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SITTING ON AN ISLAND:
NURSES IN THE CANADIAN NORTH

By

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I have no doubt the Devil grins
As seas of ink I spatter;
Ye gods, forgive my literary sins --
The other kind don't matter.

Robert Service

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Abstract

The nature of the practitioner/patient relationship has profound effect on the quality of health care. If this relationship is poorly managed (i.e. is susceptible to misunderstandings, tension and breakdowns), health care will be socially, psychologically, and sometimes even medically, inadequate and/or inappropriate. Intercultural health care is especially vulnerable to this problem, as practitioner and patient often interpret events or situations in different ways, according to their own cultural background.

This paper is concerned with one such case of intercultural health care. In the Canadian north, health care is almost always controlled and distributed by non-native doctors and nurses from the south. These people may have good intentions towards their native patients, but they are usually unable to communicate these attitudes to their patients and/or actualize them as behaviour. As a rule, natives and non-natives view and treat one another in terms of stereotypes rather than as individuals.

Northern nurses are expected to be empathetic "comforters" as well as curers, but the structure of native/white (i.e. non-native) relations in the north

makes this very difficult. Both interactional and network theories will be used to analysize the manner in which most nurses relate to their patient population. The quality and quantity of a nurse's relations to the community around her strongly influence her tenure in the north and how she is evaluated by others.

A great many northern nurses retreat to the "total institution" of the nursing station or hospital and have few informal or personalistic encounters with native people. It will be argued that this behaviour is largely a response to the double bind inherent in northern society as to how nurses should interact with their native patients. Many of the problems exhibited in northern health care stem not from indifference or negligence, but are created by the poor quality of cross-cultural communication currently typical of white nurses and native patients.

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Introduction

Throughout history mankind has been faced with the problem of disease and the threat of death. In response, all human groups have developed bodies of belief about the nature of disease and practices by which to prevent or defeat it (Hughes 1978: 150-151). Health care systems are deeply enmeshed in the cultural fabric of a society and reflect underlying themes concerning man's relationship with himself, his society, the natural world and the supernatural (eg. Ohnuki-Tierney 1977; Foster 1976). Disease is not an isolated "thing" or "event," but "an entity that groups (societies, cultures, and so forth) partially shape and make operable using as raw material problematic changes that take place in members of the group" (Fabrega 1975: 189). When the patient presents these psychobiological changes to a healer he is seeking therapy not just as "a means of curing sickness but, equally important, ... [as] a means by which specific, named kinds of sickness are defined and given culturally recognizable forms" (Young 1976: 8). Although our society has traditionally viewed disease as a purely biomedical condition (eg. Cassell 1979; Chrichton

1972: 2.5), for other societies the interpretation of disease is "integrally linked with the maintenance of evolving systems of social action, and characterized by a normative orientation and an evolving capacity for self-awareness" (Hallowell 1976: 396). Different health care systems vary not only in their epistemology and ontology of health and disease, but also in the social relations they both reflect and engender. In our own society, for example, only the certified doctor can legitimize the role of patient by defining a set of symptoms as consisting of illness (Dreitzel 1971: vii; Blishen 1969: 18; Zola 1972; Illich 1977: 174-175). A similar situation exists in other cultures. Throughout the world, both social and political elements are crucial to the definition and treatment of ill health.

Despite differences in diagnosis and treatment, western health practices have enjoyed world-wide expansion. Whereas the effectiveness of early western medicine can be debated (McKeown 1971; Illich 1977; Strong 1979), it cannot be denied that the advent of antibiotics, modern surgery, etc., can bring about dynamic cures and treatments that all cultural groups are anxious to obtain. Primitive medicine usually recognizes the difference between common ailments treatable by home remedies and ailments which have an extranatural basis and which must be treated in a ritual manner (Read 1966; Hughes 1978; Ohnuki-Tierney

1977; Hallowell 1976). Because of its technical advances, however, western medicine can be therapeutically successful in both situations. As a result, modern medicine has become expansionist in content as well as geography (Zola 1972; Illich 1977; Weidman 1979). Unfortunately (and perhaps inevitably, as a result of their training), the personnel responsible for the expansion of western health care tend to be professionally ethnocentric (Foster 1977; Weidman 1979; Quesada 1976; Leininger 1978). Few attempts are made to solicit the attitudes or beliefs of the non-western people to whom western medicine is given. As a result, misunderstandings and alienation have been common when western medicine is practised in non-western settings.

This paper is a study of one such situation wherein western health care is given to a non-western people. Western medicine has been given to the native people of northern Canada since the first European contact. How has this care been received? Do the distributors and recipients of northern health care understand one another and communicate effectively?

Health Care in Northern Canada

This paper will focus on the nurses dispensing health care in the Canadian north. During the 1950's the Canadian government instituted the outpost nurse system, in which Euro-Canadian or European nurses act as the primary

source of western medical care. Many of the early outpost nurses were limited as to the quantity and quality of care they could give by material, educational and communicational restrictions (eg. Lee 1975; Copeland and Myles 1960). Considerable improvement has subsequently been made in northern health care, due in part to the increased number of northern nurses, doctors, and hospitals (see Henderson 1976; Keith 1971a; Percy 1967; Graham-Cumming 1967).

There are indications, however, that these technical advances have not been entirely satisfactory to many native Canadians. During the 1950's it was not uncommon for the Inuit to give a nurse a nickname such as "Lutiapik", which translates as "the little one who cares for us" (Lee 1975). A survey of the statements made by present-day Inuit and Indian leaders presents a very different picture of nurse/patient relations (Kusugak 1975, 1979; Ittinuar 1975; Emery 1978; Fines 1979, etc.). It would seem that native people feel that northern nurses do <u>not</u> care, that they "dislike Inuit" (Wenzel 1978: 14), are "cold" to Indian patients (Fines 1979: 62), or consider native people as "dirty" (Steiman 1978; Ittinuar 1975). In short, native Canadians feel psychologically and socially alienated from northern health care and blame the nurses for this situation.

Is this an accurate assessment of northern health care? Are northern nurses cold, prejudiced and uncaring? The paradox lies in the fact that most nurses do not see

themselves in this light. Outpost nurses argue that one must care in order to undertake this job and remain in isolated communities. Although nurses do not portray themselves as self-sacrificing Florence Nightingales, they do see themselves as well-intentioned, concerned, and fair to all patients.

Why is there this discrepancy between the perspective of the native people and the nurses? Although both sides may be slightly exaggerating their position, I feel that both are behaving in accordance with their cultural backgrounds. Nurses and native people possess very different ideas as to what constitutes health care and what role the healer should play in society. To understand these attitudes and expectations, we must examine the social and cultural systems from which they come. Native ideas concerning health care have been influenced by at least three stages in their history -- the pre-contact, early post-contact, and modern periods. Western nursing has also undergone changes in orientation and methodology throughout its history (eg. Baly 1973). The current difficulty in the north largely stems from the failure to achieve effective cross-cultural communication about the nature and goals of modern health care.

The poor communication between nurses and patients is not an isolated phenomenon in the north. Northern communities can be viewed as consisting of two major "clusters" (Boissevain 1974) or subsystems: (1) the

native, and (2) the "white" or non-native (Paine 1977; Brody 1975; Jensen 1979; Vallee 1962; Smith 1971; Parsons 1970; etc.). It is almost inevitable that nurses identify themselves, and socialize, with the white community. Native/nurse interactions are largely limited to the formal encounters of the clinic, in which the practitioner takes the dominant role (Prosser 1978; Illich 1977; Blishen 1969; Goffman 1959). This single-strand(Banton 1965), professional relationship is not satisfactory to the native population and helps to generate the complaint that "nurses don't like us." What I hope to show are the constraints nurses feel from their professional role model and the structure of northern society that make them limit their interactions with native people in this manner. The nurses' isolation from the native community is not a good thing in itself (and may not be what the nurses would prefer), but may appear to these women as the only logical choice under the circumstances. Is this a case of symmetrical schismogenesis (Bateson 1958) in which isolation and social segregation will continue to generate more of the same? Although this would seem to be the case in many communities, hopefully this does not have to continue indefinitely. Meaningful and effective cross-cultural communication should be possible if both sides make an effort.

Area of Research

In essence, the topic of cross-cultural communication is relevant to any situation in which transcultural nursing occurs. This paper is concerned with the Canadian north, and concentrates upon the areas of northern Manitoba and the Keewatin district of the Northwest Territories. I visited these areas during July and August of 1979 and interviewed many of the nurses working there at that time. Fieldwork was based at the two regional hospitals which act as the primary health-care institutions for their surrounding hinterlands. The Churchill Health Centre is a thirty-five bed hospital which serves the community of Churchill and the Keewatin district. Lynn Lake Hospital is approximately the same size as the Churchill Health Centre and serves Lynn Lake, surrounding towns, and various remote communities in northwestern Manitoba. The doctors at both Churchill and Lynn Lake routinely visit their respective satellite communities to hold clinics, and at both hospitals complicated cases are referred to the Winnipeg Health Centre. Specialists and dentists are regularly flown into remote communities for two or three-day clinics.

Between these two regions, there are three native Canadian groups encountered by the health personnel. The outpost nurses of the Keewatin work exclusively with

Caribou Inuit. At the Churchill Health Centre, Inuit comprise the bulk of the patient population, but the town itself has a number of Chipewyan and Metis families. (The majority of the Caribou-eater Chipewyan left Churchill in 1975 and established a new settlement of their own in the interior of northern Manitoba. These people are now handled by Lynn Lake Hospital, although they will occasionally return to the Churchill Health Centre.) The nurses of Lynn Lake Hospital and the outpost nurses of northern Manitoba work with both Swampy and Rocky Cree and Caribou-eater Chipewyan. Individual communities vary as to the mixture and proportion of Cree, Chipewyan and Metis.

The three groups are characterized by distinct stereotypes in the minds of many white northerners, although non-natives may not be aware of the cultural membership of individual Indians or of particular settlements. The Inuit, for example, are described as "easy to get along with," the Cree as "difficult and uncommunicative," and the Chipewyan (particularly one specific community) as "arrogant and demanding." One might be led to agree with Chance and Trudeau that white/Inuit relations are based on "attitudes of mutual respect" whereas white/Cree (or white/Chipewyan) relations are more discriminatory in nature (1963: 55). However, I do not feel that viewing someone as "easy to get along

with" is necessarily the same as giving him/her respect. Throughout the north, nurses report that native Canadians, no matter what group, tend to be less demanding and difficult patients than non-natives. This does not mean, however, that nurses respect (i.e. hold in esteem) native patients more than non-native patients. According to critics of western medicine, western practitioners describe a "good" patient as one who is passive and co-operative (Zola 1972; Cassell 1979: Illich 1977). Thus, the nurses' criteria of what constitutes a good patient do not necessarily coincide with those used by Euro-Canadian society as to the characteristics worthy of respect.

The Historical Background

To understand current misunderstandings in northern health care, it is useful to examine the cultural and historical roots of these problems. For this reason, a brief summary of the history of the three groups concerned (the Caribou Inuit, the Caribou-eater Chipewyan, and the Swampy and Rocky Cree) will be given. Following this, there will be a brief description of the development of Medical Services and native health care in Canada.

The Caribou Inuit

The Keewatin district was traditionally occupied by five bands, which were collectively called the Caribou Inuit. As their name implies, these bands relied primarily on the caribou for subsistence (Crowe 1974: 59). As did most Inuit, the Caribou Inuit lived in small, mobile groups that were geographically and socially adapted to the yearly hunting cycle. Medical care was provided by shamans, who have been described as "ceremonial practitioner(s) whose powers come from direct contact with the supernatural, by divine stroke, rather than from inheritance or memorized ritual" (Lessa and Vogt 1972: 381).

Initial contact with European explorers was made as early as 1576, but intensive interaction did not occur

until much later. Prior to World War II the three main agents of culture change in the Arctic were the whalers, the missionaries, and the traders (Ross 1975; Jansen 1979). The introduction of western ideas and institutions has been fairly recent in the Keewatin. A permanent trading post was not established in the district until 1911 and some interior settlements such as Baker Lake did not receive resident missionaries until the late 1920's (Usher 1971; Vallee 1962: 174).

Between World War I and World War II, medical care and social services were handled by whichever white agency was locally available. This usually consisted of the nearest missionary, Royal Canadian Mounted Police officer or Hudson Bay Company manager. It was not until the 1950's that the Canadian government began a large-scale, concentrated movement into the north to "redress the 'Eskimo problem'" (Paine 1977: 13). To facilitate the distribution of social services, including medical care, the Inuit were encouraged to settle into permanent villages. Ironically, "it is the consequences of sickness (particularly the lack of economic security for dependents) rather than sickness itself that is minimized by settlement living, for in many localities the incidence of sickness rises dramatically with movement to permanent settlements" (Freeman 1971: 226, italics included). Furthermore, as we shall see, the Inuit were not always pleased with the results when

federal nurses took over the health services previously handled by the missionaries and, before that, the shamans.

The Inuit have undergone rapid change in the past thirty years, and this change has been reflected in the status of their health. As pointed out by Otto Schaefer the acute infectious and epidemic diseases of the 1930's and 40's (especially tuberculosis) are now under control. Social problems (eg. alcoholism and violence) and "diseases of civilization" such as obesity, diabetes, and hypertension, are now the major problems in northern health care (Schaefer 1978: 23-24). Changes in diet, settlement pattern, employment, etc., have combined to produce stresses and medical problems previously unknown in the Arctic (Schaefer 1975; Vallee 1972).

The course of development of medical services in the Keewatin is typical of much of the Arctic. The first nursing station was a Roman Catholic mission built in Chesterfield Inlet in 1931. This remained the only medical institution in the entire Keewatin until 1954, when a mine infirmary was opened in Rankin Inlet. Starting in 1961, a large-scale expansion was undertaken by the Department of National Health and Welfare. By 1970 nursing stations were established in most of the settlements of the Keewatin. These stations refer all major cases to the hospital at Churchill, and ultimately to the Winnipeg

Health Centre. The military hospital at Churchill was replaced by the provincially and federally funded Churchill Health Centre in 1975, an institution designed "to deliver comprehensive social and public health services as an integral part of a community based health facility" (Martin 1978: 1). As throughout the Arctic, the last thirty years in the Keewatin has been characterized by the rapid expansion of health services (Hildes 1976; Sutherland 1975; Martin 1978), as well as sweeping social and economic changes.

The Caribou-eater Chipewyan

As their name implies, the Chipewyan of the Barren Land also based their subsistence on hunting caribou. Although contact with Europeans was made in the mid-1700's, throughout most of the eighteenth and nineteenth centuries the Caribou-eater Chipewyan continued to maintain their traditional subsistence pattern (Sharp 1977; Smith 1978a). Unlike other Chipewyan groups who moved southward into the boreal forest in search of beaver, the Caribou-eater Chipewyan remained in the taiga-tundra environment at the edge of the forest (Smith 1975a: 394). Although a permanent trading post was established for the Chipewyan at Brochet in 1859 (and was joined by an Oblate Mission in 1861), Brochet remained largely a Cree settlement until 1967. It was not until the 1920's that the Chipewyan

began to build log cabins and curtail their nomadism to any extent (Smith 1975a:395; Smith 1978: 316-317). These all-native, log cabin communities may have been characterized by the absence of white personnel, but in reality they were "oriented toward a focal centre of white institutions in the region, commonly a settlement that may be characterized as 'Point-of-Trade'" (Helm and Damas 1963: 10). Both Brochet and Churchill acted as "Points-of-Trade" for the Chipewyan during this period and were the centres of white trade and religion.

The Oblate mission at Brochet claimed to have achieved conversion of the Chipewyan as early as 1905, but a total conversion by this date seems unlikely. It should be noted that:

> Throughout the contact period Europeans exposed the Chipewyan to new economic and technological patterns and directed major ideological campaigns against the Chipewyan symbolic systems. The Chipewyan modified and incorporated many of the European offerings into their system but the commitment to caribou hunting remained unaltered (Sharp 1977: 37).

If Sharp is correct, the Chipewyan may have accepted only such aspects of white society that were of use to them. Without doubt, the medical care offered by the Oblates was an attractive element to the Chipewyan. Throughout the eighteenth and nineteenth centuries the Chipewyan experienced a number of epidemics, including outbreaks of smallpox, measles, whooping cough and so on(Young 1979: 197-199). Traditional native medicine was not designed to

cope with disease on so large a scale, and the prestige of the medicine men must have suffered when they proved to be powerless against the waves of epidemics (Dunning 1959: 118; Burnette and Koster 1974: 92; also Brody 1975: 24-26). After the Chipewyan settled in Brochet in 1967, the relvance of the traditional healer to the modern Chipewyan became even more tenuous. In many respects, Euro-Canadian religious and medical personnel were responsible for the cultural degradation of i^{n}ko^{n}ze, a Chipewyan term meaning the ability to have relevant dreams or the possession of supernatural abilities (Smith 1973: 8). As Smith points out, however,

> ... in a larger sense, the reason why there are no more medicine men enabling "the animals to look after the people" (as Joseph Moose-Sinew put it), is because the associations of the people to the "bush" are now much weaker. The roles of people with i^{n}ko^{n}ze are simply no longer very necessary for the new settled town life (1973: 20).

Nevertheless, Smith does not feel that traditional magico-religious beliefs have entirely disappeared among the Chipewyan he studied, and suspects a strong revitalization movement could bring them back into prominence.

At the present time the Chipewyan, like most northern groups, are primarily concerned with receiving adequate western-style health care. Although Treaty No. 5 negotiated in 1875 did not contain a "medicine chest" clause, medical services in the area have gradually

increased during the last forty years. In 1953 a company hospital was founded at Lynn Lake, a small mining community seventy-five air miles to the south of Brochet. In 1969 a permanent nursing station was built in Brochet (Smith 1978: 320), and a new clinic has just been built to replace these early trailers.

Medical services are less readily available for the Chipewyan communities of Lac Brochet and Tadoule Lake. Both settlements are outgrowths of older communities (Lac Brochet from Brochet and Tadoule Lake from Churchill [see Smith 1978a: 46-47]). These communities are particularly concerned about obtaining adequate health care, as they lack resident nurses and contact with the outside world can be unpredictable at best (see Code 1975 for a Chipewyan description of this problem). Both of these communities would like to have a resident nurse, but staffing shortages and federal cut-backs may delay such service. For example, a nursing station is almost complete in Lac Brochet, but many of the nurses and doctors in the area doubt it will be staffed in the near future.

The Swampy and Rocky Cree

Of the three or four major divisions of the Western Woods Cree, at least two are found in the area studied. These are the Maskegan or Swampy Cree, who traditionally extended from the Hudson Bay Lowland

through the upper Lake Winnipeg region and westward to Cumberland House, Saskatchewan, and the Rocky Cree, who were found on the lower Churchill River drainage area and west of the Nelson River (Smith 1976: 415). The identification of several different "types" of Cree is a reflection of both the ecological and social variation exhibited by these people (Fisher 1978: 131).

