with such individuals. In terms of the maintenance of institutional identity and culture, such bracketing also allows community health nurses and others to treat such clients with a “degree of distance or dispassion” (Murphy, 1987); in doing so, the threat of their deviance questioning

that institutional cultural *status quo* is radically reduced: such individuals have medical and health problems not of their own making that need to be addressed through conventional health care intervention, or else their lifestyle, individual characteristics or other factors make them *willfully* undisciplined and therefore at risk. In the former case client problems are rendered normal and conventional through inclusion in standard health care practice; in the latter, individuals' deviant practices and beliefs are rendered institutionally insignificant, except as barriers to health promotion and disease prevention; that is to say that they require no change in institutional practice or world view. I will return to this category of 'high risk' clients in the next chapter, for who gets identified as high risk and of which sort has important consequences for the encoding of cultural difference in the institution.

Hierarchical Social Structure: the Bureaucratic Reality

To this point I have discussed the shape of Centre culture without consideration of an important social fact: this establishment is hierarchically organized, and certain staff largely control key decision-making processes, finances, the hiring of staff and the generation of formal institutional charter documents.⁸⁵ This was well recognized by everyone involved, who often make reference to controls and dictates issued from on high. "N" for example enthusiastically said that "the institution gets its mandate from the top". "M" in the extended interview explained that one of his major responsibilities is:

... to see the money is spent for that which it is designated, and not to decide how the money is spent. ... the money is spent the way it has been decided by the board. The decision is made by the board in conjunction with the government of Alberta, and Alberta Health. They approve the programs and services we offer in this

⁸⁵ See Abegglen and Stalk, Jr. (1985) for a detailed description of the competitive behaviour of Japan's companies and its economic success. The local Health Board decides what and how this community health centre should operate. Decisions about how to spend the budget is made by the Board in conjunction with representatives of the government of Alberta, and Alberta Health.

community health centre. And my duty is to just administer and report to the board. People can do whatever they want as long as it does not cost money. The minute it costs money they have to follow the discipline of the system. In order to receive financial support for anything new they have to make a proposal, which goes to the board. [It would then be addressed by the board] If this doesn't get approved by the board then they would submit to Alberta Health. If it gets approved and funded, then their responsibility is to deliver them. Once the decision is made by the Alberta government to fund something they either must do it, or return the funds.

It is as important to understand this formal, i.e., hierarchical/bureaucratic structure as viewed from the "inside", as it is as some kind of "objective reality" (Berger and Luckmann, 1966).⁸⁶ Social theorists have documented the structure of the medical care primarily from an *etic* perspective - "the system and how it meshes with, reflects, and reinforces the larger society" (Todd, 1989:15). At this point it is important to understand the daily negotiation process in the hierarchical world of the Centre where I felt certain forms of knowledge are not "democratically" produced or propagated. The central objective of this section is the location of power (a word used to demonstrate staff roles and statuses in the organizational hierarchy) and how it is manifested in actual social organization.⁸⁷

Murphy (1987) in *The Body Silent* maintains that in our doctor-dominated medical culture there have traditionally been highly differentiated social roles for every member of the system. Such roles are hierarchically organized, and there is a chain of asymmetrical formal

⁸⁶ There is ethnographic literature that fleshes out the ways the social structure of the Western medical care is organized. For more detailed analysis from various perspective consult works of Todd (1989), Sacks (1988), Murphy (1987), Ghnuki-Tierney (1984) and Foucault (1973).

⁸⁷ Townshed (1971) in *Old Age: The Last Segregation* writes in detail about this observation: "A vast majority of senior citizens shared the feeling of nursing homes as a place to die. The recommendations to change the operation from the profit-oriented industry highlight the social structure of the nursing homes. The operation of the nursing home lies in the hand of the administrator of the organization. The crucial role of the administrator is to have a basic knowledge of proper health care, must have sound business knowledge. He presents the location of power at the top of the hierarchy".

authority that goes down from attending physician to nurse to patient, with obedience expected at each level. There is an elaborate division of labour, a meticulous and jealously guarded allocation of responsibilities, and careful scheduling of activities. Murphy notes that “the hospital has all the features of a bureaucracy, and, like bureaucracies everywhere, it both breeds and feeds on impersonality. It should be cautioned, however, that the “rationality” of a bureaucracy refers only to the attempt to impose order, not to its actual operation” (1987:21). He has demonstrated brilliantly the nature of typical doctor-patient “dyadic” or relationships.⁸⁸ Taylor (1970) takes this point further, detailing informal structure among the hospital staff in order to distinguish the difference between the hospital culture and that of other total institutions.

Hierarchy and Informal Knowledge Production

Looking at the formal organizational chart (see Appendix A) presented in the institution’s handbook one can see that the health centre appears to present all the features of a formalized bureaucratic hierarchy (Good, 1994). Even so, this organizational chart does not slavishly follow the traditional organizational hierarchy. It can be appropriately described as a ‘flat’ structure with comparatively few levels of administration. The implication here and throughout the institution’s charter document is that all staff are a team that ideally should function smoothly, democratically, and through consensus management.

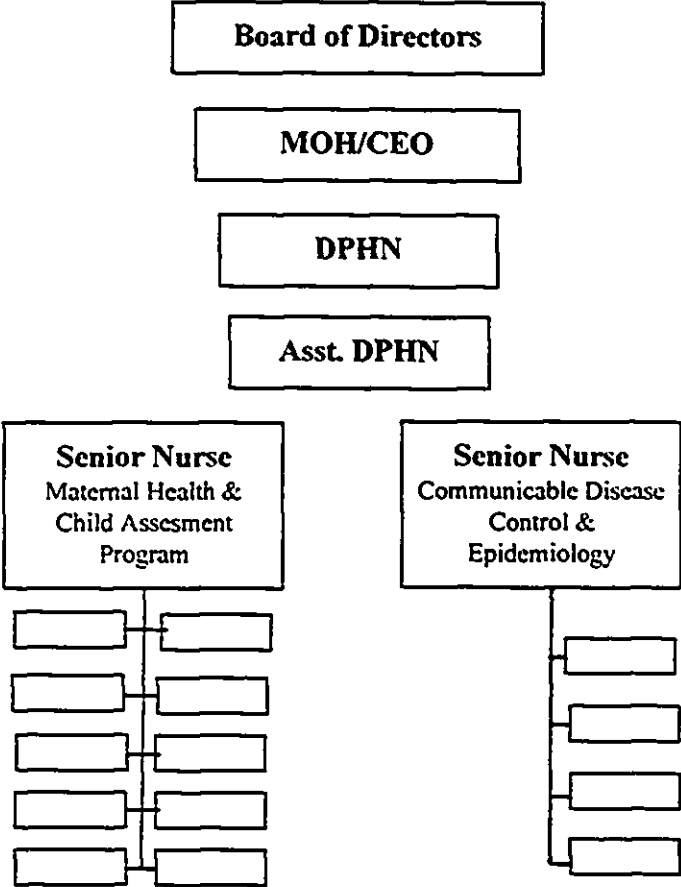
This was not the actual view, however, of anyone in the institution. This was crystal clear from my ongoing discussions with the staff regarding the Centre’s mission statement and other administrative issues. These impressions were constantly confirmed by my behavioural observations drawn from nine months of fieldwork. Such a chart notwithstanding, the informal structure of the Public Health Nursing Program represents the old pyramid-style

⁸⁸ On this point also see works of Gilad (1990), Indra (1987), and Colson (1987) where the focus is on the bureaucratic helper organizations and refugees.

formation which Taylor (1970) suggests is used often by large institutions like hospitals to avoid idiosyncrasies and guarantee the accomplishment of specific tasks (Figure 1).

The statements recorded from five nurses during my extended interviews illustrate the health centre's bureaucratic reporting system, decision-making process and practices, as perceived by these individuals.

Figure 1. The informal reporting structure of the public health nursing program.



CEO = Chief Executive Officer, MOH = Medical Officer of Health, DPHN = Director Public Health Nursing program.

The four nurses from the Communicable Disease unit are also responsible for some duties of Maternal & Child Assessment Program.

“X” paused momentarily, then in a smiling face and joking tone began to talk:

... there is a big poster upstairs, [that says] preventing and promoting a healthy lifestyle. Our mandate varies over the years as to the words that are used. I suppose government funding has lot to do with it. [There are] special words they [government] like to hear so [the] mandate, [or] objective [is] worded to match with what is expected. But, to me it means healthy lifestyles.

For further clarification I asked, “did you take part in preparing this mission statement?”

I suppose [they do get us involved] when it involves the ground rules as to what we feel is important in the program. But the actual wording is left up to them. But, we are consulted for several days with our CEO and the nursing manager going over different programs and what we feel is important.

“G” explained the health centre’s mandate in the following terms--first formal, then informal:

aahump... Right. Now mostly I guess it would be health prevention, and health promotion. So trying to educate people on keeping healthy, and not to get to the point where you have health problems where you have to do something about curing them. But trying to prevent them from occurring in the first place--like with travellers, you know, trying to give them information on how to handle traveller’s diarrheah, malaria and giving them some immunizations depending upon where they are going so they don’t get sick. And with the enteric disease, this is kind of you don’t get the information until after you had the symptoms. But then you educate them on what organism they had; about hygiene, your kitchen hygiene, toileting, and hand washing--and how hopefully they not spread it to other people. If it was hygiene problem in the first place, or kitchen problem they won’t pick up anything...

“L”’s summary of the institution’s actual mission was:

... to provide community care. It is somewhat different from acute care--in that a lot of times we access them (the clients and the community) rather than them just accessing us. It is also different from acute care in that we give them the tools that they need to keep themselves healthy. And not only that, but [we] encourage them to look past their state of health now and to take it one step further without them accessing us. So we also target them. So I guess it would be to provide community care in maternal cases, control of communicable and infectious diseases and health promotion.

“C”’s comment about the health centre’s mission displayed a certain feeling that key decision-making process here occur primarily at “higher” levels:

Could somebody actually ... could tell you? Isn’t it written up in the board room? Do you want [me] to recite it? Is that what you want? Do you want to know if I know? I cannot recite it. Oh, promoting health and well-being of families: that’s the underlying theme. I think this was written by the Board some three or four years ago and its been there since. I think it is the Board who decides on the mission statement. Certainly it wasn’t us, as far as we are concerned. I don’t remember....I am assuming that is where it is initiated.

The meanings that non-management staff appear to share regarding the institutional charter reflect daily practices of the organization; in this and other ways staff again reinforce an unspoken biomedical orientation towards community health. In this context it was found that in the Centre’s everyday life there is an verbal emphasis on providing a “lifestyle model” of preventive care. As such, virtually all the community health nurses identified themselves centrally as “information givers”, even if they did not spend the majority of their time performing related tasks. In a larger sense, they identify themselves as active members of the organization whose primary role is to provide services in the prevention, promotion and protection of health. Their practice strongly encodes the Western Health Belief Model (Good, 1994) and at the same time marks them as distinct from not only clients but other health care providers.⁸⁹

⁸⁹ It is of course people like nurses, and not nature that create a community. This is key to Douglas’s group and grid analysis. Nurses here have a strong sense of collectivity and a clear external social boundary. Teski (1981) in his ethnography of a retirement hotel shows how this thread of thought begun by Schutz and Berger can be traced through the literature. These theorists show how people actively produce and sustain the meaning of a social situation.

Decision-Making Paradigms: Formal Charters and Everyday Practice

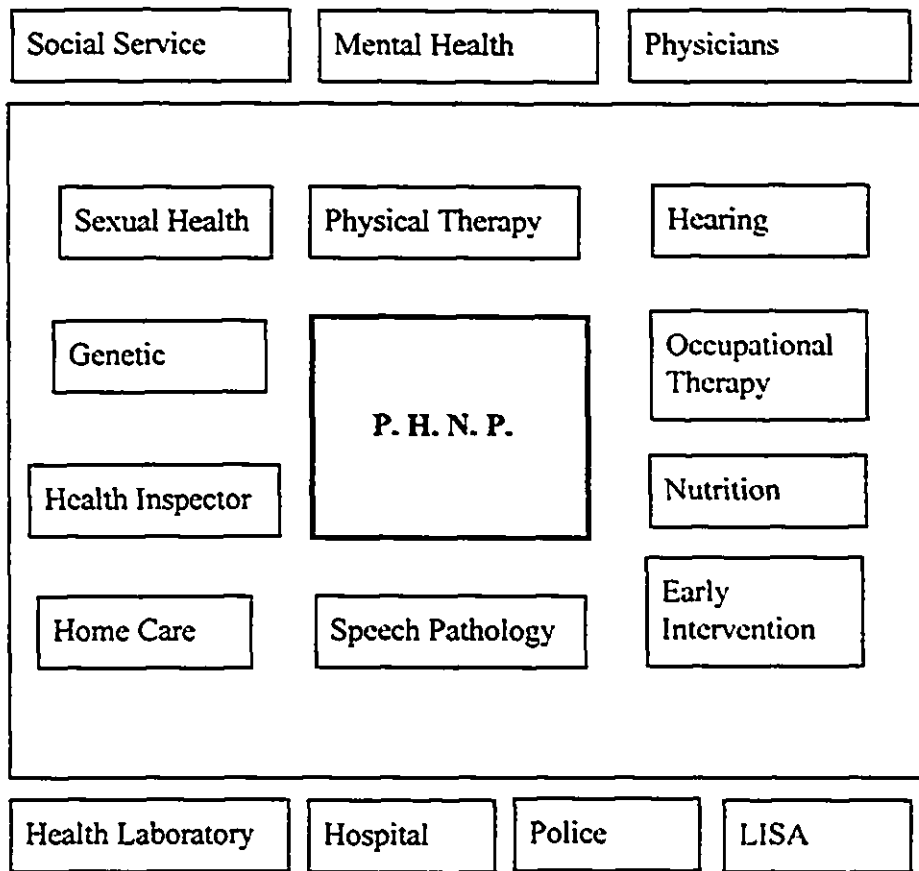
One of the fundamental formal requirements of CHC staff is to see that the mandate of the institution is carried out effectively. In recent years the CHC's staff have come to view themselves increasingly as part of a health agency whose role is to continuously re-equip themselves with specialized knowledge to serve all residents of the city. I use the Public Health Nursing Program, which is a central locus (Figure 2) of CHC service provision, as an example to show the dynamics of the decision-making patterns involved in acknowledging and addressing one such new challenge: establishing a multicultural community health service.

In this system, the Director of the Public Health Nursing Program is formally responsible for the management of community health. The responsibility for daily activities involved with maternal and child assessment and communicable disease are placed under the Assistant Director. This nurse reports to the Director of Public Health Nursing, and also has administrative authority.⁹⁰ With the cooperation of the two senior nurses, she is responsible for organizing the communicable disease and maternal and child assessment program so that these services function in an efficient and flexible manner.⁹¹ The senior nurses in turn are in charge of client care on a day by day basis, but have no administrative power.

⁹⁰ Both managers are professional nurses.

⁹¹ See Figure 1 for the reporting structure of the public health nursing program.

Figure 2. Interaction between micro and macro organizations (inter departmental and outside agencies).



P.H.N.P. = Public Health Nursing Program.
 LISA = Lethbridge Immigrant Settlement Association.

This highly hierarchical organizational structure has the potential to affect day-to-day operation of organizations in negative ways (Ng, 1988; Sacks, 1988; Taylor, 1970). It can create conflicts and resistance (Young, 1993; Taylor, 1970), as is well illustrated in Sacks' (1988) study of the bureaucratic structure of Duke hospital and the development of union for hospital workers there. Douglas (1986) notes that institutions often adopt this approach primarily as a means of maintaining social order and control; Herzfeld (1992) takes this argument further and claims that this form of everyday organizational rhetoric is the root of social indifference characterizing many service provision institutions. Such administrative structures can engender a shared sense of fellowship among those at particular levels in the administrative grid, but can also generate a sense of powerlessness and lack of privilege (Teski, 1981)

In everyday practice, however, Centre nurses have at least partially subverted this formal structure to empower themselves. For example, staff members did not in fact take certain dimensions of this plan literally; they did not identify the mandate as a concrete, binding document, and some viewed it merely as insitutional rhetoric propagated by the senior management. According to most of the nursing staff their actual mandate was viewed as flexible, and was informally replaced every so often so that it would be relevant to the social context supporting either their general biomedicine framework or new challenges. One nurse recalled from her more than 20 years of experience in community health that her formal job description has not changed in all that time. She went further and said that to her the organization has been providing essentially the same service for many years. She perceived that only the language of the mandate has changed in order to make it sound like the community health today functioned differently than before:

Our health promotion mandate says we provide a "holistic care", educate families to be responsible in taking care of their health, [and] to educate the client—to give them the facts and figures. It is a "family affair". Now-a-days there is a great emphasis on health promotion. We always did health promotion, but didn't use that word.

The success of a social organization is often traditionally said to depend on effective socialization into given institutions, which in turn supposedly guarantees compliance (Berger and Luckmann, 1966). Since the health centre is deeply encoded with clinically-derived roles and statuses, every member in this organization knows clearly their formal place, and their rights and responsibilities. Theoretically there should not be any individual or group challenges or fundamental conflicts. This was not the case, however, in everyday practice. Nursing staff involved in service provision employed various mild forms of resistance in order to either secure input when decisions were being made without them, or to block the implementation of programs unilaterally imposed on them. When so challenged, they would actively discuss the issue among themselves,⁹² or remain quiet and refuse to volunteer to carry out particular assignments unless they were specifically asked to do them by management.

In *American Medicine as Culture*, Stein (1990:73) contends that “in direct speech, metaphor can be a valuable access to feelings, or it can unnecessarily cloud meaning”. For Stein, metaphors or other speech compositions are important signifiers in the study of individuals, group relationships and identity.⁹³ In my informal conversation with nurses I found that they interpreted their actual status in the institutional hierarchy largely in the light of their personal experiences—experiences that confirmed their feeling that they were too often on the receiving end of decision-making. When asked to describe their institutional rank or position/status, they typically used self-referencing terminology like “little people”, “small people” or “grassroots people” at the “bottom of the totem pole”; people who were not always consulted in administrative decision-making processes. One noted that “When we follow a procedure that we have, it is not enough. They [the management] change it, [and]

⁹² This can be described as the sign of sub-group membership and identity.

⁹³ Todd specifically (1989) discusses speech forms in the socialization process in clinical culture.

we don't know what to do. And sometimes we [then] get into trouble with our clients".⁹⁴

Nurses in turn saw a range of clients as problematic—in essence as unwilling to accept their authority and take personal responsibility. There was a close social network among service-providing nurses, and I observed many frank discussions among them about their problematic encounters with “noncompliant” clients.

There certainly was a degree of frustration on the part of managers with the compliance of nurses. Managers largely seemed to accept the formal role delegated to them: in particular that the health centre's mandate and specific programming is prepared by the Health Board and the senior managers; to them, the role of community health nurses and other staff actually is to implement decisions made by the management. There was a difference of views between those in management and those held by service provision nurses. For example, the senior manager of nursing one day said:

I basically started the Native program. I knew there was a need, and I wanted to do this for years. You see what happens a lot, I found, is I go ahead and do it [start a project]. They [the service provision nurses] realize I don't have time to do it properly, next thing you see is they jump in there and do it. And sometimes I have to drag them into it.

It is my impression that social interaction between management and staff was often characterized by mutual friction, resentment and alienation. This was especially apparent when one nurse shared her frustration in regard to a program that was established outside the health centre site. She said:

⁹⁴ As a practical example that I was able to observe, there was a major miscommunication between the Health Centre and a daycare centre where there had been an outbreak of whooping cough. The CHC wanted to have all the children from this daycare immunized. The way this response was handled by Centre administration evidently made the executive director of the daycare centre angry, and when we arrived there the community health nurse was called into the executive director's office for a “discussion”.

The program for the “Natives” in is a one person show. That is “NN”: when a bee gets into her bonnet she does whatever she wants to do. She is the one who has been doing it on her own. We will eventually take over, and we don’t want to go to them [i.e., Native people]. They have to come here. Why do they have to be different? We are providing a service here, and they have to learn to come here. “NN” by going there it hasn’t increased the number of clients coming on their own. It is the aids who bring them. They can bring them here.

Berger and Luckmann (1969) defined this as a struggle for “agency”, which is a part of the everyday activity negotiation of modern complex institutions. Sometimes consciously but usually not, social organizations use this strategy for evolutionary internal sociocultural development in response to change. The “backstage” conflict between the nurses and the management reflect deeply entrenched processes in wider bureaucratic culture—in health care provision and without.⁹⁵

Sources of Information Collection: Taxonomizing Reality

A main source of information employed in the CHC’s decision-making processes are various statistics prepared by the community health centre through documentation completed by all nurses on the basis of their personal experiences in their encounters with the public. In addition, official figures and reports generated by the Alberta Health and Statistics Canada and other interested agencies (formal and informal) also provide information on health concerns in the city and its surrounding areas.

I believe that linked processes of documentation and bureaucratic accountability are critical elements in understanding how the nurses in their everyday discourse characterize decision-making process and respond to the world outside their ranks. I want to illustrate how medical knowledge and ideology help the nurses construct their object and serve as guide for fundamental medical practices (Good, 1994). The focus here is mainly on the “producers”

⁹⁵ See Stein (1983) for the description of the American health culture.

and “carriers” (Cohen, 1985) of specialized ways of “information formation” and the impacts that information has on institutional world view and programming.

“N”, a senior manager explained with a great zeal the extensive information gathering strategies that are in place at the Centre:

There are lots of ways [we gather information]... A, you got to recognize that a group exists. So you have to know your community. You have to do a community profile. You have to know what is out there. Then you have to become aware [or] you have to [have] some sort of awareness of the individual groups within that community and their needs. Now that may be through a survey or those sorts of things. In public health you are constantly monitoring your population, [and] the Census is important. To me it is an important document, [and also] to anyone in public health. So your Census is always there. You are in touch with your municipality. We are in touch with LISA for example. The other thing in public health is you, say, for example, get up in the morning and listen to CBC news. I do that on purpose; that is part of my working day. Because then I get to know what is going on. To give you an example, war in Bosnia broke out. You listen to what is happening in Bosnia [and] within a month or so you start saying ‘ok’ Bosnia, the Balkans, typhoid, poor living conditions, cholera, all of those situations faced by camp refugees, immigrants. So you know your immigrant transition [in the community] is going to change. [A] few years ago we knew it was going to be South American, because of the Guatemala situation. You tend to get immigrants coming up [because of a crisis there]. Before that, the boat people from Vietnam [were] coming over. So that gives you a profile. It is a global village. Because Canada is a stable society people tend to come here. So isn’t very long before you start thinking “oh yes, before long we will have people from Sarajevo”. Then what you start saying is, there will be two groups from Sarajevo. It will be like South America. So then you have to be ready for both sides, they are Muslims and Croats.

