HEALTH CARE SERVICES

AND ISOLATION OF CREE ELDERS

THE ROLE OF HEALTH CARE SERVICES

IN ISOLATION OF THE ELDERS

OF MOOSE FACTORY, ONTARIO

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By

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ABSTRACT

This thesis explores how formal health care services contribute to the isolation of some elders in the community. In Moose Factory 3 main aspects of the service system are identified as barriers to integrating the elders: Co-ordination of services, continuity of care and cross-cultural sensitivity. This formal system is examined in conjunction with the informal system of care which struggles to meet the elders' needs. The building of a long term care facility, while a practical solution may further isolate elders from the community and younger generations, enhancing the gap between generations. The model of cultural continuity is a framework that depicts elders as the conveyors of culture and points to the importance of maintaining cross-generational relationships. The profile of an elders liaison to the community is a tool that in future studies could be useful in identifying elders who are at risk of becoming isolated.

ACKNOWLEDGEMENTS

"And what you thought you came for
Is only a shell, a husk of meaning
From which the purpose breaks only when it is fulfilled,
If at all. Either you had no purpose
Or the purpose is beyond the end you figured
And is altered in fulfilment."

"We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time."

Eliot, "Little Gidding"

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CHAPTER 1

INTRODUCTION

With increasing age comes the potential for greater dependency on others for meeting one's physical, social, and emotional needs. The community offers support through the informal and formal support systems. Social support promotes physical and mental well-being. The individual's interaction and involvement with these support networks contributes to their integration into the community. Yet in 1988, I found that some elders in Moose Factory were not well integrated, and that formal health care services contributed to this. This thesis examines government provided health care services delivered to the Cree elders at Moose Factory, Ontario and shows that these services contribute to the isolation of the elders. This isolation of the elders, whether deliberately or inadvertently, tends to undermine the cultural autonomy of native people.

This formal health care system operates in a context that includes the informal system of care, general community cohesiveness, and the history of social divisions at Moose Factory.

Co-ordination of services, cross-cultural sensitivity, and continuity of care are three aspects of the formal health care system that will be examined with regard to the role that they play in contributing to the integration of elders into the community. In addition, the potential isolation of elders from the community once they become residents of the proposed long term care facility may be minimized with attention to issues in the institutionalization of the elders.

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The lack of coordination of services is fuelled by the political tensions between federal, provincial and native government health care agencies. This political tension diffuses through the agencies and blocks communication between these health care agencies. The resulting poor communication leads to a lack of coordination of services and therefore too inadequate services to elders.

In a cross-cultural setting communication is a central issue in the provision of health care services. The Cree style of communication does not lend itself well to the direct, question-response style that greater Canadian society is familiar with. Elders are more likely to use the more traditional Cree ways of communicating, yet the health care system is not sufficiently sensitive to this difference and provides no cross-cultural training for health care workers.

In addition the short residency of health care workers in the community confounds this lack of training. Because health professionals are rotated through Moose Factory there is rarely time enough to establish, through "on the job" learning, vital communicative skills. Health care workers also tend not to participate in the community. This lack of continuity of care and the lack of involvement of health care workers in the community contributes to creating communication barriers with the elders.

Last, authorities in the health care system propose the building of a long term care facility. While this is a practical necessity, it has implications for the further separation of elders from the younger generations. This physical separation of elders from younger generations will facilitate further social isolation given the already existent generation gap.

A MODEL OF CULTURAL CONTINUITY

Cultural continuity is ensured through the sharing and creative transformation of knowledge between generations. Elders are in the unique position of bringing the past to this interaction. To fulfill their roles, elders must remain socially integrated and acknowledged as conveyors of culture (Vanderburgh, 1987).

In figure 1.1 the present is shared by elders and younger generations. As elders become isolated this shared knowledge space declines in size. Many factors influence this shared knowledge space, some of which include: language loss, the role of tradition, the attitude of the young towards the old, and how well community organizations and institutions integrate the elders into the community.

Language loss refers to the younger generations' increasing use of English and declining familiarity and use of Cree. Communication with Cree speaking elders is reduced. The role of tradition represents potential development of relationships with elders. For example an elders practice of hunting and skinning beaver provides an opportunity to relate to younger generations that may be interested in learning such skills. Whether traditional behaviours and roles are sources of communication between young and old are tied to the attitude that the generations have towards one another. Are elders and their knowledge and skills respected and valued by the younger generations? What is the attitude of elders toward the younger generations? Community organizations and institutions convey cultural values through their structures and activities. To what extent are there effective health care programs

that reach out to elders in the community? Programs such as Indian Days that invite elders

to participate and engage with the younger generations convey a role for elders defined by

knowledge and wisdom.

This thesis provides a stimulus for future investigation into the factors influencing the

shared knowledge space, but does not provide enough data to explore broader speculation.

PROFILE OF ELDERS LIAISON TO HEALTH CARE SERVICES

The formal and informal services available to the elders are the focus of this study.

The model assumes that aspects of the system that contribute to the isolation of the elders can

be turned around so that they can actually contribute to their integration. For example

enhancing cross-cultural communication can result in better attention to the needs of the

elders. Elders will receive better health care services and increased communication and

contact with health care as an institution in the community.

Figure 1.2 is an example of a profile for an elder. It expresses the strengths and

weaknesses of their ties to the various health care services. In this example we depict three

health care services; home support, home care and public health. The lines drawn to each

service indicates the nature of the link to the service. Strength is indicated by solid lines and

weakness by dotted lines. The nature of the relationship is influenced by many variables,

including personality of the client and health care provider.

The services themselves provide either a strong or weak link to the community,

depending on the services integration into the community. Thus, the relationship between

services is also indicated. For example, the lack of coordination between service groups weakens the strength of their link for elders to the community, as does the lack of continuity of care. The general social and cultural cohesiveness of the community is a strong influence over the integrative powers of an institution.

If the model were put into the practise of assessment research, the goal would be to do individual profiles and look at the strengths and weaknesses of the various links and work towards strengthening them so that the elders physical and social needs are met and health care services acts as a liaison to the community. In achieving better integration into the community, the shared knowledge (figure 1.1) space between elders and younger generations is increased.

The "profile of an elder" aspect of this model is a microcosm of a similar, but more encompassing and detailed model developed by Rathbone-McCuan and Hashimi (1982). The central concept of the model is isolation. Isolators are identified along two dimensions; either at the individual or environmental level and then along four quadrants: biophysical, psychological, social and economic. For example, a major physical isolator is biophysical decline. Individuals become less physically mobile, experience sensory loss, physical appearance changes. These are on the individual level.