Cree involvement in the fur trade was considerable from a very early point in time. Prior to the formation of the Hudson Bay Company in 1668, the Cree had obtained trade goods through Algonkian and Huron middlemen (Helm and Leacock 1971: 351). In 1668 Fort Rupert was built and in 1717, Fort Churchill; the Cree were thereafter directly contacted by the Europeans and vice versa. During the 1700's the Cree south and west of the Hudson Bay Lowland became the centre of fierce competition between the "free traders" and the Hudson Bay Company. As direct and indirect consequences of this competition, the Cree began to suffer the effects of alcohol abuse, disease, overtrapping of the land, and intertribal warfare (Helm and Leacock 1971: 352). The smallpox epidemic of 1780-1781 probably halted Cree expansion northward, and may have facilitated Chipewyan movement into the boreal forest (Smith 1976: 428; Helm and Leacock 1971: 352; Fisher 1978: 134). As Fisher points out,

> A more intensive study of disease patterns among the Indians of Canada would

> give us another insight into the migration and adaptive patterns of the subarctic peoples. The destruction of man as a predator would, of course, influence other elements in local ecological systems, and, as studies of European epidemics have indicated, the social effects of plague and other disease are broad rather than specific (1978: 134).

Both trade and disease were important factors in the movement of Cree groups during the eighteenth century.

Although some of the Cree encountered Jesuits at Sault Ste. Marie as early as 1641, missionary work by Catholic, Anglican and Wesleyan groups extended across the next two hundred years. For example, as mentioned above, the Oblate mission at Brochet was not established until 1861. It is important to realize that,

> The Jesuit desire to see their new "flock" settle in agricultural villages was contrary to the trader's desire for furs, and, in particular, the use of liquor as a trade-good was a bone of contention between the two... Thus the two dominant forces in the north, the church and the fur trader, did not present a monolithic union, but rather two separate systems forced into uneasy association as each strove to manipulate the Indian for its own ends (Helm and Leacock 1971: 355).

As in most of the north, the mission and the fur trade were to remain the primary white influences among the Cree until after World War II.

Until 1930, health care for the Cree was largely absent, or handled by amateurs such as Hudson Bay Company managers or the local priest. Treaty No. 5 did not include a "medicine chest" clause, and on many reserves

medical care was limited to annual, one-day clinics held on Treaty Day by the Treaty Commissioner's medical consultant. During this period, tuberculosis alone accounted for thirty per cent of all deaths among native Canadians (Graham-Cummings 1967: 137). The appalling rates of disease found among Cree and other Indian groups was due in large part to the practice of sending the children to residental schools (Graham-Cummings 1967: 133-136; Robertson 1971: 131). These schools, which were usually unsanitary and overcrowded, acted as centres of contagion and generated more medical harm than educational benefit.

Medical units began to visit the reserves of Manitoba during the 1930's in order to combat the high rate of tuberculosis. An examination of the Swampy Cree of Norway House, The Pas, and Cross Lake for the Senate-Commons Committee on Indian Affairs conducted from 1941 to 1944 had the following results:

> The majority of the Indians we saw, according to our present day medical standards, were sick. They were not sick according to lay opinion, but when we examined them carefully from the medical standpoint, they had so many obvious evidences of malnutrition that if you or I were in the same condition, we would demand hospitalization at once... We found, in that particular band, the TB death rate was just fifty times the tuberculosis death rate among the white population of Manitoba. This raises a problem far beyond the Indians because there is a focus of infection which is of concern to you and me. We can never prevent tuberculosis among the white

> population of Canada when we have a focus of fifty times that among those Indians (Dr. Fredick Tisdall in Robertson 1970:133).

As in the Arctic, a massive campaign was initiated aginst tuberculosis which emphasized Euro-Canadian personnel and institutions. It was not until 1962 that native participation was actively sought by the Canadian government. The Community Health Representative program is modeled directly after an American program used in Alaska, and to date has achieved moderate success (see Rymer 1969). Most communities still prefer to have a resident, Euro-Canadian nurse, and nursing stations are still being built. The community of South Indian Lake, for example, did not receive a permanent nurse until 1971 (Brandt 1975: 69), and the new clinic-styled station built to replace the original trailers tends to be chronically understaffed.

The history of white/native relations in northern Canada is more complex than this brief summary is able to show. Both the native and the non-native groups involved varied in intent and orientation (eg. missionaries and traders had very different goals and methods), so that no simple, linear process of acculturation occurred. Despite these problems, native health care will be categorized as consisting of three types according to both their content and historical context. These three categories are: (1) the pre-contact or indigenous health

care supplied by medicine men or shamans; (2) the early post-contact period during which western health care was supplied primarily by missionaries, and incidentally by other white agencies such as the Royal Canadian Mounted Police or the Hudson Bay Company; and (3) the modern period in which western medicine is financed and supplied by the federal government. The experiences and expectations typical of each period or category has profound effects on people's acceptance of any subsequent system. These categories are not discrete units, and what people have experienced in the past influences their evaluation of the present. Even though shamans may, or may not, presently deliver health care, the western-style doctor or nurse must understand the mileu created by any former health care system if he/she is to distribute effective medical care.

(1) The indigenous health care system

Non-western medical systems vary greatly as to how they define and categorize disease, which also determines the nature of the curing strategies used by each society (Frake 1961; Ackerknacht 1946; Hughes 1978). There has been considerable debate among anthropologists and sociologists as to the importance of the magical component in most non-western health care systems (Young 1978; Ackerknacht 1946; Fabrega 1971; etc.). It has generally been acknowledged, however, that "all human

groups have a pharmacopoeia and at least rudimentary medical techniques; some groups, indeed, are exceptional in their exploitation of the environment for medicinal purposes and in the degree of their diagnostic and surgical skills" (Hughes 1978: 154). All groups possess basic health care strategies used by the individual or within the family to handle common and/or minor illnesses. In some cases, knowledge of these home remedies is attributed to a supernatural source, even though these cures are not performed in a ritual manner or context (Ohnuki-Tierney 1977: 15).

Non-western medical systems have traditionally been holistic in orientation and emphasize the links between man, society, nature, and the supernatural (Read 1966; Hallowell 1976; Morley 1978). (It is interesting to note that it is only since 1970 that western medicine has adopted the same type of holistic approach, as exemplified by the modern schools of family, preventative and social medicine [Chrichton 1972: 2.5]). Throughout North America, public confession of social and/or religious violations by the patient or a member of his/her family was used by various Indian groups (La Barre 1974: 45). By eliciting and manipulating these confessions, the shaman or medicine man combined a variety of social functions (eg. policeman, judge) with his religious and medical roles (Hallowell 1976: 398; Vallee 1962: 170). Because the sha-

man possessed both power and prestige, he was feared as well as respected (Black 1977: 149-150; Murphy 1978: 65-66; Landes 1971: 57-60). Magical power could be used for evil purposes as well as good, and shamans were not generally responsive to the usual forms of social control exercised in these small-scale societies (eg. gossip, ridicule).

Although differences existed in the religious beliefs and practices of the three groups concerned (the Caribou Inuit, the Cree, and the Caribou-eater Chipewyan), a considerable number of similarities can also be found. As throughout North America, confession of wrong behaviour was often the basis of the curing ritual for those illnesses which demanded the attention of the shaman. One of the main differences between the groups concerned the type of taboo violation most commonly used to explain the occurrence of disease. Among the Inuit violation of supernatural taboos was considered the most common source of illness or misfortune, whereas among the two Indian groups, violation of social taboos tended to be more prominent in the explanation of disease (Vallee 1962: 170-178).

The three groups also varied as to the number and nature of their medical remedies. The Inuit possessed only a small inventory of herbal and animal medicines, as they were limited by the scarcity of vegetation in their environment (Murphy 1978: 154; Read 1966: 33). The Cree were acknowledged to have one of the most extensive

pharmacopoeia in the north, and the Chipewyan often borrowed herbal cures from them (Smith 1973: 10). As may be expected from these differences, the Inuit tended to emphasize the psychotherapeutic aspects of curing rituals (disease being an entity that could be "brushed aside," "blown away," etc.) more than the Cree or Chipewyan (Murphy 1978: 70).

Despite these differences, all three groups saw disease as an occurrence that was integrally linked to the social and supernatural worlds surrounding the patient. All three viewed health care as a holistic discipline aimed at treating the body, mind, soul and society of the patient. In many respects the shaman or medicine man acted as "an essential link in the chain binding the patient and his kin group to the process of diagnosing and treating the illness" (Read 1966: 21). Although the shaman activated and verbalized concepts concerning the causes and treatment of illness (and gained power and prestige from these actions), these explanations were basically given in terms understandable to all members of society. Participation by both kin and community was considered essential to the curing process, so the curing rite acted as a reaffirmation of social ties as well as of ideological commitment.

With the coming of the Europeans, native health care systems came under attack on several fronts. First and foremost, indigenous healers lost prestige when they

could not control the epidemics of European diseases. White "reformers" such as missionaries and the Royal Canadian Mounted Police deliberately worked to further discredit native Canadian religion as foolish superstition. In many cases, native religions publicly disappeared, although they may continue to exist privately or hidden from whites (eg. Smith 1973: 20; Vallee 1962: 178-179).

What is of importance to the modern medical system is the attitude about health care that native people retain, in varying degree, from the shamanistic period. During the precontact period, native people experienced a health care system that was holistic in theory and community oriented in practice. The shaman possessed power and prestige, but he was also a member of that society and shared basic assumptions about the nature of time, communication, and the definition of his role in society. Western health care, which comes from a very different type of society and ideology, may not be amenable to the native Canadian's criteria of what constitutes good health care and desirable practitioner/patient relations.

(2) The post-contact period -- the doctoring missionaries

Traders and whalers often dispensed rudimentary western medicine to the native peoples of the north, but this did not constitute a deliberate attack upon the native health care system. The introduction of European diseases,

however, had far-ranging impact on all native groups. Although it is difficult to reconstruct the health of precontact native groups, Young hypothesizes that these people had lived in equilibrium with both their resources and diseases (1979: 192-196). Whereas some infectious and parasitic diseases were endemic, the small size of the scattered bands acted to limit disturbance to the environment and the spread of contagious diseases. This state of active equilibrium was disrupted, and ultimately destroyed, by the fur trade.

Three factors combined to account for the appalling mortality and morbidity rates experienced by native groups from the 1700's to the present. First, increasing dependence on the fur trade often led to overtrapping and severe changes in diet, resulting in chronic malnutrition and/or starvation (Young 1979: 196; Crowe 1974: 80-81; Burnett and Koster 1974: 84-86). Second, contact with Europeans brought the Indians and Inuit diseases against which they had no immunity (eg. measles, whooping cough). The effect of these diseases was aggravated by the third factor, a change in settlement patterns. As explained by Helm and Leacock (1971: 361), fur trapping involved two situations in which disease could be contracted: (1) at the trading post, where the trapper must go to buy supplies and sell his furs; and (2) at the settlement which was permanently occupied by the trapper's wife and children. An increasing involvement in permanent settlements and residental schools facilitated

the spread of disease throughout the north.

Unlike the traders and the police, the missionaries distributed western health care as part of a deliberate attempt to undermine native religions. Furthermore, the missionaries had a lasting influence on northern health care, one that was probably not shared by the Hudson Bay Company employee or Royal Canadian Mounted Police officer. Unfortunately, the missionaries were not ready or able to cope with the events they themselves set into motion. At least one critic points out,

> ... conversion of the Indians to Christianity spelt doom to the medicine man for, however successful it was in practice, Indian medicine was inextricably based on and bound up with the old discarded faith. Thus, at a critical period in his history, when he was being exposed to new diseases and being obliged to modify his ways...the Indian was also deprived of his own native medical services, little prepared as they might be to cope with the tide of new disease (Graham-Cummings 1967: 121).

The doctoring missionary entered the north during a crucial period in native health care. The introduction of European diseases had resulted in a very high mortality rate among Indian groups, particularly the infant mortality rate (Graham-Cummings 1967: 124; Young 1979: 209). It has been estimated that the Indian death rate in 1938 was twenty-five times that of the rest of Canada (Robertson 1970: 141). The result of these high mortality rates was that "until 1960 the percentage of Indians relative to the total Canadian population was decreasing significantly" (Frideres

1974: 13-14). Under these conditions of stress, the doctoring missionary was often embraced by the Inuit and Indians as the only source of help and/or concern.

The missionary may have been enthusiastically accepted by native Canadians because he/she shared at least one trait in common with the traditional healer or shaman. Like the medicine man, the doctoring missionary was concerned with the total world of the patient, including his body, soul and society. The doctoring missionary, in contrast to the federal nurse, tended to learn the native language as part of a continual effort to gain the trust, and ultimately the conversion, of the native community. Although the missionary was in the north to reform, convert and change native peoples, in many respects he/she was much more a member of the total community than contemporary federal nurses.

It is this sociological aspect of health care as distributed by the missionaries that many people in the north remember fondly (eg. Ittinuar 1975; Kusugak 1975; Wenzel 1978). Two factors are considered important in describing this health care: (1) the missionary was concerned with the patient as a total person, rather than simply as a symptom or disease; and (2) the missionary assumed total care for a patient. The Grey Nuns and other nursing orders emphasized in-patient care, particularly when children were involved. Many native Canadians, par-

ticularly the Inuit, look back at this as an ideal form of health care and wonder why modern nurses seem reluctant to use their in-patient facilities (eg. Ittinuar 1975). In Inuktittut, for example, the word for nurse is nayanguak, which translates literally as "fake nun" (Kusugak 1975). Modern nurses are often compared to a compassionate ideal which has probably been embellished over time (see Savishinsky and Frimmer 1973: 35, for an example of a doctoring priest who would not conform to this ideal).

Although the quantity and quality of health care distributed during this period was limited by restrictions of resources and science, this was the time during which western medicine became firmly entrenched in the north. The doctoring missionaries are often referred to as an ideal by many native people, and have considerably influenced their expectations about modern health care. It must be remembered, however, that western health care, even during this period, was not put in the hands of native people. Health care became something that white people gave to natives, thereby increasing native dependency upon Euro-Canadian society.

(3) The federal system

Considerable debate has existed as to the responsibility of the Canadian government to native peoples for providing health services (Graham-Cumming 1967: 117, 123-124;

Doepker 1977: 6-7; Cuming and Mickenberg 1972: 129-131). Prior to the 1900's, health services was left entirely to private interests such as the missionaries. By 1905, however, the government was forced to become involved in native health care for a variety of humanitarian, political and pragmatic reasons. One of the major forces behind this change in policy was the Euro-Canadian fear that "the Indians were becoming a dangerous health hazard to the rest of the population", i.e. to white Canadians (Graham-Cumming 1967: 117). The Canadian government has never admitted that it is legally obligated to provide medical care to native people, but considers this a service for its legal "wards" (see Lalonde 1974: 50). Although the Indians requested medical services during the negotiations for Treaties No. 6, 8, and 11, only Treaty No. 6 included a "medicine chest" clause (Cumming and Mickenberg 1972: 129). The Inuit also lack any written agreement with the federal government for the provision of health services.

Prior to the 1950's and 60's, many native Canadians had to pay for their own medical care from doctors in private practice. Although this system may have been reasonable for Indian groups in southern Canada who could afford such arrangement, this was totally impractical in the north, where doctors were (and sometimes still remain) extremely scarce. Even in the south, this system was not satisfactory. As early as 1850 the Six Nations people, who were geographically close to private practitioners in

Brantford, saw fit to hire a residental doctor who was paid by, and responsible to, the band council (Weaver 1972: 39-42). The form of medical care used by the majority of white Canadians is simply not suitable, either in content or location, for many reserve situations.

In 1905 Dr. P.H. Bryce was appointed the first General Medical Superintendent for the Department of Indian Affairs. This appointment was the first official acknowledgement by the government of its responsibility for native health care. Dr. Bryce's zeal in fighting for medical care for the Indians and crusading against tuberculosis earned him an early retirement. In 1910 his services were terminated, and "it is indicative of the impression he had made that no attempt was made to refill his vacant post for 17 years" (Graham-Cumming 1967: 125). Although field nurses were first employed in 1922, medical services to native Canadians remained disorganized, rudimentary and underfinanced until at least 1945. In 1934, for example, the per capita cost of health care for Euro-Canadians was thirty-one dollars, whereas the cost for Indians was unchanged since 1930 -- nine dollars and sixty cents (Graham-Cumming 1967: 126). Obviously, native health services during this period were unsatisfactory.

Reorganization and expansion characterized native health services during the 1930's and 40's. In 1936 the Department of Mines and Resources replaced the Department of Indian Affairs and took over the Indian Health Services

Division. During this period, a separate service for the Inuit was developed under the tutelage of personnel from the Department of Pensions and National Health, yet still within the Branch of Mines and Surveys. In 1939, establishment of federal health facilities (i.e. hospitals and nursing stations) actually began. In 1944 the Department of National Health and Welfare was created, and in 1945 both Indian and Inuit health services were united in a new Indian Health Service Division (although many environment and social services remained within the Ministry of Indian Affairs and Northern Development). Minor revisions and reorganization have continued. In 1954 a Northern Health Services Division was created within the Department of National Health and Welfare. In 1962 certain areas (eg. Civil Service Health) were added to the Indian and Northern Health Services, and the whole was renamed Medical Services. Medical Services today is responsible for the following: Indian and Northern Health Services, Public Service Health, Quarantine and Regulatory Services, Immigration Medical Services, Civil Aviation Medicine, Prosthetic Services, and Emergency Health Services (Doepker 1977: 3-4).

For most native Canadians, these bureaucratic manoeuvres would be of little or no interest. What matters to them is the quantity and quality of health care which is locally available. Throughout the 1930's,

40's and 50's, health services to native Canadians were essentially a crusade against tuberculosis and other epidemic diseases, rather than preventative or community health. Due to their more isolated location, the Inuit were somewhat later in receiving these services than most Indian groups. During the 1930's and 40's the main form of health care in the Eastern Arctic was the annual survey ship, first the Nascopie and then the C.D. Howe (see Wiebe and McDonald 1963). Subsequently, nursing stations were built. This development was in large part a response to national and international criticism of the government's neglect of the Inuit prior to the 1950's.

Because of the vast territories involved, the low population density, and the shortage of doctors, nurses became (and remain) the backbone of Medical Services in the north. During the 1950's, both cultural and clinical orientation for these nurses was virtually absent, and nurses had to improvise with little or no supervision or advice (see Lee 1975; Copeland and Myles 1960). During the 1960's and 70's a great emphasis was placed upon better clinical training for outpost nurses (Ferrari 1976; Percy 1967; Miller 1976), and cultural orientation is now following (Dr. Brian Brett, personal communication). Nevertheless, as we shall see in the next chapter, white nurses in the north often do not fulfil the expectations of their native patients.

As mentioned earlier, native participation in northern health care is a very recent development. Dorothy Knight, who was one of the first outpost nurses in the Eastern Arctic, argues that the Canadian government denied the Inuit (and Indians) a valuable chance to regain some of their self-sufficiency when they failed to include native Canadians in the early days of Indian and Northern Health Services. She writes:

> The major health problems that we faced in Africa were identical to those we dealt with in the Arctic. Strangely, though, WHO [World Health Organization] strategy was the reverse of that chosen by Canada. In assisting developing countries (and Canada's Arctic was certainly undeveloped), WHO spared no money or effort in sending native people out of their home country for years at a time to be educated. The problem of tuberculosis, on the other hand, was handled in the patient's home. Canada spared no money or effort in sending Eskimos away from their camps for treatment in southern sanatoriums. But there was no interest in spending a similar amount to help educate the Inuit in health care. Perhaps we needed, and still need, WHO to advise Canada with its problems of developing peoples (Knight in Lee 1975: 236-237).