This interview excerpt nicely illustrates the critical role played by (often highly selective) information collection and allied patterns of communication in bureaucratic program development.

The Client’s Chart

As mentioned, Centre public health nurses seem to adhere strongly to a “theory of essentialism” as far as the development of their service is concerned. This is hardly

surprising, as Jensen (1987) and other social scientists have long recognized that medical practices are deeply entrenched with rationalist, hard science claims and legitimations. One consequence is that episodes of clinical practice almost always began with an information-collecting assessment of the client. Indeed, each nurse spent much—often most—of their time compiling a record of each “case”.⁶ Each individual nurse is assigned a certain number of cases and through access to the client’s personal and immunization charts they update the client’s information for their personal benefit, and as required by the nursing administrator, senior managers, and the local health board. Treatments are chosen according to a complex mix of the client’s self-perceived and articulated physiological characteristics, and symptoms unilaterally identified by the nurses. Physical assessment is not the only routine data collection work nurses do when they go on home visit. They are also required to observe and record things about the “home environment”. As one nurse described it, “an additional task for me is to also do an “evaluation” of the client’s home environment”. In an immediate sense these forms of data collection function as a screen to identify the client’s immediate “problem”, whether it be medical, social, economic or cultural. Any attempts at “education” follow thereafter, as channelled by the information collected.

In a more wide-ranging sense, these collected case statistics are a significant input also into decisions made to change or integrate new services. Indeed, that this has central value to CHC staff is axiomatic; this is “hard” data from which they can deduce other near “mathematical” truths (Jensen, 1987).

“G” elaborated on how information is collected and how it is used:

A lot of it (collection of information) is done just on really a basic level by the nurses. For example, immunization for certain groups seem to be behind or you get

⁶ All nurses refer to each single client issue as a case. For example, an early discharge appointment is called a home visit. But the mother and the baby together become a “case” in the institution’s record keeping. The community health centre also prepares a separate health record for each individual.

more referrals or they seem to be at a lower socio-economic level when you visit them..... Well, we bring it up in when we have our meetings with [the senior manager named] and you know if you say that you like to try a project and work on it then you get approval. Our senior management is very good about it. I can't think too many times that they said no.

Another senior nurse had a similar experience. To explain how decisions are made to establish a specific program other than their traditional service she used the following example:

Their [the clients'] immunization records are kept up to date. You see when there are a group of immunization appointments for a day and they all fall into one group [referring to "Natives"] then we automatically assume that they are not going to show up. I do not know if it is right on our part to think that way. But it happens and many times they haven't kept their appointments. Because there are few Natives who keep appointments, when we see scheduled a bunch of them, then we automatically assume that they won't come....

Families who consistently have no shows, and doctors phoning,⁹⁷ they become our target populations. So it is more families and not groups that are our problems.

This suggests that the CHC treats every case as an individual case or problem, not group problems.

"O", said with a lot of enthusiasm when asked the above question that such information was critical to planning interventions:

We notice that, for example, in looking at the well baby clinic you may not see a Native child until they are eighteen months of age. And they may never have been immunized at that eighteen month of age or seen a medical practitioner either. And so you notice there is a high need, or when you are discussing not necessarily "Natives", but other cultural groups as well. But if you are discussing their (mother's) nutritional needs and of the child's, Ichiban soup does not cut for a four months [old] baby. And these things kept repeatedly coming and popping at us. As general nurses, I know with myself you get these high risk families over and over

⁹⁷ If doctors have any health concern about a client they may refer these clients to the CHC nurses.

and over again. And it is a multi-generational cycle of disfunction and so somewhere you have to try and step in and change [the situation].

“B”, a manager and the supervisor of the Public Nursing Program said:

It depends upon the case. In this case [the Native Health Program] depending on the population. We see if there is no compliance from the clients [as then it is a problem case]. For example, the chart which we have for every client...It again depends upon the needs and requests of the staff, and the community member. Administration makes the final decision. I know this institution one time had hired a Spanish worker and a Native worker. They were hired for a while.

From observations and talking to the nurses at both levels (management and non-management) I find that all staff have a general understanding of chart maintenance and place great value in it. This cultural element serves several functions for the CHC.⁹⁸ It inevitably served as an important source of information, but there is little evidence that such information always is persuasive to management. In this regard, on one occasion a nurse made the revealing comment that “it is the nursing supervisor who decides which group of clients should be targeted”. This and other inputs I received suggests that nurses may spend a great deal of time identifying “problems” through documentary exercises which they expect to be disregarded.⁹⁹

The second important point is that this clinic documentary processes symbolically convert the client in the clinical setting, at least for the purposes of identification. He or she becomes a “case” or “number” for the appropriate application of health care knowledge and practice. This process, as Good (1994) contends, reflects nursing training, and is central to medical gaze. In a wider sense, in *The Symbolic Construction of Community*, Cohen (1982:42) suggests that routine and routinizing behaviour of members in any community is of great importance to the development of internal collective identity, because the meanings which

⁹⁸ This is a basic feature for the function of all bureaucratic organizations.

⁹⁹ Fisher (1981) in her study of health provision in Nepal has observed the same pattern.

people find in such behaviour goes far beyond the literal functions or character of their behaviour as these may be perceived by others. Cohen further argues that such routine behaviour may have a symbolic aspect of marking commonality or difference, if members of the group wish to endow it with such significance. This medical ideology of assessment and documentation clearly conforms to a body of norms that have their roots in the Health Belief Model, and as such conforms staff and Centre participation to an orthodox, highly legitimated set of societally approved practices.

It also marks the boundary between the normal and the deviant. The importance of such forms of medical evaluation is stressed by Schneider and Conrad (1980), when discussing the politics of deviance. He asserts that such superficially neutral and non-evaluative procedures both form the subject specifically and in some cases generate deviancy categories:

We reject the view that deviance exists “out there”,Persons concerned with the identification and control of certain kinds of deviant conduct, acting typically on behalf of some collectivity, group, or organization (1980:6) [generate it.]...¹⁰⁰

Dealing with Diversity in a Context of Universal Programs and General Ideologies

Like other modern Canadian health institutions, this community health centre primarily provides a set of predefined, highly generalized programs aimed either at large subsegments or “all” of the local population—programs which have been discussed in an earlier chapter. The general objective of this suite of health programs is to provide, as “B” explained, a “blanket” type service that is uniformly applicable to the total city population. In this latter

¹⁰⁰ Fisher (1981) echoes Schneider and Conrad’s observation about the significance of the principle of evaluation. In Fisher’s study, reporting is used by a health organization to provide information to other international and national agencies, and government. She shows the complexity of the decision-making, and the location of institutional “authority” and documentation in an international health setting.

regard, the staff clearly recognized that both the population at large and its clients are diverse: they are from different gender, age, ethnic, cultural, religious and socioeconomic/class backgrounds. Some dimensions of this diversity easily incorporated into the medical model were of course addressed in part, particularly ones that activated the categorical variables of gender, life cycle, and age; that they *should* be addressed had wide approval among staff. Yet all the staff that I interviewed and observed without exception appeared to be extremely uncomfortable with the concept of cultural diversity and the possible generation of programs or techniques that might address it. Furthermore, some members of the organization even asserted that multiculturally-oriented care would imply that people of different “ethnicities” and “races” would expect costly, labour-intensive, norm-disrupting “VIP treatment” (Gold, 1987).¹⁰¹ As “I” expounded:

Multiculturalizing services means you are trying to get all cultures to have access to our services, so that they know exactly what is going on. They [the institution] have to have everything translated, [and] you have to be sensitive to that [culture]. When I hear [the word] multicultural, I think of whole range of cultures, which may become difficult when you have [only] a few people or families of one culture. [This] might make it an expensive venture to provide that [multicultural service] for everybody. When I think of “cross-culture” I think in terms of major groups that we [do in fact] see. When I hear “multiculture”, then I think of the whole pot of range...

It is not surprising that a common fall back argument was to stress the potentially universal access already available through extant “universal” programs; for example, in pursuit of providing appropriate multicultural health care one of the public health nurses said, “We don’t direct our services to one group of people. We direct them to all”. It was clear that cultural diversity *itself* was problematic—doubly so in that it was a problem and it threatened to *cause* problems for service delivery. Indeed, *any* perceived new problem that did not conceptually fall under the definitional and documentary categories of existing programs was

¹⁰¹ Gold (1987) in his study of resettlement staff and refugees had coined this word.

seen by the staff as problematic in one critical and quite reasonable sense: it was something needing either additional funding and time or resource reallocation. Besides, most of the staff thought that the establishment of any new programs would be as “add on’s” to their present tasks. In this regard, most front line staff seemed to react to the notion of multicultural care firstly in terms of additional workload.

The alternative, establishing and maintaining new programs using new resources costs time, energy and money. Senior managers at the Centre are always preparing proposals to bring in extra funds to establish new programs in a wide range of domains. They call most of these “special projects”, which are established under highly bounded criteria and for a temporary period of time. Such programs cease to operate as soon as the funding runs out. The junior manager in the Public Nursing Program explained this in an extended interview:

We do not have [a] budget for special programs. To establish any new service other than the basic ones, the money is taken either from other programs, or you try to generate new funds through writing new research proposals. For example, [for] the restaurant program “Hearts Delight” there was funding available. We (a committee made up of the staff from the Centre) decided that this would be a good project.

Such proposal writing appears endemic in the Centre. This constant exploration for outside funding may be as much a matter of survival as it is a reach for new opportunities (Douglas 1992, 1986; Thompson et al., 1990). This exercise also has symbolic implications, and can be compared to Abegglen and Stalk’s (1985:42) observations of Japanese corporate life, where for companies to survive they must establish a “winner’s competitive cycle” which is then a key locus of the company’s identity.¹⁰² Moreover, this is particularly important now, when governments in Canada at both federal and provincial levels are reducing funding to health care and related social programs and through designated funding are directing health

¹⁰² See Baum and Oliver (1992) for their analysis of the influence of population density and institutional legitimacy.

care and maintenance organizations to move away from the traditional medical model to a “lifestyle model”. This has made health institutions scramble for extra revenue, at once as one of their innovative strategies and as a means to maintain themselves in a changing institutional world.

This of course generates many of the predictable institutional stresses and strains that come with high rates of organizational change. I asked nurses and managers about how many and what kind of programs they had initiated and maintained in the past few years and in the present time. The majority of staff referred specifically to the “bicycle helmet” program and the “healthy heart” project as typically successful endeavours. They received limited funding to do these local programs. The comparative failure of projects like a community kitchen and north side drop-in clinic were narrated as:

Well, we tried to establish a community kitchen with the cooperation of our nutritionist, but it didn't take off. [In] the north side clinic, which was a good program, we dealt with immigrant population because that is where a lot of them lived. So we sort of had that there for them. But it was just unfortunate that we lost the space there. “L” tried a different kind of clinic program. These are the major ones I can think of. Once or twice or even more than that we tried what you may call a drop in night clinic. We just tried to have a night where we were doing immunization with no appointment and we advertised it and send out notices to people that were further behind in their immunization, like a lot of Native clients. And we were hoping that if they didn't have to make an appointment may be they would come in and we would catch up [with] their immunization. But it seemed mostly the people that came were the people on schedule anyhow (a laugh) and they thought [they] will get in quick without an appointment. They were not that far behind. So we weren't getting the group that we were trying to get, we were busy, we got people that if we didn't have would have made an appointment and come in anyhow. And people who were really far behind and we were trying to phone them and tell them or send them notice never came in anyhow. So we did it a couple times and then we didn't do it any more.

What we need is a community survey to see what is needed in the community, but that needs a full time person to do it. Unless somebody funds it we probably won't get it done. So you have to set your priorities and see where is your money best spent, said a senior nurse. Right now most of our money and effort is gone to provide service to the majority. Until the funding system is changed. I don't see we will be able to do a lot of that other stuff.

Lack of ongoing finances, manpower shortages and client noncompliance were some of the reasons given for the cancellation of some special programs. As one nurse stated, "our staffing only gets less and less as years go by, and what we are expected is to do more and more. Our service is increasing with less and less people". Many staff agreed that currently they do have limited multicultural programming and this could be improved; but, the organization does not have the staff, time and space to do it. Therefore, only project proposals that were to be financed from different new external sources received strong support from the management. The following quotation is illustrative:

The Native project--one of the things we did as part of that project was a survey. We actually did a survey. It was quick and dirty survey and you could run a truck through it. Because you needed some basis to say yes, we need to fund it. And they were going to give us some money for Native health. I mean really any of us who have been with Native health for any length of time know what problems exist. So we did a quick and dirty survey. This just tells me yes that is what exists. We are probably going to do another study in May, in another part of the [CHC] now to conform the needs are the same there. But, basically the need is there. You know the issues of poverty, illiteracy, the language issue. You got the issues of alcohol consumption and substance abuse. You have problems that come about from lifestyle because of lack of exercise, and imposition of [a] white man's diet [on people] who were basically a hunter and gather community. So you know all of these. If you know it is sort of there, it [is a] matter of just going out and getting it. Then we can put a name on it.

The Ones Who Are Most Vocal: the Involvement of Other Agencies

The willingness of the CHC and various other agencies to establish collaborative work and liaison provides a third source of information. It should be stressed that the institutional barriers which for the last forty years limited the integration of other kinds of people and institutions--non-medical professionals, social agencies and associations, etc.--are now gradually dissolving. The Centre now works in close association with several different

community agencies and organizations.¹⁰³ Such ongoing ties have clearly made access to some problematic clients easier and more effective. For example, in the spring of 1994 the community health centre in collaboration with the local Native Friendship Centre developed a program called Native Health—one of very few programs that had a clear focus highlighting a specific ethnocultural population. Some staff members of the CHC said of this that:

This pilot project with the Natives which was part of an assessment done by the city, say like a community assessment. Several of the Natives kept repeatedly popping up in high needs, high risk or noncompliant categories and so it helps us to twig in that we are to respond.

We think they saw it themselves as well. We have seen that because, when you go through the files that there are some who are behind immunizations or when I (“L’s” personal story) had families, made home visits to them and all of a sudden they are gone and you phone the landlord. [Then] they move back. Some of these were high risk children and you know that they really needed care. Then it seems there is a need for it from these type of situation. And then the need of people themselves.

Well, said “J”, “I think it seems it was all coming together at the same time. That there was a need: the “Natives”, the “aboriginal”, or the “Indians” themselves realized that there is a need. Plus, I think we had some money and this got started. Because we have tried before having a community health representative, we have tried that before. And it didn’t work out. I don’t know all the ramifications [of] why. But it seem that the Aboriginal people that came here didn’t stay. They left and we didn’t know why they left”.

“O”, supporting the above comment continued the conversation. “I think this is an ongoing project, because they are tying in with the initiative coming from the “Aboriginal Community”. It started with that Native transition house, and the Friendship Centre. They have recently moved to try and make it more accessible to all of them [Natives]”.

And also we had positive input from the Native community. Like they are saying “look this is where help is needed. This is what we see as our needs being, and can you help us out here?” And there was some funding that was applied for and achieved and so they took the project.

¹⁰³ I thank the Director of Nursing for giving me the opportunity to attend the representative *Emergency Shelter Advisory Council Meeting*, on February 22, 1995.

We think it is open to be kind of a long term thing. I don't know how the funding is going to run on. But we know the outreach will be more long--and not necessarily with just the city of Lethbridge, but to work with the Native community within southern Alberta. Because we do liaise with the other health centres in regards to the Natives, because they are very transient people, some of them are quite transient population, you know. They tend to migrate very quickly and are flipping back and forth between urban and rural or urban and reserve life. And so we do have a lot of contact, and people within the reserve or people with any of the other health units were saying "hey, look this is what we are seeing or you are seeing the same thing and what can we do about it". And so that's how it is coming about.

Not all staff see this collaborative work as "essential" or believe that it will be beneficial in the future. Using the Native Program as an example, "W" voiced her frustration by saying that she believed that it was "the most vocal ones" in the population who got this sort of attention. Then she went on to suggest paternalistically that groups like Natives would like to have things without understanding the long term consequences. One reason for this kind of uncertainty and doubt is that staff interpret this and other potential programs through the lens of their past experience, particularly experiences with two Native women staff who were hired to improve interpersonal relations between the two groups.¹⁰⁴ Some expressed a myriad of felt problems with those women, and finally the program was discontinued. While strongly negative personal views regarding this particular program were expressed, it would be misrepresentative to suggest that this kind thinking was pervasive within CHC culture, or that nurses resisted interacting with multiculturally diverse clients; in regard to the latter, there was considerable enthusiasm for institutionally "capturing" them more effectively. Rather, my purpose here is to demonstrate the way in which terms like "multicultural" link the medically-oriented, political, social and economic orders of the CHC's decision-making

¹⁰⁴ Gold (1987) has discussed a similar point. His focus is on the Russian and Vietnamese refugees and settlement officers in the US. Also see Gilad (1990).

process.¹⁰⁵ This then leads us to the last section of my general discussion.

“Cultural Diversity”: Perceived Problem and Organizational Response

What then does cultural diversity appear to mean to Centre staff? In most cases, it is viewed and talked about in reference to people of different “ethnic” backgrounds, who are in turn identified as primarily being people who have come from different countries. The following are samples of the asserted meanings assigned to this concept by CHC staff during my personal interviews:

It is lots of different cultures, lots of different people from different places, different ways, that perceive things ... uummm ... like how you raise your children. Sometimes I believe that the more Canadianized or Americanized you are the closer you are about those kind of values ... For example, just that you get used to ways that things are done in the western culture and not so much the way things are done whatever your background was - like you follow the calendar here rather than [elsewhere] ...

I guess it would mean my beliefs that I grew up with and how everyone else grew up with. Diversity I know means difference, but for me it also means similarities or things that we could find in common. For example, ok, say I was working with a breast-feeding mother. Many things we would do is the same and something we may do different. Like their diet, because of their culture is influencing their breast feeding ...

Cultural diversity means differences in lifestyle practices, or beliefs from one group of people to another.

To me it means many cultures. Or many different ways of living and there is just not one way.

¹⁰⁵ Scheper-Hughes (1992) in *Death Without Weeping* likewise demonstrates the use of polysemic terms, language and dreams used by women of Alto do Cruzeiro, a small community in northern Brazil. The purpose of her study was to make the Brazilian government and the international community conscious about the poverty and world views of these people.

At the conceptual level these staff perceptions closely parallel folk views of ethnic phenomena as analysed by many social theorists (Verkuyten, 1995; Anthias, 1992; Buchignani, 1991; De Voes, 1975; Barth, 1969). The social construction of ethnic membership has been described in considerable detail elsewhere (De Voes, 1975). My intention is not to inventory this, but to understand how this term helps the nurses understand personally relevant dimensions of providing a culturally sensitive client-centred care. In this regard, I have stayed away from an “essentialist” search for the cultural attributes of particular ethnocultural populations, and instead focus on institutionally-based ethnic identifications: identifications of who are relevantly “ethnic” or “culturally different” to Centre staff.¹⁰⁶

Again, there can be no doubt that virtually all staff recognized that Lethbridge is a multicultural community where nurses interact on a day-to-day basis with clients from various--though clearly, a limited range of-- cultural, racial, socioeconomic and religious groups. “I” explains that:

We have several different cultures [here]. We certainly don't have the numbers that the larger cities like Toronto or Montreal have. I see very few black people. But, we do have a large Vietnamese population, Chinese, Central American populations, then people from India and Pakistan. But black people I tend to see very few. That's one group we don't have too many here.

The above explanation clearly shows that ongoing social situations and extant categories of person and action can greatly influence the actor's subjective perceptions. Whether knowingly or unknowingly, the nurse in question quoted above (and those quoted earlier)

¹⁰⁶ Barth (1984) chides those seeking an essentialist answer: “Our habits of speech may hark back to the days of Wissler and Kroeber, when a culture was a trait list of customs and the coloured distributions of such cultures might overlap, so one The trait list also provided a methodology whereby cultures could be compared with respect to degree of difference and whereby acculturation and assimilation might be measured (1984:79).”

associate “multicultural” almost exclusively with an immigrant population. *Critically, the city’s aboriginal peoples do not get categorized with this label.*¹⁰⁷ In this limited way they are rendered invisible as a collectivity, along with some other groups.

This shows the unconscious manipulation of a key cultural category in the nurses’ everyday lives; the institutional culture has limited the range of potentially disruptive “outsider” deviant input by selectively focusing its attention first on “groups”—whether such populations are group-like or not. It has then imbued each of these conceptual groups with agency, much as if they were collective individuals; each group is assigned a finite range of necessarily stereotypic qualities and markers of group membership. Finally, most individuals in the general population who could from an outsider’s point of view be considered in some way “culturally different” are rendered invisible and hence unproblematic by simply not being so characterized; they are “muted” by institutional cultural practice.¹⁰⁸

This is not altogether a surprising result. Stein (1990), using an essentially psychoanalytic approach, has shown for example how American medicine deeply represents core values of American culture; it must certainly be likewise for Canada, where folk notions of cultural diversity tend to focus on only a few key “groups”. This does not fully explain, however, why Natives are excluded, for while formal state-supported multicultural programming does concentrate on immigrant origin cultures, there are evidences of a widespread folk Canadian feeling that Natives are culturally different in significant ways.

Douglas (1992) contends that when institutions are threatened by external challenges they

¹⁰⁷ See Okamura (1981) for a detailed analysis of the situational application of ethnic labels.