The dimension that relates most to this study is a significant physical isolator on the environmental dimension: A lack of medical and health care resources. "Rehabilitation services may not exist. Health care settings may fail to identify and/or address social, emotional, and/or economic needs coexisting and interacting with health problems. The

MODEL FOR CULTURAL CONTINUITY

FIGURE 1.1

The present is shared by elders and younger generations. As elders become isolated, the present (shared knowledge space) declines in size. There is less sharing between generations. Many factors influence the shared knowledge space. The focus in this study is on how aspects of health care services contribute to the isolation of elders and subsequent reduction in the shared knowledge between generations.
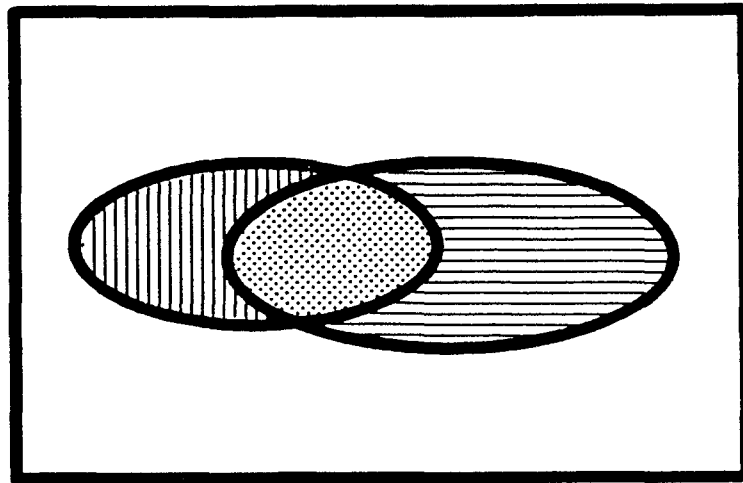
|||| PAST/ELDERS

PRESENT/WHERE ELDERS AND
YOUNGER GENERATIONS SHARE
KNOWLEDGE

FUTURE/CHILDREN

PROFILE OF AN ELDER'S LIAISON TO THE COMMUNITY

FIGURE 1.2

PUBLIC HEALTH

ELDER   HOME SUPPORT
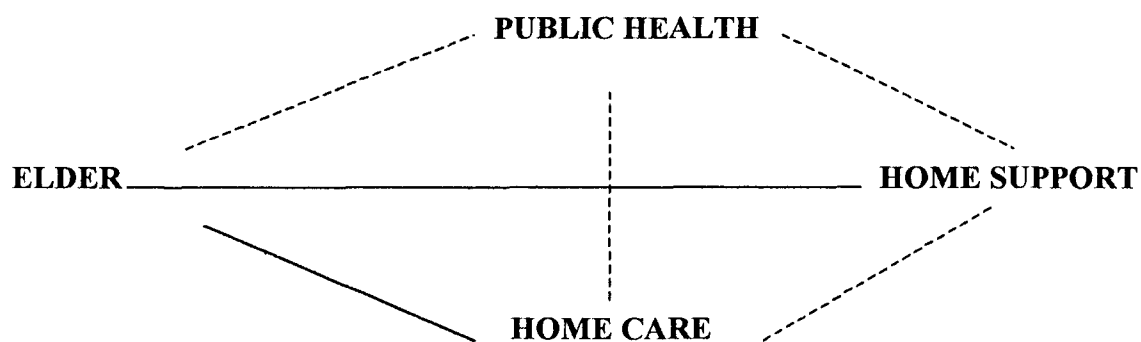
HOME CARE

For a particular elder a profile can be drawn to express the strength of their links to the community. In this example we take 3 health care services; home support, home care and public health. The dotted lines indicate a weaker link (the extent of an established relationship or less than satisfactory delivery of services) to the elder.

The relationship between services is also indicated. The dotted line between home support and public health indicates a weak relationship (i.e. poor communication). Various factors influence the strength of the link between services and between elders and services. In this study, the lack of cross-cultural sensitivity weakens the link between elders and services, as does the lack of continuity of care. The lack of communication between services weakens the relationship between services.

This model can be applied to any elder to explore their ties to the community, organizations, and family. The goal is to look at the strengths and weaknesses of their links and use this knowledge to work towards keeping elders integrated into the community so that their physical, social and emotional needs are met.

elderly need time with health practitioners to explain their fears and concerns, discuss symptoms, and have clear explanations of their conditions." (1982:12)

While the profile of an elder model evolved from the data gathered in the field and some exploration of the literature, the data is not extensive enough to apply the model here. In a future project the model could be applied in the community of Moose Factory resulting in an in-depth analysis of each elder's situation and subsequently in an effective assessment tool for evaluating the elders needs on a case by case basis.

GEOGRAPHICAL SETTING

Moose Factory is an island, two and a half miles long by a half mile wide, located near the mouth of the Moose River, on James Bay. The community is five kilometres from Moosonee, a community located on the mainland shore of the Moose River, inland 13 kilometres from James Bay. Cochrane is a town with population 4,500 located 270 km. south east of Moose Factory connected by railway or aircraft travel, but not by road.

These two communities (Moose Factory and Moosonee) are the largest of the Ontario section of the James Bay coastal region. Moosonee has a population of approximately 1,200. Moose Factory has a population of approximately 1,700 (Agnew Peckham, 1987; Canadian Census 1991). It is difficult to report an exact population figure for Moose Factory. This is most likely due to the inclusion and exclusion of different segments of the population. The population consists of both status or nonstatus Cree Indians, not all of whom are native to

MAP OF JAMES BAY

FIGURE 1.3
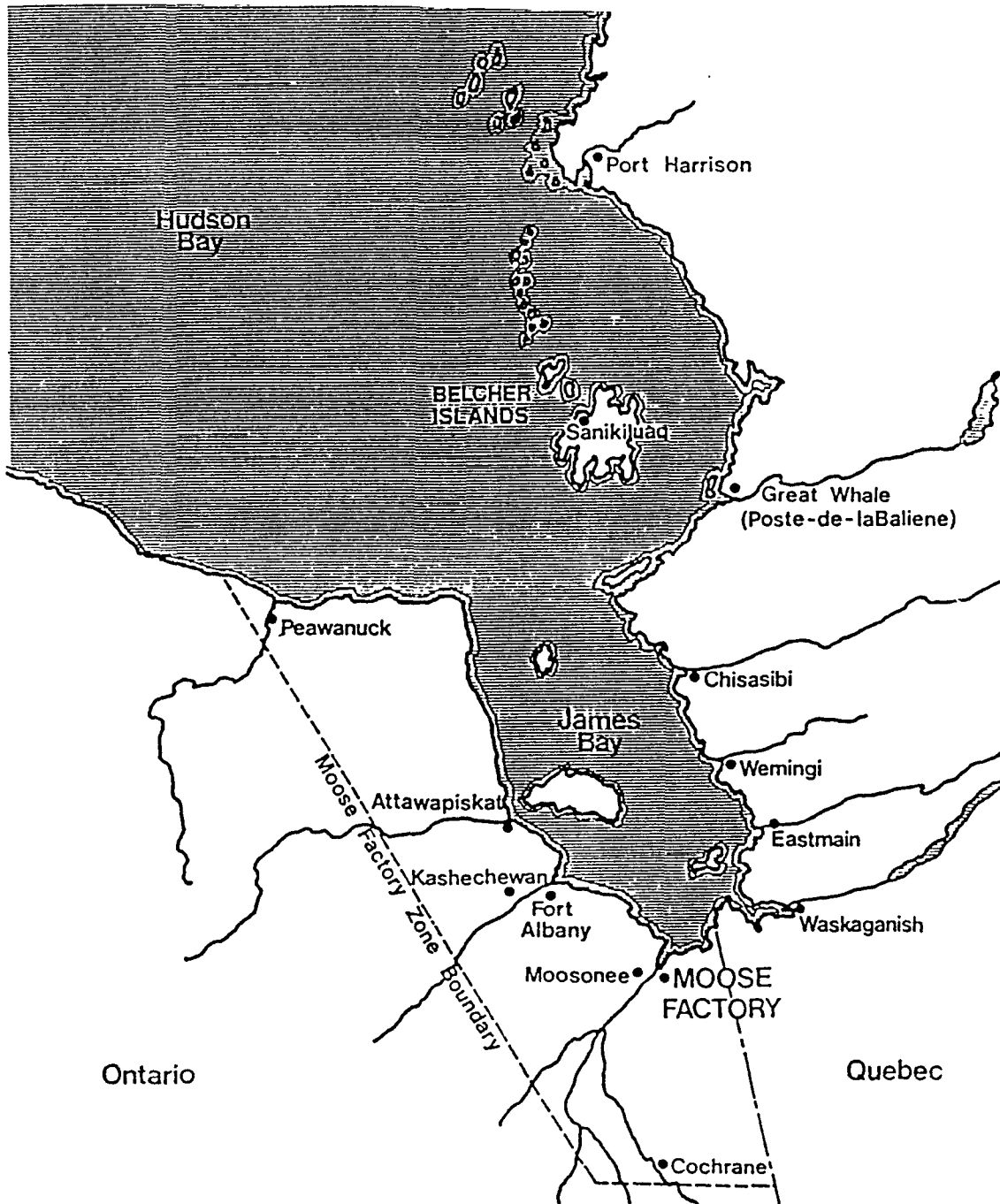
Moose Factory, and health care and government workers most of whom are not native to the area.