As Brian Maegraith has pointed out, in dealing with Third World countries "aid must be the means of providing economic assistance (and everything that stems from it) in order to help the developing country progress and reach the point where external support is no longer needed" (1970: 6). True aid should increase a group's self-sufficiency. In Canada, however, medical aid has created greater dependency and helplessness among our native people.

Native Criticisms

Over the years, native Canadians and their spokesmen have become increasingly critical of their health care as supplied by the federal government. These criticisms can be viewed as existing on three levels or concerned with three, inter-related aspects: (1) the national health dilemma of native groups throughout North America; (2) the institutional framework of federal health care in Canada; and (3) the relationships between individual physicians and nurses and native patients. When receiving medical care, native people are usually interacting with, and dependent upon, "white" (i.e. non-native) Canadians. The tensions typical of white/native relations in Canada (eg. Braroe 1975; Stymeist 1975) therefore form the backdrop of white practitioner/native patient relations.

(1) The national health crisis of native Canadians

Although most of the epidemic diseases of the eighteenth and nineteenth centuries are no longer uncontrollable or untreatable in most of the world, native Canadians still suffer from many of them. In

reality, this situation is one created by socioeconomic factors rather than genetic or biological considerations. The poor (whether native or non-native) suffer from a variety of socioeconomic inequalities (eg. substandard housing, poor nutrition) which combine to create a generally lower standard of health than the middle or upper classes. In many respects, "the health status of the poor person ... is similar to other aspects of the impoverished life: it is both a reflection and a cause of his low socioeconomic status" (Hurley 1971: 88). Furthermore, "if the incidence of illness is to a large extent a social problem, the organization of health is a political one" (Dreitzel 1971: xv, italics included). This is particularly evident when considering the status of native health care in North America. In both Canada and the United States, native people are dependent upon the white government and medical profession for health care. Due to their low socioeconomic status and lack of political power, native people have often had to accept inferior and/or limited health care. Throughout North America, Indian groups suffer shorter life spans and a higher infant mortality rate than non-native Americans or Canadians (Hurley 1971: 87; Bullough and Bullough 1972: 106; Frideres 1974: 17-19; Robertson 1970: 138-139). This injustice will probably continue until a large number of socioeconomic inequalities can be rectified (Reinhard 1976; Emery 1978;

Schaefer 1978; Burnette and Koster 1974: 85-86).

Ray Obonsawin of the National Indian Brotherhood has called Canada's native health care "a national disgrace" (Emery 1978: 52), and the statistics support his claim. Although a high birth rate has generated a tremendous growth in the absolute number of native people, the infant mortality rate for Indians is still nearly three times that for the white population (Frideres 1974: 17-19). The crude death rate among Indians also tends to be higher than that of white Canadians. It has been estimated that in 1970 the average life span of an Indian was thirty-four years (33.67 for males and 36.82 for females), while for the average white person it was nearly seventy-two years (69.04 for males and 75.60 for females [ibid]). Indians still die from diseases which should no longer be life-threatening with modern medical care (Robertson 1970: 138). According to an Indian Affairs Branch statement for a 1965 federal-provincial conference on poverty:

> The fact that Indians appear to die most from causes which are <u>preventable</u> suggests that living conditions and health habits are important factors in the picture. It is perhaps reasonable to assume, though difficult to establish statistically, that many Indians who do not die nevertheless are affected for the same reasons by debilitation and disability which in turn reduces their employability (quoted in Robertson 1970: 139, italics included).

Social problems and diseases such as alcoholism, violence and venereal disease are rampant throughout the north.

Among the Inuit, otitis media, obesity, heart disease and other "diseases of civilization" are widespread, reflecting radical changes in diet and lifestyle during the past thirty years (Schaefer 1964, 1975, 1978).

The dilemma of present-day Indian and Inuit health care is a complex issue involving a wide range of socioeconomic factors. The following figures for Churchill give an indication of the size of this problem:

> In 1975, Churchill had one of the highest rates of tuberculosis in the world. It had been identified by the Alcohol Foundation of Manitoba as an area with severe alcohol abuse problems. The number of chilren in care through the Child Welfare Act was astonishing. At one stage in the early 1970's virtually every child from Dene Village in Churchill was in care. Juvenile delinquency and violence in the community had reached extraordinary levels (Martin 1978: 3).

The Churchill Health Centre's Outreach Department was designed to deliver a variety of social services and thereby assist both medical and social programs. Throughout most of Canada native people give evidence of needing social services tailored to their own cultural background. To give but one example: over four per cent of status Indian children and three and a half per cent of all native children are in the care of federal and provincial child welfare services. Not only is this figure far above that for all Canadian children (1.35 per cent), but native children are less likely than non-native children to either return to their parents or be adopted (Hepworth 1979).

A white social worker or counsellor must take native culture and history into account when working with native people. The white social worker must recognize the fact that "however benevolent and sincere his intentions, he is often identified with the government bureaucracy which, in the Native mind, has been the historic oppressor" (Carlson 1975: 8). Despite these problems, extensive social work is needed among native Canadians. Native health can never improve unless the socioeconomic conditions of native life are upgraded.

(2) The institutional framework of federal health care

Western-style health care in the north has often involved hospitalization outside of the patient's own community. It is obvious that separating a sick person from his/her family and community "is a very costly matter, both in financial and in human terms" (Hewitt 1978: 46). The attitude of many native people to western hospitals is illustrated by the fact that

> ... " hospital" in Inuktittut is aniarvik which means that is where you go to be sick. You don't go home and be sick. You go to that place and be sick (Kusugak 1975: 146).

Native people often experience the hospital as a cold, frightening place peopled by intimidating and uncaring doctors and nurses (see Fines 1979). This is not the intent of the nurses and doctors, but is the unfortunate result of the institutional atmosphere and the structure

of white/native relations in Canada.

Most of the problems experienced by native Canadians in hospitals stem from the poor lines of communication between themselves and white practitioners. Even when interpreters can be found for those who do not speak English, cultural differences may remain as "subtle barriers" between the practitioner and patient (Good 1975: 162). Complicating this problem is the tendency of many native people to passively acquiesce to white instructions and authority (Briggs 1970, 1975; Brody 1975; Stymeist 1975). It is typical of Indian and Inuit people to defer to white doctors and nurses and ask few questions. White medical practitioners are identified with the federal government, white society, and the specialized field of medical technology. It is unlikely that the individual native person would feel free to deny or question anyone with access to these three sources of authority. Native spokesmen have charged that as a result,

> There has been a passive acceptance of a lower level of care because of our non-verbal behaviour patterns and lack of awareness of patients' rights. Because native people don't ask for explanations often they don't understand what is going on because they are usually scared to ask about what is going to happen to their child (James 1976: 150).

As with many lower-class people in the south, Indians and Inuit tend to become "passive health consumers" (Illich 1977: 21), totally dependent upon, and subservient to, the medical profession.

Hospitalization can be traumatic for all people, as it inevitably involves a separation from one's home and family (Foster and Anderson 1978; Cassell 1979; etc.). Native Canadians tend to be particularly fearful of being sent to southern hospitals. Sylvia James explains:

> There is still fear of institutions which probably originated with boarding schools. It was just a few years ago that the school-age native kids were simply taken off to the schools and away from the parents. The parents did not have very much to say in this matter. A lot of native people including myself were kept in Sanatoria for longer period of time, and this is still very much remembered by older people because some of the people never came back from these institutions (1976: 151).

Although attitudes are changing, traditionally Indians and Inuit felt powerless to control the fates of themselves or their children once submitted to health care. Despite the fact that southern hospitals were profoundly disliked, natives did not feel they could contradict the orders of a white nurse or doctor (for several examples of this behaviour see Copeland and Myles 1960). Horror stories still exist in the north of children who were "lost" in the bureaucracy of the south and never returned home. Hospitalization can generate considerable anxiety on the part of a patient and his/her family.

The inability to communicate effectively, created in large part by native fear of white hospitals and personnel, can lead to various kinds of misunderstandings. Nurses will joke about the difficulties a language barrier

creates when trying to obtain specimens or explaining medical procedures. At other times, these breakdowns in communication can create situations of intense suffering and alienation.

A classic example of such a breakdown in communication was described to me in Churchill. An infant from one of the settlements was evacuated to Winnipeg, but due to a mix-up in interpretation, the mother was told that the child had been sent to Churchill. Shortly afterwards, the mother herself required evacuation to Churchill. For several days the mother searched the Health Centre for her child but, of course, was unable to find it. Significantly, the mother never approached any of the nurses or doctors at the Health Centre to ask them what had happened to her baby. Although the nurses at Churchill appeared to me to be young, friendly, and eager to help their patients, the woman did not feel free to come to them and demand this information. It was not until the woman returned to her own settlement that she contacted the hamlet council and demanded to know where her child was. The confusion was finally settled, but not without bad feelings on all sides. The woman had suffered considerable mental anguish during this period, and probably became angry and distrustful of western institutions and personnel as a result. The nurses at the settlement were embarrassed about the entire incident and frustrated with the interpreter who had generated

this problem. What is interesting, however, is that the nurses at Churchill also felt "burned" by this incident. They were confused and embarassed by the fact that, although they try to be good to their native patients, the woman had not been able to approach them about such an important matter. They were also afraid that in the public mind this incident would imply that hospitals are not to be trusted and nurses are oblivious to the sufferings of their patients. Due to poor cross-cultural communication, almost everyone associated with this incident either lost prestige or suffered mentally.

In such situations, interpreters and native social workers can be invaluable in explaining the patient to the nurse and vice versa (see Whitford 1976; James 1976; Williams 1976; Fines 1979). This can be especially important when native people from the north are sent to hospitals in the south. Southern nurses may have little knowledge of the living conditions and cultural background of northern natives. These nurses may be tempted to judge native people as dirty, uncivilized, or inferior if they know nothing of the socioeconomic conditions under which they live (Steiman 1978: 40). Ignorance may lead to stereotyping, which can limit the kinds of interactions between nurse and patient to purely professional (i.e. medical) matters.

Unfortunately, native interpreters and counsellors

are currently limited in both number and power. The para-professional native health worker must be able to interact and work in two worlds -- the western medical system and the native social and cultural milieu. Sometimes these two sides can exert conflicting loyalties and obligations upon native health care workers (Steiman 1978; Kane and McConatha 1975).

More professional interpreters could help to eliminate the current practice of having patients interpret for other patients. Cultural factors such as Inuit name taboos, segregation of the sexes, etc., can make this an inefficient procedure. Furthermore, interpreting between doctors and patients involves not only a great deal of insight, knowledge and creativity (eg. explaining a concept such as "cancer" or "germ" which have no indigenous parallel), but strict standards of confidentiality as well. Waking up whatever patient is handy to interpret for a critically injured admission is a haphazard method of recruitment. Moreover, it is always possible that the admission is someone known by, or even related to, the interpreter/patient. In such cases, thoughtlessness or ignorance on the part of the hospital staff can result in very painful experiences for their patients.

(3) Nurse/patient relations

Throughout the north, native Canadians appear to

be dissatisfied with the quality of most nurse/patient interactions. A brief survey of the literature shows that, among other things, native Canadians see nurses as "cold or prejudiced" (Fines 1979: 62), uncaring (Ittinuar 1975; Jones 1975: 144), incompetent (Jones and Sulurayok 1975: 143), and short-tempered (Jones 1975: 144). In the Arctic, one of the most common complaints is that the nurses "dislike Inuit and stay inside all the time" (Wenzel 1975: 14), i.e. do not participate in community activities. Native people obviously feel socially and emotionally isolated from their nurses, which makes northern health care a rather cold, impersonal experience for them.

Unlike the other two areas of criticism, which are essentially aimed at institutions and entire social systems, this level of criticism concerns the behaviour of individual nurses in direct patient care. Nurses resent this kind of personal criticism since they feel: (1) their personal behaviour, especially off-duty, should not be open to public discussion and control; and (2) generally speaking, this criticism is inaccurate. The irony of the situation lies in the fact that whereas natives see nurses as cold and uncaring, the nurses feel that their very presence in the north is a testament to their concern and involvement. Nurses argue that "you have to care to come up north". It is felt that northern nursing is professionally, socially and emotionally more demanding than

nursing in the south and that salary levels (even including isolation pay) are not commensurate with this greater responsibility.

Why do native Canadians feel so ignored and isolated by white nurses? As any observer can see, nurses are socially segregated from natives in most northern communities (this will be discussed in greater detail in later chapters). Nurses believe that this does not influence the quality of their work and that it should not be included in any assessment of their work. It is clear that nurses are working with the practitioner/patient role model as used in the south. This model is based upon the concept of the practitioner as "a technical specialist in health and disease" who "is expected to be objective and emotionally detached" (Bloom 1965: 93-94). As far as most nurses are concerned, nurse/patient relations should be warm and compassionate, but basically single-strand and professional in nature.

Native Canadians are apt to be dissatisfied with such a single-strand relationship. Their past experiences with health care and the pattern of most interactions in small, isolated communities, have created very different expectations and models for health care. In small communities relationships tend to be multi-strand or multiplex, in that people interact in a variety of ways and activities (Boissevain 1974: 29-32; Banton 1965: 128-131).

It is only logical to assume that when people interact in a variety of roles, familarity and personal bonds tend to develop. Such was the case during both the shamanistic and missionary periods of northern health care. The shaman, as a member of the community in a largely kin-based society, was related to people in a variety of ways. The missionary may not have been a consanguineal or cultural member of native society, but he/she tended to build multi-strand ties to the community. The missionaries deliberately involved themselves with a wide range of activities in the native community. The doctoring missionary therefore interacted with his patients on a social, religious, and often economic basis as well as the purely medical. Looking back, many native groups (especially the Inuit) see the practitioner/patient relationship during the missionary period as an ideal. It is described as a time when "there was a complete relationsip with the nurses, the nuns, the priest and the people" (Kusugak 1975: 146, italics added). As we shall see, such a "complete relationship" is no longer characteristic or northern health care.

Indians and Inuit have no control over the selection and behaviour of nurses who serve them. In choosing a white agency or personnel, the procedure among the Inuit has been to

> ... avoid (that is, postpone) close relations with a white who is a newcomer to the

> settlement until he has been there long enough for them to learn what kind of person he is. As he becomes known, individual Inuit will come to know whether, and on what basis, they can interact with him. It would almost certainly be a dyadic relationship, on the basis of a dyadic mutual consensus, and not in terms of the occupational role of the white (Lange 1977: 119, italics included).

For both Inuit and Indians, personal relations and interactions are essential in the evaluation of non-natives (see Gurian 1977).

In the case of health care, personal interactions are the only logical means by which an uneducated people can evaluate medical practitioners for themselves. Nurses in the north are vaguely aware of this pattern among native Canadians, but tend to be confused about it and/or contemptuous. One nurse, for example, said that the Inuit are "juvenile" in the manner by which they evaluate nurses, as it emphasizes the personal, rather than the professional, qualities of the nurse. But how else can Inuit and Indians assess white nurses? Native people do not hire these people, so they have no information about their training or experience. Furthermore, as is discussed below, even people in the south tend to judge nurses on humanistic criteria such as friendliness and compassion, rather than technical expertise.

Native Canadians have little control over the duties or behaviour of white nurses in the north. This

can create conflict when nurses and natives disagree on the range of a nurse's job and/or the behaviour expected of her in the community. Nurses are annoyed when they are called upon to perform tasks that are not part of their work (eg. breaking up fights). Indians and Inuit, however, are often equally annoyed by the lack of community involvement on the part of many nurses. Several issues such as birth control or wife-beating can also generate conflict. Native peoples may see a nurse's involvement in such issues as unwanted meddling, whereas the nurse sees it as part of her public health work.

In the past, native Canadians had no control over the quality of their health care. Cases of incompetence are not unknown (eg. "Overwork, isolation blamed for negligence of doctor", Winnipeg Free Press 1979: 11), and can create feelings of insecurity among native people. Natives are also aware that medical services can be arbitrarily withdrawn by the government. Staff shortages can sometimes result in the understaffing or even closure of nursing stations. Small hospitals like Lynn Lake sometimes lack the personnel, though not the facilities, for some surgical procedures.

The Nurses' Perspective -- Hospital Nurses

> "Up here you really get attached to them 'cause they're the majority of the patients. A while ago we had an old Indian patient pass away, and boy, everyone got real upset." -- Nurse, northern Manitoba

> "In some respects they can't demand unless you have an interpreter in there because you can't understand them. But I think even if we could understand -- they could speak English -- they still wouldn't be as demanding a race." -- Nurse, northern Manitoba

> "They don't keep as good care [of their homes] as a white person does. I'm not saying that every white person does. [But the Indians], they wreck things. It makes me mad because they are beautiful homes and you walk in there and find holes in the walls and in the floor, and this [i.e. housing] is given to them free." -- Nurse, northern Manitoba

Nursing in the hospitals of northern Canada combines many of the advantages and disadvantages of working in a small institution, as well as being involved in a cross-cultural situation. Many of the dissatisfactions and problems faced by these nurses are typical of hospital nursing anywhere, whereas others are unique to the north. A nurse's relations with her patients, the doctors at the hospital, and her fellow nurses are crucial factors determining the satisfaction she will find in the north.

(1) Nurse/patient relations

As in the south, nurse/patient relations in the north are influenced by the continuing controversy over the professionalism of nursing. During the early days of nursing, its appeal largely lay in the fact that it "did not involve vulgar competition with men, no one could accuse nurses of being inspired by base pecuniary motives and above all it was worthy" (Baly 1973: 129). Until the last decade, this romantic image of the compassionate nurse has dominated in both the public mind and the medical hierarchy (Foster and Anderson 1978: 193, Leininger 1970). Contemporary nurses are apt to view this image as an antiquated stereotype based upon a sexist attitude towards women and "women's work" (Godfrey 1978: 15). A "drive towards professionalism" has characterized the recent trend in nursing (Flaskerud et al 1979; Ray 1978; Bloom 1965: 91-92, 171-172). Unfortunately, "the higher nurses climb up the ladder of success in a nursing department, the more they distance themselves from the patient" (Flaskerud et al 1979: 164). Conflict has developed between the ideals traditionally held about nursing (the nurturing role) and the professional goals presently sought by many nurses. Kramer (1974) calls this conflict "reality shock" and claims that it is most evident and painful among recent graduates. For many nurses, this conflict is never really solved, and is often avoided by distancing oneself from

patients and direct patient care. Furthermore, it is not uncommon for nurses who become excessively involved with their patients to experience "burnout", a form of professional and emotional disillusionment and exhaustion (Shubin 1978). Nursing as a career has a high "drop-out" rate, and burnout is a significant factor in this problem. (For a personalized account of these predicaments see Anderson 1979).

In a purely professional sense, many nurses enjoy small northern hospitals because the nursing staff is given greater responsibility than is the norm in the south. Nurses handle all types of patients and often assist the doctor by screening night calls, etc. As the amount of authority a job contains has been positively correlated with job satisfaction (Godfrey 1978a: 26), it is not surprising that many nurses find this a desirable aspect of working in the north.

Small northern hospitals also involve several professional disadvantages. Work can become routine and boring, in that more complex cases are almost always evacuated to Winnipeg and inservice seminars and courses are limited. Furthermore, as the hierarchy is small in these institutions, the potential for career advancement is restricted. Many nurses feel that they must leave the north if they are to progress professionally.