¹⁰⁸ Okamura (1981) suggests; “it is noteworthy that Van Velsen (ibid:) states that this manipulation proceeds ‘without necessarily impairing [the] apparently enduring structure of the social relationship’ or in the terminology used here, the setting of social action” (1981:456).

will respond by various means to defend themselves from conceptual pollution, in this case, from an institutionally disruptive form of the concept “multicultural” entering into the CHC world view. One way that the Centre achieves this is to assert that they have in fact always addressed the challenge in question through conventional programming; the staff of the community health centre first of all sincerely believe that their organization has always provided effective care to multicultural clients. The 1980s was an era when there was a lot of talk about “transcultural care”, or “cross-cultural care” in the western society--what Stevens (1993) terms “multicultural health care”. Exposed to such ideas, the nurses and other staff certainly are now aware of the Canadian cultural mosaic and of the effort made by other institutions and government to hire staff from diverse backgrounds in order to improve institutional service efficiency and lessen miscommunication. This organization was not far behind others in finding an approachable way to address this issue in ways that would allow them continue maintaining their extant identities largely unchanged.

In order to address this challenge, avoid frustration and incompetency, reduce confusion and misunderstanding and continue to maintain its core institutional values, the CHC adopted several strategies. The following comment is an illustration of one formal mechanism that has been established by CHC to provide service to their multicultural clients:

We work with [a local immigrant settlement association] for translation. Mr. “V” is the translator for the Vietnamese clients. Then we have a binder with translated literature relating to immunization in every language that can be found Mostly we need translation for Asians - the Cambodians, Vietnamese and for Latin Americans. At one time we needed help for Polish immigrants.

In an overview, I identified two predominant strategies. They are: redefining the institutional code¹⁰⁹, and the use of translated literature, and translators.

¹⁰⁹ This refers to changes in the community health centre’s objectives.

Redefining the Institutional Code

Many of the staff members perceive that the focus of their intervention program was so basic and universally applicable to all embodied individuals (like immunization, maternal and child assessment) that they thought their organization of necessity provided equal service to all the (responsible) residents of Lethbridge. They also viewed things somewhat circularly: because the CHC's objective is to provide one type of service to all, there is a general assumption that with few notable exceptions this is actually what happens. "B", the junior manager of the nursing program explained:

Right now we have nothing different. We treat the Natives and other immigrants the same way. We treat them individually like any other clients. We don't differentiate between clients. There are no special programs established to deal with them. Services are available and they are served like other clients. If they don't use it then they don't need it. Basically, nurses visit them at their homes and that is about it. They tell them all the services that are available at our health centre.

"M" was confidently vocal in his views and comments:

I do not think that—it would be my observation—that cultural differences or diversity are not a big issue in public health. Because, again, public health is dealing with the promotion of health, prevention of diseases, [and] staying healthy. I don't know of a culture in the universe that doesn't value health and keeping it. Where you and I understand there are a lot of cultural variables where you get into [problems] is when you are treating illness, like for example, my niece is a nurse and she was working in Saudi Arabia. Female nurses are not allowed to touch the male clients. So, how the hell do you treat somebody? But in public health that [is] not an issue. I don't see a great deal of culture. I mean you are talking about clean water, clean air, [and] managing waste. They might not do it very effectively because of their ignorance. But it doesn't mean that they are not trying Even in the case of home care [service] or your home visits, basically you [nurses] are there to see if everything is all right. If things aren't all right, you are there to help them to do better. If you find that a child is sick then you will get that child over to [the] people who look after sick people. So I don't think in public health you run into the "cultural problems" the way you would do in [more specifically medical] treatments.

“M” said the organization’s highest priority was to provide primary health care. Some nurses perceive that “cultural diversity” is not an issue, as they abide by their medical ideology of scientific neutrality, universal commitment, and professionalism (Stein, 1990). As a result, most of the staff assert that their organization provides multicultural health care. As “Z”, explained:

In public health the nature of our job is [such that] we have to be aware of cultural difference. I don’t consciously We have to be extremely open-minded. You don’t need to have a degree in cultural diversity. It might be being brought up in a multicultural community; as a child I never thought about cultural difference as my parents came from Japan. We grew up in a farming community...

The CHC nurses perceive that acute issues of cultural diversity come in phases as determined in large part by Canadian immigration and refugee practice. When an acknowledged need of this sort arises the CHC can address related issues through a special project. “F” recalls an event which took place in the 1980s with Vietnamese refugees:

When I first started work here in the 80s all the Vietnamese refugees were coming over. So there was a special nurse for many years set up just to deal with them, all their health concerns and like that. But there aren’t as many coming now. And they have integrated fairly well, too. They are not quite like the Native extreme. On the whole they have come a long way. They don’t come to [the] postnatal classes and all those sorts of things. But they come regularly for immunization and they are hard working people.... The other groups sort of integrate and move into the main stream as the years go by...

“Y”, a nurse with several years of community health work experience said:

When we had the Spanish speaking people moving into Lethbridge two Spanish speaking gals were hired mainly for communication [as translators]. At home they [immigrants] had mistrust with [the] medical profession. So in order to remove that mistrust those girls were hired. It was strictly for interpretation. They helped us in translation of the handouts. Then we had problems; it arose within the Spanish community that we were unaware of. There was a class variation within the community. So finally we had [to] stop that service.

The above examples can be analysed taking Rhodes's (1990) argument that biomedicine's aura of factuality is precisely its source of power. She further suggests, "medicine can describe events in a value-neutral language that makes them appear to be part of the natural world and thus neutralize what are in reality, social problems" (1990:168). Thus it does not appear paradoxical to "M" that he sees only issues of "clean air" and the like, even though he works in that end of the health service provision spectrum that intuitively would have to know the most about sociocultural and other lifestyle factors.

Immunization and cultural difference

The concept of *magic bullet* (Jensen, 1987) coined nearly a century ago to refer to the immediate successes of certain treatments for infectious disease continues to be an important procedural metaphor in medical culture; this includes the Centre. In community health care provision, immunization is one of the major tasks of CHC nurses; every nurse has relevant clients, starting from infancy to seniors. They are also assigned different schools to do immunizations and update students' health records. Immunization is seen as an especially potent, transcultural process operating like a protective "magic bullet": get immunized and you won't get sick—or get anyone else sick. In Alberta, the community health centres primarily are in charge of the immunization program.¹¹⁰ Even though in Alberta immunization is formally a volunteer-based program, it is practised as a mandatory citizen requirement by Centre community health nurses.

There is a strong sense of mission among nurses concerning related practices. For example, as we were driving for a home visit "P", a veteran community nurse said:

Since the Natives do not keep appointments, for the sake of the child's health, I do this. I do not know how else I can immunize the children. Today, I am going to

¹¹⁰ Some doctors in clinics also provide this service.

"shoot" (immunize) her at home. Last baby I did didn't start immunization until six months. You see, they expect to have these services [specially] provided to them. But they do not come for them ... I would rather stay in good terms (with this particular family) so that they let me into their house. I just do not want to alienate them, therefore, I go out of my way to help them. This family first lived on the north side of the city and I was assigned to that zone. Then they moved to the south Lethbridge which is [now] my zone. Now they have again moved back to the north Lethbridge.

I observed the nurse as she made this home visit and here she basically talked with the mother and then weighed the newborn baby. She did not follow her elaborate routine work of documentation, her stated reason being that the house wasn't conducive to performing her task. But the real reason for her visit was to immunize an older child, and she was successful in achieving this goal.

The immunization program is also a key contribution of institutional identity. Even though the majority of the staff object to further proliferation of services, a minority of nurses like "P" took it as a personal moral responsibility to secure high rates of compliance with the immunization program; just like physicians feel that it is their professional obligation to cure patients (Stein, 1983). The establishment of immunization programs in Street Alive and the local Friendship Centre also illustrate the high salience of this highly medically-oriented and mechanically effective service and its consequent application to Native contexts.

Use of Translated Literature and Translators

Providing all clients equal health care service is another major stated function of the CHC. To remove perceived communication barriers between the care-giver and the "culturally different" client, the CHC has developed a partnership with local agencies which assert that they have relevant constituencies: an immigrant services association and a Native Friendship Centre in particular. It has also sought to provide translated literature to "immigrants" collected from other agencies and the Alberta Health department. This literature is placed behind the nursing assistant's desk for easy access by staff. The information relates to

different types of infectious disease prevention, particularly regarding tuberculosis, measles, German measles, mumps, chicken pox and salmonella. They also have translated information on child safety, nutrition and family planning. There is no cost incurred by the CHC to access the immigrant settlement association's translation and interpretation services. These resources consequently are claimed to be valuable by the CHC staff. They are asserted to be used in particular to develop positive personal relationships with their clients (Gold, 1987). There is of course strong literary support for this stance. Gilad (1990) in particular notes that communication barriers between immigrants and others can have an immense psychological impact on people who cannot speak English. Likewise, in order to better address the multicultural population Krefting (1991:33), suggests strategies such as this "that will bring a kind of cultural change that will facilitate the development of more culturally sensitive practitioners ..".

Ironically, in nine months of fieldwork at the Centre I never had an opportunity to see any of the staff in the programs I focused upon using these services that they had identified as such important resources to deal with "culturally different" clients.¹¹¹ Instead, I observed that some clients brought their own interpreters when they came for their immunizations. This caught my attention, and at a later period I asked some nurses "when do you use these services?" One nurse replied: "I have to do some home visits where the person didn't speak English. And in the clinic, whenever such persons have come in, they have had their own person come with them. Like they use "V" [a Vietnamese person]. But everyone I have dealt with has brought someone with them that could speak English. So it hasn't been a problem for me". The following were some additional reasons given to me by various staff members for their consistent disuse of interpretive services:

See sometimes language can be a problem. But generally speaking... ok, I will give you an example. When I was rounding up some baby [car] seats they weren't

¹¹¹ I did see an interpreter used in the travel clinic.

coming back. So I went out to the north side to find them ... So I walked into the door, a woman answered the door, she couldn't speak any English. She was an "East Indian" and she couldn't speak English. But they had a solution. She went like this (sign language) and said wait a minute and she got the kid next door. A ten-year-old kid translated [our conversation]. And I mean that's evolution. I mean that kid was perfectly bilingual... I am saying people will find their way if it's something that they want.

Another example is the translation sheets, which I never use. For example, once I used the translation sheet for one of the Spanish speaking families and the interpreter who was with me was involved in this translation. This translation was done by our immigrant services association and there were many mistakes. I do not know how long these sheets have been there and whether they update them on a regular basis.

I do the adult clinic and the interpreter comes here quite often with people who are coming into for immunization ... And they bring their own interpreters.

Once I had a male interpreter in my visit. I find it more difficult to converse through the interpreter because, you ask a [short] question in English the interpreter then talks in long sentences, then he turns around and tells me "everything is all right" For new Canadians we used interpreters. They were the "boat people". Now we don't have that many coming.

The above narratives clearly demonstrate the bureaucratic constraints and frustrations experienced by the CHC nursing staff. The nature of their work does not always give them the opportunity for much prior preparation, for extensive elaboration of interactional strategies or for temporal flexibility. In *The Hidden Injuries of Bureaucracy*, Foner (1995) argues that narrowly formed bureaucratic regulations are at least claimed to be essential for administrative "efficiency". In this he refers centrally to Weber's image of the "iron cage". The staff of the CHC certainly do not have that kind of image of their institution. Instead, in describing their past experiences, the staff view cultural diversity as a potential barrier to, and an inefficiency in achieving the most important goals of their institution; the problem

is not with the institution, but with the “culturally different” client.¹¹²

Conclusion

In this chapter I have addressed the everyday activities and activated meanings of a bureaucratic culture. For a better understanding of the social process of institutional knowledge construction relevant there, I have explored at a general level the CHC’s values, metaphors, social roles and group process. I first focused on the outlines of the general institutional culture, and then focused on the meaning of “multicultural” and how it is integrated in the institution’s everyday practice, ideologies of institutional legitimacy and mechanisms of boundary maintenance.

In the next chapter I turn to focus on the actual bureaucratic classification processes involved in identifying the culturally different client. Here we shall see in institutional everyday ritual and language the key locus of institutional categorization of its clients. This is, as Herzfeld (1992:97) says, “the essence of the essentialist project” and something vital to the maintenance of institutional identity.

¹¹² Herzfeld (1992:81) suggests that “bureaucrats often appeal to this image in order to explain, justify, or excuse their seemingly arbitrary actions and decisions”. Despite Foner’s argument, the bureaucratic practice of CHC can be best explained in the language of Douglas (1988). It can be said that both bureaucrat and client alike are unequally empowered social actors rather than ciphers in a machine. This quotation I have taken from Herzfeld’s (1992: 82) *The Social Production of Indifference*; the original discussion can be found in Douglas (1988:1144).

CHAPTER FIVE

FRAMING CLIENT AND CULTURE

Today the relevance of cultures to health policies is even more important than it ever was before - the world is smaller, international health care is a reality, and immigration of people from other countries has brought increasing challenges to health practitioners, institutions, and systems. The impact that ethno-racial diversity had upon health, health promotion and the delivery of health care is increasingly recognized as fundamental to the development and implementation of effective programs and services (Masi, 1993:back of the text)

Near the beginning of this thesis and again in Chapter Four, I noted that the community health centre was founded on principles of essentialism and the prevention of specific diseases. I have illustrated how this master ideology continues to be an integral part of the CHC identity, even though staff are challenged with new issues like “multicultural health care” in a poly-ethnic Canadian environment—both of which might have fundamentally challenged those principles. Drawing on my empirical data and diverse literature, in Chapter Four I have shown that the CHC is a dynamic social organization which is continuously developing systematic strategies for its organizational validity. The decision-making process of the organization was also discussed in detail.

The goal of this chapter is to explore how the client classification system is constructed and used for furthering staff medical knowledge and understanding.¹¹³ The CHC members are

¹¹³ Much research relating to health and illness has shown that in the empirical world of medicine, identification, categorization or classification of disease and illness is crucial for the application of proper, systematic and efficient medical knowledge and practice. For example, in a study of disease, ecology and human behaviour in the context of disease and culture, Brown and Inhorn (1990:187) show that culture plays a major role in patterns of disease and death. Another illness classification case study done in the South Kanara District of Karnataka State showed that the ranking of disease is dependant upon the prognosis (Nichter, 1989). My aim here however is to present the complex negotiation process where clients are framed according to attributes identified by the CHC nurses, particularly with respect to clients that are culturally different.

doing more than just categorizing people and identifying problems.¹¹⁴ They are using this classification system extensively to expand their medical knowledge in new contexts (Good, 1994; Young, 1993). I specifically focus on this process of knowledge construction.

Once during a conversation with the nurses of the Public Health Nursing Program, I was explicitly told by one of the managers:

Public health nurses are very notorious. We put people into little pigeonholes. You have to realize when you are working with different people (a whole cross-section, like age, socioeconomic, education, etc.) or you can say working with both [the] WASP¹¹⁵ population and non-WASP¹¹⁶ population, if we don't categorize, then we will have a problem. We want to have a long lasting relationship, and not be thrown out. For example, if you know that there is a "yuppie couple" for a home visit. Then there is no point sending a public health nurse who does not know how to deal with them. You cannot remove this prejudice. To us culture is another variable we manipulate This is how they [we] work.

Douglas suggests that institutions are involved in an ongoing process of classifying clients which is critical to their operations and that "since the mind is already colonized, we should at least try to examine the colonizing process" (1986:97). In public health, nurses in their everyday tasks are identified with dealing with "treating disease, assisting the client in coping with discomfort, and adapting life-styles to the illness and treatment" (Dougherty and Tripp-Reimer 1990:175). Notions concerning these duties constitute a major part of staff institutional culture. In this context, the staff of CHC know the client classification system (both formal/informal) very well and use it routinely in their everyday practice. My focus

¹¹⁴ For examples see Murphy (1987); De Voe (1981); Townshed (1971); (Goffman, 1961).

¹¹⁵ According to *The Oxford Dictionary of Current English*, the conventional meaning of *WASP* "(usus. derog.) is White Anglo-Saxon Protestant." Second edition. Della Thompson (ed.). Oxford: Oxford University Press, 1992. But, nurses in the CHC use this term to describe 'white' clients ultimately originating from European countries.

¹¹⁶ Non-WASP: Nurses use this term to describe a 'non-white' person, especially people from Asia, South America and Africa.

here is to elucidate the CHC staff discourse to understand the complex classification process involved where a person within the health context becomes a particular *type* of client. The intention is to highlight several findings with respect to client categorization and cultural difference.

First, I elaborate on the institutionalized notion presented in the previous chapter that “we treat everybody equally”¹¹⁷. Is this “real”— validated by practice— or are there contradictions present in actual practice in the CHC system? In most social organizations there are gaps between ideology and actual practice (Cohen, 1985; Fisher, 1981) and the CHC is no exception. In fact, the early postpartum visit process illustrated clearly to me that as a ritual nurses not only classify clients on a formal basis¹¹⁸ but also create informal categories. They appear to do this primarily to make some of their tasks easier and to shorten the list of tasks applied to a particular case. For example, in each home visit every nurse is expected to follow a systematic evaluation procedure that is prepared jointly by the nursing manager and the senior nurse of the Maternal and Child Assessment Program. In practice, this is not done consistently.¹¹⁹

Secondly, I develop an understanding of how the CHC’s emphasis on service accountability has influenced the public health nurses to slot every client into a particular predefined

¹¹⁷ This refers to the formal Public Health mandate.

¹¹⁸ Using a classification chart prepared by Alberta Health in which clients are categorized on the basis of their illness. Please see Appendix E.

¹¹⁹ On one occasion, during a home visit with a mother who had fourth child in a normal delivery, the nurse told me even before we got to the house that she shouldn’t take too long in performing her routine work. She said, “according to the hospital records everything looks fine and I am not going to be bothered going over the information package as she is an experienced mother”.

"box".¹²⁰ In discussing with nurses the use of programs such as the well-baby clinic and the postpartum support class, I observed that they systematically and pervasively categorized clients according to perceived personal and background attributes. To summarize here a much longer explanation that follows in the beginning, all clients are classified informally into one of the two main categories: "responsible" and "irresponsible". All clients are also divided into one of four other categories: "normal", "culturally different", "Indian" and "single mother". This latter identification of clients took place both on the basis of perceived sociocultural attributes and clinical information. These four overlap with "responsible" and "irresponsible" in complex ways. A diagrammatic representation of this classification system is given in Figure 3.

¹²⁰ These predefined "boxes" were created collectively by staff, and were identified by me through the language they used to refer to each client.

Figure 3: Perceived attributes of the CHC client and the role of the CHC nurse.

Who	Responsible		Irresponsible¹²¹	
Basic Category	Normal ¹²²	Culturally Different	Indian	Single Mother
Sub-Category	WASP	Non WASP		
	White Canadian Good Indian Middle Class	East Indian, Ethiopian Filipino, Chinese Vietnamese Cambodian	Transient Problem with law and order	Young Mother Unmarried white
Characteristics of the members	Familiar with the system, Married with children, Educated, Financially settled, Motivated	Communication barrier, Physically different, Food, Clothing, Extended family, Compliant, Respectful to nurses	Less educated, Low socioeconomic status, Non-compliant, Incapable of looking after themselves	Less educated, Non-compliant, Know it all
Nurse's role	Facilitator		Guardian	

These categories were somewhat fluid in nature and could change depending on social situation. Still (and critically), most nurses did not typically categorize the Native population

¹²¹ I have used “irresponsible” and “guardian” terms to categorize the clients perceived to be problem clients needing special care by the nurses.

¹²² These are the four categories the nurses used to separate clients.

of Lethbridge as culturally different. At the most, nurses saw them as a sub-culture of the predominant culture, a class-based subculture at that. In this context, the classification of culturally different clients here was very different from those that found in earlier institutional studies involving “racial” and ethnic phenomenon (Mahmood, 1992; Anthias, 1992; Scott, 1990; Mitchell, 1974; Cohen, 1974). Here, culturally different clients usually were perceived as responsible groups of people who were very good in complying with CHC’s mandate. The majority of the Native clients and single mothers belonged to a different major group, Natives, more clearly than the single mothers group. They were perceived as being actively irresponsible people (Natives) or people incapable of full responsibility (single mothers) who need close help and guidance.¹²³ In overview, the CHC client classification system was more complex than those described earlier by social scientists and health specialists.¹²⁴ This point will be elaborated further later in the Chapter.

A third issue involves exploring ways in which the CHC’s new health knowledge changes the meaning of cultural diversity in the context of institutional legitimacy. On several occasions nurses indicated that institutional constraints influenced them to continue with the practice of client segregation and medicalization of “new” groups of people like Natives and single mothers. I later analyse the consequence of such “bracketing” of clients and discuss how this encourages differential primary health care.

Client Identification : Making Cultural Sense

In order to analyse everyday medical knowledge construction I draw upon data from three central sub-programs: postpartum home visits, the well-baby clinic (or “drop-in clinic”, as it is usually referred to), and postnatal classes. These are where I spent most of my field work

¹²³ A similar finding was made by Knudson (1991); see also De Voe (1981) on refugees.

¹²⁴ For other client classification systems see Stein (1990); Todd (1989); Murphy (1987); Cowie and Roebuck (1975); Taylor (1970); and Goffman (1961).

time. I had the opportunity to observe nurses interacting with clients in hospital (in obstetric, intensive care, and paediatric units), at home, in the centre clinic, and in the classroom. This allowed me to achieve an understanding of the complex nature of the nurse and client framing rituals. In addition, I have also used information from some interpersonal concerns that were voiced during my participant observations with community health nurses in Lethbridge.

A CHC Nurses' Discourse: "Patient" Transformed to "Client"

The concept of "framing" in the literature refers mostly to a process of categorizing, where individuals or a group of individuals are described and analysed from a sociological perspective of deviance.¹²⁵ For the purpose of my CHC staff discourse analysis I have borrowed the following definition of "frame" from Ponting (1990):

A "frame" is an interpretation scheme that enables individuals to perceive, identify, and label occurrences which they observe. It is a set of categories through which individuals perceive and give meaning to events in the real world, either for themselves or, when used in discourse, for others. These categories organize experience and provide guides for action (Goffman, 1974, summarized in Ponting (1990:92-93).

Reflecting this definition, I focus on the nurses' cognitive, experiential, and sociocultural reasoning to understand their client identification system.