The area is characterized by long, cold winters and short, warm summers. Winter begins in late October, lasting until mid March with temperatures averaging -30 degrees centigrade. The average summer temperature is 16 degrees centigrade and it tends to be cloudy. Transportation from the mainland to the island is possible only by helicopter during freeze up and break up of the river. Between late October and mid-December freeze up occurs and between early April and mid May break up occurs.

A SEGMENTED COMMUNITY

In 1988, when I arrived at Moose Factory by water from Moosonee, I climbed a slight embankment and was struck by the view of the Moose Factory General Hospital (M. F. G. H.), a large 3 story awkward looking building resting on federally owned land. Walking beyond it, I recognized blue and white suburban style housing. These too were federally owned and occupied by health care workers. A similar section, "Government Row" occurred a little further along. Beige and on a smaller scale, these homes were for native affairs employees. The land beyond these was provincially owned and had the nurse's residence, public school, and an Indian Affairs office shared with the Mushkegowuk Council. A little further on this main dirt road, while still on provincially owned land, the occupants were nonstatus Indians. Going off to the right, the Hudson's Bay store was not far off. Continuing down the main street, the next dividing line was a privately owned store called G. G.'s,

beyond which was the reserve, owned by the federal government but held in trust for and occupied by the Moose Cree First Nation. These spacial divisions reinforced social divisions that are historically rooted.

The status/non-status division originated with the Indian Act of 1880, which excludes people of mixed ancestry from Treaty except under special circumstances. Treaty nine was signed at Moose Factory in 1905. The Moose Band reservation was established initially some miles upstream at the French River. After World War II veterans decided to settle on the island of Moose Factory and so the government obtained land from the Hudson's Bay Company and established the present reserve. Most Company servants of mixed ancestry were omitted from the Treaty at Moose Factory (Long, 1984). Generally, status and non-status Indians correspond to hunting Indians and company families, as indicated by this informant:

"My grandfather was a cook for Hudson's Bay, my father also worked for Hudson's Bay. As a child it was very lonely since most families went to the bush and other kids were in residential school and boarded there. I only went to day school. Having been Hudson's Bay people we were different from other Indians. My mother had never been to the bush" (S. A., 1988; all initials referring to those quoted have been changed).

Geographical origins vary for status and non-status Indians. Migration from coastal communities on the Ontario side of the Bay to Moose Factory was common. The Anglican residential schools and the hospital promoted movement to Moose Factory from other communities. Once children were in school, families would settle down for permanent

residence at Moose Factory until summer. The hospital was also a reason to migrate to Moose Factory. "My son had a problem with his eye. The doctor said we had to be here all the time to fix it. My husband found a job and I cleaned. It was so easy " (S. A, 1988). Moose Factory General Hospital was built as a TB hospital. This saved the cost of travel to southern centres for care and allowed families to settle at Moose Factory to be close to the patients. Some of these people were adopted by the Moose Band and moved onto the reserve, while others remained on the off-reserve land, establishing homes.

Those immigrants to the Moose Factory/ Moose area who originated in the Cree region of Quebec and who may be beneficiaries under section 3 of the James Bay and Northern Quebec Agreement are represented by the MoCreebec organization. (Blythe et al., 1985:182) Those people who hold no band numbers are non-status Indians while those who hold Moose Band numbers or numbers in their original band are status Indians. (ibid) Regardless of their origin, status Indians became the responsibility of the federal government while non-status Indians became that of the provincial government.

The federal government agencies at Moose Factory were Canada Manpower, Canada Post, and Indian Affairs and Northern Development. Indian Affairs and Northern Development administered four programs, including administration, reserves and trusts, education and social development, and economic and community development for six First Nations or bands in the James Bay area. The First Nation proposes projects that it decides to carry out on the reserve. Most of the provincial government's agencies were based in Moosonee. They included: Ontario Northland Railway, Ontario Hydro, Ontario Housing

Corporation, Ministry of Northern Affairs, Ministry of Natural Resources, Ministry of the Environment, Ministry of Correctional Services and the Ministry of Community and Social Services.

Segments of the population received services from different governments, reinforcing separation between groups. For example, non-status and non-native people in Moose Factory must travel to Moosonee for provincial services. Structural competition between the communities of Moosonee and Moose Factory results when the service is a joint venture of provincial and federal governments. For example, the report of the Women and Work Project (Blythe et. al., 104:1985) points out that "... in education where financing is a joint federal and provincial responsibility, there has been neither duplication nor parallel development of services."

The Moosonee Metis and non-status Indians Association (MMNSIA) was the local branch of Ontario Metis and non-status Indians Association and was affiliated with the Aboriginal People's Alliance of Ontario (APANO). They were in competition with the Moose Band for government recognition and land allocation (Blythe et al., 1985).

Northern communities have historically been divided into two distinct groups- native and non-native (Hodgson, 1980) and consist of two interlocking social systems instead of one heterogeneous whole (Vallee, 1962 in Hodgson 1980). The federal and provincial agencies providing services to status and non-status Indians tended to employ white southerners. This included professional staff for the hospital, school teachers and a few government workers. According to Hodgson (1980) whites tend to see themselves as the administrators, tutors and

managers of the native community. The incoming whites identify with the non-native group and soon find themselves within this clique - learning quickly that the native community is "different from us". As described above, the location of housing and the housing standards reinforce the difference between groups.

The native's views of the native and non-native distinction were clear in the following comments: "The whites take very little interest in the Indian culture. They separate themselves. They claim that the Indians are not friendly or welcoming."(C. B., 1988) "My husband is not like other whites-he likes Indians-he married me."(S. A., 1988) "Whites treat Indians as if they're different and so they are." "We know who comes to be part of the community and who doesn't. They're afraid"(C. B., 1988). In addition, many of the white professional population are considered to be transient and therefore uncommitted to the community (Blythe et al, 1985).