Despite these problems, northern nursing is preferred by some nurses over nursing in large urban hospi-

tals in the south. Because of the low nurse/patient ratio, it is felt that greater responsibility can be combined with the traditional bedside functions of direct nursing care. Indeed, nurse/patient relations often seem to be relatively informal in the north, aided in part by the lack of continual supervision by a bureaucratic hierarchy.

Nurses state that they enjoy direct nursing care and become very attached to their native patients. A certain amount of discrepancy, however, can be observed between these stated values and actual behaviour on the wards. Most of the nurses mean well and would like to be helpful, but may not appreciate how confusing, frightening or lonely the hospital can be for a native patient. Even Euro-Canadians or Euro-Americans who enter hospitals suffer from feelings of culture shock, depersonalization, loss of self-identity and loss of control over their bodily and physical environments (Foster and Anderson 1978: 170; Cassell 1979; Szasz 1977: 18-20; Brink and Saunders 1976). These problems are severe for a native patient who cannot speak the language and who is not used to a strict scheduling of time and activities (Fines 1979; Wauneka 1976; Jones 1975; etc.). Unfortunately, many white nurses have difficulty reading the subtle body language and communication cues given by their native patients (Fire and Baker 1976; also cf. Braroe 1975: 92; Basso 1972). As many native people withdraw and become very passive when

placed in the intimidating atmosphere of the hospital, communication between patients and practitioners becomes very poor. As a result, even simple situations can act as sources of conflict.

Many of the nurses at Churchill state that their work in the north has increased their tolerance of native Canadians. Though not doubting the sincerity of their words, it must be remembered that these nurses are working primarily with Inuit evacuated from the Keewatin. Two factors may encourage this attitude: (1) specific norms of Inuit culture, and (2) the one-dimensional nature of the nurse/patient relationship. Inuit culture has traditionally encouraged people to act in a friendly, co-operative manner, to suppress expressions of anger and avoid emotional "scenes" (Briggs 1970). Until recently, Inuit have been reluctant to criticize white authority figures for fear that the services supplied by these people would be arbitrarily withdrawn (Brody 1975: 156). It would appear that these traits have been sustained, and Inuit patients are charcterized as being passive, stoic and co-operative. Although the Inuit are not similar to the nurses in lifestyle, values, etc., they appear to be "good" patients since their passivity is taken to mean total confidence in the health care worker (Olesen 1973: 72; Cassels 1979: 50-51).

At times this reluctance to criticize or even ask questions has worked to the detriment of the Inuit. For

example, many of the nurses believe that the Inuit have a high pain tolerance since they seldom ask for pain killers or give overt signs of suffering. This evaluation may have less to do with the objective experience of pain than with the norms of emotional control held by Inuit and how Euro-Canadian nurses interpret the behaviour dictated by these norms (Briggs 1975: 95; also cf. Davitz et al 1976). Nurses do not appear to see the contradiction in the fact that, although Inuit patients seldom ask for painkillers, they will usually accept such medication with relief and/or gratitude. Throughout the north, the "stoicism" of both Indian and Inuit patients is admired by white nurses. One wonders if this stoicism is admired for its own sake, or because it makes the job of caring for these people easier for the nurses. It should be noted that the younger generation of natives who are better educated and speak more English are both more demanding of their rights and more liable to question hospital procedures and personnel. People of this generation are often considered by nurses as less desirable patients than the more passive older generation. (Whites are considered the most difficult kind of people to nurse, since they are the most demanding, time-consuming and the most apt to question the health care workers.)

The second point raised above refers to the fact that the nurse/patient relationship is essentially one-dimensional and limited to the hospital setting. Points

of conflict are minimized in the hospital, in that nurses are not exposed to the full range of native culture and behaviour. In the hospital, nurses largely control the behaviour and setting of both patients and visitors; Inuit and Indians here act as patients first and as a members of a native culture only second. Nurses in Churchill see very little of the lives of Inuit who are brought in from the Keewatin. They do not have to deal with the totality of Inuit life, but just those few parts which are exhibited within the controlled environment of the hospital. In contrast, they can quickly become disillusioned with local Indians who they see around town at both their worst (usually meaning drunk) as well as their best. This problem is particularly evident in Lynn Lake, which acts as the watering hole for the immediate community and a number of surrounding settlements. Daily experience is apt to have a profound affect upon actual behaviour, often in contradiction to a nurse's stated norms.

Effective communication between white nurses and native patients is made difficult, if not impossible, by a variety of linguistic, cultural and socioeconomic barriers. It can be expected that "professionals in public health and private practice are not immune to the common tendency to place people in categories and label them accordingly, especially when they differ from the social, educational or ethnic group of the professional

worker" (Bergner and Yerby 1977: 37). Furthermore, "perceptual differences of socio-economic status between clients and providers tend to get magnified when cultural differences are added to the obscure overall health communication picture" (Quesada 1976: 326). Whether a nurse will attempt to overcome these barriers may depend in part upon her own cultural background and personality variables such as "ego defensiveness or open-closed mindedness" (Bonaparte 1979). Attempting to overcome socio-cultural barriers and achieve meaningful cross-cultural communication can be vital in providing satisfactory health care. As Leininger writes:

> Cultural differences between nurses and clients can markedly influence the interactional patterns and the quality of care rendered. If nurses are not aware of their cultural patterns of behaviour, language, and action, they may not be able to recognize and understand what occurs between them and clients (1977: 14-15).

In the field of health services, interpersonal skills are equally important as technical expertise.

The following example from my fieldnotes illustrates how faulty communication can lead to bad feelings on the part of both the professionals and the patients (in this case, the patient's family). The incident involved a two-year-old Indian girl (called here Marie) who was back at the hospital for a second time. The doctors were unable to diagnose her problem and her family was understandably upset.

Marie is back and her family is with her.

> Sue [the nurse] is particularly upset, as she feels they're [Marie's family] giving her a rough time about Marie's treatment. ... Sue feels they are criticizing the hospital and herself as a nurse. They [the family] complained that the children were ignored by the nurses and Sue was incensed when the mother claimed that it was the cornstarch [which the hospital uses] that gave Marie diaper rash. At one point ... [Marie's teenage brother] came out and stood looking at the x-rays of Marie. He then turned and walked back to her room without saying anything to the nurses. I thought it was funny but Sue was annoyed. She thought it was "typical" and "arrogant" -- "As if he could understand it." The mother had apparently asked for a coffee and later it was spilled. The boy came out, got directions as to where to get a mop, and asked if she could have another. Sue snapped out "no" so fast (and so openly rude) that I was ... shocked. Later, when I was alone at the desk he came back and asked if there was a coffee machine, but of course there wasn't. In a way I could see Sue's annoyance a bit -- having three adults constantly asking for things (paper cups, coffee, etc.) is a nuisance. Furthermore, their constant fussing over Marie kept her up and ... probably made her harder to handle when they left. On the other hand, they must be frustrated -- no-one has been able to figure out what's wrong with her and she has been kept away from home for a long time.

A few words of caution must be made lest we exaggerate this incident out of proportion. First, such situations are not limited to the north or to white/native interactions, but arise whenever health professionals feel their specialized territory is being encroached upon by an overprotective family. Second, the nurse involved was atypical in her overt dislike of native people. Whereas most nurses believe in "working around" or "talking

around" a drunk native patient or visitor, this nurse was apt to call the police for assistance.

This incident does act to highlight at least three areas of conflict which one can observe in nurse/native interactions in northern hospitals. Briefly, they are: (1) the role of the family of a native patient; (2) the treatment of native children; and (3) differential interpretations of "failures" in western diagnosis and/or treatment. Sue's main problem was that she did not understand or appreciate the traditional role of the family of a native patient in his/her care and treatment (see Read 1966: 8,21; Leininger 1978; Primeaux 1977: 64). A family of any culture would probably be reluctant to leave a sick child in a strange community, among strangers who speak another language and belong to another culture. As far as Sue was concerned, Marie's family was being difficult and critical of her professional abilities. To Marie's family, however, this participation was only a natural and necessary interest in their daughter's care.

This problem is compounded by the fact that many native people feel that children are not treated properly by white nurses. Native people tend to be "particularly careful with their children because they cherish their little ones" (Old 1979: 17), and will watch the treatment of their children at the hands of white medical personnel very closely. It is upsetting for them to see children alone, crying in their cribs or playpens, while

the nurse sits at her desk, absorbed in paper work and apparently unconcerned about the child's distress. To the nurses, this is necessary behaviour and something they actually learn to do. Although their first instinct may be to pick up a crying child, unless there is something physically wrong the nurses are reluctant to do so. This behaviour is rationalized as a response to staffing shortages, and/or the unwillingness to "spoil" a child or "encouraging" it to demand attention. Erroneous stereotypes (eg. "nurses are heartless" or "native people spoil their children") are generated as neither side is liable to discuss this situation with the other.

This type of poor communication also marks the third area of conflict -- differential interpretations of "failures" of western medicine. In the past, as in the present, native Canadians were taught that western medicine is far superior to their own health care systems (see von Schaik 1979: 10; Copeland and Myles 1960). It may be very difficult for natives to understand shortcomings in this "superior" system. It must be remembered that many of these people are literally trapped in a strange community and institution until they can be cured and/or treated. For example, the child Marie came from a remote community which lacked resident health care facilities. As that community's contacts with the outside world is limited to short-wave radio and planes (both of which are dependent upon the weather), Marie's family

could not risk taking her home until her condition was diagnosed and treated. Sue should have realized that if Marie's family appeared critical of the hospital and the staff, it was an attitude motivated by fear as well as frustration. Nurses and doctors may realize the difficulties involved in making an accurate diagnosis, but it should not be expected that the lay community will be able to understand this situation without careful explanations. In the above example, Marie's brother looked at the x-rays (perhaps trying to make sense out of an inexplicable and frustrating situation), but did not feel free to ask the nurses to explain it. Significantly, the nurses involved did not speak to the brother at that time or volunteer any information or explanations. Too many things are left unsaid on both sides.

As shown in the last chapter, native Canadians often assume that white nurses are uncaring and/or prejudiced. In my experience, only a very small minority of nurses act in a manner consistent with such attitudes. Rather, it is faulty cross-cultural communication which makes nurses appear this way to their native patients. As a recent study has shown, most patients do not have the technical knowledge upon which to evaluate a nurse on her medical expertise. Patients judge their nurse on humanistic criteria such as degree of friendliness, helpfulness, kindness, etc. (Doll 1979). Interpersonal skills

conforming to the traditional stereotype of the compassionate nurse, rather than technical knowledge, are what people still look for in a nurse. The northern nurse has a doubly difficult task, for she must achieve interpersonal compentence in a cross-cultural situation. Unless she can achieve meaningful cross-cultural communication, her behaviour will continue to be misunderstood by native patients, just as she will misinterpret their behaviour and needs.

(2) Nurse/doctor relations

Nurse/doctor relations are another part of nursing which has undergone considerable change in recent years. In the past, the nurse/doctor relationship was characterized by an unequal distribution of power, with the doctor holding the dominant position (Phillips 1979: 738-739; Bloom 1965: 91-92; Foster and Anderson: 194-195). Even though this situation is now changing, Godfrey found that "curiously, even though 76% of our sample find their professional relationship with doctors to be satisfactory, only about half (53%) reported that the doctors they work with have a lot, or quite a lot, of respect for the nurses' professional ability" (1978: 20). This lack of respect is often the source of stress in nurse/doctor relations.

The intimacy of small northern hospitals would appear to ease some of the tensions typical of nurse/doctor relations. These relations appear to be less formal

than is often the norm in the south, and many nurses feel that the lines of communication between themselves and the doctors are very open. Doctors may offer to show nurses how to start an intravenous, put in sutures, or some other task outside of the regular duties of a ward nurse. This willingness to share experience and training was most evident at the Churchill Health Centre, where the doctors are young and familiar with informal nurse/doctor relations.

Doctors in northern hospitals may view nurses with greater respect than is the norm in the south because they are forced to give greater responsibility and authority to the nursing staff (see von Schaik 1979: 9). As the number of doctors is limited (three in Churchill and two in Lynn Lake), it is considered advantageous for the night shift to screen night calls, handle minor emergencies, etc. Furthermore, northern doctors routinely work with outpost nurses and appreciate the heavy burdens these nurses handle all the time.

Inevitably, nurse/doctor relations are not perfect in the north, and individual variation does occur. It is safe to say, however, that the personalistic relations and greater authority enjoyed by nurses in small, northern hospitals can contribute to better relations with most doctors. Nurse/doctor relations therefore tend to be mutually supportive and relatively free of stress.

(3) Inter-nurse relations

Respect and trust between nurses is essential to the morale of individual nurses and the preventation of factionalism within a nursing staff (Godfrey 1978: 18; Phillips 1979: 741). Nurses can form support networks to aid one another professionally, socially and psychologically if inter-nurse relations are positive in nature.

Due to differences in age and marital status, the networks between nurses varies greatly between the staff of Churchill and that of Lynn Lake. The majority of the nurses at Churchill are young, single, and are in the north without their families. Due to a lack of male companionship in town, there is a tendency for the nurses to socialize almost exclusively among themselves. Those who do make friends outside of the hospital staff tend to do so deliberately, and it is difficult to find people of similar tastes, education, etc., in the wider community.

The main disadvantage of this pattern of socializing is that it tends to create a rather closed world, one in which personal and professional aspects of life overlap to a larger degree than one would expect in the south. This pattern also exhibits several advantages for the nurses, however. The close-knit staff tend to form a kind of surrogate family for one another, so that newcomers do not feel socially and psychologically abandoned in a new community. These personalistic, multistrand relationships can be very useful in helping new nurses, particularly those recently

graduated from school, to adjust to work in a strange institution. Despite the greater responsibility given to nurses in the north, very few of the nurses in Churchill (a significant number of whom are recent graduates) report experiencing Kramer's (1974) "reality shock." Nurses seem capable of making the adjustment from school to work with relative ease. It is the isolation of the community, rather than the strain of the job, that tends to be responsible for the high turnover rate among nurses in Churchill.

The pattern of socializing observed among the nurses of Lynn Lake is very different from that of Churchill. Almost all of the nurses in Lynn Lake are married and have been in the community for several years. Many of them came to Lynn Lake because their husbands moved the family unit here in response to their employment needs, not because of the nurses' desire to work at this particular hospital. Unlike the Churchill Health Centre, Lynn Lake Hospital has been able to hire nurses on a part-time or casual basis, as there is a pool of qualified nurses already living in the community. As will be explained in greater detail in a later chapter, the nurses at Lynn Lake tend to have wider social networks than those at Churchill. These nurses do not socialize exclusively, or even primarily, with one another. Nurses form relationships through and with their husbands as well as through their work. Inter-nurse relations in Lynn Lake are warm and supportive, but generally less intense than those

typical of the nursing staff at Churchill.

This chapter has attempted to describe three of the main sociological factors affecting hospital nursing in the north. Both nurse/doctor and inter-nurse relations tend to be positive and supportive, thus contributing to the emotional and professional well-being of most nurses. Achieving satisfactory nurse/patient relations tends to be more difficult, as nurses are often linguistically, socially and/or culturally separate from their native patients. Because of the poor cross-cultural communication between white nurses and native patients, each side operates with erroneous stereotypes of the other. Such stereotyping adversely effects nurse/patient relations, and therefore lowers the overall quality of northern health care.

The Nurses' Perspective -- Outpost Nurses

Outpost nurses are the sole source of health care in many remote reserves and settlements in northern Canada. They are expected to function in a wide variety of medically-oriented issues, ranging from family counsellor to midwife (see Sutherland and Besner 1975; Percy 1967; Keith 1971, 1971a; Ferrari 1976). Within limits, outpost nurses possess a mandate to act independently and with little supervision. Though they do not see themselves as doctors, they must be adept at a number of diagnostic and clinical skills outside of the usual duties of their profession. It is obvious that "this is not the kind of job for an inexperienced girl with a couple of years' classroom training" (Brigstocke 1975: 604). Both emotional and professional maturity are necessary in order to become a good outpost nurse.

Most outpost nurses seem excited about the scope of their professional duties in the north. It is the challenge of this work, they say, that brings them to the north and which keeps them there. Most of the nurses I spoke with either have specialized training (eg. midwifery) or have traveled extensively. These women are not satisfied with the routine and limited responsibility of hospital nursing, and deliberately chose outpost nursing because

of the professional challenge it represents. At times, especially during a nurse's initial days at a new post, the intensive and demanding nature of this job can be unnerving. For many nurses, however, this is precisely the challenge which they desire. Outpost nurses see themselves as a breed apart from other nurses, and are proud of the aura of independence and individualism surrounding their work. For many outpost nurses, the major dilemma they must face is not handling their work in the north, but re-adjusting to the medical hierarchy when they return to the south. Many northerners suspect that former outpost nurses either go back to school, become administrators or leave the nursing profession. After the responsibilities and independence of action typical of outpost nursing, many of them cannot adjust to the close supervision and limited responsibilities typical of ward nursing.

The majority of outpost nurses have few personal ties in the communities within which they live and work (an issue that is explored in greater detail in the following chapters). Their commitment is based on professional ties rather than personal relationships or obligations. As a result, single nurses are free to change postings whenever they wish. A high turnover rate is typical of the staffs of most nursing stations. Nurses claim that this situation is understood and accepted by the native community, but one wonders if this is so. A

constant changeover of personnel could be interpreted by the native population as a rejection of themselves as individuals and as a group. Such feelings of rejection could lie behind native complaints that "nurses don't care" and/or "nurses dislike Inuit."

Nurses are sensitive to such complaints, and defend themselves by declaring "you wouldn't come north unless you cared." They feel that their presence in the north is a visible sign of their humanitarian motives and involvement. Although they avoid saying they have made sacrifices in coming north, this would seem to be an underlying theme for some.

A distinction must be made between professional and personal involvement if we are to understand these statements. Nurses are being accurate and truthful when they say they are committed to their work and professionally involved and caring. However, this does not constitute personal involvement or commitment. Native Canadians are not incorrect when they state that nurses do not care -- nurses care deeply in a professional sense, but may exhibit little or no personal involvement.

This distinction between personal and professional involvement must be clear if we are to understand why nurses who say they care about their native patients will only stay in any specific posting or community for a short period of time. Nurses state that one or two years is the longest length of time a nurse

should stay in any one community. Frequent moves are described as necessary for one's professional and emotional health, despite the fact that a rapid changeover in staff can detrimentally effect health care services. As one nurse explains:

> You can get into too much routine and its good to move. It keeps you fresh. It gives you different opportunities because each settlement must be different, the demands of the people are different. On the other hand you need continuity for public health teaching. You get nice and comfortable when you get to know the patients and they get to know you, and it gives them a feeling of security. The isolation, again the routine, I think its good for people to come out every so often and do something else. -- Nurse, Keewatin Zone

Although this nurse is aware of the importance of continuity in public health programs, she nevertheless defends frequent moves as a necessity. It should be noted that her arguments are based solely on the professional needs and aspirations of outpost nurses. Neither the personal needs of the nurses nor their patients are mentioned.

The decision to leave a posting is a complex one, and usually motivated by several factors. For many nurses, northern postings are only a temporary stage in their professional careers. Personal and professional lives remain centered in the south, and the northern community is never considered a true "home." As is true of northern hospital nurses, outpost nurses spend considerable amounts of time and energy maintaining their ties with families and friends in the south.