The early postpartum program was one of the most important daily activities of community health nurses. Every day between 9:00 and 9:30 a.m. the senior community health nurse travelled to the hospital to visit new mothers and collect pertinent medical information, such

¹²⁵ Much has been written illustrating how people come to be defined and labelled. For examples, see studies of social attitudes towards old age (Hazan, 1994; Townshed, 1971), the mentally ill (Young, 1993; Rhodes, 1993; Goffman, 1961), the disabled (Estroff, 1993; Murphy, 1987), social deviants (Cohen, 1985), and refugees (De Voe, 1981).

as the birth notices and other referral documents from the hospital's obstetrics unit.¹²⁶ This is the central place where both the "formal" and "informal" client identification began. In some cases, the label already informally used in client categorization was transferred from the hospital to the CHC nurses. During the visit, the hospital nurse transfers related medical information to the community health nurse in a highly formal and "professional" manner. This ritual was similar to a "rite of passage" as described by Turner (1969) in religious contexts and was a social drama carried out systematically in three stages. It began with the evaluation of each patient's hospital record and was completed with a personal visit made by the CHC nurse to each discharged patient.¹²⁷ Similar rituals are a crucial element of western medical culture (Good, 1994; Young, 1993; Stein, 1990).

The CHC nurse also acted as a liaison between the CHC department and the hospital. One of the important responsibilities of the nurse was to visit personally the patients in the hospital and to inform these new "clients" of the role of the CHC. The nurse informed the client that they would do a follow-up visit and make sure that the patient was recovering from her sick status without difficulty. They also informed the client that CHC nurses were available to the individual and that they could be contacted for consultation. Ideally, the central task of the CHC nurse was to help individuals recover from illness or to prevent disease. Thus, from the CHC nurses' perspective, the acquisition of knowledge about a specific client was intrinsic to the CHC organizational mandate, and constituted the initial "framing" procedure.

"I", a self identified "experienced health promotion nurse" who enjoyed working with clients

¹²⁶ Every Tuesday morning the senior nurse also visited the paediatrics unit. She had a meeting with the supervisor of this department and a hospital social worker. During this period all three professionals carefully evaluated every case, and after this referral forms were passed on to the CHC staff to be used in the monitoring of the health condition of each discharged patient.

¹²⁷ These three stages are expanded upon later in the Chapter.

like young single mothers (including Spanish-speaking women from Central America and other immigrants), talked about the positive contribution of the client's medical assessment, sociocultural background, and the setting of the institution to the provision of "holistic care". She maintained that the CHC's formal client classification information had immensely helped the nurses in achieving their "dream", which was to address their clients' health needs in the best possible way:

I am not sure if we provide every single client all the three objectives of public health at one time.¹²⁸ It may be that a particular situation demands one objective and not all of them.... also, we have certain agendas that we take to our clients, but they also may have agendas. Sometimes the client's agenda may be more important than the agenda we bring to them. So then you might tend to focus on what is of concern to them. Take the mother I visited today for example-a single mother with a baby that is really struggling to thrive. In this situation, I am going to focus more on the feeding of this child than other things. Especially since this mother really couldn't care less whether I come or not. Similarly, in another case, I knew the concern-here again it is the baby-so I am going to focus on the baby. I may not focus on alcohol or drugs or so on ... when it seems it is not needed. If I don't see an ashtray, I may focus on something else, because that is more important in that situation. ... Therefore, it depends on the evaluation agenda.¹²⁹

"I" presented another example from her recent interaction with a young mother who lived in a basement suite, immediately adjacent to an apartment building. As a result of the location the young mother always had her window drapes drawn. This condition was considered by the nurse as a major factor in the client's emotional health:

... I had a situation where one mom was always on the verge of depression. Her husband was going to school, plus [he] was working. So he wasn't home much at all. When we did the postpartum depression scale [test], her score was quite high, then she was referred back to me. And I offered postnatal classes to her when she was coming to [the] clinic.

¹²⁸ The nurse was referring to the "life style" model, where the three areas of focus are physical, social and emotional aspects of health.

¹²⁹ Here "evaluation agenda" refers to the client's health information record.

"T"'s account is a typical representation of CHC nurses' perceptions relating to the above issue. During my extended interviews, virtually all the nurses mentioned the importance of having detailed information about clients. The in-depth physical assessment and other records catered to, and facilitated most of the nurses' medical/professional tasks, so that they were able at least to perceive that they provided appropriate services to clients.

CHC Nurse and Physician Interaction

Separate from the above process, there was another somewhat more hidden determinant which made the CHC senior nurse's ritual of visiting the patient in the hospital significant. The CHC nurses interacted with community members daily, and perceived that most people in the community defined the CHC's role as useful. However, they also felt that some clients thought of them (CHC nurses) as less credible than doctors, and that this affected their ability to be "taken seriously" in their job.¹³⁰ Reflecting this sense of the incomplete professional legitimation, a discontented nurse confided to me:

... There are moms, even if the nurse tells her to do something that is good for her baby, she won't do it. But the nurse told the doctor and if the doctor tells the mom, then she would do it. For some women what the doctor says goes, and especially if there is a conflict with what we say here, even though our programs are all backed by the dietitians. It is a medically sound program, but if there is a doctor who isn't completely aware or deviates from our program there are mothers that will listen only to the doctor and not to us, the nurses.

It should be noted that the nurses recognized that in a formal sense they had lesser status than doctors in the local medical culture, and yet (regardless of this acknowledgment) they also

¹³⁰ This was explicitly expressed by some with great disappointment and frustration. Some felt that the physicians were not helping their cause and they blamed the doctors for client's attitudes. For example, one nurse said, we have two young gynaecologists in this city, who now want to see their clients within the first week of their discharge. This makes it difficult for us. They know very well "we do home visits within forty-eight hours of the mother and baby's release".

often maintained that they had better and more appropriate practical experience than physicians.

The nurses also had the ability, to a considerable extent, to manipulate actual situations to create a favourable audience for their orientations and agendas. This initiative is demonstrated clearly in the community health nurses' conversation and practices. They used both reactive comments and leadership role-playing in certain interactions with clients, and in establishing cooperative programs with other health professionals. For example, there was once some miscommunication between physicians and CHC nurses regarding new mothers and breast feeding. To alleviate this problem, one nurse said they decided to do the following:

In September 1994, we established a breast feeding support group. This group is made up of physicians, community health nurses, nutritionists, and some other interested parties. The reason being, some doctors said that their clients stopped breast feeding because they were not getting milk. And according to the doctor his clients said that they were told by the community health nurse to stop breast feeding. They accuse us that we didn't encourage them to breast feed. You have seen that we spent a lot of time to show them how to breast feed. Maybe this doctor had one mom who stopped breast feeding, but that is not because of us. You see, the doctors do not spend the amount of time [with clients] we do. Therefore, we thought, let's start a support program among the [health care] professionals, so that we all will know exactly what we are doing, and doing it the same. We will prepare some kind of document that everyone can follow.

In an attempt to combat this very important perceived problem of legitimation, the senior nurse as a ritual began her initial client contact at the hospital. She explained to me with a smiling face, "people do not know what we do. So, I basically show my face and tell the mothers, Hi! we are out here. If you need help look for us. We are in the telephone book". It seemed critical for these nurses to make the community aware of their unique occupational identity. In a larger sense they of course needed this validation from the community for their institutional continuity.

Throughout much of social and historical context of western medical culture, nurses have had to nurture, feed and tend the sick people. This nurturer role (which evokes an image of nourishment and suckling in a maternal sense) has changed to some extent in the twentieth century. In addition to their traditional roles, nurses today are also working as counsellors, educators, practitioners, facilitators, and operators of sophisticated technological equipment. Whatever their new roles maybe, they continue to work largely under the jurisdiction of the physicians (Clark, 1992). As a result, they continue to experience sexism, classism and status ambiguity. Terry Wotherspoon (1988) summarizes the transformation of the Canadian nursing occupation from a subordinate service occupation into a more specialized and sophisticated profession. In her anthropological study of transcultural nursing, Madeleine Leininger does a comparative study of two “subcultures” (1978), those of nurses and doctors, within American medical culture. She revealed key differences in the professional role/status between nurses and physicians in everyday health practices in American medicine. According to her, this differential role/responsibility often leads to conflict between the two subcultures in their everyday discourse. Leininger’s findings apply to a great extent in this local health culture. The implication of this professional conflict between the physicians and the CHC nurses in this city can be overtly identified in the context of vocabulary used by the CHC nurses during the process of client categorization. These will be expanded upon later in this Chapter.

The second institutional differentiator I identified from my daily conversations with, and observations of CHC nurses and other staff was the continual use of the term “client”, instead of “patient”, as used in hospital scenarios. All staff repeatedly used the term “client” in reference to individuals accessing their services, as noted in Chapter Four. Once more, this term reflects a dominant image of CHC culture--a clear distinction between “us” (the CHC organization) and “them” (the hospital). This strong distinction suggests that the CHC as an institution did not expect their “clients” to be framed for the role of a sick person needing institutionalization. Instead, the community health nurses repeatedly portrayed themselves as a group of people representing an institution aimed at *preventing* disease and illness.

Within this context, the individual is viewed differently than a "patient" by the CHC nurses. They are most often characterized as "healthy" individuals who are in control of their health and their lives more generally. CHC staff are there to provide helpful information and to be the "facilitators" of good health.

Yet, this did not fully reflect the staff's everyday institutional practice. When nurses talked about clients, it was almost always related, explicitly or implicitly, to specific *types* of clients. They usually began their client identification with issues of medical concern, followed by other categories and sub-categories which were based upon the client's perceived socioeconomic, cultural, and interpersonal attributes. The fact that the CHC worldview still rested upon an ideology of "essentialism" and a fixation on "specific problems", made this type of client categorization central to institutional identity. It was also necessary for successful "impression management", as described by Goffman (1959). Douglas (1986) further suggests that institutions such as the CHC depend on client classification to make client variability compatible with their existing institutional vision. In some ways, however, this method of adopting a category like "client" is not much more than what Taylor calls "sociological sheep shearing" (1970:81). The main substantive thing that has happened is that the old label has been removed and replaced with a new one. When one follows the CHC client identification procedure used by the nurses it is evident that: 1) staff oriented their clients to follow traditional patient roles; 2) the paternalistic treatment of human ailments continued to be central; and therefore, 3) staff do not seriously entertain the possibility of expanding Centre activities involving greater attention to client social organization and culture.

As a result, what happened was that the patient was removed from the hospital orbit of patient care and transferred into the CHC orbit, so that the staff there could complete the medical/curatively formed cultural process. Clients are indexed according to what Thompson

et al. (1990) calls a “means-end reasoning chain”.¹³¹ My point is not that the client categorization process is “dehumanizing”, or what Garfinkel (1975) referred to as a “status degradation ceremony”. Rather, it is to highlight patterns of “new client” knowledge construction. In short, nurses used their power and knowledge to generate client categories which they perceived would benefit them as well as clients. Foucault calls this as a “strategic model” (Foucault, 1979:128).

Sources of Client Identification Information

Good (1994), in *How Medicine Constructs its Objects*, suggests that human knowledge is socially constructed and applies this concept to understand how individuals learn to treat the human body as an object in order to become good physicians. This concept can be extended to show how the CHC value system influences the construction of new client categories. After receiving formal information from their liaison nurse, the CHC nurse was expected to contact new mothers on the day of discharge or before 10:00 a.m. the following day to arrange a visit. Ideally, the first home visit was made within twenty-four to forty-eight hours of hospital discharge. Home visits offer an insight into the beginning of the CHC client identification process. To illustrate this, I offer my observations of the entire sequence developed by the CHC senior nurse.

In this context, there are three important sites where client information was collected by the CHC senior nurse. One critical site for collecting a person’s medical information was the hospital patient chart. This chart provided formal documentation relating to the patient’s physical assessment, type of illness, and personal background (see Appendix E). The second site was the obstetrics and pediatric nursing staff. Each client chart was re-evaluated by the

¹³¹ Thompson et al. (1990) in *Cultural Theory* uses this concept mainly to discuss how social organizations such as the World Bank catalogue and justify their organizational decision-making process. A similar analogy can be applied to analyse the CHC’s daily client indexing system.

nurses of the source health institution before clients were transferred to the CHC and other health organizations like physician clinics. Here a lengthy discussion typically took place about the physical, behavioural, and interpersonal relationships of the client and the hospital staff. This included informal information relating to the hospital nurse's experience with the client from the labour room to the maternity ward. In this way the hospital nurses placed individuals into one of a few basic hospital patient categories¹³². Mothers who had breast feeding problems were repeatedly portrayed by the hospital nurses as "high risk cases" where the CHC nurse was advised to provide immediate attention.

The CHC nurse's personal visit to the mother in the maternity ward was the last hospital site where identification of the client took place. After the formal debriefing the CHC nurse toured every room belonging to mothers who were being discharged on that particular day and introduced herself by saying something much like: "Hi, I am the public health nurse. How are you doing? Are you going home today?" The objective of the nurse's visit was to make a brief client evaluation through face to face conversation and to collect additional information that was sometimes not available from hospital charts – such things as family situation, support system,¹³³ ethnicity,¹³⁴ and breast feeding status. This extra information helped the CHC senior nurse to allocate the day's client distribution among the nurses. The nursing managers and senior nurse mentioned several times that it was critical to distribute

¹³² Hospitals most generally classify patients into two basic categories, "good" and bad". Murphy (1987) suggests that a patient who is successful in meeting the sick role is a "good" patient.

¹³³ The nurse specifically asked each new mother if she had family members to take care of the house for a few days so she and the baby can have plenty of rest. For a healthy recovery "rest" was deemed essential for a new mother. As one CHC nurse explained, "our focus is to see that the mother and the new born are not in health related danger."

¹³⁴ On one occasion the liaison nurse after the initial visit with a Native mother in the hospital shared her perception about this mother to the CHC nurse in the following manner. The senior nurse said, "she is a better and communicative Native, so you shouldn't have any problem with her."

clients to “appropriate” nurses in order to avoid any unanticipated problems. During my conversation with her, the senior nurse repeated that one of her job responsibilities is to coordinate and establish the initial (formal) client classification system for the home visit program. “W” explained in greater detail how she performs this task:

We have divided the city into basically three areas. And there are certain nurses assigned to those areas. But because in last few months we had disruptions in our staffing ... And then if one side has lots more babies than the other side then those will be more important than the less busy side. And in that I tried to kind of match up the client and nurse - who would be more inclined [to address the issue]. Say of breast-feeding problems, it is much easier to give it to the one who is most interested in dealing with breast-feeding problems than the ones whose speciality is not in that area. So I try to kind of match to a certain extent within areas if possible, but sometimes it is matter of who is available that could go and who is the best match for them.

Like the breast-feeding; there are some problem families. Some nurses work better with certain problems these families have while others [work] in other areas, like [with] medical problems. Not that they [other nurses] don't do a good job. But this particular nurse has more of interest in that thing. Some had similar clients and are used to dealing with those type of work.

On the whole the cultural issue doesn't really come into the picture. Because all the nurses deal with everybody and we try to have everybody treated as equal people... We probably work in that way, medical or social problems being sometimes like single moms or a high risk family who has a history of neglect, or abuse. Except some nurses work better than others. That is true and we take that into consideration too.

"Moral Responsibility": A Criterion for Client Differentiation

During my fifty-two home visits and participation in other daily activities, I observed that when nurses talked about or made any reference to their clients they used vocabulary which combined several important themes of biomedical culture. Key terms that were frequently employed by nurses in this context were: “problem”, “caring for”, “moral responsibility”, “fixing”, “planning”, “teaching”, “education”, “chasing”, “trouble” and “concern”. These

highlighted the fact that community health nurses, other office staff and their managers were daily involved in a largely “medical approach” to a health promotion program.¹³⁵ As a result, nurses at this centre have adapted and evolved a classification that is grounded in a “diagnostic approach”. Within this framework clients are also labelled as “good” “interesting”, “a nuisance”, or “unusual”. Here, perceived prospects for compliance were central. The individual cases that the nurses identified clearly indicated that clients who asked “relevant” health-related questions, or who could be persuaded by the individual nurse to follow their health promotion instructions were categorized as “good”. This appears to be primarily because these complying client activities made the particular nurse feel effective and good about her job. This moralizing and categorizing phenomenon is commonly observed among the bureaucrats who are in control of social situations where they deal with clients (Herzfeld, 1992)

In *American Medicine as Culture*, Stein (1990) has applied Kleinman’s explanatory model to analyse the doctor and patient clinical relationship and “good” or “bad” patients.¹³⁶ The objective here was to show how the CHC nurses have developed comparative client categories for a better explanation of the client’s action. I also wish to add to this model that the nurses’ construction of health care knowledge makes the client classification much more complex. In fact, nurses bring variable, “folk” or “naive” knowledge to the process of distinguishing different types of clients. I hope to show in what follows that how this hierarchical structure is formed is not static; available new information and nurses’ personal experiences are continuously changing or attempting to change the client taxonomy. This

¹³⁵ Ewiles and Simnett (1992) in *Promoting Health: A Practical Guide*, have presented five approaches to health promotion. They are medical, behaviour change, educational, client centred, and societal change. In this institution nurses are centrally occupied in providing medical based health promotion care, where the main focus is “freedom from medically-defined disease and disability, such as infectious disease, cancer, and cancer...This approach values medical procedures, and the medical profession’s responsibility to ensure that patients comply with recommended procedure” (1992:37-38).

¹³⁶ For doctor - patient relationships also see Todd (1989); Kleinman (1975); Taylor (1970).

“profiling” (Goffman, 1963) of individuals or groups of individuals is an important part of our society and it is reflected in CHC medical culture. Goffman has mainly focused on persons who are unable to conform to standards which our society calls “normal”. But here CHC nurses are using this framing process for their professional and cultural benefit where they contract and expand boundaries to include or exclude clients in particular categories.

This categorization occurred both in a formal and informal manner. It began when the individual was formally accepted by the CHC staff. As indicated earlier, in the situation of the postpartum program, a new client is first evaluated and segregated according to a formal medical classification system beginning in the hospital. At this stage the nurses’ reasons for client differentiation reside primarily in the domain of “sickness”, in which delivery is considered to be a pathological ailment (Todd, 1989). Invariably the nurses discuss their home visits through the use of clinical terms like; “regular”, “early discharge”, and a “special case”. “O”, one of my interviewees, very carefully explained what each category specifically meant to nurses:

A regular visit is where the mother had a regular pregnancy. There were no complications during and after delivery and the hospital discharge time is over forty-eight hours.

An early discharge case is where the new mother is released from the hospital within forty-eight hours,¹³⁷ or where the mother has a Caesarean baby and was released from the hospital within three days of the delivery.

The last category is called the special case. Under this category several types of cases are clustered. They are referrals that have come from the hospital, community agencies, or physicians. Then there are high risk cases like premature babies, mothers or babies with health problems. For example, an older child can be referred by an outside agency. Generally the referral cases are contacted by phone within twenty-four hours.

¹³⁷ In Alberta the Health Care Reform has forced the hospitals to discharge the mother and baby earlier than was traditionally practised.

In addition, there are other unofficial terms that are also regularly used to divide clients into distinct social and cultural categories. Among them the most significant and consistently used social differentiator has to do with ethnic identities like “Vietnamese”, “Spanish”, “East Indian”, “Filipino”, “Polish”, “Indian”, “Asian” and “Chinese”.

Who exactly are these people? Are these clients being categorized by their national identity, source country, or self ascribed identity? One nurse explained, “partly it is people who look different, I mean physically different, like the Asians. Asians are people from Vietnam, Cambodia, and China, and not *you* people [East Indians]. There aren’t very many of *your* people in Lethbridge”. It is also not unusual to hear terms such as “boat people” or “Central Americans”. For example, during the interviews when nurses were asked to speak about their workshops and seminars, one nurse remembered, “one time when Lethbridge was getting a lot of “boat people” we had a workshop for these people. We had experts come and tell us what is their cultural background. How these people have spent many years in the refugee camps. They didn’t trust police, or the system...”

Identifying clients in terms of their social and personal characteristics also generated other, more fluid sub-categories that were in some way connected to cultural difference or its lack. Words like “integrated” or “assimilated” were mostly used in reference to “normal” clients whom the nurses perceived as compliant immigrants. One of the main reasons for using these terms was to ensure that they followed the institutional protocol. In other contexts, attributes like “good” and “keener” were used both in positive and negative senses, sometimes in reference to the same “normal” client. For example, when a new mother maintained her child’s immunization record she was viewed as a “good” client in this context. But when the same mother too often came to the drop-in clinic she was perceived as a bothersome “keener” who was chiefly interested in completing her baby’s passport requirements and was wasting too much of the nurse’s time. “Keeners” were primarily “normal” parents from what were spoken of as “educated” and “middle class” backgrounds. They were never “immigrants”. Frequent use of this label by nurses displayed a clear latent aim of CHC nurses to provide services primarily to people perceived to be sick or at risk.

Indeed when the nurses were asked to reflect on their general perceptions about service users, virtually all nurses said that one problem they face was overuse of services by “people that don’t need them”. These people are perceived as wasting the nurse’s time because they are “normal” and at most only in need of routine service. As “Q” explained:

The majority of our service users are the first moms, because they are overwhelmed. They come to see us, they are eager, they want to keep records in their baby book, like how much their baby has grown and gained in weight. What I personally feel is [that] they waste my time. But we can’t say that - don’t use the service. I would rather like to see those moms who are at “risk”. But our stumbling block is how to get these people to come and use the service. This is my major concern.

Most often everything is just going fine... It is the people that we are concerned about that don’t access the services at the CHC.

“C”, points out:

It is typical we get the people who need it the least. One example comes to my mind is a wife of an accountant. This mother took one of the classes with me and her concern within the house was their open spiral staircase. We didn’t get the mothers that needed the most. I suppose that is little unfair. Just because somebody comes from the middle class or upper middle class doesn’t mean that their concern for their child is any less valid. But, you know, we have idealist[ic] thinking that it’s these under educated and poverty moms that we are going to help along through this time frame. But when you offer something very often it is those white middle class moms; [who] hears about it, reads about it; that has the means of transportation to get here to attend.