Within the native group many non-status Indians expressed resentment toward status Indians. One informant pointed out: "Education is free for them...I worked so that my children would at least make it through high school...I didn't want to let them go but I knew it was better for them. They (status Indians) have it too easy and then they have no ambition." (C. B., 1988) Similarly, "We (non-status) have worked for everything and they can just sit and it comes to them (status), but it doesn't make them feel good about themselves."(C. E., 1988)

Some (status Indian) families from other locations were adopted by the Moose Band. Many original Moose Band members expressed resentment toward those adopted. "Those neighbours, I don't know them, they come from somewhere up the coast and live here like

us." (H. L. 1988) In summary, Moose Factory has long been a segmented population based on origin and/or affiliation. The community institutions were also separate from each other and had internal divisions within the institutions. The description of these divisions demonstrates the political and social environment the health care system operates in. As an institution in this divided community, health care was vulnerable to the social environment. Within the health care system itself there were divisions. The federal and provincial health care services compete with one another the way businesses do. Agencies compete for funding. In many cases giving funding to one service means cutting it off to another. This competition contributes to the tension between groups and maintains divisions within the community. In addition, the transfer of control for health care services from the Federal government to the Moose Cree First Nation had recently been initiated.

With regard to providing health care services to the elders, services operated in an environment that invited competition instead of cooperation. Within the health care system itself agencies were operated by different bodies of government and provided services for certain groups. For example, Home Care was a federal program that provided a homemaking service, as did the Moose Band's Home Support program. For the elders, the health care system was a potential liaison to the community. However, agencies can be a strong or weak link depending on the politics between groups.

BACKGROUND STUDIES

Health care and long term care are areas of concern for the elders of Moose Factory. This statement is based on findings of two studies which served as sources of background information; namely, the Agnew Peckham report (A. P.) (1987) and the Resource Management Consultants study (R. M. C.) (1986). The A. P. report was commissioned by the Mushkegowuk Council (A regional council representing most of the First Nations) to establish a plan for the development of a health care delivery system to the coastal communities on James Bay in the Moose Factory Zone. The R. M. C. study was commissioned by the Cochrane District Health Council to assess the health services needs of the James Bay region. Moose Factory and Moosonee served as a focus for both these studies.

OBJECTIVES

I visited Moose Factory, Ontario in the summer of 1988 (for 3 months) to investigate health care services to the Cree elders in the community. My first objective was to determine what health care services were available to the Cree elders. These services included hospitalization, public health, home care, home support, an elder's residence and long term care. The second objective was to determine views of health care services held by elders, other residents, native, and non-native government and health care workers. In summary, the

first objective was to describe the existing health care system and the second was to investigate feelings, experiences, and thoughts about the health care services.

The two previous studies provide a formal description of the services available; i.e. 25 beds, 13 rooms, etc. In these studies, little thought was directed toward the how care was provided. The effective provision of services depends on both the physical and social structures. This study moved beyond the simple description of services to the subjective perceptions of the individuals involved. In doing so this study gives a fuller, more realistic view of services to elders in Moose Factory.

CHAPTER 2

METHOD

SELECTION OF THE STUDY AREA

The Federal Government's department of Indian Affairs and Northern Development

provides funds for graduate student researchers interested in pursuing research in the north.

I was interested in going to a community in the north with a specific interest in the elderly.

In 1988, the Chairman of the Mushkegowuk Council visited McMaster and indicated to me

that long term care of the elderly in the community of Moose Factory was an issue that

warranted investigation. He referred me to the Cochrane District Health Council from whom

I obtained the R. M. C.. study. I then contacted Health and Welfare Canada's special projects

division and discovered another study, the A. P.. report (1987), the focus of which is the

move toward transfer of responsibility for health care services to the Mushkegowuk Council.

Both studies identify needs and concerns in the delivery of health care services of which long

term care is one. A proposal for research was drawn up on the basis of these studies

(Appendix A). Moose Factory would serve as the central community under study. Moosonee

would provide a sample of elders who resided in an elders apartment complex, and Cochrane

was the site of a nursing home to which residents of Moose Factory were sometimes sent. I

would make a short trip to Cochrane.

ACCESS TO THE COMMUNITY

Upon arrival in Moose Factory I met with the Chairman of the Mushkegowuk Council who then introduced me to the Health Care Coordinator for the Council, who would be my contact person. We reviewed the research proposal and decided that I should be introduced to the community by someone who had access to the elders. She suggested the Community Health Representative (C. H. R.) for the Moose Band. This proved to be unsuccessful as the C. H. R.. "was otherwise engaged". I decided to begin by simply knocking at peoples doors, introducing myself, explaining the reason for my visit to Moose Factory, and asking whether they would mind me visiting with them. During this time I constructed a map of the community that showed the locations of residents and institutions.

The other approach to meeting people on a more informal basis was my involvement in community activities. For example, the Canada Day celebrations provided an excellent opportunity to see the community in action. I volunteered to help out with community activities. On a day to day basis, regular attendance at church, at the MoCreebec Ladies Sewing Club and visiting both the bannock tent and parish hall, once tourist season had started, all served to establish informal relationships with some of the residents of Moose Factory. In addition, Rula who was collecting life history data for her research referred me to several elders.

POPULATIONS SAMPLED

The total sample size (n) for this study is 102. This number includes residents of Moose Factory, the Moosonee apartment complex (M. A. C.) and Cochrane. These populations are the following: elders of Moose Factory, the Moosonee Apartment and the Cochrane nursing home; health care workers of the various service groups; native and non-native government administrators of health care services.

TABLE 1.1

POPULATIONS SAMPLED

	Elders	Health Care Workers	Administrators	Residents
Moose Factory	40	10	7	15
Cochrane	2	8	4	0
Moosonee	10	3	3	0
TOTALS	52	21	14	15

DEFINING GROUPS

Identifying native and non-native health care workers and government administrators

was easy in contrast to defining the elders. My preconception was to target people over 65.

The Moose Cree First Nation's list of elders included status Indians who were over the age

of 60 or married to someone over 60. I became aware of some people over 60 who were not

on the list.

The traditional Cree conceptualization of elder has less to do with age and more to

do with experience, acquired knowledge and respect (N. W. 1988). This is also the case in

other native groups (Vanderburgh, 1987; Williams, 1980). In general for non- western

cultures people are considered old when they can no longer perform their functions, not when

they reach a certain age (Holmes, 1980). Keith (1980) reports that from 60 societies from the

Human Relations Area Files, function is the most common criteria for defining age, followed

by chronology and then by physical or mental decline. Counts and Counts (1985) include

historical age (birth at the time of some historical event in ones society or memory for them)

and social age (timing of rites of passage in the life cycle) as other criteria. It was difficult to

determine the exact criteria for being on the Moose band senior's list, however it seemed to

reflect the adoption of larger North America's chronological criteria. This made sense given

that funding for such services as home support was most likely based on the federal

government's definition of a senior. Given the focus of this study (health care services) anyone

who required services, or was on the Moose Cree First Nation's list or older than 60 was considered.

I assigned no set number to the sample size of elders. My intention was to interview as many as possible without compromising the quality of the data. The number of male elders interviewed is 27 and the number of females is 25. The number of elders in Moose Factory included in this study is 40. As with the total population the exact number of elder residents in Moose Factory was difficult to establish. Both sources used age (65 or older) as the criteria to define an elder. According to the A. P. report, the total number of elders in Moose Factory was 76, 54 on reserve and 22 off reserve (A.P., 1987). This is in contrast to the Moose Cree First Nation's senior citizen's list revised June 1988 which claimed 64 on reserve.