In understanding this pattern of frequent moves, one should not underestimate the importance of the white northerners' fear of becoming "bushed" or "going native" as a motivating factor. These terms are defined in various ways by both folk and anthropological theories (eg. Brody 1975; Koster 1977; Lange 1977). Although they are sometimes used synonymously, these terms actually describe two different types of emotional or mental problems. According to the nurses I spoke to, a person is classified as "bushed" when they can no longer function in middle class, white society, or cope with the activity and/or scale of southern cities. When one cannot function in crowded southern stores, begins avoiding people, acting strangely, or neglecting one's appearance, it is considered symptomatic of being "bushed." Nurses explain that this can be a temporary, minor phenomenon, or can be more severe. In both cases, returning to the south (if only temporarily) is seen as the only cure.

Although northerners may not explain the phenomenon in this manner, I suspect being "bushed" is actually a state of cultural disorientation. People are considered "bushed" when they drop the nicities of white culture or lose their adeptness in dealing with white society. When "bushed", they are neither native or non-native in orientation. They exist between cultures and therefore function imperfectly in both.

"Going native" is generally considered much less

common and more serious than being "bushed". In this case, the victim is described as abandoning white mannerisms and adopting what is considered a "native" lifestyle. "Going native" can be understood as a state of voluntary acculturation, in which individual white northerners accept a cultural orientation other than Euro-Canadian society.

Being "bushed" or "going native" pose challenges to the cultural survival of white northern society as a whole and individual Euro-Canadians. Both states are characterized by withdrawal from white society, either into oneself (one of the first symptoms of being "bushed") or into native society ("going native"). Many white northerners speak as though it is crucial to treat these problems as soon as possible. It is not unknown for supervisors (including those in the administration of Medical Services) to instruct their employees to take vacations and/or leave remote settlements because they are "becoming bushed" and "need to get out for awhile."

Nurses are very aware of these problems and are anxious to avoid them. Frequent moves are seen as one means of "keeping fresh" and preventing both states. Outpost nurses not only change postings within the north, but frequently return to the south for vacations and specialized training. Some nurses periodically ask family members or friends in the south if their behaviour or attitudes appear "normal". Whether they remain in, or

return to, the north depends upon the answer they receive.

Closely related to this problem is the issue of "burnout" among outpost nurses. As described by Shubin (1978), "burnout" develops when excessive involvement in one's professional duties leads to physical and mental exhaustion. Unless halted, these feelings of fatigue harden into "negative, cynical and dehumanized attitudes" about their patients, co-workers and themselves (Shubin 1978: 25). Nurses who progress to this point and beyond are doing themselves, their co-workers and the community in which they work a disservice if they remain. In such cases, leaving is probably a legitimate and necessary strategy by which nurses can treat this problem and "keep fresh."

Few of the nurses I spoke to would admit to having experienced "burnout", but almost all recognize the fact that it could occur and/or had developed in others. Although they may not be willing to admit to entertaining "negative, cynical and dehumanized attitudes," I suspect "burnout" is a major problem for many outpost nurses. As we have seen, outpost nurses are primarily committed to their work and therefore can become over-zealous with respect to their professional responsibilities. Because they have few personal ties in northern communities, their work can dominate their lives. It is difficult for outpost nurses to escape their professional role, as they live surrounded by their work in what Goffman

(1961) calls a "total institution" (an issue that is explored further in later chapters). The isolation characteristic of outpost nursing is often social as well as geographical. Under these conditions, "burn-out" is probably common, and a high turnover rate among nurses inevitable.

As outpost nurses have few personal ties in these remote communities, positive nurse/doctor and inter-nurse relations are crucial in providing them with both professional and emotional support. Inter-nurse relations are particularly important as

> There's a lot of strain in the fact that in a lot of areas you're still living in the station. Even if its a one-nurse station, you're still living on top of your work. If its more than one nurse, than you're living on top of people that you're working with all day. -- Nurse, Keewatin Zone

Communal living arrangements attached to the clinic have been the norm in the north (although this is now changing in some regions). This system originated in the days when all outpost nurses were required to be single and assumed to be chaste. The popular stereotype of outpost nurses is that they must be independent individuals capable of withstanding isolation and loneliness (eg. Percy 1967). In reality, a more relevant trait for most outpost nurses is the ability to tolerate little privacy. Because of this, positive inter-nurse relations in both the professional and personal spheres are a necessity.

Support from doctors and Medical Services supervisors and administrators can be important in maintaining the morale of many outpost nurses. Nurses report that they seldom receive overt signs of gratitude from their native patients (in part, a result of traditional native norms of communication). In the majority of cases, nurses must generate their own sense of gratification from a job well done. However, even the most self-sufficient individuals occasionally need external sources of support and encouragement. Periodic visits by doctors and zone supervisors can be crucial for the mental and emotional health of outpost nurses, as they provide the forum for messages of support. Even if nothing "concrete" is accomplished (eg. a cure for a chronic patient, the furnace fixed, the radio replaced), the presence of an outsider is in itself a reaffirmation of someone's continued interest in, and support of, the nurses.

Medical Services Branch can be an invaluable source of support for outpost nurses. At the same time, Medical Services can also be the focus of bitter criticism by these women. The majority of nurses I spoke to seemed disappointed with the administrative system, some vehemently so. Nurses realize that specific individuals may mean well, but have their hands tied by bureaucratic red tape. Nevertheless, the system is severely criticized when nurses feel that there have been shortcomings in the performance of their employer. Nurses are particularly upset when they feel that the standards of their living

conditions are being threatened, or information is being withheld from them. Strong feelings are also generated by the issue of the present salary levels, as most outpost nurses feel they are not receiving adequate compensation for the services they give.

Nurses feel strongly that budget restraints and cutbacks should not affect either their working or living conditions. They argue that these two areas of life are so closely interwoven in most nursing stations that Medical Services are responsible for the quality of both. Cutbacks or attempts to economize on either are bitterly resented. Such resentment is rationalized on the grounds that anything affecting the individual outpost nurse will influence the quality of northern health care. For example, it is argued that decreasing the household budgets will detrimentally effect health care services, in that many nurses may leave the organization, while those who remain will be dissatisfied.

Many nurses are also disturbed when they feel that Medical Services has withheld information relevant to their work or personal safety. Assaults, rapes, and other acts of violence are often the focus for such complaints, as nurses seldom receive official notice of such occurrences. Nurses feel that they should know about these incidents so they can take steps to protect themselves. In defense, administrators argue that the decision as to whether charges are pressed and the incident publicized rests with the nurses involved, not with them-

selves. Nevertheless, vague rumours about such incidents travel through the northern grapevine, generating a sense of insecurity in the minds of many nurses.

Nurses charge that not only is Medical Services reluctant to divulge such information, but it is also slow to respond to messages supplied by the nurses. As is typical of any government service, endless paperwork is the norm. Getting even simple things such as a new door knob can take a long time. Nurses are constantly barraged with questionnaires, reports, and even visiting anthropologists, yet seldom see any results from these studies. Many nurses feel that, although solicited in good faith, their opinions disappear into the bureaucratic process and will never be implemented. As a result, they feel powerless to influence the system determining the quality of their work and the nature of their living conditions.

The greatest amount of controversy and discontent among outpost nurses is usually generated by the issue of salary levels. Many nurses are not satisfied with the present levels, even including isolation pay and overtime. They feel that the federal government has underpaid outpost nurses in the past and will continue to do so unless they themselves take action. Nurses point out that it took a "work-to-rule" strike in 1978 to bring salaries up to their present levels. Many feel that they could receive better renumeration

in the south (although they would not receive benefits such as food and accomodations at minimal cost). A few nurses are quite militant in their desire to organize federal nurses and press for various improvements. Such attitudes are in many respects typical of the current "drive to professionalism" presently active within the nursing profession.

Both hospital and outpost nurses are experiencing the conflicts the "drive to professionalism" can generate when carrying out their duties. In both cases, these tensions and conflicts can influence the nurse/patient relationship. Nurses who are concerned with the technical or administrative aspects of their work often abandon the personalistic elements of direct nursing care and become "emotionally distanced" from their patients (eg. Shubin 1978; Flaskerud et al 1979; Kramer 1974). Outpost nurses are faced with a large number of administrative and technical skills to master. It would not be surprising if the personalistic aspects of nursing were occasionally "lost in the shuffle."

A common complaint among native people is that nurses are not responsive to their needs. Nurses feel they are responsive within the limits of their profession, but that their responsibilities do not necessarily extend beyond these boundaries. The issue of clinic hours provides an example of this conflict. Nurses feel that

as professionals they should operate under regular nine-to-five schedules, and should only be called during their off-duty hours if it is an emergency. They argue that regular hours are necessary so (a) they will have free time, and (b) native people will learn to become more self-sufficient (i.e. by learning to handle minor problems at home until clinic hours).

Many native people appear neither to understand nor accept the concept of scheduled clinic hours. Treatment clinics are usually held in the morning, when many of the unemployed are still asleep. Furthermore, as one nurse puts it, "What they [native people] consider an emergency and what we consider an emergency are generally two different things." Nurses are annoyed when they are called during their off-duty hours for what appears to them as only minor problems. They charge that native people make no distinction between a nurse's private and professional time and assume that she is always on duty.

The antagonism generated by this issue is but one illustration of the conflicting interpretations of "nurse" held by native Canadians and white nurses. Nurses see themselves as professionals who are doing a job and are entitled to time free of these duties. Native people, on the other hand, view nurses only in terms of the function they perform. To them, health care

is not just a job, but a vocation that is a continual part of the practitioner's life. During the shamanistic and missionary periods, the medico-religious practitioner was always "on duty" and responsive to the demands of the moment. Health services run by the clock have no precedent in native culture, and it is to be expected that native people will have difficulty understanding this concept and/or complying with its rules. To the native community, the reluctance to respond to after-hour calls is indicative of a "poor" nurse, one who is not dedicated to her work or the people she serves. A nurse's attempts to establish "professional" prerogatives (in this example, regular hours) can be misinterpreted by native people as lack of concern.

Native criticism of health care services, whether it be overall quality or specific issues such as the hours during which it is given, is resented by most outpost nurses. Nurses feel that native people underestimate the quality of northern health care, and thereby the nurses as professionals. One nurse explains:

> I don't think any of the people in the settlement really understand and appreciate the service that they're getting. I don't think they stop and compare what the situation would be like in the city. They have a twenty-four hour service. They're referred out whenever they need a referral very quickly. They see specialists whenever they need to. They're not kept waiting very long,

> whereas in an average city they would have ... a fairly long drive to a hospital for emergency treatment. [In the city] they wouldn't be seen by their own doctor, they would have to go to the emergency department. Whereas [in the settlement] there's more continuity. At least when they come into the station they know us and we have all their records and everything that's possible available. -- Nurse, Keewatin Zone

Nurses recognize the fact that northern health care is not perfect (although I find it difficult to understand how Indians and Inuit are supposed to compare these services with those in areas in which most of them have never lived). They admit that even with good interpreters, information can be "distorted or some vital part can be missed." Communication and transportation difficulties can delay medical evacuations, supplies, etc. (see Wiebe n.d.: 3-8; also Henderson 1976). Moreover outpost nurses are still nurses rather than doctors, so that their education still imposes certain boundaries and limitations.

Nevertheless, most outpost nurses continue to defend the quality of northern health care. They are angry when they feel the lay community is criticizing matters of which **it has no knowledge or understanding.** Interestingly, these arguments are aired only in private. Most nurses feel constrained not to speak out on these matters in public, despite the fact that health services are often publicly discussed and criticized at hamlet

or band councils. They believe they should not become embroiled in political issues, and avoid making the latent political content of medicine an overt issue (cf Dreitzel 1978; Weaver 1972). Nurses avoid political controversy as they do not wish to polarize the community or alienate themselves from any part of their patient population. The majority of nurses see their role in society as apolitical, a viewpoint characteristic of the historically non-political nature of their profession. As nursing becomes more professionalized and politicized, these attitudes may change. In the future, outpost nurses may take a more active role in northern politics.

Social Interaction in the North

One of the most obvious features of northern communities is the lack of social interaction between native and non-native people. As a rule, white people socialize among themselves. Natives who are included in white social affairs are usually atypical in that they work at a job closely identified with white society and norms (eg. special police constable, teaching assistant). For example, after a boating trip with the resident police officer and two Inuit men, the nurses and myself were invited to the officer's house for supper. The two Inuit, who had given the officer the char he barbaecued that night, were not included. This is not to say that the process of social segregation is a one-sided affair, totally the fault of the whites. Native people are equally reluctant to invite white people to their homes or include them in their personal lives. Many of the nurses complain that even after several months or years in a community, they are never encouraged to participate in most native social activities.

Even when natives and non-natives do meet in a purely social situation, interactions tend to be

strained and uncomfortable. In the same community as above, a dinner party was held at the nursing station to say good-bye to one of the nurses. What made this party unique was the fact that Inuit were also invited. Significantly, natives and non-natives had great difficulty in making "small talk" after the meal. People literally did not know what to talk about, and inter-ethnic conversation died slowly and very painfully. Only the presence of a small baby saved the public facades of the participants, as attention could be diverted to the child and the communication problem between the adults ignored or evaded.

Northern settlements are clearly divided into two main groups -- native and non-native (or "white"). As noted by Barth, "the ethnic boundary canalizes social life," in that it largely determines the organization of behaviour and social relations (1969: 15). He argues that:

> ... ethnic distinctions do not depend on an absence of social interaction and acceptance, but are quite to the contrary often the very foundations on which embracing social systems are built. Integration in such a social system does not lead to its liquidation through change and acculturation; cultural differences can persist despite inter-ethnic contact and interdependence (1969: 10).

Ethnic boundaries depend upon social processes of exclusion (from others) and incorporation (within the group), but this does not preclude contact between the groups

involved. Either complementary or symmetrical schismogenesis can act to differentiate between two groups that are in frequent interaction (Bateson 1958: 175-187).

The categories "native" and "non-native" contain internal subdivisions (eg. Swampy and Rocky Cree; Italian and French-Canadians), but inter-racial relations seldom recognize these finer distinctions. To an Inuk or Indian, all non-natives are considered "white" since they live in a "white" manner (eg. black or East Indian nurses are described as "white"). In a similar manner, to a white, the important fact in inter-racial interactions is that the other person is "native" (see Stymeist 1975: 73). Even the obvious and basic distinction between Inuit and Indian becomes minor in contrast to the difference between "white" and "native".

Natives and non-natives interact frequently, but seldom in the form of informal socializing. Publicly (i.e. on the job, in the stores, at community-wide activities), natives and whites are in frequent interaction. Privately, however, inter-ethnic interaction is infrequent and, if it does occur, strained and disconcerting for the participants. The private realm may be defined here as concerned with one's personal, as opposed to public or professional, life (eg. friends, family, home).

The notion of ethnicity in northern communities has been well documented by anthropologists (Dunning 1959;

Fried 1963; Brody 1975; Chance and Trudeau 1963; Paine 1977; Vallee 1962; Smith 1971, 1975; Parsons 1970; Lange 1977; etc.). According to Honigmann and Honigmann (1965), the separation between white and native peoples is tolerable, and even beneficial, in that whites are acting as role models and tutors to the native population. Although this concept has been attacked by other anthropologists (eg. Paine 1977), it remains a popular folk theory among white northerners. White northerners as a group see themselves as the administrators, tutors, and managers of the native community, an attitude that is often reinforced by their actual work in the north (eg. teachers, policemen). Whereas both the native and non-native communities contain internal cliques and ranking (see Smith 1975; Riches 1977), inter-ethnic interactions emphasize the solidarity of each group in face of its opposite. Northern settlements consist of two "interlocking social systems" (Vallee 1962: 98), rather than a heterogeneous whole.

Major factors in this process of social segregation are the norms governing the behaviour of the white community or "enclave" (Paine 1977). The white enclave is a self-perpetuating social entity which actively works at maintaining its boundaries despite a high turnover of personnel.

As described by Brody (1975, 1977), Vallee

(1962), Riches (1977), Parsons (1980), and Smith (1975), upon arrival in the north whites undergo a sequence of orientation and indoctrination which molds their subsequent attitude towards the native population and their commitment to the white enclave. Newcomers often arrive with enthusiastic service ideals, including a desire to "get to know" the local population, perhaps even learn the Indian or Inuit language. His/her first contacts, however, are with the white population, who will help the newcomer settle in and orient him/her to the community. At this point, native people may seem friendly, but linguistic, cultural and social barriers prevent any real contact. Moreover, the newcomer soon learns from the white community that native people are "not like us." The newcomer also discovers that his living conditions have little in common with that of the native population. Not only is white housing usually geographically separated from native housing (settlements are often divided into white and native sections) but it is usually bigger, better furnished and more comfortable than native housing. Due to government policy (Brody 1975; Smith 1971), white northerners continue to live according to southern middle-class standards. Brody feels that "the Whites of the far north are class-conscious to a remarkable degree, and the nature and minutiae of their social life are informed by that consciousness" (1975: 74).

Not only is the newcomer unlikely to find a basis for compatibility with most native people, but he/she is actively discouraged from looking for such by the white enclave.

Membership in the white enclave is offered to, if not imposed upon, almost all non-native newcomers. (The exception seems to be summer labourers, particularly if they strongly identify themselves as an ethnic group, eg. French-Canadians, and/or insist upon socializing with native people.) It is only natural that the newcomer would accept and enjoy membership in a group which shares a linguistic, social and cultural background very similar to his/her own. Membership in the white enclave also involves certain obligations. Probably the most important of these obligations is loyalty to the enclave and a commitment to group solidarity.

Although the white enclave contains internal cliques (Paine 1977; Riches 1977; Koster 1977), the enclave as a whole is anxious to appear united and harmonious to all outsiders. Brody explains:

> The whites expect solidarity. Each member of the community is expected to show goodwill and friendliness towards others. Any failure to get along with others breaches an informal social code (1975: 58).

In order to maintain group solidarity, whites are actively discouraged from interacting, or becoming friends, with

native people. To go against these norms is to risk being labelled as either "bushed" or "going native" (as discussed in the previous chapter). Both labels suggest that it is a personal problem of the individual white if he/she will not accept this social system, rather than any flaw in the system itself.

No matter what their official status, white northerners feel compelled to act as role models and socializers who will instruct a "stone-age" people in middle class Canadian ways (cf Vallee 1962: 128-130). In any interaction with a native person, whites feel they must act assured, competent and knowledgable, despite any ambiguities they might feel about their work or presence in the north. Paine has commented on

> ... the stark disjunction maintained by whites between their public and private lives or roles. Whites are either on-duty (public) or off-duty (private). When on-duty they face Inuit with problems and in these performances they are characteristically competent and confident-appearing... Off-duty, however, is a white social world in which the Inuit have no assigned place except at its edges (1977: 87).

Because native Canadians have "no assigned place" in the private world of most white northerners,

> Social contact between northern Whites and Eskimos [or Indians] is minimal or absent. There is scant basis for everyday sociability; cultural and class differences are compounded by a serious language problem. Circumscribed by the paraphernalia of material comfort and social influence, the White community

> is self-contained and remote from the lives of the real northerners (Brody 1975: 75).