This suggests that nurses are consciously aware of their personal commitment to address high risk clients, but are constrained because of the voluntary nature of their clientele and by their institutional value and belief system to allocate many resources elsewhere. It is this mandate to concentrate on clients seen as “high risk” that consequently frames some middle class clients negatively as “time wasters”.

Stein (1990) explains this kind of client categorization as being an unofficial moralistic taxonomy. This taxonomy also evokes the pressure nurses are under in addressing and

sustaining their health care mandate with limited resources. The construction of this taxonomy took place at two levels, that of the natural sciences (diagnostic), and the social/moral. Diagnostic criteria related to the nurses' medical knowledge and skill, where the client is identified via "medical" information; and the social/moral related to the establishment of separate programs, allocation of money, staff, additional tasks, new policies for new types of clients, and available time. The following direct quotes illustrate that it was not unusual for CHC nurses to use language combining both diagnostic and moralistic criteria in client categorization. The quotations also show that there was an explicit acknowledgement of various kinds of differences in the construction of this client grid:

This is a first visit; a regular visit; a Native mother; fourth child; the mother likes to drink. It is not a stable kind of home. First three children have the father's name. They have no telephone. They do not see the doctor, and don't come to the clinic.

A first visit; regular visit; mother has no complications and therefore this visit will not be a long one.

This is a second visit. A Native mother, age fifteen. Single mother, lives with a man whose name does not tell me that the father of this child is Native. But, the baby looks "Native". This mom has given the baby the father's name. She is nothing but only trouble. She does not have a telephone. These are her foster parents.

A single mom, who is twenty years of age, but looks sixteen. Just being a single mother puts her on high risk category. She also lives in a tiny place. A lifestyle that you should see. This gal has no cooking skill. Ninety-nine percent of the time she lives on junk food. She has pop and pizza for meals. She eats soup from the can. The baby is healthy, and in that tiny place she has a playpen, and other toys. She also has a cat. She gives all her time to the baby and does not look after herself. My concern here is the mother. She needs help to straighten out her life.

This will be our new baby visit. This is our regular visit. She is a Native mother. This is her second child. "W" told me when she met the gal in the hospital she sensed that she is a better and communicative native. They live in an apartment. Right now they don't have a telephone. But her name is not very common. I have never seen this name before. Yet according to the record it shows she is from the reserve.

This is a follow-up visit. I am going to is basically weigh the baby. This the second child for the mother. It is a regular discharge. There is no health problem with the baby and mom. I had done the first visit, the mother wanted me to come back to weigh the baby.

I thought you would want to see this referral visit. This is my fourth visit. She is a seizure patient. She had her first baby at age seventeen, grandma said she had this child out of wedlock, and the baby was given for adoption. Given the passing years this girl has spent time at the vocational school. She is a nice girl to talk to and not an ideal person. The first three visits I made when her mother was around. Her mother said she is a slow learner and so when I was there, she was all worried and kept on telling me - "I am a slow learner. I want to be able to look after the baby"..... What this girl is going through is part of baby blues. This postpartum depression. She is on social assistance, and probably has a disability payment too. I don't know exactly.... She has good support from the family. This is an excuse for me to get out of the office.

This is my first visit. This is not an early visit. We don't have to do physical assessment like we do for early discharge moms and babies. We don't have to do intrusive assessment. We don't have [to] touch them. Same with the baby, I personally like to check the baby's heartbeat. But, we don't do the baby's temperature. She has other children, one nine and the other five years old. She is breast feeding this baby. I don't [know] anything about her previous babies' history.

It is a Spanish family, it is a problem home. The girl has two babies. Her mother and sister with her baby live in this house. The girl is not married. Her mother is taking ESL class. Her sister is going to school as well. She has a boy friend. He doesn't live with her. Lots of people live in this house. When you talk to her boyfriend he says not more than two children. But I don't know....

This is a special observation. This referral came from the Social Services. It is called at risk observation. I have to stop and see if the baby has gained weight. The baby isn't thriving the way it should be. The mother is young, there is a question of parenting. One of the possible fathers is dead. She is on social assistance and lacks in care giving. Or you can say the parental caring is poor. There is a possibility a man is living there and for Social Service purposes he is not living at that house. She is an uncooperative mother. She does not comply to our suggestions.

CHC staff began their construction of client categories with clinical labels, but as above it did not stop there. The nurses continued to highlight each case with other pertinent

information that influenced their client hierarchy (De Voe, 1981). For example, identification of clients using the dichotomy of “us” (“Canadian”) and “them” (“non-Canadian”) came easily to CHC nurses. Similarly, in some instances nurses used family names to describe a client. By using the family name (like Mrs. Brown) the nurse speaks of the client as being in the “us” group.¹³⁸ Usually in these cases ethnic markers were absent from nurse discourse, and the client was described as a “normal” Canadian,¹³⁹ a mainstream person of the community. Some other clients were without question labelled according to perceived biological traits, nationalist identity or cultural behaviour. This included aboriginal peoples, “visible” new immigrants and some other people with visible physical characteristics.

“Responsible” Versus “Irresponsible” Clients

When the nurses were asked during the extended interview to reflect on the meaning of “responsible” and “irresponsible” clients, two major oppositional characteristics emerged. They are “compliant”, and “noncompliant”, respectively. Identifying clients with these labels is certainly different from the official system. To me, it seemed that nurses took great pride in being able to quickly identify and act upon these two major categories of clients during their first encounter. This was evident throughout when they used positive descriptions such as “very nice people”, “very polite”, “extremely concerned”, “motivated mother” and “concerned mom” to refer to a responsible client.

This process usually followed a predictable pattern. The most crucial cues found in the language were regarding the nurse’s encounter. For instance, clients (whether “normal”,

¹³⁸ The nurses categorically identified these clients to be the dominant ethnic group of the Canadian society.

¹³⁹ When I asked nurses to describe Canadian culture, all found it very difficult to define. One nurse said, “Canadian culture is you live with it, you are part of it, but don’t really think about it.” Most of them compared it with the American culture.

“culturally different”, “Indian” or “single mother”) who obediently followed regular medical practice were labelled by the nurses as “responsible”. The “normal” “responsible” client was spoken of as a “fairly well motivated” client, who belonged to the middle class. They were actively interested people who wanted to make sure that their child got the necessary immunizations to get protection from illnesses. The following two statements given by two nurses during interviews discussing “normal” clients, draws salience from the western medical value system:

“I”...These are parents who want [the] best for their children. They want to make sure that they get their children’s immunization so that they are protected. They want them to grow up healthy. They want them to be fed well and so they will ask for feeding guidelines and so on. Sometimes they are more educated, but that is not always the case, because we have some that are less educated and they are in the same category.

“Q”... it almost seems like the better educated they are the more interested in learning and want to learn more things. Money doesn’t seem to have great bearing on it. ...

These terms were not used in their literal sense as much as categories (Demaine, 1989). They were used selectively (most of the time unconsciously) to separate and identify different types of people. Almost all nurses identified normal people as mostly “white” middle class Canadians who have middle incomes, and can opt for other options for help, if they want to. “They aren’t so dependent on just one source”, said another nurse.

During discussions about “compliant” clients there were instances when nurses distinguished a “good Indian” from a “bad Indian”, evidently based upon their institutional assessments and perceptions of Indian public behaviour. The following excerpts from three nurses explain how preconceived notions of an “Indian”¹⁴⁰ influenced client categorization. In these excerpts and more generally a “good Indian” is considered an exception--a rare contrast to the type

¹⁴⁰ Baroe (1975) *Indians and Whites*, has made a similar observation in his ethnographic study in Southern Saskatchewan.

of “Indian” the nurses believe they naturally encounter in everyday practice as “F”, stated:

... there are some very middle class natives, who can live on the reserve, off the reserve. They are well educated. They hold jobs and everything else. We don't see that many of them. Most definitely we don't see most of them. But the Natives we see a lot are not from this group. Especially being right here. You see all the people going to the food (soup) kitchen. You see all the drunks, see the ones in the park. So we see a lot of the others. And a lot of the visits we make are to this type”.

Every visit to a “good” Native home I made either began with distinguishing words like “interesting”, or ended with a comment “that this was an unusual” case:

This house we are just about to enter looks decent. I see they have a new van. The young mother goes to the college, she wants to become a secretary. The grandmother lives in this house with her three foster children. This [is] a “peculiar set-up”. It is understandable that the father of the baby does not live in this house. This is an unusual case.

This house we are entering is a “good” Indian home. You know there are some nice Indians. This man is a police officer for the city. He is very good. ... Did you see their house was clean. He was feeding his child and taking him to the skating program. This is the first time I saw an Indian home with a plant in their house. You see Natives don't have plants in their homes. They are a very nice family.

This mom is a working mother [said with approval]. We are having [a] hard time in coordinating a visit. She is juggling three part time jobs. I am making this home visit to give some TB pills to her daughter and do a TB testing on another child. This is something we would not do on a regular basis. But this is an unusual case. The family is originally from Brocket. The grandmother died of TB, and the mother is so busy that we want to make sure that everyone in the family is tested for TB....[my quote]

The above situations were seen as rare occasions and support the assertion that the cognitive view of typical Native clients in general continues to be congruent with historical stereotypic

images:¹⁴¹ irresponsible, unemployed, unsociable, and disorganized.

In contrast Chinese, Vietnamese, and Polish clients were identified with the opposite referent: "responsible". They were considered "sincere", "quiet", and "hard working" people, who invariably made sure that their child was looked after very well. They did everything possible within the scope of their available knowledge to keep their babies free from disease. These groups are perceived as people who had few parenting problems. On many occasions, they were thought to use 'traditional' health practices not in conflict with the medical model. In fact, while discussing the CHC's nutritional program, one nurse said:

... You see those babies eating rice as their main diet and they are just doing fine. In fact, they are very successful in their careers. Tell me one thing, why do we have to go and teach them about nutrition?

The following quote from another nurse is an example of a "responsible" and "concerned" Vietnamese mother's strategy to address her communication problems: "[this is] a responsible Vietnamese mother who cannot speak English, yet makes sure that all child immunization is done. She uses her friend who speaks English. If I have any questions for this mom, then we communicate through her friend. It seems to work fairly well". The nurse went so far as to point out that the use of multicultural service is not crucial in this context. This nurse's account also highlights a commonly voiced perception: that in general a "responsible" client can almost always find effective ways to address their own problems. People like this Vietnamese mother were mostly spoken about in a positive and genuinely supportive way. This was in contrast to a number of studies of Canadian ethnic relation situations¹⁴² where such people were spoken about disparagingly or negatively. Such positive

¹⁴¹ These views about the Native population of Lethbridge are very similar to those identified in anthropological and sociological literature. For a detailed analysis see Broroe (1975).

¹⁴² See Basran (1983) in *Canadian Immigration Policy and Theories of Racism*, and Bolaria and Li (1983) in *Racial Oppression in Canada*, where the authors point out the Canadian Government racial policies against the Chinese and Sikhs. Also see works of Burnet & Palmer (1988); Buchignani, Indra and Srivastiva (1985).

descriptions of a range of key ethnic or immigrant clients was related to CHC nurses' practice of following the biomedical mandate, and their perception that the present institutional structure can handle these personally responsible clients without any extra effort or additional programs.

Another of my linked observations was that virtually all the clients identified with "ethnic" backgrounds were people who were perceived to have extended families and from the nurses' points of view this was a good thing. The additional members that lived with them were often seen to provide a significant social support system. In reverse, sometimes if there was a perceived "problem" with an "ethnic" young mother the blame was placed on that family or on the ethnic "community" at large—not on the mother.

These perceptions appear to involve various types of cultural reasoning, not all consistent with each other. For one thing these "ethnic" people were identified as the least frequent users of certain CHC service yet they were said to know how to look after their own health and illness. Their representation as clients was so low in regard to certain programs that CHC nurses have stopped maintaining statistics on them, which nurses have read as a health promotion success. This was pointedly so of Vietnamese clients. In overview, descriptions of local Vietnamese cultural practices was similar to that of many Vietnamese groups elsewhere (Habarad, 1987). Many positive perceptions of these clients involved their supposed eagerness to "assimilate" with, conform to or "integrate" into the dominant Canadian culture.

There were, however, occasions when immigrant-origin culturally different groups were described as people who could not escape from their traditional practices, which at times negatively affected their adaptation to Canadian medical practices. As one nurse pointed out:

.... the fact is that they come from different backgrounds than the majority of the people that are here. Even if they speak fluent English, the fact that they have come from Africa fifteen years ago will continue to affect the way they function here.

This manner of talking about the local immigrant and minority populations is common among the staff of many bureaucratic organizations.¹⁴³

In the interviews there were also instances when the nurses pointed out specific characteristics of immigrant and ethnic clients that were culturally “*similar*” to Canadians. In response to the question whether and how clients from Iran, Fiji or Cyprus would have ethnic backgrounds that were culturally similar, one nurse said:

A client who is a professional and has a genetic heritage from Iran, Fiji, Cyprus is considered culturally similar if they did the same things that we are doing [similar health practices]. Then they are culturally similar people.

If they are born here then they are probably [the] same as anybody else who was born here.

From quotations like these it seems that the nurses consider clients from different source cultures as culturally similar to the extent that they are seen to conform to the dominant cultural value system of this society and thus, to be potentially compliant. This is not a condemnation of the ethnicity of those seen as different. Rather this type of labelling is primarily used as an indicator of how to perform their professional nursing tasks with ethnic clients: whether to use an interpreter or translation sheets, or whether to establish programs for these people.¹⁴⁴

I would also note that culturally different “immigrants” and “ethnics” were rarely blamed for not using CHC services, other than occasionally in the context of the immunization program. Yet at the same time from the nurses’ point of view many of these clients did *not* attend the well-baby clinic or the postnatal class, especially people such as those seen to have

¹⁴³ See *People in Upheaval*, edited by Scott Morgan and Elizabeth Colsen. New York: Centre for Migration Studies, 1987. Also see work of Chan and Indra (1987).

¹⁴⁴ In July 1994, a one day nutritional workshop was set up specifically for the Spanish mothers who had some knowledge of English.

Vietnamese, Cambodian and Ethiopian ethnic backgrounds. In general, such “withdrawal” was attributed to culturally different reasoning rather than to anything to do with the CHC culture or individual “ethnics”. For example, “P”, in her interview explained:

The moms from Cambodia, Ethiopia, from these cultural backgrounds, get the same invitation to come to the postnatal class - but don't come. Perhaps it could be cultural, or they are adjusting to the new culture here. They depend upon extended families. I suspect that could be the biggest reason. For example, Filipinos bring out their families. Lot [of] them seek out their own people [instead] and that is understandable.

Similarly, one nurse suggested several possible reasons for not attracting new mothers from certain minority groups. The following reasons are a sample of comments received in this regard:

My perception of it being intimidating, may be its the building, may be the location of the building, may be it is hard to access that way. Not that I don't know enough about cultural nursing, but from what I understand there are certain groups who do stay very close to home for the first while (postpartum) and we cater to zero to three months babies. We don't have anything past that time.

I don't know if a group type setting is for me. A group type of setting is not for everybody. It appeals to some people and doesn't to others.

I think the mothers of other ethnic groups need support more because they are not even [in] their homeland. They also have to adjust to a new language, new home, and new life. But they don't come—I suppose one reason could be that they do not understand English well enough, and may be not comfortable being in a group. Or may be just that [they] go elsewhere and feel comfortable.

In these citations, “communication barriers”, and “discomfort in group settings” were repeatedly stressed as ethnic group cultural characteristics. Some nurses also suggested that Vietnamese mothers practised different birth rituals. “Vietnamese women don't do anything for one month after the delivery of their baby”, said one nurse. “This home visit I did few years ago I found the new mom and the baby were staying upstairs. The dad had taken a T.V. to the mom's room. The dad looked after the house work. Here, you see, I was thinking how we stress exercise, walking and how important it is to us. But for them complete rest is crucial”.

To summarize, “ethnic” clients were seen as friendly, helpful and compliant within the constraints of their languages and cultures. On one occasion a nurse said, “Their reception to you is different. Oh, a lot of times the other cultures from other countries are far more receptive. I mean they can’t wait for you to come. They have always something for you to eat, or drink. And I mean they are so grateful that you have come...”. “Immigrants are absolutely grateful that you are there. They are waiting to greet you at the door”, said another nurse. In comparison with other client groups all this places these people and groups into a special category. There is a strong positive image built up among nurses in regard to their behaviour. Significant health-related limitations faced by these people are seen to be due to cultural attributes they got from birth and for which they are therefore not responsible. Their occasional (or even systematic) non-compliance is rarely then seen as a personal client problem, rather, one of cross-cultural or cross-linguistic communication. In some cases, nurses even assign positive values to non-compliance, arguing that (as in the Vietnamese case) home and community support based on different cultural values compensates at least partially.

In the CHC nurses’ discourse, the descriptive term “irresponsible” had a definite, unflattering reference to “problem” and “deviant” clients. This socially constructed definition has its roots in the legitimation of service-providing bureaucratic culture (Foner, 1995; Herzfeld, 1992; Douglas, 1986), and was routinely assigned when a client did not keep his/her appointment or did not comply with a nurse’s suggestions; also often when there was a perceived potential for such things to happen. Here, the nurses use the word “irresponsible” in a categorical sense mostly to bracket two kinds of people: “Natives” definitively and “young single mothers” at certain times. Some of the pattern of discourse used in identifying these clients was similar to the physicians approach described by Stein (1990) and Todd (1989). In this regard in many instances they were referred to as “difficult” cases and such categorization generated a generalized problematic concern among CHC nurses for these two categories of person.

Problem Clients: "Single Mothers" and "Native Indians"

The critical indicators of the "problem client" were primarily patterns of attendance, perceived living conditions, and perceived non-cooperative attitudes. As non-compliant people, these clients were central objects of the nurses' professional discourse. The best way in which images relating to these two groups can be understood is through situational narratives of the nurses' experiences - powerful rhetorical devices for achieving and supporting given constructions (Verkuyten, 1995:166).

Single Mothers as Sometime "Problem Clients"

The following discourse elaborated by CHC nurses shows that one of many social or health characteristics may lead to people being classified as "problem" clients. Centrally, it is perceived by the nurses that the single mothers were often undisciplined "rebels" who did not want to obey any societal norms—a characterization also applied to Natives. An example is a narrative by "J", a long time community health nurse who appeared to me to be very sincere about helping perceived "problem clients", especially the single mothers. She continued with a brief history of a young mother who did not fit the "normal" family definition:

A twenty-three year old mother. She is a single mother with three children. All [three] children are fathered by different men. She hasn't got [a] relationship with any one of them. This is a mom who has her own ideas on health. The baby is tiny. She is a heavy smoker. The baby started very small at birth. Her birth weight was four pounds, and [she] was jaundiced. But the mother will not listen to our suggestions. Basically that's all we can do is see the baby gain weight.

And yet, sometimes single mothers were the object of much nurse compassion. While talking about prioritizing "problem" cases one nurse described young single mothers as a group high on the CHC client stratification chart, in that they were viewed by this nurse as a "neglected" group that needed more help than any other. The following quote illustrates that nurse's perception of the single mothers "problem":

Mostly definitely, single moms are my concern. This is a real tender spot for me. There is nothing like going to see a mom that is crying and is just by herself, because there is no one there to give her support. And I mean I am at work and I can't be there more than an hour and half. I mean I will visit and in order to get home care services they have to pay for it. So you know what do you do for this mom. They need a lot of support.

During this narrative it was clear that although the nurse was willing to help this mother further, service accountability constraints and the institution's mandate prevented her from realizing this goal. CHC nurses' talk about single mothers frequently evoked similar images. On the whole single mothers were viewed as needy, and in part a genuinely helpless group who were under-assisted by "society". By implication, CHC nurses should try to help them as much as possible when, that is, these mothers demonstrated at least a wish for responsibility. In overview, this group belonged to a "problem client" category, but one that deserved sympathy and assistance under certain conditions. This is unlike traditional connotations assigned to problem patients or clients considered "deviant" (Cohen, 1985), or "difficult"—who are usually those who do not comply with the organization's rules—and who as non-compliant patients sometimes make physicians and other health professionals feel unsuccessful, defeated, powerless, or incompetent (Stein, 1990). In contrast, as a general category of person single mothers appeared to me to be a potential nurse target of program growth with rewarding potential for nurses.

Single mothers were seen as high risk and lacking in personal resources whether responsible or not. And there were many nurse indications that some single mothers *were* responsible. In the next extract a nurse is pleased to note that she had three single mothers in her post-natal class. "P", the initiator of the post-natal program said:

It is quite evident we mostly get middle class married mothers. But we are also getting single mothers and others like what you call the common law relationship. I don't know whether you noticed it or not, there was one single mother and two young single moms who came with their partners in that father's night class.

To understand how or if these single mother clients could be considered in any way “culturally different”, during the extended interviews I asked each nurse whether a single mother was “culturally different” by virtue of their social situation. The following were representative answers:

I don't think [a] single mother is culturally different. Sometimes what makes them different is the fact that sometimes single mothers leave [home] very young. Sometimes they are teenagers and its their age that makes them different from a married women of twenty-four. When we have a sixteen year old girl, she will have very different ideas than a twenty-four year old married woman. It is [the] fact of age rather than culture that makes them different to deal with, because many teenagers tend to think they know everything and they don't think they need any teaching, whereas we think they do. And we may have a twenty-four year old mother who may be very well read which causes them to even ask more questions than the information you present. She is motivated to learn and doesn't think she knows everything. She is willing to learn whereas teenagers are just a different type of client....

... I don't know if she would be particularly culturally different. But, her problem will be different, because she is the single soul who is responsible. You have to put this into consideration. I don't know if she is culturally different. When I think of norm I think of father, mother, and children.

“Problem Natives” as Classical Deviants

Most Natives were also identified as key “problem clients” but in a quite different way. Earlier I discussed the most obvious indicator of their problematic status, that of parents' neglecting the child's immunization chart. This and other like common references to non-compliance suggest that this group is a major health programming concern for CHC nurses.

During discussions concerning the use of other available CHC services, nurses often stressed the classically “deviant” attitude of many Native clients. Similar types of narratives have been documented in the social scientific literature concerning Natives and other dimensions of life.¹⁴⁵ The following are some samples:

¹⁴⁵ See Ponting (1990).