Initially the only two groups to be included in this study were the elders and those aged from 50-65. I was advised that representatives of the various health care services be excluded because my asking questions might create tension. However I felt that it was important to include the views of these other groups to provide a broader context for understanding health care services to the elders in Moose Factory.

RESEARCH PROCEDURE

The data for this study were collected through participant observation and interviews. Participant observation is an ongoing process, so each evening my perceptions and information obtained were recorded in a personal diary. Interviews were recorded through

note taking if permission had been granted. Interview style varied, depending on the person being interviewed.

With the elders I felt that repeated visits with a very unstructured approach led to the most informative data; interviews were unstructured with respect both to time and to the style of the interview. Repeated visits allowed me to observe the environment that the elders lived in and with whom. In addition, repeated visits allowed the development of a relationship based on trust and respect, thereby reducing the elders' anxiety about being interviewed by an outsider. I was told on a number of different occasions about the outsiders who came to Moose Factory, asked questions, and were never heard from again, other than through their writings. In many instances these writings were considered an inaccurate representation of life in Moose Factory. Two copies of this thesis will go to Moose Factory, one for the library and the other for the Mushkegowuk Council. One copy will go to the Director of the Queen's University Program, responsible for the provision of services.

I considered the importance of our different styles of communicating. Darnell (1981) and others describe Cree interactional style: "Do not use talk to fill silences. Listen rather than speaking. Avoid direct eye contact. Do not use formal greetings or introductions."(Darnell, 1981:3) Awareness of this difference helped to make the fieldwork experience a successful one.

Initial visits averaged half an hour. Some elders were willing to visit longer than others. I showed interest in a return visit but remained flexible about timing. Most responded positively to another visit. In some cases a yes to a return visit actually meant no. Upon

return, most did not demonstrate much enthusiasm for my presence. Gradually, I became more comfortable with this style of greeting and interaction, and visits sometimes lasted three hours. The time spent together consisted of some combination of the following activities: watching television, looking at old pictures, going for walks, engaging in conversation and sitting in silence.

Time spent with the children of the elders was not as long, tended to be more structured and interactions possessed a more direct style of communication. With regard to directness there was more variation in the style of interaction among this group. I relied on my own perceptions of the interaction, and proceeded accordingly with questions, comments or silence. These interviews were conducted at their home, workplace, or somewhere in between.

Interviews with the administrators and health care workers were arranged appointments. Once I had initially asked a question, the MoCreebec representative, Chairman of the Mushkegowuk Council and Chief of the Moose Band responded directly. There was a similar structure to interviews with the public health nurses, the zone director and the medical director of the hospital.

THE DATA

The original proposal questionnaires (Appendix A) were designed to serve as guidelines for interviews with the various populations. These questionnaires served as a loose mental outline during interviews early on in the fieldwork. They were not administered because previous experience (Blythe et al., 1985) demonstrated a low rate of questionnaire return in this community. Recently, Counts & Counts (1992) explored the issue of reciprocity with regard to the ineffectiveness of questionnaires in their studies with RVers (Recreational Vehicle). Counts & Counts (see Kaufman 1986 also) conclude that questionnaires are not effective because they represent an unequal exchange; and do not allow for reciprocity. This explanation for the ineffectiveness of questionnaires in a Cree community seems likely given the cultural value of reciprocity.

Topics of conversation with the elders in Moose Factory included the Band, the federal government, community feeling, children, the Moose Factory General hospital, and health care. The issues surrounding these topics were discussed in a historical and current perspective. Personal histories included experiences about living in the bush, attending residential school, and the role of The Hudson's Bay Company. The subject of long term care and the role of the family is a very sensitive area, so elders were left to address these issues only if they chose to.

Life experience revealed through personal narratives relays not only actual events but also a historical context that acts as a stimulus for thoughts and feelings about the present. In a typical example one elder described attending residential school. She spoke of the

experience as something in the past and referred to what was done to her in terms of not speaking Cree, how she was away from family, touched on the role of the Band, the government, Hudson's Bay and then related it to present schooling for children. "Children can live at home and go to school, the government pays for them to go to University but they don't go. We can't tell them what to do, they don't listen anymore. When we were kids we listened." As the listener, in cases such as this one I would zero in on the fact that a comparison was set up between how it was in the past and how they are now. The speaker has chosen to comment on children and schooling today, but in doing so she focusses her comments on the relationship between elders and children. "We can't tell them what to do...When we were kids we listened." She highlights her own feelings of lack of influence over the children of today.

The other populations, health care workers, administrators, and Moose Factory residents required less of this indirect type of analysis. Access to their views was more direct. Frequently individuals were quite willing to express spontaneously their views on health care, long term care and the politics of Moose Factory. In other cases information was gained in response to direct questioning by me. Health care workers and administrators frequently asked what I was interested in and then proceeded to give their own views on the adequacy of health care services to elders, the integration of services, long term care of elders and the politics of health care in Moose Factory.

The data gathered in Moose Factory through interviews confirmed my perceptions that some elders were vulnerable to the need for better co-ordination of services, the lack of cross-cultural sensitivity and the lack of continuity of care. In addition, on a case by case basis I acquired information on the informal system of care that was, or was not in place and found that patterns of residency, availability of women as caregivers, housing shortages and employment status could contribute to an elders' vulnerability.

MOOSONEE APARTMENT COMPLEX

Because of the need for translation,   visits to the Moosonee Apartment Complex depended on the availability of the elders' coordinator from the Moosonee Friendship Centre. I spent one or two afternoons a week with the coordinator during her daily routine. This allowed me repeated visits with the elders. Activities in the daily routine of the coordinator included visits to the elders for shopping lists, shopping, and taking them to the doctor. On the initial visit the coordinator would introduce me and describe the project to be done over the summer. The residents were asked if they would mind a return visit. The second visit usually consisted of personal history, including living in the bush and the reason for moving to Moosonee. The need for translation made the interaction awkward. I felt it as a barrier to effective communication. I asked direct questions on their feelings about being a resident in a nursing home, living with family and how they felt about living in the apartment complex.

The data from the Moosonee Apartment Complex confirmed some of the aspects of the informal system that influence an elders care. For example, no available kin was clearly a reason for becoming a resident. The fact that an elder's co-ordinator was in place demonstrated the need for elders to have someone link them to the community. The co-ordinator is bi-cultural and therefore able to access resources in the formal health care system, as well as relate and understand the elder's needs. This link to the community reduces their isolation.

COCHRANE

I visited Cochrane for one week. Initially I was apprehensive about this short stay and the possible lack of co-operation that might occur. This feeling was based on the lack of co-operation encountered in Moose Factory where public health staff had initially seemed open and interested in my study, but then put constraints on who I should visit with them and what information they could share with me. The public health nurses said they were concerned with the issue of confidentiality. In contrast, my visit to Cochrane proved to be an informative, rewarding break from the frustrations at Moose Factory. Various agencies that offer services to the elderly in Cochrane were sought out, including Public Health, the Red Cross, Home Care and the Cochrane Friendship Centre. All agencies were extremely co-operative. They readily expressed their concerns about health care and long term care of the elderly.