Many white northerners do not know how to socialize with their native clients or neighbours in any sort of an informal manner. The facade of "role model" or "socializer" common to many does not readily accomodate informal, egalitarian native/white interactions.

Individuals engaged in public performances (in this case, "the competent white manager") often employ defensive practices to safeguard the impression they are trying to create (Goffman 1959: 14). As a result:

> ... the performance of an individual accentuates certain matters and conceals others. If we see perception as a form of contact and communion, then control over what is perceived is control over contact that is made, and the limitations and regulation of what is shown is limitation and regulation of contact. There is a relation here between informational terms and ritual ones. Failure to regulate the information acquired by the audience involves possible ritual contamination of the performer (Goffman 1959: 67).

White northerners limit their interactions with native Canadians to professional, on-duty matters. By doing so, they are helping to protect and/or maintain a public image of competence and superiority. Only other whites (who share this problem) are allowed "backstage" where the performance may be temporarily suspended (see Goffman 1959: 112-113). Although a considerable amount

of middle-class role playing is evident within the white enclave (Brody 1975: 64-67), the enclave is the sole place where whites can "let down their hair." Only within the white enclave can these people step out of their professional personae and vent their true feelings about the north, their native clients, and so on.

Alcohol can be a particularly important point of contention in the north, and often acts as a block to inter-ethnic socializing. Among themselves whites will drink and even drink heavily. However, a "good" member of the white enclave will not drink in front of native people. As one nurse explains, "I haven't mixed a lot in parties, because if there's a party there's alcohol and I don't think its fair to drink in front of people we're trying to educate in the dangers of alcohol." Although whites cannot prevent native people from drinking among themselves, they do make a point of not drinking in the presence of natives and of not permitting (or strictly limiting) native people to drink with them. As a result, native people are seldom invited to parties at which whites are drinking or planning to drink.

White northerners need their native clients, in that without native Canadians many of their jobs (eg. teachers, nurses, welfare officers) would not

exist. Simultaneously, native Canadians need the information and services supplied by these white specialists. Communication exists between the two groups, but tends to support, rather than dissolve, the ethnic boundaries. Like symbiotic plants, the two entities exist in close interdependence, yet remain distinct and discrete units onto themselves.

Communication in northern settlements

Communication is an activity vital to human beings and human society. Casmir states, "our survival depends upon interactions with others, as well as adequate interactions within our individual, internal physiological-neurological systems" (1978: 245). Communication itself involves a pragmatic, as well as a syntactic and semantic, aspect, and has been defined in numerous ways. For our discussion, it is most useful to define communication as "the process by which information, decisions and directives are transmitted among actors and the ways in which knowledge, opinions and attitudes are formed or modified by interaction" (Loomis and Epstein 1978: 347). The act of communicating can in itself modify the thoughts or behaviour of the participants.

Efficient communication necessitates at least a minimal amount of similarity between the communicators (Stewart 1978: 268-270). Similarities are most evident

in the speech community, which has been defined as "any human aggregate characterized by regular and frequent interaction by means of a shared body of verbal signs and set off from similar aggregates by significant differences in language usuage" (Gumperz 1972: 219). Regularized speech systems emerge because "they are related to a shared set of social norms" (Gumperz 1972: 220). Social consensus and norms form a base from which individual speech and an endless variety of interactions can be derived.

Communication is concerned with differences as well as similarities. It is axiomatic that "the need to communicate arises when senders and receivers do not share something which should be conveyed" (Stewart 1978: 270). The mathematical theory of communication even argues that a message must contain data new to the receiver before it can be called information (eg. Rapoport 1966: 42-43). What is important to our discussion, however, are the differences between communicators in a cross-cultural situation. Speech communities can use linguistic or dialectic differences in order to maintain their boundaries against the impingement of outsiders (Gumperz 1972: 227; Loomis and Epstein 1978: 355-356). As no society can be entirely isolated, however, inter-cultural communication is bound to occur. As in any kind of interaction, "the communication experience

itself transforms the communicators and hence also the resources for communication they will use" (Fitchen 1978: 132). Some cultures may attempt to impose their own communications system on others (Casmir 1978: 132). In most cases, though, "intercultural transactions involve a mutual activity of creating and adjusting communication behavior" (Fitchen 1978: 133). This mutual activity usually involves the creation of "an alternate realm of communication" (Casmir 1978: 250-252), or Sprachbund (Gumperz 1972: 223). This "alternate realm of communication" is described as a communications system (usually a speech system) which is a compromise between those of the two cultures in contact (eg. Melanesian Pidgin). Such an "alternate realm of communication" has not developed in the Canadian north. Although there are important differences between white and native speech systems, inter-ethnic communication is carried out in a predominately white mode.

Communication within northern settlements is reflected in, and shaped by, the division of society into two ethnic groups. It is important to realize that "cultural styles of communication essentially define topics and styles of exchange according to event-structures and roles" (Stewart 1978: 319). Furthermore, as we have already seen, the role of whites in the north tends to keep them socially isolated from the native population. However, as

Watzlawick points out, "if it is accepted that all behavior in an interaction situation has message value, i.e., is communication, it follows that no matter how one may try, one cannot not communicate" (Watzlawick et al 1967: 49, italics included). The failure to participate in cross-cultural socializing is therefore in itself a powerful statement about white and native roles in these communities. A pattern emerges whereby intra-ethnic communication tends to be intensive and personalistic, where inter-ethnic (i.e. white/native) communication is less frequent and far less personal in content and format.

Communication in the form of interpersonal interaction is more than merely the verbal exchange of information. Interpersonal interaction is primarily concerned with establishing who the participants are in a social sense and the nature of their relationship (see Goffman 1959: 1-16). Although each individual in the interaction is concerned with projecting his/her own goals and attitudes,

> ... the existence of an encounter presupposes that the participants can interrelate their performances. They must do this in several ways at once. They must be able to agree as to what the encounter is about, who is dominant, who submissive; they must agree upon the level of intimacy; and these must be co-ordinated in terms of emotionality and the patterning of actions. All these are aspects of what Goffman (1959) called the working consensus of an encounter (Argyle and Kendon 1972: 23, italics included).

As will be explained, the working consensus for intra- and inter-ethnic interactions in the north vary greatly from one another.

Native Canadians communicate most frequently with fellow ethnic members, for these are the people with whom they live and socialize. Such interactions are usually carried out in an Inuit or Indian language and follow native patterns of speech, kinetics, and so on. These interactions are usually personal in both format and content (or potentially so). Native communities are bound by a variety of kinship, social and economic ties. Relationships tend to be multistrand or multiplex, in that individuals fill several roles in the society and can interact in many ways (Boissevain 1974: 30-32; Banton 1965: 127-131; Bailey 1971: 6).

Multistrand relationships tend to be more intimate than single-strand relations, both because the actors have more opportunities or bases upon which to interact and because the relationship itself is more responsive to the personalities of the participants. As in the white enclave, interpersonal interaction among natives is not only a forum in which social identity can be expressed, but also a means by which relationships are defined and a social hierarchy shaped. People do not merely act on the information gained during an interaction, but act upon the rela-

tionship created by the interaction as well.

Native people have little need to extend personal relations beyond the ethnic group, as an entire range of family and friends probably live in the same community. Boissevain (1974) has developed a schema of six "zones of intimacy" into which relationships with Ego can be categorized. They are:

> (1) Personal Cell -- closeset relatives and a few of his/her most intimate friends. A great deal of material and emotional resources are spent by Ego on these people.
>
> (2) Intimate Zone A -- very close friends and relatives with whom Ego maintains active, intimate relationships.
>
> (3) Intimate Zone B -- friends and relatives with whom more passive relations are maintained, but nevertheless persons of emotional importance to Ego.
>
> (4) Effective Zone -- individuals which are important to Ego for pragmatic rather than emotional reasons (eg. economic and political purposes, the logistics of daily life).
>
> (5) Nominal Zone -- acquaintances which have little pragmatic or emotional value to Ego, yet are known by name.
>
> (6) Extended Zone -- vague collection of persons whom Ego recognizes by sight, yet does not know, or cannot remember, their names. (Boissevain 1974: 46-48)

Native people usually create these zones, especially the most intimate ones, within the ethnic community. Despite the fact that "whites perform for Inuit [and/or Indians] extremely personal services (in the course of which Inuit

[and/or Indians] are open to personal cross-examination)" these services are carried out "in the absence of personal relations" (Paine 1977: 85-86). Whites are seldom found in a native person's circle of intimate friends; their relationships with their native clients tend to be instrumental rather than personal.

In a parallel fashion, the white enclave interacts most frequently and most intimately among themselves. White northerners can be placed in a lonely position, as many of them do not have their families with them and lack a personal cell in the remote community. Other members of the white enclave can be very different from Ego, but this is still his most likely source of people with whom to socialize.

Inter-ethnic communication exists in northern settlements, but is of a different nature than most intra-ethnic interactions. As already explained, native/white interactions are almost always held in a professional context. Such interactions place whites in a position dominant to the natives who, of necessity, are seeking specialized information or services. Interactions tend to be stereotypical, and act to reinforce the dominance of whites in the north.

The dependency of native people upon whites, and the subordinate role they must often play in white/native

interactions, can generate tension and hostility. As Smith explains:

> ... it is as if the Native people use their dependence upon Outsiders [i.e. whites] as a weapon with which to flail the Outsiders at every available opportunity. If Outsiders do something of which Native people approve, a typical reaction is to say 'that's good, but they should have been doing this for us thirty years ago;' if Outsiders do something of which Native people do not approve the reaction is 'well, what would you expect, that's the way they always work.' In this way, any action by Outsiders can become a big stick in the hands of Native people with which to beat Outsiders; the relationship is one of dependence marked by hostility (1975: 40).

This type of hostility can make personalistic cross-cultural relations extremely difficult. Past history and previous experiences create stereotypes and prejudices that often make it impossible for the two ethnic groups to deal with each other openly.

Under these conditions, private or intimate inter-ethnic interactions become very difficult. A professional encounter provides a standardized model for white/native, professional/client relations, but no such model exists for purely social encounters. As a result,

> In these interactions, although outwardly jolly and breezy, quite a few Outsiders are somewhat ill-at-ease and adopt a certain tone of voice, speaking slowly and carefully to ensure that they are understood and attempting to use local jargon words for the state of weather and hunting

> conditions. Native people are very aware of this pose, which they call the "Santa Claus" or "Mickey Mouse" voice (Smith 1975: 37).

Whites may state that they are "fond" of native people, but their uncomfortable pose when in their actual presence gives off very different signals. The stiff, formal behaviour of many whites is interpreted by natives as disapproval, arrogance or hostility, whereas a superficial sociability can appear patronizing. Likewise, native people (who feel equally constrained in white/native interactions) are often interpreted by whites as sullen, uncommunicative or stupid. Thus, the pattern of inter-ethnic communication does not act to minimize misunderstandings between the two groups. Despite the fact that they interact continually, natives and non-natives remain socially and emotionally isolated from one another. In this case, cross-cultural communication has not resulted in mutual understanding or acceptance.

Outpost Nurses and Inter-Ethnic Relations

> "Nurses are sort of put on the spot, in the sense that they're an identity of their own up here. You're sitting on sort of a little island, work-wise especially, and it effects your social life as well."
> -- Nurse, Keewatin Zone

Outpost nurses provide an interesting example of the problems involved in inter-ethnic communication and role-playing in the north. Unlike hospital nurses (who work in northern towns), outpost nurses live and work in small settlements and reserves. Because of the small number of whites in these communities, outpost nurses are highly visible at all times. As a result, even private actions tend to take on public significance.

In theory, almost all nurses believe that involvement in the community is important for their own well-being and the success of their work. One nurse explains,

> I think all nurses get involved in the community in some way or other. You have to, you're living there. If you're not involved in the community, how can you expect people to come to you? You've got to give something as well as expecting them to come... They've got to feel

> that you're part of the community as well, and not there just as somebody who's going to lay down the law or criticize. You've got to try and become part of them. -- Nurse, Keewatin Zone

Nurses often become involved in a variety of off-duty activities. These range from public activities such as coaching teams and teaching adult education classes (which are inter-ethnic) and private forms of recreation such as playing cards or partying (which are basically restricted to whites). Many nurses believe that through these activities and their work they can make friends among the native people they are serving. Some nurses are quite blunt in stating that they wish to have nothing to do with native people beyond the requirements of their work (i.e. they do not want to socialize with them). The majority, however, say that inter-ethnic friendships are both desirable and obtainable.

The criteria used for defining "friendship" varies greatly among the nurses with which I spoke. One nurse, for example, stated that even a language barrier does not affect her ability to make "friends" among her Inuit patients. She argues that,

> I don't find it [the language barrier] a problem there, because friendship can be interpreted with sign language, just making someone welcome. It's the fact that when you go into someone's house you're greeted with a smile and you feel that they want you there. -- Nurse, Keewatin Zone

This nurse, and many others, views inter-ethnic friendships as an extension of her role in the clinic. It is questionable, however, what is meant here by "friendship." As one nurse warns about the Inuit, "They're easy to talk to in the sense that you go down and say hi and all that, its fine; but to get to know them [as] buddies, chums, its not that easy." Good intentions aside, are nurses actually making friends with native Canadians in these remote settlements?

Although most nurses mean well, I would have to conclude that inter-ethnic friendship is, as a rule, not possible or simply not feasible in these communities. It is ultimately ironic that many nurses believe themselves to be "friends" with their native patients. In these cases, they see themselves as being trusted, respected and liked, and call this "friendship." In friendship, however, trust and respect must not only be reciprocal, but the relationship should generate emotional involvement as well. As was discussed earlier, native Canadians see few indications of emotional involvement on the part of most outpost nurses.

Why is there this discrepancy between what the nurses and their native patients say about this subject? Assuming that neither side is deliberately falsifying it's interpretation, it would appear that the two sides view inter-ethnic interactions in very different

ways. For the nurses, both professional and social norms are important influences on their interpretation of white/native relations.

Confusing professional with personal acceptance is a common problem for people delivering a social service such as medical care. Whereas being welcomed into a home may be pleasant, nurses may be naively exaggerating the emotional content of the situation when they label this an example of inter-ethnic friendship. Allport explains:

> The basic motives for social service can only be charity, compassion and tolerance -- all of which are central ingredients in friendship. At the same time, we are rightly warned that these virtues may lead us into sentimentality and unwisdom. Only strict objectivity and a professional view of our roles will save us; yet professionalism may freeze the heart, lead to parataxis in our relationships and betray us into harmful excess of specialism (1960: 282).

Maintaining a balance between personalism and objectivity can be difficult in a community which limits the number of inter-ethnic interactions. Rather than abandon the ideal of personalistic health care, outpost nurses may prefer to place considerable significance on interactions which may seem to the native participants as trivial, strictly formal, or merely routine. Traditionally nurses were taught to avoid personal discussions and "maintain a professional attitude" at all times (eg. Leininger 1970: 79). This image of the

nurse is still in effect in many ways, and can severely limit their freedom to socialize or truly give of themselves.

The criticisms described earlier would suggest that native Canadians are anxious to establish personal ties with outpost nurses. Further impetus for inter-ethnic contact comes from the nurses themselves. White northerners actively seek the approval and acceptance of their native clients, in part to allay their own doubts about their role in the north (Paine 1977) or as a means of engendering prestige within the white community (Brody 1975: 76). Nurses, who deal in a social service traditionally identified with "charity, compassion and tolerance," are particularly apt to seek native approval as a public testimony to their effectiveness. The idea of inter-ethnic friendship is both professionally and personally gratifying to most white nurses, as it would reaffirm the humanistic aspects of their work.

Despite these forces in favour of inter-ethnic friendship, in reality such relationships seldom occur. As a rule:

> When whites arrive in the north, they usually have intentions of breaking down the cultural barrier between themselves and the Inuit; in practice, most find it too difficult. At best only superficial Inuit-white friendships develop (Riches 1977: 168).

Whether in Indian or Inuit communities, the nurses I met seldom visit native homes for purely social reasons or allow native people into their private living quarters. Socializing between the two groups never quite reaches the ideal about which nurses talk.

Why is there this gap between theory and practice in inter-ethnic relations? My hypothesis is that nurses are not being simply, or deliberately, hypocritical when their behaviour fails to follow their stated norms. Rather, nurses are living within a social system that makes the very behaviour they idealize (i.e. making native friends) a practical impossibility. Life in remote settlements place nurses in a series of Batesonian double binds. Their behaviour may not be entirely desirable from either their own viewpoint or that of the wider community, but is the only practical response to these double binds.

According to Bateson, the essence of the double bind is that "the individual is caught in a situation in which the other person in the relationship is expressing two orders of message and one of them denies the other" (1972: 208). The individual can neither leave the situation or avoid a response (n.b. the lack of response is in itself as communicative as any active reply). Some response to the double bind must be

made. No matter what action is taken, however, it is inevitably denounced as wrong or unsatisfactory (since at least one message is ignored or denied), and negative sanctions are imposed. The individual caught in a double bind can never "win." The best he/she can hope for is to minimize his/her losses by limiting the severity of the negative sanctions to be invoked.

This is the dilemma faced by outpost nurses. Outpost nurses receive strong messages from both their professional standards and the native community which promote the ideal of inter-ethnic contact. At the same time, they receive equally strong messages from the same sources condemning this type of behaviour. Pressures to avoid inter-ethnic contact emanate from three sources: (1) the native community, (2) the nurses themselves, and (3) the white enclave. Whether or not nurses seek out inter-ethnic contact, they are equally vulnerable to criticism. Outpost nurses are faced with two conflicting sets of norms, and since neither can be entirely satisfied, they are constantly "in the wrong."

According to native Canadians, they would like to establish more personalistic ties with their nurses. One would therefore expect to see native people engaging in behaviour which would help achieve this goal (i.e.

acting in a friendly manner to nurses). Nurses charge that in reality such behaviour is not the norm. As a rule, native Canadians do not extend a welcoming hand to new nurses or make an effort to include them in native social activities.

It is obvious that nurses themselves must accept at least partial responsibility for this situation, as any relationship involves a two-way process of acceptance and involvement. In many cases, the native community neither actively encourages or discourages intimate relations with new nurses. Rather, a community will wait passively to see what they are like before deciding whether to seek them out for more intimate involvement (cf Lange 1977: 119). Intense curiosity about new nurses need not be transformed into actively "friendly" or "welcoming" behaviour. In those communities which have experienced, or are experiencing, a rapid turnover of nurses, a "wait and see" attitude may be particularly evident. Unfortunately, many nurses interpret this passive response as being unfriendly or uncaring.

It is important to realize that, although native people may say they would like to socialize with white nurses, in reality such interactions are apt to be very uncomfortable for them. Native people may fear that nurses will judge them, their homes, diet, lifestyle,

etc., as inferior or "bad." Having a white person, who lives in a far more luxurious building, into his/her own home can be very unnerving for an Inuk or Indian. Simultaneously, the nurse will probably feel awkward and uncomfortable, As pointed out in the last chapter, few guidelines exist for informal or private inter-ethnic interactions.