... the minute you single them out they then complain that we are picking on them. I feel they should be coming to us, but they think that we have to beg them. We are providing a service for everybody and they are a high risk group. It seems this is not a priority to them. This is how the majority of the Native people are like that. There are a minority of the Native people who are educated and have best of both worlds or two worlds ...

Another nurse said:

With our Native population I don't know what is the problem. They speak English, so language is not a barrier. May be to them if the child is not sick then keeping the immunization [up] is not a priority. ... The urban Natives do not have telephones. It is very hard for us to contact them. Similarly, I can see it must be hard for a mom like ... to go to a doctor with four little babies. They have support systems. Her sister, mom and many other people live in their house. But still she doesn't keep or make appointments to see the doctor. May be she does not have money to take a bus. These people will not talk to you by looking at you. Therefore, I make special efforts to look at her face. To make the eye contact I bend down and look upwards to her face.

"P", an experienced nurse, said:

The problem with the Natives is [that] time is not an important issue. For us we value time. It means a lot to us. We are accountable to our time.

A Native time is like any time they feel like it. It is like West Indian time, which is usually late. According to the white time, or Canadian time and what ever... That is fine if it is their own thing. It can't run like that. May be you can but, I don't like it. So Native time is late. They have their own time whatever they want to do.

Critically, the above comments reflect the larger societal discourse, in portraying Native clients as largely responsible for their own problems, at least in an immediate sense. From the nurses' point of view, although attempts were made continually by the CHC to help them, these attempts had repeatedly failed because of low response. When Native clients were brought up, very often a sense of frustration was expressed by nurses. There were even doubts asserted that attempts to help Natives would ever be successful in future. Said one, "I don't know if the new program that we have just started with "S" and the Native liaison worker will fly..." Low response rates and other problems were not seen to be cultural, but

rather personal. Neither were they seen to be compensated for (as in some ethnic groups) by culturally-grounded social support or medical practice.

The Ambiguous Roles of Nurses in the Face of Client Diversity

Analysis of the process of client identification and categorization is of course significant in its own right. But how do all these client categories relate to how nurses define their various roles? Even if fundamentally based on a biomedical model of *essentialism* and *fixing problems*, the everyday roles of CHC nurses nevertheless can be described as complex. During my conversations and observations it was apparent that in order to provide health promotion services the nurses are actually participating in two distinct set of roles. Each nurse in fact appeared to see herself wearing two pairs of “sunglasses” all the time when on the job. This dual role set has evolved in part because of institutional expectations and from personal-moral reasons. Depending upon the case and context, nurses view themselves as *facilitators*, or as *guardians*. The type and form of service each client receives is in part dependant upon how the nurse evaluates each case and where the clients rank in the “problem” hierarchy. Thus facilitator and guardian roles systematically interact with the qualities and categories of clients outlined above.

The Nurse as Facilitator

A *facilitator* in this context is a person who is responsible for leveraging others’ actions and disseminating information. One of the core activities of the CHC nurse was to be a facilitator, as outlined earlier. The main objective of this role set was to motivate and educate clients by providing information and through this, to build up confidence and trust with the client (Ewles & Simnett, 1992). All nurses identified themselves first and foremost as facilitators of client self-help. As a ritual, every nurse routinely delivered what she deemed to be pertinent information to every client. A standardized information package was prepared for every new mother, which was distributed at the time of home visits. If additional

information was requested it was also available from the nurses. When I asked for an explanation of how they did this job, the following was a response from a nurse:

We talk to clients and also by example. For instance, when I go in to visit a mom with a new baby, I always wash my hands. So by example, they can see [its value]... And they have also seen that I wash my hand after and before examining the baby. Also through discussion, pamphlets, I educate. Well, sometimes I give talks....

In reality, nurses initially framed clients into a particular categorical or problem box, and then decided accordingly how much information a particular client actually needed. Most of the time the facilitator role was continuously activated when they were visiting clients who they perceived as “responsible” and “normal” and the overall interaction appeared routine and reciprocal. There was one encounter where the nurse pointed out:

... you see I offered her all the information. ... We feel they will benefit. Then at the end it becomes your decision. We provide client centred care kind of thing, and we can't force people to do these things....

In this case, by occupying the *facilitator* role in what is viewed as a successful interaction, the nurse sees herself centrally as providing effective *client-centred* care. At the same time, this perception arises in part because the nurses take control of the client's information. This gives the nurse the primary authority to decide the complaint client's health service needs.

Within certain limits nurses have the power and knowledge to define and redefine every client situation. However, following the underlying mandate of “equal care for everyone”, both “culturally different” and “normal” clients were often not seen as needing any more information than what was provided on a regular standardized basis. At a time when cultural diversity is one of the major concerns in the Canadian health organization this was presented here as a small problem at most.

The Nurse: As Guardian

The *guardian* is a paternalistic role which is extensively used by many service providers to explain and enable their professional goals. Being a health promoter by profession seems to imply that nurses have specific rights and reasons for categorizing clients into specific categories, which can directly affect the type of care provided. Interestingly enough, even with the change in focus implied by modern health promotion models, the CHC nurses continued to support a traditional medical model based on a paternalistic approach to clients. Whether they fully agreed with this or not, this paternalistic role was deeply encoded in the institution's charter, programs, accountability structure and administrative hierarchy.

What is particularly relevant here is that by medicalizing Native and single mothers as key "problem" cases, CHC staff were able to maintain an image of themselves as concerned health workers. They extended this image to the extent that they could justify virtually all their daily discourse as part their professional mandate. On this basis, there were occasions when nurses visited a client's home without prior telephone calls or any other arrangement. They have also taken certain services to the "problem" client's home. Many of the home visits to the "problem" homes were carried out without initial consent from the client, even though every home visit that was labelled as "normal" was arranged with prior consent from the client over the phone. This displayed a distinct assumed authority status where the nurse took control over the client's daily schedule. These "problem" clients were placed under, as one nurse called it, "special observation".

CONCLUSION

In this research I have addressed a set of topics that will be increasingly crucial to western health care systems, yet had rarely been identified as a subject of research outside a few large cities: the clinical community's staff perceptions of culture, cultural diversity and cultural difference, and how these perceptions guide and are themselves supported by practice. The thesis began with a series of questions, which the ensuing chapters explored by gradually moving from textual sources to field data. Analysis of discourse among nurses at the CHC, between them and their clients, and with other professional and lay people who together constitute their social working community, revealed that nurses in this organization employed a great variety of medical, sociocultural and even moralistic assumptions, categories, symbols, and reasoning processes to construct knowledge about their roles and their clients. This multifaceted social knowledge construction in the end framed clients into various categories that directly affected how such clients were treated.

As a medical bureaucratic organization, the community health centre revealed that it had a core biomedically-oriented culture; attitudes of the CHC managers, nurses and staff on the whole were closely aligned with the broader biomedical cultural framework of mainstream health care in general. It was also shown how CHC nurse discourse of "essentialism" and "caring" extended the medical gaze to fit a wide variety of nurse personal and professional experiences. This epistemological base helped to construct new objects and new problems for the CHC nurses as client and contextual circumstances changed. I have also ethnographically studied how the CHC staff have come to understand and act upon the notion that they were to provide primary health promotion care based on a mandate of equal access for all city residents.

This research process has helped to address and accomplish several things. First, it has offered an elaborate description about how institutional change in Canadian society related

to the health care system actually proceeds; that how superficially static mandates in reality must be rendered continuously fluid, because knowledge and interactions at the microscopic level are not strictly predetermined, but rather are actively socially constructed on a day-by-day basis. The micro, institutionally based, anthropologically oriented questions on which I have focused were contextualized throughout by information on development of the Canadian society and its health care system; particularly the macro-social, historical, political and economic processes involved in these developments. I have of course primarily concentrated on aspects of Canadian history pertaining to sociopolitical and socioeconomic forces that have led to the establishment of a multicultural Canada and to demands for a more multicultural health care system. This analysis of societal transformations at the macroscopic level, in ongoing comparison with a look at CHC understandings and practices at the grassroots level, allows one to better locate CHC medical culture within the larger context of Canadian society.

As indicated earlier, a key focus of this study was on how CHC staff formally and informally constructed their perceived problem object. This was addressed first by establishing the location of bureaucratic power and forms of hierarchy that influence the institution's decision-making processes. Here I demonstrated both links and discrepancies between the underlying semi-axiomatic general medical orientation of the CHC and actually established services and programs. Tying the two together were a wide range of different strategies developed by nurses and managers to address perceived problems within institutional constraints. Although on a few occasions special programs had been developed to address health issues concerning individuals or types of person labelled as "problem" clients, definitions of which clients these problem people were was based on many factors other than strictly medical ones. Neither did they always fall strictly within the overall institutional charter.

Compounding this diversity of grassroots interpretations and practices, CHC bureaucratic mandates sometimes create confusion and misunderstandings among both nurses and

management. When asked about it in many ways they particularly worried that stressing concepts like cultural diversity might erode and dilute the traditional focus of this organization. And yet at the same time, all nurses perceived that they already provided multicultural care, even if they were unsure about the effectiveness of their (few) existing programs of this sort. They either prorated ambiguously to past programming efforts aimed at Natives that deemed to have failed due to client noncompliance, or to the "fact" that they saved every (compliant) client who approached them fairly under their universal mandate to serve everyone equally.

In this context, I would note that while all community health centres in Canada were established with the same general principle, providing equal primary health care, that there are some large urban centres like Edmonton, where new types of community health centres have been established to specifically address the health needs of the Natives. Other centres (Toronto for example) make specific efforts to develop programs and language brokering mechanisms aimed at a range of new immigrant clients. This culturally-tailored type of institutional elaboration had not as yet occurred in the Centre in which I did my research. Rather, CHC personnel, tried for the most part to incorporate multicultural health care within a pre-existing institutional structure and mandate in which multiculturalism once had no place. It is not surprising that their understandings of cultural diversity remain strongly guided by frameworks originating in western biomedical culture. Neither is it surprising that this was accompanied by fluid and sometimes inconsistent individual and institutional experience-based perceptions, ones that were often moralistic.

Another point I have analyzed extensively is the client classification system informally generated by staff. I have presented an anthropological account of how the CHC's client taxonomy system has developed, based primarily on the same cosmology of values as found in the larger western ethnomedical system. Here I concentrated on how the "problem" label was constructed around social factors such as client behaviour, attitudes or degree of conformity and compliance. In this regard, I highlighted how the inability to receive full

cooperation from a client allowed the nurse to label that individual as “noncompliant” and thus as having a different sense of personal responsibility. This type of labelling incorporates very different standards than those suggested by a strictly medical taxonomy. As the CHC’s goals were multidimensional (to prevent illness, provide health education and give emotional support to individuals), a client’s label sometimes shifted as the nurse went through her routine health evaluations and identified (or did not identify) new health-related problems. While the overall process was historical and therefore unavailable to me, presumably the perceptions of many staff evolved and were discussed, problematic objects for the medical gaze were being reconstructed constantly.

Some of the “outputs” from these conceptualizing processes highlighted in Chapter Five have important health care and societal implications. Perhaps the most central of these implications relates to how perceived cultural difference and perceived personal client responsibility were connected conceptually. On the whole, the allocation of the attribute “culturally different” absolved those clients so categorized of being charged with being irresponsible where they did not comply with institutional or staff objectives; through no fault of their own, cultural or linguistic barriers were seen as preventing such individuals from achieving full compliance. Immigrant, source country-based, cultural differences relating to health and health care themselves were even occasionally seen to be valuable in their own right, and compensation for client non-participation in Centre programs. In any case, the Centre gave immigrant cultural difference itself virtual insignificance, if significance is judged by the place of cultural difference in the institution’s charter, organizational chart, job descriptions, statuses and roles, or programs. No institutional resources of any kind were then directed towards sensitizing staff to immigrant cultural values or beliefs, or even to educate how basic *disease* symptoms might be reported by such clients. Even the use of the translated materials and interpreters was desultory and clearly, a low priority. Again, I have argued throughout that the key determinant here is the still well entrenched medical model of treatment. Talk of the lifestyle model of health promotion notwithstanding, most Centre practice proceeds like classical disease curing in reverse:

prevent some single factor from increasing a client's risk of disease through specific service interventions. In the absence of vocal local pressure- groups urging change (as found in most larger cities) cultural difference was easily integrated into everyday generic practice with virtually no discernable institutional change. At most, the label "culturally different" protected clients so termed from being blamed for occasional lack of compliance or for their own misfortunes more generally. Immigrant origin clients on the whole were talked about, addressed and dealt with respect and compassion.

Critically, though, staff did not accord either this "culturally different" category or its associated positive or protective meaning structures to Native clients. Natives were instead at most seen to participate in a *mainstream*, highly deviant, underclass subculture of which nurses disapproved. In this regard, they as individuals *were* usually seen to be wilfully noncompliant and personally irresponsible.¹⁴⁶ This finding is very consequential. First, it clearly contributed to the underdevelopment of Native-specific programing. Even though all CHC staff would have agreed (rightly or wrongly) that Native people were the single identifiable group or category of persons in Lethbridge with the poorest health prospects, formally few Centre resources were directed specifically at this population, and these largely comprised a set of erratically established programs aimed at increasing Native compliance with extant nominally "universal" services. Informally, frontline nurses compensated by adjusting their planning, visitation patterns and interactional strategies to best address what they perceived as the most pressing medical or health needs of this "high risk" group. Otherwise, there were few institutional responses to the challenge of promoting Native health, either direct or indirect. Moreover, it would be fair to say that staff views of Natives were coloured by an air of resentment and frustration at what was perceived as their willful lack of discipline. Though no one ever said it so explicitly, nurses felt that they could have given Native clients good service within the constraints of conventional programs if only

¹⁴⁶ See Frideres' (1988) discussion of how narrow medical thinking applied to Native clients obscures a range of macro-determinants of Native lives.

Natives would comply more often. It would not be too strong to say that there was an element of blaming the victim underlying such attitudes. Certainly, without question, no staff attempted a parallel with their talk about culturally different immigrant clients; Native behaviours was rarely “excused” by reference to cultural, economic, social, or political factors outside their control.

I would like to end by once more highlighting the central role of frontline CHC staff as producers and reproducers of institutional culture and therefore, as key agents of change. Throughout my nine months of participation in CHC affairs I was repeatedly struck by how much initiative and innovation nurses expressed, albeit incrementally and always within the constraints of programs, resource availability, their world view, and the selective inputs they received on everything from the institution’s charter to individual client lives. This seems to me to point to possible key institutional entry points to facilitate more extensive CHC (and other like Centres’) involvement in meaningful cross cultural service delivery in the future: entry points all involving the organizational and other constraints on nurses’ everyday activities. Past cultural patterns continue to exist today because they are actively maintained, not from sheer inertia. Frontline nurse orientations towards cultural diversity in this case were constrained by a set of factors identified throughout this thesis; but “innate” nurse conservatism was not one of them. My findings suggest that if internal or external forces were to lead to significant changes in Centre mandates, programming, resource allocation and liaison patterns with other institutions that more vigorously placed meaningful multicultural health promotion on the agenda, nurses would quickly fall into line. I believe it would not be long thereafter before nurses would start to reformulate their collective views and individual practice to reflect, legitimate and further facilitate such institutional changes.

REFERENCES CITED

- Abegglen, J. C., and Stalk Jr., G. (1985) *KAISHA, The Japanese Corporation*. New York: Basic Books, Inc., Publishers.
- Aboriginal Peoples Surveys (1994) Aboriginal Census of the City of Lethbridge*. Lethbridge.
- Abud-Lughod, C. A., and Lutz, C. A. (1990) "Introduction: Emotion, Discourse, and the Politics of Everyday Life." In *Language and the Politics of Emotion*. Catherine A. Lutz and Lila Abu-Lughod (eds.). Cambridge: Cambridge University Press, pp. 1-23.
- Ahluwalia, S., and MacLean, B. D.(1988) "The Medicalization of Domestic Violence." In *Sociology of Health Care in Canada*. B. Singh Bolaria, and Harley D. Dickinson (eds.). Toronto: Harcourt Brace Jovanovich, pp. 183-197.
- Albert, L. (1990) "Language in Canada." In *Canadian Social Trends*, Craig McKie and Keith Thompson (eds.), vol. 1. Ottawa: Thompson Educational Publishing, Inc.
- Alberta. Alberta Culture & Multiculturalism (1989) *Alberta Culture and Multiculturalism: Annual Report*. Edmonton: Department of Culture & Multiculturalism.
- Alberta. Alberta Health (1994) *Strengthening the Circle: What Aboriginal Albertans Say About Their Health*. Edmonton: Alberta Health.
- Anderson, J. M. (1990) "Health Care Across Cultures." *Nursing Outlook*, vol. 38(3), pp. 136-139.
- Anderson, T., Waxler-Morrison, N., Richardson, E., Herbert, C., and Murphy, M. (eds.)(1990) *Cross-Cultural Caring: A Handbook for Health Professionals in Western Canada*. Vancouver: University of British Columbia Press.
- Anthias, F. (1992) "Connecting 'Race' and Ethnic Phenomena." *Sociology*, vol. 26(3), pp. 421-438.
- Ashworth, M. (1975) *Immigrant Children and Canadian Schools*. Toronto: McClelland and Stewart Education, UBC.
- Ashworth, M. (1977) "The Settlement of Immigrants in Greater Vancouver." *Canadian Welfare*, vol. 53(2), pp. 9-12.
- Babbie, E. (1992) *The Practice of Social Research*. Sixth edition. California: Wadsworth Company.

- Badets, J. (1990) "Canada's Immigrant Population." In *Canadian Social Trends*, Craig McKie and Keith Thompson (eds.), vol. 1, Ottawa: Thompson Educational Publishing, Inc. pp. 7-11.
- Badets, J. (1990) "Canada's Immigrants." In *Canadian Social Trends: A Canadian Studies Reader*, vol. 2. Ottawa: Thompson Educational Publishing, Inc., pp. 27-30.
- Badets, J., and Chui, T. W. L. (1994) *Canada's Changing Immigrant Population*. Ottawa: Statistics Canada & Prentice Hall Canada Inc.
- Barth, F. (1968) "Introduction." In *Ethnic Groups and Boundaries: The Social Organization of Cultural Difference*, F. Barth, (ed.). Boston: Little Brown and Co.
- Barth, F. (1981) *Process and Form in Social Life: Selected Essays of Fredrik Barth*, vol. 1. London: Rutledge and Keegan Paul.
- Barth, F. (1984) "Problems in Conceptualizing Cultural Pluralism, with Illustrations from Somar, Oman." In *The Prospects for Plural Societies*, Stuart Plattner and David Maybury-Lewis (eds.). Washington: American Ethnological Society, pp. 77-87.
- Basran, G. S. (1983) "Canadian Immigration Policy and Theories of Racism." In *Racial Minorities in Multicultural Canada*. Peter S. Li and B. Singh Bolaria (eds.) Toronto: Garamond Press.
- Baum, J. A., and Oliver, C. (1992) "Institutional Embeddedness and the Dynamics of Organizational Populations." *American Sociological Review*, vol. 57, pp. 540-559.
- Beaujot, R. (1988) "Canada's Demographic Profile." In *Understanding Canadian Society*, James Curtis & Lorne Tepperman (eds.). Toronto: McGraw-Hill Ryerson Limited, pp. 39-72.
- Becker, H. S., and McCall, M. M. (eds.) (1990) *Symbolic Interaction and Cultural Studies*. Chicago: The University of Chicago Press.
- Bell, C. (1992) *Ritual Theory, Ritual Practice*. Oxford: Oxford University Press.
- Bell, J. A. (1994) *Negotiation of Autonomy in the Local Rock Music Industry: A Case Study*. M.A. Thesis. University of Alberta.
- Berger, P., and Luckmann, T. (1966) *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. New York: Anchor Books.

- Bernard, H. R. (1988) *Research Methods In Cultural Anthropology*. Newbury Park: Sage Publication.
- Biggs, B., and Bollman, R. (1994) "Urbanization in Canada." In *Canadian Social Trends: A Canadian Studies Reader*, vol. 2. Ottawa: Thompson Educational Publishing, Inc., pp. 67-72.
- Bloom, A. (1985) "Introduction: The Client's Perspective in Primary Health Care." *Medical Anthropology*, vol. 9(1), pp. 7-8.
- Blumer, H. (1969) *Symbolic Interactionism: Perspective and Method*. New Jersey: Prentice-Hall, Inc.
- Boden, D. (1990) "People Are Talking: Conversation Analysis and Symbolic Interaction." In *Symbolic Interaction and Cultural Studies*, Howard S. Becker, and Michal M. McCall (eds.). Chicago: The University of Chicago Press, pp. 244-267.
- Bolaria, B. S., and Li, S. (eds.) (1983) *Racial Minorities in Multicultural Canada*. Toronto: Garamond Press.
- Bolaria, B. S., and Bolaria, R. (eds.) (1994) *Racial Minorities, Medicine and Health*. Halifax: Fernwood Publishing.
- Boldt, M. (1993) *Surviving as Indians: The Challenge of Self-Government*. Toronto: University Press.
- Bradfield, R. M. (1973) *A Natural History of Associations: A Study in the Meaning of Community, volume 1*. New York: International Universities Press Inc.
- Brosnan, J. (1990) "A Proposed Diabetic Educational Program for Puerto Ricans in New York City." In *Transcultural Nursing: A Book of Readings (Revised)*. Prospect Heights, Illinois: Waveland Press, pp. 263-275.
- Brown, P. J., and Inhorn, M. (1990) "Disease, Ecology, and Human Behavior." In *Medical Anthropology: Contemporary Theory and Method*, Thomas M. Johnson and Carolyn F. Sargent (eds.), New York: Praeger, pp. 187-214.
- Brunt, J. H., and Love, E. J. (1992) "Hypertension and Its Correlates in the Hutterite Community of Alberta." *Canadian Journal of Public Health*, vol. 83(5), pp. 362-364.
- Buchignani, N. L. (1983) "Determinants of Fijian Indian Social Organization in Canada." In *Overseas Indians: A Study in Adaptation*, G. Kurian and R. Srivastava (eds.). Toronto: McClelland and Stewart Limited, pp. 68-89.