The Nursing Home in Cochrane is an Extendicare Nursing Home. Ten of the 33 residents are native. The Director of Care was very co-operative and encouraged me to visit with the residents. My short stay did not allow the establishment of a relationship with residents that would allow discussion of the topics that I was interested in. Instead talks with the residents centred on personal history.

The Director of Care had two items that she suggested I investigate. One resident was a native of Moose Factory and he had not had any visitors for some time now. Her efforts to establish communication with family were ineffective and she wondered if I could do anything. Second, she was concerned in general about how native residents could be encouraged to have contact with their own culture.

The Cochrane data is not extensive enough to explore how these elders experience the long term care setting. However, most importantly, it provides a comparison with the community of Moose Factory with regard to the role of politics and services, and it draws attention to the need for cross cultural sensitivity when providing health care services.

CHAPTER 3

HEALTH CARE SERVICES FOR THE ELDERS

This chapter describes the health care services that were available to the elders in Moose Factory and identifies issues related to these services. Lack of coordination of services, cultural insensitivity and breaks in continuity of care were the main issues that impaired elders' access to services and in doing so resulted in their physical and social isolation from the community.

SERVICES

THE MOOSE CREE FIRST NATION

The Moose Cree First Nation, as the only formal governing body on the Moose Factory reservation, was responsible for the following services: welfare, economic development, sanitation, housing, alcohol and drug abuse treatment, recreation, police and by-law reinforcement, and was involved in issues concerning health and education.

The Moose Cree First Nation provided Home Support. This service maintained elders in their homes. Physical tasks such as cutting grass, waste disposal, and getting water were attended to, as well other needs of the home environment such as laundry and house cleaning.Home Support employed an administrator, 3 female homemakers and one male

worker. Of recent concern was difficulty with salaries, facilities for performing services, and too few staff.

COMMUNITY HEALTH REPRESENTATIVE

The C. H. R. was usually a community member who acts as both an advocate for clientele and as a liaison person between Chief and Council and Health Care Agencies. The role of the C. H. R. was to assist in identifying community health care needs and to provide community health information. In addition, instruction and guidance in safe health practices and the proper utilization of the available health care services was also an important responsibility. This person functioned only on the reserve.

The following duties were included:

1) Advise health care personnel and other visiting health professionals on local culture, traditions and ways of life and how to adapt health care services.

2) Help to coordinate preventative health programs in conjunction with Band Council and other members of the health care delivery team to meet the needs of the community.

3) Teach and encourage proper use of health services to community members to ensure the best treatment for their families.

4) Help people understand the need for improvement in community and family health care, sanitation and hygiene by:

    a) teaching proper garbage and sewage disposal and food storage

    b) taking water samples for lab analysis

    c) inspecting dump monthly

d) working closely with Environmental Health Officer for follow up of problem

e) working to control pests and rodents.

5) Work closely with public health nurses to assist with vision screening, home visiting, school health programs, communicable disease follow up, translation when needed, and making referrals to OPD (outpatient department) or to other community agencies.

6) Monitoring vacant housing and living conditions. Writing letters of referral to Chief and Council to indicate which homes are in need of repair, unfit for living or overcrowded (from a description of services provided by the Community Health Representative, 1985).

PUBLIC HEALTH

All Public Health services in Moosonee and Moose Factory was the responsibility of the Board of the Porcupine Health Unit located in Timmins and funded by the federal government. Public Health operated out of offices in the M. F. G. H..

At the time of this study there were 3 nurses, one of who would travel to communities northwest on the James Bay coast. At Moose Factory, public health nurses went out into the community visiting individuals, who need the services they provide. If residents were able, they came to the hospital to receive services. These included: geriatric surveillance, blood pressure monitoring, diet counselling, dressing wounds and the promotion of sanitation and a proper healthy environment. These services were provided on medical referral by a

physician. The staff could request assessment of individuals by specialists in services such as physical therapy, occupational therapy, meals on wheels, social work etc.

HOME CARE

In the summer of 1986, Home Care began on Moose Factory Island, operating out of the Moose Factory General Hospital. As a provincially funded program organized through the Porcupine Health unit, the provincial government provided funds for office space in the M. F. G. H..

One nurse in a part-time position provided hands-on medical care to 13 residents of Moose Factory (1988 & 1991). In addition to the Home Care nurse there was an aide who looked after the physical environment, providing personal care, meal preparation, light housekeeping and shopping. This service was only for those clients who did not have others to perform these duties for them. Clients could be referred for physical therapy, occupational therapy, speech therapy, nutritional counselling, social work and medical supplies. Home Care began in the summer of 1986, however the position was vacant by June of 1988 and remained so for the following 3 months. In December 1991 there was a Home Care nurse in a part time position with approximately 12 cases (personal correspondence, Director Cochrane District Health Council, December 21, 1991).

MOOSE FACTORY GENERAL HOSPITAL

In 1948 the federal government built this 200 bed tuberculosis (TB) hospital in Moose Factory for natives and Eskimos. This northern location reduced travel required to obtain care. Since 1968 it has served as a general hospital to the surrounding communities on the coasts of James Bay. Gradually its service role has been reduced. It now services only the communities as far south of Moose Factory as Cochrane and as far north on the west coast of James Bay as Peawanuk. With this has come a reduction in the number of beds from 200 to 70.

Since 1968 services offered by the hospital have been in conjunction with teaching centres in the south. National Health and Welfare contracts with Queen's University for physicians services, including specialists in internal medicine, paediatrics and surgery, with the University of Toronto for dental care and with the University of Western Ontario for Ophthalmology, Ear, Nose and Throat, Obstetrics and Gynaecology. The usual staff was 3 family physicians and a resident. Medical and dental workers rotated through the hospital for a period that may range from 4 weeks to one year. Two rotating interns and a medical student might supplement these physicians.

In addition to servicing Moose Factory, clinics and hospitals in the communities up the west coast of James Bay were also serviced. Visits by a physician to Attawapiskat, Kashechewan, Fort Albany and Peawanuk were 4 to 5 days in length twice a month.

There was no input from the community in defining the range of services appropriate to the population. The Moose Cree First Nation played some role in the policies of the operation of the hospital, but the role was ill-defined and the impact was not great. Currently, in 1997 there is a local Board of Directors responsible for the operation of the hospital.

MOOSONEE APARTMENT COMPLEX

The Ontario Housing Corporation built this complex in 1975 to provide subsidized housing for those age 60 and over who reside in the James Bay Coastal region. The Timmins Housing Authority assumed responsibility for it in 1977.

The complex has 28 single residential units available to elders who meet both the age and income requirements. The rent was 25% of their monthly income. There was a caretaker who maintained the complex with day to day supervision. The James Bay General Hospital clinic (located right next door) provided hospital care for the residents, while the Porcupine Public Health Unit Home Care program provided nursing and homemaking services.

The Moosonee Friendship Centre also played a very important role in the complex. It provided an elders' coordinator who takes care to see that the residents get to doctors appointments, shopping, and other essentials.

The A. P. report states that the apartment complex was popular, while the earlier report by R. M. C. states that the Timmins Housing authority reported a long standing vacancy problem. Five to ten units were empty at any one time. During the summer vacancy

increased when residents moved home, while it decreased in the winter. The report attributes

this to the cultural practice of elders being taken care of by their extended family. In addition,

the security of the building was threatened by non-residents attempting to get in and by

residents letting them in, to party.