White northerners not only recognize the tensions inherent in private inter-ethnic interactions, but use them as a partial justification for avoiding such situations. As one woman states:

> There's also the fact that they themselves are not very keen or not very comfortable in a white social environment. They'll work alongside you very happily. They'll welcome you into their homes once you've gained their friendship. But I think they are very much aware of the difference. I don't know if its that they don't want to lose their culture and they don't want to become part of your civilization or whether they're just aware of the difference. -- Nurse, Keewatin Zone

Since such interactions are uncomfortable for themselves, white northerners tend to assume that the native community would also prefer to avoid them. It cannot be denied that in many cases, native people involved in private inter-ethnic interactions subtly signal their desire to avoid or end the conversation. This avoidance behaviour by both ethnic communities merely reinforces the social separation between the

two groups.

Outpost nurses therefore receive two conflicting messages from the native community: (1) in the media and at hamlet or band councils they are told to socialize more with the native community, but (2) in daily interactions they receive signals that such interactions are neither comfortable nor wholly desirable. No matter how they behave, nurses are vulnerable to criticism from the native and, we shall see, the white communities.

Nurses themselves may have doubts about socializing with their native patients. One nurse describes her social life in the north by saying:

> I don't think I really wanted to be mixing with the community hand and glove, because it would have entailed doing lots of things I do not really like to do. I found a large number of the Indian community there, their enjoyment was mainly the pub. Which is absolutely distasteful to me. That's just not my cup of tea. And their morals -- not my cup of tea either. -- Nurse, Keewatin Zone

In many cases, drinking acts as a barrier to inter-ethnic socializing. Most nurses are not only reluctant to drink in front of native Canadians (which would be considered "setting a poor example"), but are scared of intoxicated natives. In some cases this fear is well founded. During community binges, widespread violence can occur, and nurses are not immune to assault.

Nurses tend to avoid intimate inter-ethnic relations both out of fear and because they wish to maintain their professional image. It is not uncommon for nurses to state sentiments such as:

> I was friendly with the native people but not buddy-buddy chums. This is a difficult thing when you're working with people and you're being their nurse. Some people you can be a nurse and a friend. Other times its very difficult. I was weighed down with confidentialities and you were just the one burdening them. You couldn't get it out of your system at all -- that was the problem." -- Nurse, Keewatin Zone.

The main forum for information (and an important form of entertainment) in these small communities is gossiping. Nurses, who possess confidential information about almost everyone in the community, cannot divulge any of this knowledge without violating their professional standards.

Unable to understand native culture, afraid of native drinking, and apprehensive of disclosing confidential information, many nurses find it convenient to remain within the familar confines of the nursing station. Unfortunately, this action reinforces their dependency on the "total institution" of the station.

In the north, outpost nurses usually live in accomodations provided by the government which are directly attached to, or part of, the nursing station. This communal-type housing fulfills Goffman's criteria

of a "total institution:"

> A basic social arrangement in modern society is that the individual tends to sleep, play, and work in different places, with different co-participants, under different authorities, and without an over-all rational plan. The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life. First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution (1961: 5-6, italics added).

Although nursing stations do not consist of large groups of people, in every other aspect they conform to Goffman's description of a total institution. Nurses live, work, and predominantly play, at the station, usually in the company of other nurses. The elements of daily routine (treatment clinics, paper work, public health programs, etc.) are largely determined by their employer, Medical Services. (It is interesting to note that all the stations I visited maintained very similar schedules, with treatment clinics in the morning and public health

programs in the afternoon.) All of these activities are designed to fulfill the aims of Medical Services in the north, and any nurse can be added or taken away without disrupting the overall schema.

In the past, communal housing at the nursing station was probably seen by the government as a convenient and economical ways of accomodating "the girls." (Male nurses also work in the north, although there were none in the regions in which I conducted fieldwork.) Until recently, federally-employed outpost nurses were required to be single and childless. Even today, there is a strong feeling in some regions that "you can't even keep a dog, letalone a kid and a lover." Communal housing is not only a convenience for the government (eg. it made it possible to provide around the clock care at minimal cost) but is often a comfortable refuge for newcomers who have no family or ties in the community. By living together, nurses can create an "instant family" capable of extending emotional support to one another. At times, however, nurses resent the lack of privacy involved in this type of accomodations. It is the dilemma of the outpost nurse to create a private life while working at a public job and living in an essentially public building.

One of the most significant aspects about

these communal accomodations is that they are attached to the clinics where the nurses work. Establishing a "backstage" (Goffman 1959) and a private life can be very difficult when work and leisure are combined in the same building. Much of the nurses' alleged "unfriendly" behaviour can be seen as part of a continuing effort to establish a backstage despite their public status and accomodations. Unnecessary after-hour calls, for example, are resisted by nurses because they interject professional duties into what they consider their personal time. Some nurses will not discuss any sort of medical matter during their off-duty hours, behaviour that is probably incomprehensible to native people.

Nurses often complain that the native community treats them as part of the nursing station, something that comes with the furniture and belongs only in the station. Indeed, nurses are often criticized if they leave the station for even short periods of time (eg. to hold clinics in satellite communities, a couple of hours recreation). Native people tend to see, and treat, the nurses only in terms of their professional role in the community. By withdrawing to the station, however, nurses are only reinforcing this attitude about which they complain.

As part of their efforts to establish a "backstage," nurses try to regulate who is allowed into their private quarters. As we saw in the previous chapter, white northerners are reluctant to permit native Canadians to join social activities in which the public facades of whites are relaxed and/or dropped. In other words, white northerners do not allow native people backstage of their public performances. In the case of outpost nurses, this process is physically expressed by the absence of native people in the private living quarters of the nursing stations. Sometimes children are allowed in, basically because they themselves take the initiative and invite themselves, and because their age alone gives them liberties not enjoyed by adults. Adult natives are almost never casually allowed into the private quarters. Although the clinic area may be only a few feet away, nurses have created an invisible but effective barrier between their public and private worlds.

Keeping native people out of their private quarters not only gives nurses a feeling of security and privacy, but, they claim, avoids censorious gossip from both the native and white communities. Many northern nurses seem convinced that native Canadians expect high standards of behaviour from their nurses. Private behaviour, they argue, is directly related to one's professional reputation. The doctoring nun

wore a habit as an unambiguous signal of her nonsexual and nonthreatening role. Nurses, on the other hand, do not possess this type of visible sign of their intentions, and must state (and sometimes overstate) their (professional) asexual role by carefully regulating their own behaviour in the community. Nurses fear that even innocent behaviour can become the object of gossip if it is misinterpreted.

Maintaining their public reputation is essential if nurses are to remain members of good standing in the white enclave. Brody explains:

> The single White men are, of course, much preoccupied with the single White women of any settlement ... So it is that young nurses are regarded as a social resource, well suited to young men who -- in their southern lives -- would very likely be too inhibited to approach them openly. Nurses are therefore strongly encouraged to participate actively in the everyday social life of White communities. Refusal, or even a slight disinclination, to participate can easily generate hostility, whereas a too-ready friendliness may be seen as disgraceful promiscuity (1975: 47).

Inter-ethnic relations involving white nurses are particularly threatening to the white enclave, as they entail the loss of single, white women (a rather scarce resource in the north) from white social activities. Even within the white community, nurses must learn to strike a balance between what is considered "aloof" and "promiscuous" behaviour.

So far, we have been looking at the conditions which generate two conflicting sets of norms for outpost nurses. Publicly and in theory, nurses are encouraged to develop personalistic ties with their native patients. In practice, however, the established structure of native/white relations in the north acts to restrict, and in many cases entirely prevent, intimate inter-ethnic relations. Nurses are caught between two conflicting norms, both of which have advantages for their personal and professional roles in the north. In practice, the norm of avoiding intimate inter-ethnic relations usually dominates. If nurses appear unfriendly to their native patients, it is not necessarily because this is the way they wish to appear or act. Rather, this "unfriendly" behaviour may be the only viable course of action open to nurses caught in a pervasive double bind as to the nature of white/native relations in the north.

Little Lake: mismanagement of role

What happens when outpost nurses cannot maintain an acceptable compromise between social segregation and personal involvement during their dealings with the native community? According to most of the nurses I spoke to, disastrous consequences face those who cannot maintain this balance, especially if the error is on the side of too much imtimacy and involve-

ment with natives. To support this argument, they use as their example the fate of the nurses at Little Lake (a pseudonym). Little Lake, they say, is an illustration of ethnic relations "gone wrong" because a nurse mismanaged both her professional and personal roles in the community.

Like most people in the area, I am not certain of what really happened at Little Lake. The nurse involved has either decided not to speak to the press, or has been instructed not to do so by Medical Services. Nevertheless, the white community has created what it thinks is a logical explanation for the events, based largely on its assumptions and norms about inter-ethnic relations. This reconstruction is based on the theories that (a) sexual relations between white nurses and native men are undesirable, (b) native people resent inter-ethnic relations as much as the white community, and (c) nurses who break this norm (i.e. have sexual relations with native men) deserve to be punished. Although the true facts of the case will never be known, the type of gossip which flowed between nurses on this topic is probably an accurate reflection of their interpretation of the events. What is of interest to me is not what did or did not happen at Little Lake, but how nurses in this area view these events and what they consider significant.

Basic to the trouble at Little Lake was a long-term, large-scale problem with alcoholism and violence within the native community. Visitors to the station reported bullet holes in the walls, and for some time prior to the final incident, the nurses were sleeping on the floor and barricading the windows. Throughout this period, they received little support from their superiors (eg. Christmas vacations were denied). It is believed, however, that the nurses became over-zealous about carrying out their duties and failed to fully explain to their supervisors the dangerous conditions under which they were living.

As violence centered more and more around the nursing station, rumours began to circulate about the public and private behaviour of one of the nurses. Charges are made that the this woman acted in a promiscuous and emotionally unstable manner that destroyed her private reputation in the community. Whether there is any truth to these rumours, and whether this occurred as a response to months of stress or helped to precipitate problems in the community, is not clear. What matters is that the image of improper behaviour was widely circulated in the area. Furthermore, it is tacitly accepted by the people telling this story that standards for the private behaviour of nurses exist, and violating these standards will have disasterous consequences.

Other nurses feel that the main problem of this particular nurse lay not in her personal behaviour, but in her professional manner. Specifically, she is accused of breaking two informal rules considered essential in outpost nursing: (1) being especially careful and gentle with children, and (2) non-interference in the domestic affairs of the native population.

The first rule reflects the importance of children to native Canadian families. How a nurse handles small children is often used by native people as an indication of their medical ability. Nurses who yank, scold, or generally misuse children are bitterly disliked by natives. It is not difficult to see that a nurse, living for months under tremendous pressure, might be careless or impatient with a difficult child. Native complaints about the nurses at Little Lake, as reported in the press, centre around the charge that the nurse in question had hurt a child undergoing treatment. The truth about this charge (was the child really hurt? was it unavoidable, intentional, or accidental?) is impossible to determine. Both native and non-native people recognize the seriousness of this charge, however, and how it could contribute to the disruption of health services.

Second, both of the nurses at Little Lake

are criticized for stepping beyond the limits of their professional role and interfering in the domestic affairs of the native community. The charge is that the nurses allowed women who were being beaten by their husbands to shelter in the nursing station. Although this would appear to be a humanitarian action, it interjects the nurse between a man and his wife. Such interference would not be tolerated, and violence often erupted as the furious husband came to the nursing station to take his wife home. Such stories are told to illustrate both the dangerous nature of the community and the professional limitations a nurse must observe in the north. Nurses must not overstep these boundaries unless they are specifically requested to do so by the participants.

A point of crisis was finally reached when the nurse in question was physically assaulted within the nursing station. The next day, both nurses locked the station and left the community. There was no reprimand from Medical Services and the station was left unstaffed. (Subsequent to this, various other white agencies in the community were also closed.) Nurses in the area doubt if Little Lake will ever again have resident Euro-Canadian nurses.

It is possible that the nurse at Little Lake was disliked by the native community only because of

her professional shortcomings. To the whites, however, her personal, as well as her professional, behaviour was at issue. The nurse at Little Lake was condemned not so much because of the quality of her nursing care, or even because of her so-called "immorality," but because she had failed to sustain that fine balance between native and white relations in the north. Although "sitting on an island" can be very restrictive, it can also be safer than life in the mainstream.

Ties and Tenure

Throughout the north, white professionals tend to be temporary residents, and nurses are no exception. Lured by benefits such as isolation pay, furnished accomodations, etc., many southerners come to remote northern settlements for one or two years. Such a move is usually seen as a means of bringing about advancement in a career based in the south and/or a form of "adventure" (see Parsons 1970; Koster 1977). Although most nurses belittle the immediate economic advantages of working in the north (claiming that pay levels are not commensurate with their responsibilities), many agree that long-term career benefits can be derived from northern experience. For example, the Churchill Health Centre hires many of its nurses straight out of school. For recent graduates, work at the Health Centre can be an opportunity to explore a bread range of nursing duties while obtaining the experience needed for better jobs in the south. Both sides in this situation benefit: the Health Centre obtains a number of eager, well-schooled nurses, and the nurses derive valuable,

and needed, practical experience.

Professional and/or economic advantages can be crucial in attracting them, but what acts to keep nurses in the north? Many of the disadvantages of northern communities are obvious even to a visitor: a lack of entertainment and shopping facilities, poor transportation links with the south, and for a southerner, poor climate (also see Riffel 1975). It should be noted, however, that communities which are the most isolated and are the least "sophisicated" are not necessarily those which experience the fastest turnover of nurses. For example, the nurse at the small Inuit community of Resolute Bay has been there for about ten years, whereas the turnover at Churchill (which is much larger and sophisicated) is very high. Although social and cultural facilities are important in determining a white's adjustment to, and satisfaction with, a remote community, these are not the sole criteria. It is my assertion that the quality and quantity of a nurse's relationships within a community have an important influence on her length of stay in the north.

To test this hypothesis I would like to contrast three groups of northern nurses -- those at Churchill, Lynn Lake, and outpost nurses of the Keewatin and northern Manitoba. Among these three groups, both the social ties typical of the nurses

and the length of their stay exhibits considerable variation.

As described earlier, the type of social relations characteristic of nurses differs greatly between those of Lynn Lake and those working in Churchill. To recapitulate briefly, the majority of nurses at Lynn Lake are married, live in independent family housing, and make friends through their husbands and children as well as through their work. At Churchill, most of the nurses are single and generally younger than those in Lynn Lake (many have just graduate from nursing school). These nurses live close together (in two apartment buildings subsidized by the hospital) and socialize intensively with one another. Although some people deliberately try to make friends outside of the hospital staff, as a rule nurses at Churchill create a socially self-sufficient unit.

For the purpose of this discussion, the third group is composed of outpost nurses from both the Keewatin and northern Manitoba. These nurses live in remote settlements or reserves in which imtimate inter-ethnic relations are seldom found. Though they may have a few close friends in the white enclave, it is not uncommon for outpost nurses to essentially remain within the "total institution" of the nursing station. Nurses may know everyone in the community, but are not necessarily close to any of them. Out-

post nurses often describe themselves as "independent," and this quality appears to apply to their emotional and social lives as well as their professional duties.

Of what significance are these different patterns of social interaction? Using Boissevain's "zones of intimacy," we can analyze and categorize the types of relations typical of each group (individual exceptions, of course, always being present and/or possible). A pattern may emerge which will help explain the turnover rate characteristic of each group.

In Lynn Lake, most of the nurses have their husbands and families with them. These nurses thereby possess a personal cell within the community. Although nurses may socialize with some of their co-workers (the community, after all, being rather small), they also have the option of making friends through their family members, social activities in town (eg. clubs or sports), or in their neighbourhood. Inter-nurse relations thus vary between the multi-strand and intimate to the single-strand and instrumental, depending upon the tastes and interests of the individuals involved. Nurses are not limited to the hospital staff in making friends, and a wide number of ties to other townspeople (both instrumental and affective) also exist.

The turnover rate of nurses is probably

closely connected to this pattern of social interaction and relations. Although the rate has been higher in the past, currently the turnover at Lynn Lake is the slowest of the three groups. Since the nurses are married to men working in the community and other sources of nursing jobs do not exist in, or near, the town, it is unlikely that nurses will quit. As long as employment within the community is stable, the turnover of nurses will probably remain low. In fact, the hospital employs the majority of its nurses on a part-time or casual basis (whereas a hospital which must recruit nurses from outside the community can seldom attract employees with only part-time positions).

Unlike the other two groups, these nurses generally see their work at the hospital as a part of their lives, but not the sole, or most important, part. Furthermore, although most of them will complain about the limitations of a small, isolated town, to the vast majority of these women Lynn Lake is now their home. They may not plan to stay in Lynn Lake indefinitely, but for the next several years this is where they will raise their families. If, and when, they leave, it is as part of a family unit. Nurses tend to leave only if the best interests of their families are served by moving, rather than for

their own professional and/or personal benefit.

The pattern of social relations exhibited among the nurses of Churchill contrasts sharply with that of Lynn Lake. At Churchill the vast majority of the nurses are single and geographically separated from their personal cell of family and friends still located in the south. Since nurses work together, live in close proximity, and are similar in marital status and (less often) age, socializing between members of the hospital staff is the rule. (This tendency is exacerbated by the lack of eligible white males in the community for the single nurses to date.) Professional and personal ties overlap, which acts to qualitatively and quantitatively intensify a nurse's relationships with her co-workers.

At the same time, this pattern is characterized by a relative lack of ties with the wider community of Churchill. As a rule, nurses do not make intimate friends beyond the limits of the hospital staff. Nurses at Churchill can therefore be described as (a) lacking a personal cell in their community, (b) maintaining intensive relations (probably Intimate Zone A and/or B) with a small number of co-workers, and (c) largely lacking personal ties with the wider community. Relations with the people of Churchill itself are generally typical of Boissevain's effective and nominal zones, in that they are instrument-

ally important but lacking in emotional involvement.

Unlike Lynn Lake, the hospital at Churchill experiences a very high turnover of nurses. Although most nurses try to stay at least a year (the minimal amount of time before the hospital will pay for moving expenses to and from Churchill), some nurses will leave after only a few months. In many respects, this high turnover rate can be considered a response to the pattern of relationships typical of the hospital staff. These nurses are separated from their families and old friends (the personal cell) and lack a large or varied number of intimate relationships throughout the community. The intense inter-nurse relations typical of Churchill can help compensate for the lack of a personal cell, but they do not make the nurse feel like a part of the town itself. Inter-nurse relations can create a sort of "total institution" in that nurses are working with, living close to, and usually playing with, the same people.

To most nurses, this informal "total institution" does not, and should not, satisfy all of their emotional, social and professional needs. Nurses feel that sooner or later they will move back south, whether to marry, pursue their careers, or obtain more education. "Real" life remains in the south. Remaining in Churchill too long (eg. over two years)

is considered a withdrawal from this "real" world and generally criticized as unhealthy.

Generalizing about the social relations of outpost nurses is extremely difficult, as they vary greatly between individual nurses and communities. Although there are now married outpost nurses, as a rule they are both single and childless. Outpost nurses, like the nurses at Churchill, are therefore separated from their personal cell (their family of orientation and old friends) and must make new friends in each new community. Nurses interact mostly with their co-workers with whom they share the "total institution" of the nursing station. Extremely close ties can be created among these nurses, but these are numerically limited (most nursing stations being built for only two or three nurses). Furthermore, outpost nurses must learn to strike a balance between closeness and suffocation, as living in a nursing station means living "on top of" both their work and their co-workers.