- Buchignani, N. L. (1988) "Towards a Sociology of Indochinese Canadian Social Organization: A Preliminary Statement." In *Ten Years Later: Indochinese Communities in Canada*, Louis-Jacques Dorais, Kwok B. Chan, and Doreen M. Indra (eds.). Montreal: Canadian Asian Studies Association, pp. 13-36.
- Buchignani, N. L. (1991) *Fijian Indians in Canada: The Structural Determinants of a New Community*. New York: AMS Press.
- Buchignani, N. L., Indra, D., and Srivastava, R. (1985) *Continuous Journey: A Social History of South Asians in Canada*. Ottawa: McClelland and Stewart Ltd.
- Burke, M. A. (1990) "Urban Canada." In *Canadian Social Trends*, Craig McKie and Keith Thompson (eds.), vol. 1, Ottawa: Thompson Educational Publishing, Inc., pp. 35-41.
- Burner, O., Cunningham, P., and Hattar, H. (1990) "Managing a Multicultural Nurse Staff in a Multicultural Environment." *Journal of Nursing Administration*, vol. 20(6), pp. 30-34.
- Burnet J. R., and Howard P. (1988) *Coming Canadians: An Introduction to a History of Canada's Peoples*. Ottawa: Ministry of Supply and Services.
- Butrin, J. (1992) "Cultural Diversity in the Nurse-Client Encounter." *Clinical Nursing Research*, vol. 1, pp. 238-251.
- Canada. Department of Indian Affairs & Northern Development (1993) *Indian Register Population by Sex and Residence 1992*. Ottawa: Ministry of Supply and Services.
- Canada. Department of Indian Affairs & Northern Development (1992) *Indian Register Population by Sex and Residence 1991*. Ottawa: Ministry of Supply and Services.
- Canada. Program Statistics Division & Indian & Eskimo Affairs Program, Department of Indian Affairs & Northern Development (1983) *Registered Indian Population by Sex and Residence for Bands, Districts, Regions and Canada December 31, 1982*. Ottawa: Ministry of Supply and Services.
- Canada. Program Statistics Division & Indian & Eskimo Affairs Program, Department of Indian Affairs & Northern Development (1982) *Registered Indian Population by Sex and Residence for Bands, Districts, Regions and Canada December 31, 1981*. Ottawa: Ministry of Supply and Services.

- Canada. Program Statistics Division & Indian & Eskimo Affairs Program, Department of Indian Affairs & Northern Development (1976) *Registered Indian Population by Sex and Residence for Bands, Districts, Regions and Canada December 31, 1975*. Ottawa: Ministry of Supply and Services.
- Canada. Statistics Canada (1991) *Ethnic Origin: 91 Census*. Ottawa: Statistics Canada. Catalogue No. 95-315.
- Canada. Statistics Canada (1991) *Profile of Census Tracts in Lethbridge*. Ottawa: Statistics Canada. Catalogue No. 95-381.
- Canada. Statistics Canada (1994) *Canada and the World*. 2nd edition. Scarborough: Prentice Hall Canada Inc.
- Charon, J. M. (1992) *Symbolic Interactionism: An Introduction, An Interpretation, An Integration*, fourth edition. Englewood: Prentice Hall.
- Chuchryk, P. (1984) "The Research Methods: Doing Research in an Authoritarian Context." In *Protest, Politics and Personal Life: The Emergence of Feminism in a Military Dictatorship 1973-1983*. Unpublished Doctoral Thesis. Toronto: York University.
- Clarke, J. N. (1992) *Health, Illness, and Medicine In Canada*. Toronto: Best/Gane Book Manufacturers.
- Coates, D., and Penrod, S. (1980/81) "Social Psychology and the Emergence of Disputes." *Law and Society*, vol. 15(3/4), pp. 653-655.
- Cohen, A. P. (1974) "The Lesson of Ethnicity." In *Urban Ethnicity*, Abner Cohen (ed.) London: Tavistock, pp. ix-xxiii.
- Cohen, A. P. (1985) *The Symbolic Construction of Community*. Chichester: Ellis Horwood Limited.
- Cohen, R. (1978) "Ethnicity: Problem and Focus in Anthropology." *Annual Review of Anthropology*, vol. 7, pp. 379-403.
- Cohen, S. (1985) *Visions of Social Control: Crime, Punishment and Classification*. Glasgow: Polity Press.
- Colson, E. (1987) "Introduction: Migrants and Their Hosts." In *People in Upheaval*, Scott Morgan, and Elizabeth Colson (eds.), New York: Center For Migration Studies, pp. 1-16.

- Communications Division of Statistics Canada (1993) *Canada Year Book 1994*. Ottawa: Minister of Industry, Science and Technology.
- Coombe, R. J. (1991) "Encountering the Postmodern: New Directions in Cultural Anthropology." *The Canadian Review of Sociology and Anthropology*, vol. 28(2), pp. 188-205.
- Cowie, J. B., and Roebuck, J. (1975) *An Ethnography of a Chiropractic Clinic: Definitions of a Deviant Situation*. New York: The Free Press.
- Craib, I. (1992) *Modern Social Theory: From Parsons to Habermas*. New York: St. Martin's Press.
- Crichton, A., and Hsu, D. (1990) *Canada's Health Care System: Its Funding and Organization*. Ottawa: Canadian Hospital Association Press.
- Currie, D. (1988) "Starvation Amidst Abundance: Female Adolescents and Anorexia." In *Sociology of Health Care in Canada*, B. Singh Bolaria and Harley D. Dickinson (eds.). Toronto: Harcourt Brace Jovanovich, pp. 198-215.
- Davis, D. (1992) "Culturally Responsive Nursing Management in an International Health Care Setting." *Nursing Administration Quarterly*, vol. 17(2), pp. 21-29.
- de Certeau, M. (1984) *The Practice of Everyday Life*. Translated by Steven F. Rendall. Berkeley: University of California Press.
- de Voe, D. M. (1981) "Framing Refugees as Clients." *International Migration Review*, vol. 15(1), pp. 88-94.
- de Vos, G. (1975) "Ethnic Pluralism: Conflict and Accommodation." In *Ethnic Identity: Cultural Continuities and Change*, George DeVos, and L. Romanucci-Ross (eds.). Palo Alto, CA: Mayfield Publication Co., pp. 5-41.
- Demaine, J. (1989) "Race, Categorisation and Educational Achievement." *British Journal of Sociology of Education*, vol. 10(2), pp. 195-214.
- Denzin, N. K. (1992) *Symbolic Interactionism and Cultural Studies: The Politics of Interpretation*. Cambridge: Blackwell.
- Dickinson, H. D., and A., G. "Community Psychiatry: The Institutional Transformation of Psychiatric Practice." In *Sociology of Health Care in Canada*, B. Singh Bolaria, and Harley D. Dickinson (eds.). Toronto: Harcourt Brace Jovanovich, pp. 295-308.
- Dobson, S. (1991) *Transcultural Nursing*. London: Scutari Press.

- Dorais, L. J., Chan, K. B., and Indra, Doreen (eds.) (1988) *Ten Years Later: Indochinese Communities in Canada*. Ottawa: Canadian Asian Studies Association.
- Dougherty, M., and Tripp-Reimer, T. (1990) "Nursing and Anthropology." In *Medical Anthropology: Contemporary Theory and Method*, Thomas M. Johnson and Carolyn F. Sargent (eds.). New York: Praeger, pp. 174-186.
- Douglas, M. (1973) *Rules and Meanings*. London: Penguin.
- Douglas, M. (1975) *Implicit Meanings: Essays in Anthropology*. London: Routledge & Kegan Paul.
- Douglas, M. (1982) *Essays in the Sociology of Perception*. Routledge & Kegan Paul: Russell Sage Foundation.
- Douglas, M. (1986) *How Institutions Think*. Syracuse: Syracuse University Press.
- Douglas, M. (1992). *Risk and Blame: Essays in Cultural Theory*. Routledge: London.
- Dhruvarajan, V. (1994) "Hindu Asian Indian Women, Multiculturalism and Reproductive Technologies." In *Racial Minorities: Medicine and Health*, S. Bolaria, and Rosmary S. Bolaria (eds.). Saskatoon: University of Saskatchewan, pp. 189-200.
- Edelman, M. (1974) "The Political Language of the Helping Professions". *Politics and Society*, vol. 3(4), pp. 295-310.
- Edwards, N., Ciliska, D., Halbert, T., and Pond, M. (1992) "Health Promotion and Health Advocacy for and by Immigrants Enroled in English as Second Language Classes." *Canadian Journal of Public Health*, vol. 83(2), pp. 159-161.
- Ervin, A. M. (1993) "Service Providers' Perceptions of the factors associated with Immigrant well being and their Implications for Health Promotion Delivery." In *Racial Minorities: Medicine and Health*, S. Bolaria, and Rosmary S. Bolaria (eds.). Saskatoon: University of Saskatchewan, pp. 225-243.
- Estroff, S. E. (1993) "Identity, Disability, and Schizophrenia: The Problem of Chronicity." In *Knowledge, Power & Practice*, Shirley Lindenbaum and Margaret Lock (eds.). Berkeley: University of California Press, pp. 247-286.
- Ewles, L., and Simnett, I. (1992) *Promoting Health: A Practical Guide*, 2nd edition. London: Scutari Press.
- Farganis, J. (ed.) (1993) *Readings in Social Theory: The Classic Tradition to Post-Modernism*. New York: Mcraw-Hill, Inc.

- Feather, J., Irvine, J., Belanger, B., Dumais, W., Gladue, R., Isbister, W., and Leach, P. (1993) "Promoting Social Health in Northern Saskatchewan." *Canadian Journal of Public Health*, vol. 84(4), pp. 250-256.
- Fleras, A., and Elliott, J. L. (1992) *Multiculturalism in Canada: The Challenge of Diversity*. Scarborough, Ontario: Nelson Canada.
- Foner, N. (1995) "The Hidden Injuries of Bureaucracy: Work in an American Nursing Home." *Human Organization*, vol. 54(3), pp. 229-237.
- Foster-Carter, O. (1987) "Categorisation and Studies of Identity." *Research Education*, vol. 38, pp. 65-72.
- Foucault, M. (1973) *Birth of a Clinic: An Archaeology of Medical Perception*. Translated by A. Sheridan Smith. New York: Pantheon Books.
- Foucault, M. (1977) *Discipline and Punish: The Birth of the Prison*. Translated by A. Sheridan Smith. New York: Random House.
- Foucault, M. (1979) *Power, Truth, Strategy*. Meaghan Morris, and Paul Patton (eds.). Sydney: Feral Publication.
- Frankel, G. (1988) "Racism and Health: The Case of the Native People." In *Sociology of Health Care in Canada*, B. S. Bolaria and H.D. Dickinson (eds.). Toronto: Harcourt Brace Jovanovich, pp. 135-148.
- Frankenberg, R. (1993) "Risk: Anthropological and Epidemiological Narratives of Prevention." In *Knowledge, Power and Practice*, Shirley Lindenbaum and Margaret Lock (eds.). Berkeley: University of California Press, pp. 219-244.
- Galanti, G. A. (1991) *Caring for Patients from Different Cultures: Case Studies from American Hospitals*. Philadelphia: University of Pennsylvania Press.
- Garfinkel, H. (1967) *Studies in Ethnomethodology*. New Jersey: Prentice-Hall, Inc.
- Geertz, Clifford (1973) *The Interpretation of Cultures*. New York: Basic Books.
- Gilad, L. (1990) *The Northern Route: An Ethnography of Refugee Experiences*. The Institute for Social and Economic Research, St. John's Memorial University of Newfoundland.
- Good, B. J. (1994) *Medicine, Rationality, and Experience*. Cambridge, University Press.

- Good, B. J. and Good, M.V. (1993) "Learning Medicine: The Constructing of Medical Knowledge at Harvard Medical School." In *Knowledge, Power & Practice*, Shirley Lindenbaum and Margaret Lock (eds.). Berkeley: University of California Press, pp. 81-107.
- Goffman, E. (1959) *Presentation of Self*. Harmondsworth: Penguin.
- Goffman, E. (1961). *Asylum: Essays on the Social Situation of Mental Patients and Other Inmates*. New York.
- Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs: Prentice-Hall.
- Goffman, E. (1963) *Behavior in Public Places: Notes on the Social Organization of Gathering*. New York: Free Press.
- Goffman, E. (1967) *Interaction Ritual*. Garden City: Anchor.
- Goffman, E. (1974) *Frame Analysis: An Essay on the Organization of Experience*. Cambridge, MA: Harvard University Press.
- Gold, S. J. (1987) "Dealing with Frustration: A Study of Interactions Between Resettlement Staff and Refugees." In *People in Upheaval*, Scott Morgan, and Elizabeth Colson (eds.). New York: Center for Migration Studies, pp. 108-128.
- Golander, H. (1995) "Chronically Ill, Old, and Institutionalized: Being a Nursing Home Resident." *Family and Community Health*, vol. 17(4), pp. 63-79.
- Grant, K. R. (1988) "The Inverse Care Law in Canada: Differential Access Under Universal Free Health Insurance." In *Sociology of Health Care in Canada*, B. Singh Bolaria, and Harley D. Dickinson (eds.). Toronto: Harcourt Brace Jovanovich, pp. 118-134.
- Crumperz, J. J., and Cook-Grumperz, J. (1982) "Introduction: Language and the Communication of Social Identity." In *Language and Social Identity*, John Grumperz (ed.). Cambridge: Cambridge University Press, pp. 1-21.
- Guilmet, G. M., and Whited, D. L. (1987) "Cultural Lessons For Clinical Mental Health Practice The Puyallup Tribal Community." *American Indian and Alaska Native Mental Health Research*, vol. 1(2), pp. 32-49.
- Habarad, J. (1987) "Refugees and the Structure of Opportunity: Transitional Adjustments to Immigrants." In *People in Upheaval*, Scott Morgan, and Elizabeth Colson (eds.). New York: Center for Migration Studies, pp. 66-87.

- Hall, J. M. (1994) "Lesbians Recovering from Alcohol Problems: An Ethnographic Study of Health Care Experiences." *Nursing Research*, vol. 43(4), pp. 238-244.
- Hannerz, U. (1992) *Cultural Complexity: Studies in the Social Organization of Meaning*. New York: Columbia University Press.
- Harrison, M. (1993) "Medical Dominance or Proletarianization? Evidence from Israel." In Research in *The Sociology of Health Care*, Jennie Jacob, Kronen Feld, and Rose Weitz (eds.), vol. 10, pp. 73-96.
- Hastrup, K. (1987) "Fieldwork among friends: Ethnographic exchange Within the Northern Civilization." In *Anthropology At Home*, Anthony Jackson (ed.). New York: Tavistock Publications, pp. 94-107.
- Hazan, H. (1994) *Old Age: Construction and Deconstruction*. Cambridge: University Press.
- Henderson, D., Sampsel, C., Mayes, F., and Oakley, D. (1992) "Toward Culturally Sensitive Research in a Multicultural Society." *Health Care For Women International*, vol:13, pp. 339-350.
- Henkle, J. O., and Kennerly, S. (1990) "Cultural Diversity: A Resource in Planning and Implementing Nursing Care." *Nursing*, vol. 7(3), pp. 145-149.
- Herzfeld, M. (1992) *The Social Production of Indifference: Exploring the Symbolic Roots of Western Bureaucracy*. New York: Berg.
- Howard, G. (1991) "Cultural Tales: A Narrative Approach to Thinking, Cross-Cultural Psychology & Psychotherapy." *Psychology Today*, vol. 46, pp. 187-197.
- Indra, D. (1987) "Bureaucratic Constraints, Middlemen and Community Organization: Aspects of the Political Incorporation of Southeast Asians in Canada." In *Uprooting, Loss and Adaptation: The Resettlement of Indo Chinese Refugees in Canada*, Kwok B. Chan and Doreen Marie Indra (eds.). Ottawa: Canadian Public Health Association, pp. 147-170.
- Indra, D. (1991) "Some Anthropological Qualifications on the Effects of Ethnicity and Social Change on Mental Health." *Sante Culture Health*, vol. 8(1-2), pp. 7-32.
- Jenkins, R. (1994) "Rethinking Ethnicity: Identity, Categorization and Power." *Ethnic and Racial Studies*, vol. 17(2), pp. 197-223.
- Jensen, U. J. (1987) *Practice & Progress*. Oxford: Blackwell Scientific Publications.

- Johnson, T. M., and Sargent, C. F. (eds.) (1990) *Medical Anthropology: Contemporary Theory and Method*. New York: Praeger.
- Johnston, C., Beiser, M., and Kresch, K. (1991) *The Delivery of Parent Education Services to Ethnocultural Groups: Review and Recommendations*. Unpublished. Report.
- Justice, J. (1981) *Policies, Plans, & People: Culture and Health Development in Nepal*. Berkeley: University of California Press.
- Kaufert, T., O'Neil, J., and Koolage, W. (1985). "Cultural Brokerage and Advocacy in Urban Hospitals: The Impact of Native Language Interpreters." *Culture Health*, vol:3(2), pp. 3-9.
- Kaufert, P. A., and O'Neil, J. (1993) "Analysis of a Dialogue on Risks in Childbirth." In *Knowledge, Power and Practice: The Anthropology of Everyday Life*. Shirley Lindenbaum and Margaret Lock (eds.). Berkeley: University of California Press, pp. 32-54.
- Keefe, S. E. (1992) "Ethnic Identity: The Domain of Perceptions of and Attachment to Ethnic Groups and Cultures." *Human Organization*, vol. 51(1), pp. 35-43.
- Keesing, R. M. (1987) "Anthropology as Interpretive Quest." *Current Anthropology*, vol. 28, pp. 161-176.
- Kelly, K. (1995) "Visible Minorities: A Diverse Group." In *Canadian Social Trends*. Ottawa: Marketing Division, Statistics Canada, pp. 2-8.
- Kertzer, D. I. (1988) *Rituals, Politics, and Power*. New Haven: Yale University Press.
- Kleinman, A. M. (1980) *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*. Los Angeles: University of California Press.
- Knowles, V. (1992) *Strangers at Our Gates: Canadian Immigration and Immigration Policy, 1540-1990*. Toronto: Dundurn Press.
- Knudsen, J. (1991) "Therapeutic Strategies and Strategies for Refugee Coping." *Journal of Refugee Studies*, vol. 4(1), pp. 21-38.
- Kobayashi, A. L., and Rosenberg, M. W. (1993) "The Universal Right to Health: An Ideological Discourse." In *Health and Cultures*, vol. 1, Ralph Masi, L. Mensah and K. A. McLeod (eds.). Oakville: Mosaic Press, pp. 95-110.

- Krefting, L. (1991) "Strategies for Institutional Change: Multiculturalism and Mental Health." *Sante Culture Health*, vol. 81(1-2), pp. 33-40.
- Kreps, G. L., and Kunimoto, E. N. (1994) *Effective Communication in Multicultural Health Care Settings*. London: SAGE Publications.
- Kulig, J. (1994) "Sexuality Beliefs Among Cambodians: Implications For Health Care Professionals." *Health Care for Women International*, vol. 15, pp. 69-76.
- Leacy, F. H. (1983) *Historical Statistics of Canada*. 2nd edition. Ottawa: Statistics Canada.
- Lee, M., and Herrera, M. (1993) "A Changing City: The Response of the City of Toronto Department of Public Health." In *Health and Culture*, vol. 1. Ralph Masi, Lynette Mensah, Keith A. McLeod (eds.). New York: Mosaic Press, pp. 63-70.
- Leininger, M. (1978) *Transcultural Nursing: Concepts, Theories and Practices*. Toronto: John Wiley & Sons.
- Leininger, M. (1989) "The Transcultural Nurse Specialist: Imperative in Today's World." *Nursing & Health Care*, vol: 10(5), pp. 251-256.
- Lethbridge Community Services (1976) *Community Profile*. City of Lethbridge: Community Services Department.
- Lethbridge Social Planning Department (1985) *Community Profile*. City of Lethbridge: Urban Study.
- Lock, M., and Scheper-Hughes, N. (1990) "A Critical-Interpretive Approach in Medical Anthropology: Rituals and Routines of Discipline and Dissent." In *Medical Anthropology: Contemporary Theory and Method*, Thomas M. Johnson and Carolyn F. Sargent (eds.). New York: Praeger, pp. 47-72.
- Lofgren, O. (1987) "Deconstructing Swedishness: Culture and Class in Modern Sweden." In *Anthropology At Home*, Anthony Jackson (ed.). New York: Tavistock Publications, pp. 74-93..
- Logan, R. (1990) "Immigration During the 1980s." In *Canadian Social Trends: A Canadian Studies Reader*, vol. 2. Ottawa: Thompson Educational Publishing, Inc., pp. 31-34.
- Lowenstein, A., and Glanville, C. (1991) "Transcultural Concepts Applied to Nursing Administration." *Journal of Nursing Administration*, vol: 21(3), pp. 13-14.

- Lynam, J. (1992) "Towards the goal of Providing Culturally Sensitive Care: Principles upon which to build Nursing Curricula." *Journal of Advanced Nursing*, vol. 17, pp. 149-157.
- Macdonell, D. (1986) *Theories of Discourse: An Introduction*. Oxford: Basil Blackwell.
- Mahmood, C. K., Armstrong, S. L. (1992) "Do Ethnic Groups Exist? A Cognitive Perspective on the Concept of Cultures." *Ethnology*, vol. 31(1), pp. 1-14.
- Majumdar, D. N. (1994) "On the Development of Culture." In *Pathways: Approaches to the Study of Society in India*. Delhi: Oxford University Press, pp. 24-36.
- Malone, B. L. (1993) "Caring for Culturally Diverse Racial Groups: An Administrative Matter." *Nursing Administration*, vol. 17(2), pp. 21-29.
- Masi, R., Mensah, L., and McLeod, K. A. (eds.) (1993) *Health and Cultures*, vol 1. Oakville: Mosaic Press.
- Masi, R., K. McLeod, K. A., and Mensah, L. (eds.) (1993) "Introduction." In *Health and Culture*, vol. 1, Masi, Lynette Mensah, Keith A. McLeod (eds.). New York: Mosaic Press, pp. 3-10.
- Maykut, P., and Richard M. (1994) *Beginning Qualitative Research*. London: The Falmer Press.
- McAdoo, H. P. (1993) *Family ethnicity: Strength in Diversity*. London: Sage Publications.
- Matthews, G., and Morrow, R. (Jr.) (1994) *Canada and the World*. Scarborough: Prentice Hall Canada Inc.
- McDonald, R. J. (1994) "Canada's Off-Reserve Aboriginal Population." In *Canadian Social Trends: A Canadian Studies Reader*. Vol. 2, Ottawa: Thompson Educational Publishing, Inc., pp. 57-60.
- Michelson, W.(1988) "Urbanization and Urbanism." In *Understanding Canadian Society*, James Curtis & Lorne Tepperman (eds.). Toronto: McGraw-Hill Ryerson Limited, pp. 73-105.
- Monet, J. (1992) "A Multicultural Canada, Then and Now." *Compass*, vol. 9 (6), pp. 21-23.
- Mori, G. A. (1990) "Religious Affiliation in Canada." In *Canadian Social Trends*, Craig McKie and Keith Thompson (eds.). Vol. 1, Ottawa: Thompson Educational Publishing, Inc., pp. 28-34.