LONG TERM CARE

In 1997 there is no formal long term care facility in Moose Factory or Moosonee.

The closest facilities are an Extendicare nursing home at Cochrane with 62 beds, two nursing

homes at Timmins and an 8 bed extended care unit at Attawapiskat. In some instances the M.

F. G. H. will provide permanent residence.

BARRIERS TO EFFECTIVE SERVICES

The community offered support through both informal and formal support

systems. The individual's interaction and involvement with these support networks

contributed to their integration into the community. Not only were physical needs met, but

also important social and emotional needs were met, since the giving of care occurs in a

social context. For an elder isolated by a physical disability, a visit by the public health

nurse is an opportunity for social interaction, an exchange of information about community events, people, and even gossip. A doctor's appointment becomes a visit with an old friend. However for these services to be fully effective they must be accessible to those who require them. The services themselves can either encourage or discourage involvement with clients. Encouraging relationships with clients might come in the form of establishing a relationship outside of the clinical context or being sensitive to more traditional ways of communicating. The strength or weakness of the connection to the community depends on the services integration into the community. For example, Dr. Delahaye was a strong link because of established relationships with elders and his involvement and commitment to the community. The public health unit showed some weakness with regard to its relationship to other service groups in the community given the political tension and subsequent lack of communication between service groups. Particular public health nurses, however, may create strong links with particular clients depending on personality and cultural variables.

COORDINATION OF SERVICES

My experiences with the various health care services in Moose Factory revealed the need for a more coordinated effort to ensure the effective delivery of health care services. The lack of communication between health care service groups, a consequence of political tension, resulted in the lack of coordination of services and therefore impaired the effective delivery of these services. For elders, these services provide a liaison with the community, providing

the opportunity for relationships and social contact. When the services are impaired elders become isolated.

The lack of coordinated health care was evident in the organization of the provision of services. Health and Welfare Canada's Indian and Eskimo Health Services Division bears final responsibility for providing services. These services were either delivered by federal government agencies or purchased from provincial government agencies. Thus the level of government delivering services varied from service to service. This was evident in the construction of hospitals and provision of staff in communities along the west coast of James Bay. "At Attawapiskat and Fort Albany the province built a hospital and provides nurses and doctors. At Kashechewan, nurses are provided by the federal government. At Peawanuk the health centre is provided by the federal government." (E. E., 1988) At Moose Factory the hospital and staffing was a federal responsibility. Through the transfer of responsibility to the regional Cree authority, a local Board of Directors now oversees the operation of the hospital.

There were three governing bodies contributing to the provision of health care services in Moose Factory; the federal, provincial and native governments. Each had its own conceptualizations of the needs of the elders in the community and consequent objectives, methods and goals. To some degree all were coloured by the political tensions. With very little or no communication between these groups, each worked in isolation.

In 1983 the Cochrane District expanded to include the James Bay Coastal Region which was also part of the Moose Factory Zone under the zone divisions of Health and

Welfare Canada. The Cochrane District Health Council (C. D. H. C.) then commissioned R. M. C. to do a study to assess the needs of the region. The resulting study was released in January of 1987: "This report documents our analysis and assessment of the current health care system in the area, identifies those services which have been improved since 1977, as well as those which continue to require upgrading, and outlines and discusses our recommendations for future service program needs and improvement. Recommendations have been classified according to priority reflecting short term (1-5 years) or long term (5-10 years) action."(R. M. C. cover letter, 1987)

While the C. D. H. C. was looking at long range plans, in the fall of 1987 A. P. completed a study undertaken on behalf of the Mushkegowuk Council in conjunction with the Council's move toward self-government of health care services. "The Role Review and Master Program outline the future range of clinical services, associated health care programs and facilities necessary to meet the future needs of the Mushkegowuk people." (A. P. cover letter 1987) Through these 2 studies different governing bodies are taking action to enhance health care services to the region, identifying problems and finding solutions.

Services to elders in Moose Factory were not coordinated. The R. M. C. report recommends that "To improve coordination and planning of health services... it is recommended that a Community Health Service Planning and Coordinating Committee be established with responsibility for community-wide planning, service development, service problem resolution and continuing education.... The committee could provide a mechanism to formally link together all health agencies in the area to ensure that they meet routinely to

plan and solve problems on a community level rather than only at the service or agency level."
(R. M. C.; vii, 1986) Although another committee may not be the solution, the important point is recognition of the need for the coordination of services.

Services were duplicated by the various agencies mentioned above. For example home support and home care both offer homemaking services, yet were run by 2 different bodies, the Moose Band and the provincial government respectively.

Tension and suspicion dominate the relationships between groups. The Home Care nurse was very direct about the politics of health care: "The Moose Band was at first skeptical about taking on a provincially funded program such as home care. If they accept this service, they cannot go to the federal government for funding and they can expect to have some other program cut off."(W. M., 1988) This tension is further evidenced in the control the Moose Band exerts. The home care nurse cannot go on to the reserve without permission of the Chief of the Moose Band.

My initial involvement with the public health nurses was met with much enthusiasm. Later when I attempted to set up a meeting, I was confronted with their concern with the issue of confidentiality. After mentioning this, the public health nurse in charge said that I could go with one of the nurses to 2 homes that afternoon. This seemed contradictory to me. Somehow the issue of confidentiality did not apply to these two homes. I was confused and angry. Further attempts to establish a rapport revealed an explanation for their behaviour.

During my later fieldwork a new Zone Director was appointed. Born and raised in Moose Factory and having worked for the government in different capacities, he was

welcomed into this position by native and non-native administrators and residents. I was fortunate to have met him and to have had his encouragement. My formal meeting with him put the public health nurses' previous behaviour into a framework that I could understand. I think that those 2 homes were chosen because the public health unit had a good relationship with those residents. If they had taken me indiscriminately to other homes where the public health nurses' felt that they had a tenuous relationship with the residents, this action could be interpreted as some kind of violation. The fact that they did not feel comfortable asking residents if they minded my presence, is an indicator of tension or a lack of familiarity in the relationship. From their perspective they took me to homes where they felt the residents would welcome me, given that the relationship between nurse and client was congenial.

Because of political tensions, the hospital administration instructed health care workers to obtain an "okay" before discussing issues. I found this out later in my formal meeting with the Zone Director. After I asked the Moose Factory Zone Director for permission to speak with them, and conveyed this to the public health nurses, they co-operated.

The public health nurses recognized the tension between native and non-native governments. While they felt that there was less than adequate communication between the Moose Band, Mushkegowuk Council and themselves, they seemed unsure of how to enhance communication. A similar attitude was held by the health care coordinator of the Mushkegowuk Council, who also recognized the lack of communication between groups. In general, I found non-natives in these service positions to be more reticent about their own role

and behaviour than natives in similar positions. Perhaps this caution suggests support for the community's criticism of what it is that government health care workers and administrators actually do. Non-native workers who are more reticent may be so because they recognize issues of concern but support mechanisms are not in place to allow them to take action. My probing made them feel uncomfortable.

The fact that the public health nurses' previous behaviour with me was constrained by imposed rules about discussing issues is what suggests to me that behaviour is to some extent influenced by political tensions. This is in contrast to my experience in Cochrane with the health care professionals. They demonstrated little constraint on their willingness to discuss issues of concern. They were not concerned with feeling vulnerable to criticism, and therefore were able to give me information that demonstrated weaknesses in the health care system. They were open about the manner in which they operated the public health unit. For example, I was quite surprised that they had no native clients, given that I was aware of a vulnerable population of elderly natives living in town. I commented on this and while they seemed unaware of this group, they agreed that their access to the native population was problematic. They were not defensive.