Outpost nurses are not only separated from their personal cell, but often make only a small number of intimate friends in northern communities. Their life in the north is seen as a period of professional growth and satisfaction, and few nurses mention any personal or social advantages to be

derived from living in remote settlements. Indeed, ties to the south (through the mail, television, etc.) often seem more important to these women than relations to the community around them. Like most white northerners, outpost nurses remain oriented to the south, and spend considerable time, money and energy keeping in touch with public events and personal friends in the south.

It is difficult to determine a "typical" length of stay for outpost nurses. Although the overall turnover rate is extremely high for most of the north (eg. Wenzel 1978), it is impossible to predict the stay of individual nurses. Some nurses will stay two or more years in a community, whereas others will stay for only a few months. The extremes are illustrated by the nurse at Resolute Bay (ten years) and the station at Whale Cove which saw eleven new nurses in one year. Most nurses state that a year is the ideal tenure at any one station, and the length of stay for which they usually aim. It is argued that the limitations of remote settlements and the intense pressures of their work make it impossible for them to stay in one location for long periods of time. Even if nurses remain in the north for several years, it is not unusual for them to change postings frequently and/or return to the south periodically. That they

feel free to make so many moves is probably symptomatic of the small number of intimate ties they possess in any one community.

It should not be assumed that the relationship between the pattern of social relations and the length of tenure characteristic of these three groups is directly causal in nature. Many factors determine a nurse's relationship with the surrounding community and her tenure in any one position. A correlation, however, can be tentatively hypothesized. It would appear that average tenure is correlated with the typical pattern of social relations maintained by a northern nurse. In those communities in which most nurses have a large number of relationships within the community and, probably more importantly, intensely intimate relationships (such as with members of a personal cell), turnover is liable to be fairly low as long as conditions within the community remain constant (eg. employment for husbands remains the same). When nurses possess few intimate ties to a community, turnover is more rapid. In these situations, professional, rather than social, bonds tend to dominate their plans.

Nurses who wish to balance their professional and personal lives (eg. combine a career with marriage) will probably return to the south more rapidly

than those who are mainly concerned with professional satisfaction. For example, many of the nurses at Churchill state that they will return to the south after their year(s) in the north because they wish to marry and see few chances of meeting a compatible mate in Churchill. To many, personal and social goals are as valid reasons for leaving the north as professional ambitions. In contrast, few of the outpost nurses with which I spoke (of which only one was married) gave marriage or dating as a reason for leaving the north. The lack of male companionship is sometimes bemoaned, but is apparently accepted as one of the drawbacks of their work.

What effect does a rapid turnover of nurses have on northern health care? At first glance, one would suppose that this rate of turnover would have disastrous consequences for both the running of northern health care institutions and the quality of patient care. In reality, the high turnover of staff does not create havoc, and communities and institutions cope with the problems it does entail.

First, let us look at the problems created for the health care institutions when the nursing staff undergoes rapid and continual change. As pointed out by Martin (1978), rapid turnover can create problems in ensuring continuity of programs

and services. This is especially important in the fields of social services and counselling, where a positive practitioner/patient relationship is essential to the success of the treatment. Moreover, staff members themselves may have to continually adjust their working habits and routine in order to orient and learn to work with new personnel. Many of the nurses at Churchill felt that it can become very tiresome to explain layout and routine over and over to a succession of new recruits.

A high turnover rate can create both professional and personal disruption in the lives of outpost nurses. Outpost nurses must not only adjust to a new co-workers, but a new roomate as well. Sometimes nurses leave before their replacement arrives, in which case the new nurse does not have the chance to be oriented to her new station and community by someone familiar to them. In these cases, nurses may have to literally search the station to find where equipment, supplies, etc., are located.

For the federal and provincial governments, the high turnover of nurses is expensive (especially as they pay for their employees' costs of moving) and consumes valuable employee time. Sometimes a sufficient number of nurses cannot be recruited, and hospitals and/or nursing stations may have to operate with a reduced, and/or less qualified, staff than the norm.

Second, there is the issue of the effect of a high turnover of nurses upon the patients. In a hospital, reduced efficiency by one nurse is probably not crucial, as new nurses are usually supervised and helped by their co-workers. In many respects, nursing care in a hospital is a group process (eg. by all the nurses on the shift, followed by other shifts), rather than an individual function. The change of personnel within that group need not effect the care given to patients as long as all (or at least most) of the nurses are competent at their work.

The issue of continuity of health care personnel becomes much more important in outpost nursing. Outpost nurses are, in essence, the "family doctor" in remote communities and the source of all health care. When the staff is constantly changing, people lack a stable figure whom they know by experience to be trustworthy and who is familiar with their past history. When a settlement or reserve has a new nurse, there is apt to be considerable speculation as to her ability. As people are not told the educational qualifications of a new nurse, they must try to informally ferret out for themselves if she is capable, trustworthy, compassionate, and so on. When there is a rapid turnover of nurses, the task of uncovering

such information becomes much more difficult. Although outpost nurses claim that good medical records can solve most problems relating to continuity of care and public health programs, these records cannot compensate for the disruption in the interpersonal nurse/patient relationship. Trust and respect must be earned over time. Rapid turnover of personnel hinders the development of such ties, ties which could clarify cross-cultural communication between white nurses and native patients.

Most outpost nurses believe that native people accept a high turnover of nurses as inevitable, and do not resent or dislike it. One nurse stated:

> I think they [native people] expect it. The interpreter I was talking to, she expects it, because she realizes that the nurses who come up here are single people and that we don't have any ... emotional security here. We don't have families or anything of our own here. -- Nurse, Keewatin Zone

Although native people may appear to expect a high turnover of nurses, this does not mean that they consider this desirable. Native people may not necessarily want close personal relations with white nurses, but they have often voiced their desire to enjoy more long-lasting professional relations with the distributors of northern health care. It is argued that whereas the doctoring missionaries established long-term relationships with their

patients (in a manner similar to the concept of the "family doctor" in the south), this is no longer the norm. Rather,

> You don't have good communication with your nurse or with your doctors anymore ... We want to know if it is possible to have that relationship back with the doctors and nurses today. I don't think there are any family physicians in the Northwest Territories. We would like you as medical experts, and we, as your patients, at some time or another to sit down and talk about this and try and understand each other to see if it is possible to get that relationship back between the doctor and the patient (Kusugak 1975: 146).

Whether or not nurses are aware of it, among native people there is a strong desire for greater continuity of care. Although native people may not object to the departure of individual nurses, in general there is the belief that northern health care needs greater stability and continuity in staffing as well as programs.

A Summary:
Transcultural Nursing in the Canadian North

In the north, white nurses are socially, culturally, and therefore emotionally, separated from their native patients. Although the two sides may talk <u>at</u> each other, in reality they seldom talk <u>to</u> one another. One result of this poor cross-cultural communication is the startling contrast between what nurses think they are achieving in the north and how native Canadians interpret this behaviour. Nurses believe that they are well-meaning professionals delivering quality health care, whereas native people describe the medical system as inadequate and the distributors of this care as cold and uncaring.

It must be emphasized that native anxiety as to the quality of their health care is not unjustified. Native Canadians still suffer from a higher rate of social problems, chronic diseases, infant mortality, and a shorter life span than non-natives. I suspect that much of their criticisms of the suppliers of northern health care (eg. doctors and nurses) is aimed at the system as a whole. In this

respect, criticism is justified: white Canada has failed its native people in many areas. At the local level, this problem often emerges in the form of complaints about individual nurses or the nursing profession in general.

Northern nurses are very sensitive to criticisms about the health care system, and thus about themselves as professionals. They feel they are judged unfairly by both the general public and the native community, as typified by the following letter published in The Canadian Nurse:

> I find myself angry at the implied criticism of the northern nurse. Sure, she's retreated behind the doors of the station, probably appalled and frustrated by the enormity of her responsibilities and the apparent hopelessness of the task. She went up there, probably as a fairly new graduate, to practice nursing, which she had been taught.
>
> Now she finds herself expected to make a dent in a spectrum of social and economic problems symptomized by V.D., alcoholism, dental disease, malnutrition, despair, which the most elaborate health care system in large cities has not been able to stem, let alone control.
>
> Let's face it, ... we don't need nurses in the North; we need miracle workers -- a charismatic, emphatic blend of the Wizard of Oz, Wonder Woman and Albert Schweitzer! (Jenny 1979: 5, italics included)

In parts, this description is an exaggeration of the

situation of most outpost nurses (and does not concern itself with northern hospital nurses). The emotional tone of this letter is, however, an accurate reflection of the defensive stance taken by many northern nurses. Nurses tend to romanticize the type of ideal relationship they would like to enjoy with their native patients while simultaneously rationalizing their almost total lack of personal involvement with these people. People who criticize this behaviour are often dismissed on the grounds that "they don't know what they're talking about"; that they either do not understand the nature of nursing or the socioeconomic conditions of native Canadian communities. The sensitivity of most nurses on this topic is, I would suggest, an indication that they themselves are uneasy about their role in the north.

If northern nurses become increasingly defensive and/or angry, it will only compound the problems already apparent in inter-ethnic communication. What I have tried to show is that nurses are not the "villains" in northern health care, but, like their native patients, merely caught in the web of their own culture and society. The majority of nurses I spoke to generally hold good intentions concerning native patients, although these inten-

tions are not always actualized into behaviour. That they are not is both a reflection of the cultural and social barriers between natives and non-natives in the north, and a factor supporting these barriers. It is my contention that both nurses and native people are essentially victims of a de facto segregationist social system. Neither present-day nurses nor natives invented this system, but they must learn to live within its boundaries and tenets. As pointed out earlier, "the ethnic boundary canalizes social life" (Barth 1969: 15), and it can be extremely difficult for the individual to stray from these established patterns.

The cultural and social barriers I have described between white nurses and native patients are more than merely interesting phenomena for the anthropologist. Rather, these problems need to be studied because they directly influence the quality of northern health care. Although it is probably simplistic to imagine that either the medical profession or anthropology can produce a "solution" or "solutions" for these problems, it is certainly our responsibility to promote improvements in northern health care whenever possible.

The first step to analyzing any problem is to describe the elements involved. It is for

this reason that I have concentrated on northern nurses, and have tried to describe their attitudes and working conditions. As pointed out by Bastide (1974: 42), anthropology can not, or should not, neglect the individuals composing the "donor" culture when studying culture contact. Understanding the perspective of northern nurses, their "side of the story" as it were, is crucial if we are to help them improve the quality of their care. (Of course, a total analysis of northern health care would also include a more intensive examination of the native perspective. Such a study is highly desirable but, unfortunately, beyond the scope of this paper.)

In many respects, Bateson's definition of schismogenesis seems appropriate to the pattern of most nurse/patient relations in the north. Schismogenesis is defined as "a process of differentiation in the norms of individual behaviour resulting from cumulative interaction between individuals" (Bateson 1958: 175). In this case, the pattern of interactions common between natives and non-natives creates not greater understanding and similarity, but progressive and mutual withdrawal and alienation. Private or personal, as opposed to public or professional, inter-ethnic interactions are

atypical and uncomfortable for the participants. As a result, the pattern is for both sides to withdraw from such encounters, either physically or emotionally (into a public or professional *persona*, which brings into effect a standardized working consensus for the relationship). Whereas most native people have spent their lives coping with non-natives in various functions, white northerners (especially newcomers) often possess little knowledge about native Canadians. Accordingly, white northerners are usually the most uncomfortable in inter-ethnic interactions and the most anxious to retain the public *personae*.

Although this pattern is not easily changed, this does not mean that it should, or necessarily will, continue *ad infinitum*. Anthropology is not a "cure-all", but it could be a useful aid in explaining the two sides to one another and thereby establishing a basis for better communication and empathy. In fact, the nursing profession has already begun to recognize and use the tenets and techniques of anthropology. Led by Leininger (eg. 1970, 1976a), Brink (1976), and others, the new field of transcultural nursing is quickly gaining ground. This new sub-discipline has been defined as

> ... the domain of study in nursing which focuses upon the comparative study and analysis of different cultures and sub-

> cultures with respect to nursing and health-illness caring practices, beliefs and values with the goal of generating scientific and humanistic knowledge, and of using this knowledge to provide culture-specific and culture-universal nursing care practices (Leininger 1978: 9).

Unlike traditional nursing (which is firmly entrenched in western, scientific thought), transcultural nursing involves "health care delivery to the consumer within his cultural context; this requires of the nurse a sensitivity to the differences between her own and the patient's cultural background" (Brink 1976: 32). Such knowledge and sensitivity is not sought solely for its own sake. Being deeply pragmatic, the nursing profession is hoping to learn "how knowledge of a patient's cultural heritage can provide insights that may lead to better management and prevent self-destructive consequences" (MacGregor 1976: 42). In this respect, anthropology is being used so that nurses can better manipulate their patients. Such practices are particularly common when treating those patients which are considered by the nurses to be "difficult," "deviant," or "noncomplaint" (see MacGregor 1976; Olesen 1973: 72).

A problem arises at this point, for the definition of what constitutes "good" or "bad" behaviour, or what the ultimate fate of the patient should be, shifts from the patient to the medical

and nursing professions. It must be remembered that anthropology is essentially an art rather than a science, in that we cannot guarantee its effects or how it will be used (Bastide 1974: 210). If nurses use anthropological insights to manipulate the behaviour of their patients, the results may not necessarily be in the best interest of the patients. An interesting parallel can be drawn between the current use of anthropology in medicine and its use in the European colonies before World War II (see Asad 1975). We must not forget that the health care practitioner is "the agent of the party that pays him and thus controls him; whether he helps or harms the so-called patient thus depends not so much on whether he is a good or bad man as on whether the function of the institution whose agent he is, is to help or harm the so-called patient" (Szasz 1977: 16). Modern medicine is continuously grappling with a variety of ethical and moral dilemmas, and the use of anthropology as a manipulative technique should be included.

Despite these problems, I do not feel that transcultural nursing or anthropology in nursing should be abandonned. Although dangers do exist if it is used in an unscrupulous manner, the potential benefits of transcultural nursing probably outweigh the risks. To be effective, transcultural

nursing should be concerned with opening up the lines of communication between nurse and patient. In this manner,

> Transcultural nursing is also concerned with symbolic interaction; the communicative system used by the nurse and the patient; the values and beliefs which guide behavior; the level at which shared meaning occurs; and finally, what happens when cultural barriers are crossed. Nurse and patient interact around the concepts of health and illness. The degree to which they agree on what is health, illness, treatment, and cure will affect their subsequent interactions (Brink 1976: 32).

Transcultural nursing should make nurses more sensitive to the desires and attitudes of the patient, thus balancing in part the manipulative aspects of the discipline.

Such a study and emphasis upon cross-cultural communication is badly needed in the Canadian north. As I have shown, white nurses and native patients seldom interact on more than a professional basis. If the two sides do not exchange a wide spectrum of ideas, cultural intolerance could result, for:

> One distressing outcome of unicultural or unidirectional encounters may be that the patient's concerns focus upon an entirely different kind of problem from that upon which the health professional's attention is centered. The latter could be responding to the same set of symptoms as the patient, but his efforts might be directed toward treating the patient in ways that have no meaning for

> him. Such instances begin to border on an unintended but very real intolerance and contempt for the patient's cognitive system (Weidman 1979: 86).

Only if nurses and patients begin to communicate more efficiently can these misunderstandings be corrected and/or avoided. To achieve cross-cultural communication, both natives and non-natives will have to change some of their behaviour and attitudes. Transcultural nursing may help northern nurses to start making these changes within themselves.

If nurses can achieve effective cross-cultural communication with their patients, perhaps northern health care can shift from curing to healing. Although the two terms are usually used synonymously, Cassell (1979) sees them as two separate functions. The difference between the two is rooted in the distinction between disease and illness. According to Cassell, disease "is something an organ has; illness is something a man has" (1979: 48). Disease is the organic imbalance or injury which produces symptoms, whereas illness is the interpretation of these symptoms according to the victim's cultural belief system. Western medicine concerns itself predominantly with disease. It is based upon the assumption

> ... that the body can be regarded as a machine whose protection from disease and its effects depends primarily on internal intervention. This approach has led to indifference to the external influences and personal

> behaviour which are the predominant determinants of health. It has also resulted in the relative neglect of the majority of sick people who provide no scope for the internal measures which are at the centre of medical interest (McKeown 1979: xvi).

This concern with the disease rather than the patient as a whole person, can be labelled curing. Healing, on the other hand, means treating the patient as a whole. Essentially, healing "involves returning the sick to the world of the healthy" (Cassell 1979: 46), thus including the emotional, social and cultural aspects as well as the organic.

Critics such as Cassell, McKeown (1979), and Illich (1977) are primarily concerned with doctors when they discuss the neglect of healing in modern medicine. It should not be forgotten, however, that a similar dilemma faces the modern nurse. Bloom explains that over time,

> ... the nurse has become more and more a skilled technician as the complexity of the technical demands of good medical care has increased. As the techniques of ...[curing] have fallen increasingly to the nurses, a shift has been observed in her role from comforter to healer [i.e. "curer", in Cassell's use of the term]. The concern for the patient's comfort, it has been argued, is inherently secondary in importance to... [curing], and the changing role of the nurse is used as a demonstration. The implication is that he who cannot help, comforts. The fallacy of such reasoning lies in its implicit assumption that the science of ...[curing] and the "art" of comforting are at opposite ends of a single continuum. They are,

> in fact, two separate functions that are not necessarily related. That the ascension of one sometimes leads to the neglect of the other does not change the fact of their separateness (1965: 146-147).

Although nurses may be given humanistic theories while in school, it is often difficult to retain these ideals in the practical world. Olesen notes that, "the processes of learning a health work role and becoming a health worker do not terminate with the completion of formal schooling or training, but extend well into the remainder of the individual's life and career, carrying implications not only for the person inolved, but the occupation and its structure as well" (1973: 72). Pressured by the technical requirements of their job and influenced by more experienced, and perhaps somewhat disillusioned, co-workers, many nurses quickly lose their humanistic ideals. As pointed out by Kramer, these ideals are "untried and untested by the student while she is in school," so that "they are very vulnerable to capitulation upon graduation" (1974: 63). Retention of these concepts is essential, however, if nurses are to exploit the healing potential of their profession.

The concept of healing, rather than merely curing, is especially relevant for northern nurses. In many northern communities nurses form the basis, or even the sole source, of medical care. Due in

part to the historical sequence of health care in the north, many native Canadians want and expect healing, rather than merely curing, in times of illness. To accomplish this, northern nurses will have to learn to communicate with their native patients in a more effective and meaningful manner. Leininger has argued that the nursing profession in general needs to learn to

> ... accomodate shades of differences and tolerate a range of different opinions and viewpoints. Most importantly, we should endeavor to understand such differences and be willing to work toward some degree of resolution through compromises, agreement and conciliations (1976: 181, italics omitted).

Such lessons are needed in the Canadian north. Nurses must learn to see and treat the native community "as a responsible body with a significant culture and group personality of its own" (Thompson 1959: 134). Concurrently, native Canadians must recognize the fact that nurses are individuals, not machines, and become more sensitive to their needs as well.

The social problems evident in northern health care were neither created by one side, nor are they capable of being solved by minimal or one-sided effort. Considerable time and effort will be necessary in trying to bridge the gap between the two sides, and the results are not guaranteed. It is hoped, however,

that mutual effort is possible, and that someday the northern nurse will be able to leave the island and join the community around her.

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