- Morse, J. M., and Johnson, J. L. (1991) "Understanding Illness Experience." In *The Illness Experience: Dimensions of Suffering*. Janice M. Morse, and Joy L. Johnson (eds.). Newbury Park: Sage Publications, pp. 1-12.
- Muecke, M. (1992) "Nursing Research with Refugees: A Review and Guide." *Western Journal of Nursing Research*, vol. 14(6), pp. 703-720.
- Murphy, R. F. (1987) *The Body Silent*. New York: Henry Holt Company.
- Nadirshaw, Z. (1992) "Therapeutic Practice in Multi-Racial Britain." *Counselling Psychology Quarterly*, vol. 5(3), pp. 257-261.
- Nichter, M. (1989) *Anthropology and International Health: South Asian Case Studies*. Dordrecht: Kluwer Academic Publishers.
- Ng, R. (1988) *The Politics of Community Services: Immigrant Women, Class and State*. Toronto: Garamond Press.
- Nolde, T., and Smillie, C. (1987) "Planning and evaluation of Cross-Cultural Health Education Activities." *Journal of Advanced Nursing*, vol. 12(2), pp. 154-165.
- Northcott, H. C. (1988) "Health-Care Resources and Extra-Billing: Financing, Allocation, and Utilization. In *Sociology of Health Care in Canada*, B. S. Bolaria and H.D. Dickinson (eds.). Toronto: Harcourt Brace Jovanovich, pp. 38-50.
- Obidinski, E. (1978) "Methodological Considerations in the Definition of Ethnicity." *Ethnicity*, vol. 5, pp. 213-228.
- Ohnuki-Tierney, E. (1984) *Illness and Culture in Contemporary Japan: An Anthropological View*. New York: Cambridge University Press.
- Okamura, J. Y. (1981) "Situational Ethnicity." *Ethnic and Racial Studies*, vol. 4(4), pp. 452-465.
- Osborn, O. (1990) "Anthropology and Nursing: Some Common Traditions and Interests." In *Transcultural Nursing: A Book of Readings*, P. Brink (ed.). Prospect Heights, Illinois: Waveland Press, pp. 6-15.
- Parson, T. (1951) *The Social System*. New York: Free Press.
- Payer, L. (1989) *Medicine and Culture*. New York: Penguin Books.
- Ponting, J. R. (1990) "Internationalization: Perspectives on an Emerging Direction in Aboriginal Affairs." *Canadian Ethnic Studies*, vol. XXII(3), pp. 85-109.

- Prus, R. (1994) "Generic Social Processes: Intersubjectivity and Transcontextuality in the Social Sciences." In *Doing in Everyday Life: Ethnography as Human Lived Experience*, Mary L. Dietz, Robert Prus, and William Shaffir (eds.). Missisagua, Ontario: Copp Clark & Longman, pp. 393-412.
- Prus, R. (1994) "Field Research as Social Experience: Learning to Do Ethnography." In *Doing in Everyday Life: Ethnography as Human Lived Experience*, Mary L. Dietz, Robert Prus, and William Shaffir (eds.). Missisagua, Ontario: Copp Clark & Longman, pp. 10-29.
- Quareshi, A. N. (1989) *Transcultural Medicine: Dealing With Patients From Different Cultures*. Dordrecht: Kluwer Academic Publishers.
- Ram, B., Shin, Y. E., and Pouliot, M. (1991) *Canadians on the Move*. Canada: Statistics Canada.
- Ramsay, H. (1995) "Lesbians and the Health Care System: Invisibility, Isolation and Ignorance-You Say You're a What"?. *Canadian Woman Studies*, vol. 14(3), pp. 22-28.
- Regional Centre For Health Promotion & Community Studies (1995) *Native Seniors in Alberta: A Situation Report*.
- Ritzer, G. (1992) *Contemporary Sociological Theory*. New York: McGraw-Hill, Inc.
- Rhodes, L. A. (1990) "Studying Biomedicine As a Cultural System." In *Medical Anthropology: Contemporary Theory and Method*, Thomas M. Johnson and Carolyn F. Sargent (eds.), New York: Praeger, pp. 159-173.
- Russell, K., & Jewell, N. (1992) "Cultural Impact of Health-Care Access: Challenges for Improving the Health of African-Americans." *Journal of Community Health Nursing*, vol. 9(3), pp. 161-169.
- Sacks, K. B. (1988) *Caring by the Hour: Women, Work, and Organizing at Duke Medical Center*. Chicago: University of Illinois Press.
- Samuel, G. (1990) *Mind, Body and Culture: Anthropology and the Biological Interface*. New York: Cambridge University Press.
- Schartner, A. (1982). *Health Units of Alberta*. Edmonton: Health Unit Association of Alberta.

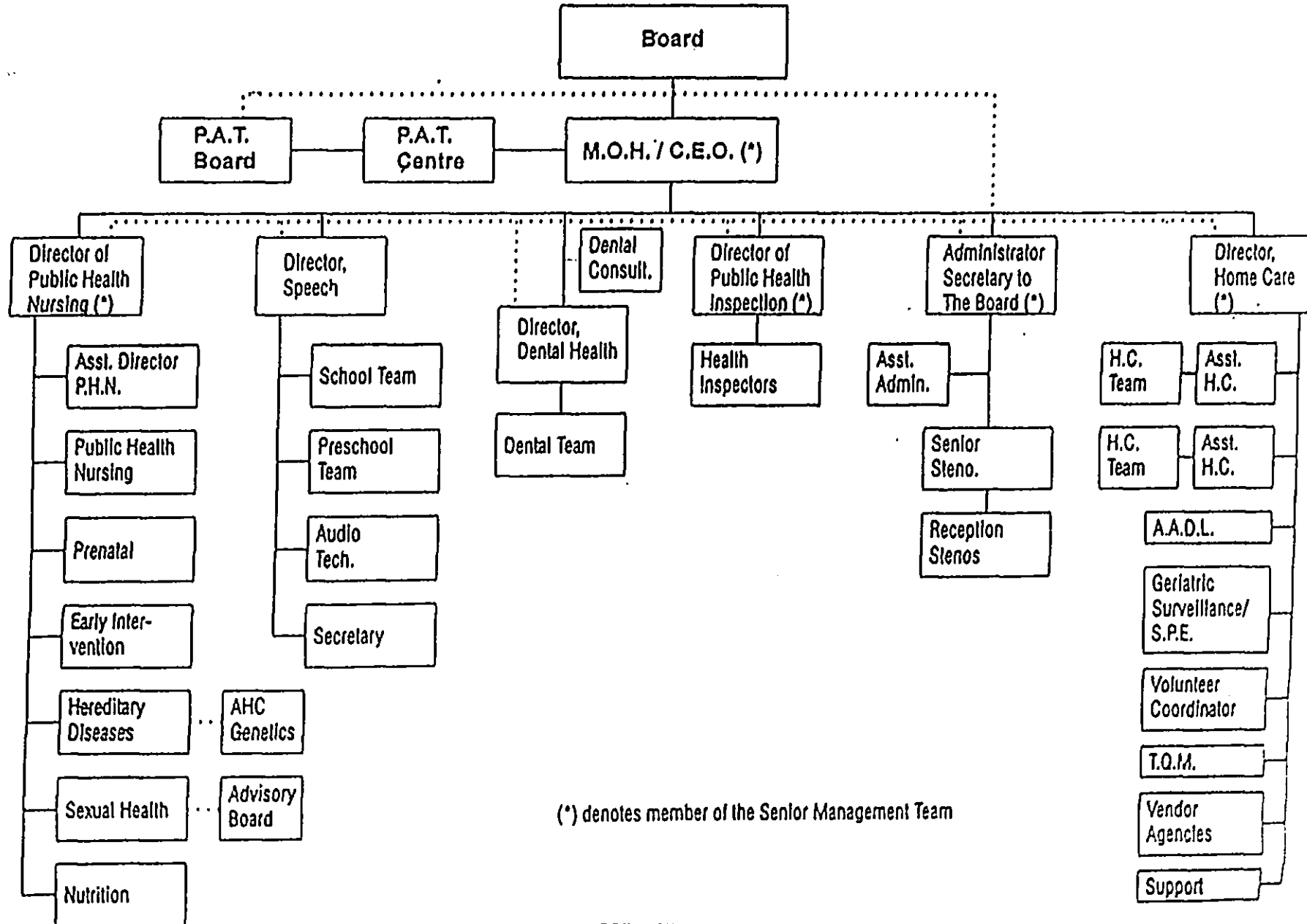
- Scheff, T. J. (1990). *Microsociology: Discourse, Emotion, and Social Structure*. Chicago: The University of Chicago Press.
- Scheper-Hughes, N. (1988) *The Madness of Hunger: Sickness, Delirium and Human Needs*. Paper prepared for Wenner-Gren Conference no. 106, Analysis in Medical Anthropology.
- Scheper-Hughes, N. (1992). *Death Without Weeping: The Violence of Everyday Life in Brazil*. Berkley: University of California Press.
- Schneider, J. W., and Conrad, P. (1980). "The Medical Control of Deviance: Contests and Consequences." In *Research in the Sociology of Health Care*. Julius A. Roth (ed.). Connecticut: JAI press Inc., pp. 1-55.
- Shaffir, W., Dietz, M. L., and Stebbin, R. (1994) "Field Research as Social Experience: Learning to Do Ethnography." In *Doing in Everyday Life: Ethnography as Human Lived Experience*, Mary L. Dietz, R. Prus, and W. Shaffir (eds.). Missisagua: Copp Clark & Longman, pp. 30-54.
- Shah, C. P., and Shah, S. S. (1990) *Public Health and Preventive Medicine in Canada*. Ottawa: Printed in Canada.
- Singer, M. (1992) "The Application of Theory in Medical Anthropology: An Introduction." *Medical Anthropology*, vol. 14, pp. 1-8.
- Spradely, J. P. (1979) *The Ethnographic Interview*. New York: Holt, Rimejart and Winston.
- Spradley, J. P. (1980) *Participant Observation*. New York: Harcourt Brace Jovanovich College Publishers.
- Sprott, J. F. (1994) "Symbolic Ethnicity and Alaska Natives of Mixed Ancestry Living in Anchorage: Enduring Group or a Sign of Impending Assimilation?" *Human Organization*, vol. 53(4), pp. 311-322.
- Stanner, W. E. H. (1994) "The Social Construction of Cultural Identities in Rural Kashmir." *Pathways: Approaches to the Study of Society in India*. Delhi: Oxford University Press, pp. 167-201.
- Stein, H. F. (1983) "The Money Taboo in American Medicine." *Medical Anthropology*, vol. 7(4), pp. 1-15.
- Stein, H. F. (1990) *American Medicine as Culture*. Boulder: Westview Press.

- Stevens, S. B. (1993) *Community Based Programs For a Multicultural Society*. Winnipeg: Planned Parenthood Manitoba.
- Taylor, C. (1970) *In Horizontal Orbit: Hospitals and the Cult of Efficiency*. New York: Holt, Rinehart and Winston.
- Teram, E., and White, H. (1993) "Strategies to Address the Bureaucratic Disentitlement of Clients from Cultural Minority Groups." *Canadian Journal of Community Mental Health*, vol:12(2), pp: 59-70.
- Teski, M. (1981) *Living Together: An Ethnography of a Retirement Home*. Washington: University Press.
- Thompson, M., Ellis, R., and Wildavsky, A. (1990) *Cultural Theory*. Boulder: Westview Press.
- Todd, A. D. (1989) *Intimate Adversaries: Cultural Conflict Between Doctors and Women Patients*. Philadelphia: University Press.
- Townshed, C. (1971) *Old Age: The Last Segregation: The Last Segregation*. New York: Grossman Publishers.
- Tripp-Reimer, T., and Afifi, L. (1989) "Cross-cultural Perspectives on Patient Teaching." *Nursing Clinics of North America*, vol:24(3), pp. 613-619.
- Trovato, F. (1994) "Mortality Differences Between the Canadian Born and Foreign Born in Canada, 1985-1987." In *Racial Minorities: Medicine and Health*, B. Singh Bolaria, and Rosmary S. Bolaria (eds.). Saskatoon: University of Saskatchewan, pp. 127-148.
- Trypuc, J. M. (1988) "Women's Health." In *Sociology of Health Care in Canada*, B. Singh Bolaria, and Harley D. Dickinson (eds.). Toronto: Harcourt Brace Jovanovich, pp. 154-166.
- Turner, V. (1969) *The Ritual Process: Structure and Anti-Structure*. Chicago: Aldine Publications Co.
- Ujimoto, K. V. (1994) "Racial and Ethnic Dimensions of Aging: Implications for Health Care Services." In *Racial Minorities: Medicine and Health*, B. Singh Bolaria, and Rosmary S. Bolaria (eds.). Saskatoon: University of Saskatchewan, pp. 201-224.
- Young, A. (1982) "The Anthropologies of Illness and Sickness." *Annual Review of Anthropology*, vol. 11, pp. 257-285.

- Young, A. (1993) "A Description of How Ideology Shapes Knowledge of a Mental Disorder (Posttraumatic Stress Disorder)." In *Knowledge, Power & Practice*, Shirley Lindenbaum and Margaret Lock (eds.). Berkeley: University of California Press, pp. 108-128.
- Verkuyten, M. W., and Masson, C. N. (1995) "The Construction of Ethnic Categories: Discourses of Ethnicity in The Netherlands." *Ethnic and Racial Studies*, vol. 18 (2), pp. 251-276.
- White, P. M. (1990) "Ethnic Origins of the Canadian Population." In *Canadian Social Trends*, vol. 1, Craig McKie and Keith Thompson (eds.). Ottawa: Thompson Educational Publishing, Inc., pp. 48-55.
- Wilcox, K. (1980) *The Ethnography of Schooling: Implications for Educational Policy-Making*. Stanford, California: Institute for Research on Educational Finance and Governance.
- Winn, M. (1990) "A Proposed Tuberculosis Treatment Program for Papago Indians." In *Transcultural Nursing: A Book of Readings*, P. Brink (ed.). Waveland Press, pp. 276-289.
- Wood, R. C. (1994) "Hotel Culture and Social Control." *Annals of Tourism Research*, vol. 21(1), pp. 65-80.
- Wotherspoon, T. (1988) "Training and Containing Nurses: The Development of Nursing Education in Canada." In *Sociology of Health Care in Canada*, B. Singh Bolaria and Harley D. Dickinson (eds.). Toronto: Harcourt Brace Jovanovich, pp. 375-406.
- Zhou, X. (1993) "The Dynamics of Organizational Rules." *American Journal of Sociology*, vol. 98(5), pp. 1134-1166.

APPENDICES

CITY OF LETHBRIDGE
COMMUNITY HEALTH CENTRE



APPENDIX A

CHHS # _____ Birth Order: _____ Return to Judy by: _____

Name:			Date of Birth:		
Type of Delivery:	Hospital:	M. Screening:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disc. in hrs. after birth:	
WITHIN		24 Hrs.	48 Hrs.	72 Hrs.	>72 Hrs. Refused
1st. Phone Contact After Discharge					
1st. Home Visit					
PHN Services Within 2 Weeks of Birth			PHN Services From 2 weeks to 2 Months		
Site	Number	Hrs. of Service	Site	Number	Hrs. of Service
Home Visits			Home Visits		
Phone Calls			Phone Calls		
Clinic/Office			Clinic/Office		
Travel Time			Travel Time		

FEEDING BO = Breast Only BS = With Supplement FO = Formula Only

_____ On Discharge	_____ 1st. Home Visit	_____ 2nd. Home Visit
Reason Breastfeeding Ceased: <input checked="" type="checkbox"/> one	_____ Insufficient Milk	_____ Feeding Problem
_____ Rtn. to Work	_____ Dr.'s Advice	_____ Other

NURSE: _____



COMMUNITY HEALTH CENTRE

EARLY POSTNATAL DISCHARGE REPORT

NAME: _____ D.O.B. _____
Last First YY MM DD

PARENTS: _____
Mother Father

DOCTOR: _____ CLINIC: _____

	DISCHARGE	FIRST POSTNATAL VISIT	SECOND POSTNATAL VISIT
DATE			
INFANT ASSESSMENT			
Weight/Head C.			
General Appearance			
SKIN - color			
HEAD - fontanels			
EENT - sclera			
Chest			
Resp./Heart Rate/Temp.			
Abdomen/Cord			
Extremities/F.Pulse			
Genitals - circ			
Elimination - Voiding			
- B.M's			
Feeding-Breast/Formula			
MOTHER ASSESSMENT			
Delivery			
Temperature/Pulse/B.P.			
Energy/Coping			
Uterus			
Lochia			
Perineum			
Legs			
Breasts			
Appetite			
Elimination - Voiding			
- B.M's			
Discomfort			
Family support			
PHN Signature			

Comments/Concerns: _____

Notice of a Live Birth or Still Birth & NewBorn Record

This form must accompany newborn if transfer occurs

Section I - To Be Completed within 24 Hours						Newborn's Hospital I.D. Number		
Surname of Child				Full Given Names (if known)			Live Birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birth Date Day Month by name Year		Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Appar 1: 5: 10:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Weight gm.	Head Cir. cm.	Length (crown to heel) cm.
Gestational Age in Completed weeks		<input type="checkbox"/> Singleton <input type="checkbox"/> Twin <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> Triplet <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd			Mother's Hospital I.D. Number			
Surname of Father				Full Given Names (if known)		Age	Mother's Marital Status <input type="checkbox"/> married <input type="checkbox"/> common <input type="checkbox"/> single <input type="checkbox"/> other	
Surname of Mother		Maiden Name		Full Given Names (if known)		Age	Language Understood	
Usual Home Address			City or Municipality		Province	Postal Code	Telephone Number	
Current Address (if different from above)			City or Municipality		Province	Postal Code	Telephone Number	
Gravida	Term	Preterm	Abortions (includes Ectopic)	Living	Total Live Births (inclusive)	Stillbirths (inclusive)	Neonatal/Infant Deaths	Onset of Labour <input type="checkbox"/> Induced <input type="checkbox"/> Spontaneous
No. Prenatal Visits	Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C/S <input type="checkbox"/> VBAC		<input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other	Congenital Abnormalities <input type="checkbox"/> suspected <input type="checkbox"/> yes Details:		Hospital/Site of Birth Location		
During this pregnancy did mother?				• Consume alcohol <input type="checkbox"/> no <input type="checkbox"/> yes If yes, Specify type and oz/day or oz/wk.		Attendant at Birth (print) Title: <input type="checkbox"/> Physician <input type="checkbox"/> Other (specify) <input type="checkbox"/> Midwife Attendant's Signature X		
• Attend prenatal classes <input type="checkbox"/> no <input type="checkbox"/> yes				• Use Street Drugs <input type="checkbox"/> no <input type="checkbox"/> yes If yes, specify type and frequency.		Family Physician/Pediatrician		
• Smoke <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> quit <input type="checkbox"/> < 10 cigarettes/day <input type="checkbox"/> > 10 cigarettes/day								

Section II - Discharge Summary to be completed at time of discharge home or 7 days

Summary of Newborn Health				Summary of Maternal Health			
Date of Discharge Day Month by name Year		Discharge weight grams		Condition of breast/nipples:			
Physical Exam <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Specify:				Uterine involution <input type="checkbox"/> normal <input type="checkbox"/> abnormal Specify:			
Metabolic/thyroid screen done		No	Yes	Length of postpartum stay <input type="checkbox"/> < 24 hours <input type="checkbox"/> 24 - 48 hour <input type="checkbox"/> > 48 hours			
Bilirubin to be repeated		<input type="checkbox"/>	<input type="checkbox"/>	Social History			
last bilirubin result →		<input type="checkbox"/>	<input type="checkbox"/>	Baby for adoption <input type="checkbox"/> no <input type="checkbox"/> yes			
Admission to SCN/ICN		<input type="checkbox"/>	<input type="checkbox"/>	Discharged <input type="checkbox"/> home <input type="checkbox"/> foster care <input type="checkbox"/> adoptive parents			
No. of days in SCN/ICN		<input type="checkbox"/>	<input type="checkbox"/>	Maternal support <input type="checkbox"/> spouse <input type="checkbox"/> family/friends <input type="checkbox"/> significant other <input type="checkbox"/> none			
Congenital Hip		<input type="checkbox"/>	<input type="checkbox"/>	Number/ages of children at home			
Seizures		<input type="checkbox"/>	<input type="checkbox"/>	Other Concerns			
Neonatal Infection		<input type="checkbox"/>	<input type="checkbox"/>				
Discharged on medication		<input type="checkbox"/>	<input type="checkbox"/>				
Maternal Hepatitis B status positive		<input type="checkbox"/>	<input type="checkbox"/>				
Hepatitis vaccine Date:							
Immunoglobulin Date:							
Infant feeding: <input type="checkbox"/> breast <input type="checkbox"/> breast with supplement <input type="checkbox"/> formula							
Concerns:				Follow up recommendations to Public Health Nurse: <input type="checkbox"/> routine <input type="checkbox"/> immediate <input type="checkbox"/> Public Health notified			
				Referral to other health/community support agencies. Please specify:			
Neonatal Death Date Day Month by name Year				Cause:			
				Nurse's Signature: X			