In Moose Factory, the tensions that existed affected peoples' attitudes and their attitudes affected behaviour. The apprehension on the part of the public health nurses to go out into the community resulted in inadequate care to elders. The visit to the home environment would expose the nurses to living arrangements where prevention could be taught and the involvement of other groups could occur if necessary. For example, in a

routine visit by the public health nurse, the nurse would become aware of needs such as laundry and cleaning of the environment. The nurse could then pass this information to the home support service that could then see to meeting these needs. In some cases the elder might require a short visit to the M. F. G. H. where medication can be stabilized or the elder can be attended to until they are feeling stronger and more stable (under the unwritten policy that M. F. G. H. will take elders in for 2 weeks at a time). Alternatively, if home support is making visits the employees have contact and information about the conditions people are living in. If conveyed to the public health unit they could address the problems. But at the time of my fieldwork communication channels were blocked and the information was never conveyed.

With regard to physical care, the elders did not benefit from the services that were potentially available. Being physically alone and not able to care for one or rely on others for the necessary care resulted in feelings of isolation. Because health care happens in a social context the giving of care provides an opportunity for social interaction. The more visitors elders receive, the more social interaction they have, and the more liaisons they have with the community. They receive valuable information about the community and inevitably feel that they are part of it. Any feeling of isolation is reduced.

When asked their opinions on the services that affected them, the elders were critical of services that they did not receive. Elders did not complain about home care. It was clear that the home care nurse went out into the community to visit. Home support was only criticized on a few occasions for requests that had not been fulfilled, mostly small jobs, like

light bulb replacement. My observation was that these services, (home support and home care) were reliable and that the residents were grateful for the services. Those who received the services supported my observation.

In contrast to home support and home care, residents were critical of the C. H. R. and the public health nurses. There was a questioning of what it is exactly that these agencies do. Most complained about having seen the C. H. R. once and never again. The C. H. R. had sent out a letter to residents telling them that he would come and visit monthly. Some residents had been visited once, many were still waiting.

My personal experience with the C. H. R. was similar. It seemed practical for me to gain introduction into the community through him, (this was suggested by the health care coordinator of the Mushkegowuk Council) since my study was being supported by the Moose Band and the C. H. R.'s job includes visits into the community. While he offered to help me out with introductions into the community, this never materialized. I soon realized that he was being assigned to do other tasks and thus his role as a liaison with the community suffered.

Residents' views on public health were similar: "Public health does not go out into the community as they should. They instead wait in their offices for people to come and see them." (C. A., 1988) Many people refer to a time gone by: "There was a public health nurse here for eight years. She was extremely outgoing and would go out into the community. Every morning at 8 a. m. she would leave for her visits, having tea at everyone's house " (C. B., 1988).

What seemed important from the elder's point of view was that people come to see them and be concerned about how they are. This reflected a wish for involvement and interaction with others in the community. The residents desired a more community oriented approach on the part of administrators, health care workers and others in social service positions. To create a more unified approach, each service group needed to work towards enhancing communication both within and between groups. The resulting coordination of services would have acted to service elders better and provide a stronger liaison with the community.

CONTINUITY OF CARE

Health care professionals are unlikely to commit themselves to long term residency in isolated communities. Hodgson (1980:68) pointed to the same issue in her study on nursing in the Canadian north. Zones such as Moose Factory and Sioux Lookout are isolated and face the problem of a lack of continuity of care. With this rotation of physicians, residents of the community see many physicians over the course of a lifetime. Although the whole community is affected by it, elders are especially vulnerable as they have lived the longest and seen the greatest number of doctors. The issues the Director of the hospital was concerned about included " ...quality and continuity- scientifically the quality is good. Quality of doctors is not as important as continuity when it comes to the elders" (E. E., 1988).

The need to provide continuity of care is a basic public health and medical care tenet, a fundamental component of comprehensive health services. Physical continuity is held to be the system preferred by both physicians and patients resulting in greater efficiency and increased satisfaction. (Petchers and Milligan, 1988)

The lack of continuity of care impacts on the quality of health care and contributes to the isolation of the elders. With regard to the quality of care, a short term physician is familiar only with what he/she sees currently or reads in records. This is in contrast to a physician who sees the same patients regularly and has a historical context to place the current symptoms in. Additional information about a patient can only enhance the physician's ability to make judgments. In fact continuity permits doctors to become well acquainted with patients problems and needs. In an urban population continuity leads to relatively lower rates of ordered lab tests, illness visits and hospitalization. In addition, compliance with prescribed regimes was increased as well as keeping follow-up appointments (Becker et al. 1974).

In a cross-cultural setting, the lack of familiarity implicit in seeing many physicians is compounded by the cross-cultural differences in communication and by the lack of cross-cultural training. The following section on "cross-cultural health care" describes elders using the more traditional style of communication. The lack of familiarity can not be overcome by asking direct questions. The physician and patient's limited experience with each other's way of communicating will influence the comfort level and possibly the exchange of important information. This may influence both the course of action the physician takes, and the compliance of the elder. In general, miscommunication is an alienating experience.

A short stay in the community does not allow for the development of a doctor-patient relationship. The importance of the doctor-patient relationship to elders is exemplified in the many elders who spoke fondly as they relayed their experience with Dr. Delahaye, a paediatrician and Dr. Woolfe, a surgeon. Having returned to the community over a long period of time and become involved in community life, they are considered part of the community. It is clear that a visit to these physicians is a visit to an old friend. The relationship that elders have with these physicians is an opportunity for social interaction, and an exchange of information about community events. These physicians are well established in the community and therefore provide the elders with a strong link to the community. This is in contrast to the weak link provided by physicians who remain for a short time in the community, have little involvement in community life and are perhaps just beginning to establish relationships outside their immediate group when it is time to leave.

Residents of the community are very aware of the transient population, and their lack of commitment to the community. (Blythe et. al., 1985) My experience with elders suggests that the pattern of establishing relationships with physicians that then leave, is stressful. For example, one elder relayed her disappointment at the loss of a visiting resident physician who had come to Moose Factory for a year but was soon to leave. The resident physician had often been to the Saturday night ladies sewing group and would often seek this elder's help with sewing. They had become close to each other outside of the clinical context and enjoyed each others company. The elder felt that she was not only losing a physician, but a friend.

Another contributing factor to the continuity of care issue is the segmented nature of the community (described in Chapter One). In a segmented community such as Moose Factory, incoming physicians will associate with the group that they are most comfortable with; white, transient professionals. Upon arrival in the northern community, newcomers are greeted by members of their own group, white professionals who will orient them to the community in such a way that social segregation will be maintained. To some degree personal disposition of the physician influences involvement in the community. For example, the dietician was particularly interested in becoming involved in the community and did so. But most will remain associated exclusively with this group and not be encouraged to participate in community affairs. Their knowledge of the community and its residents will remain limited. (See Paine 1977 and Hodgson 1980 for details of this phenomena) The difference in housing, living standards, language, and culture will be maintained as social barriers. (Hodgson 1980:87)

Over the course of their short stay, what limited exposure these health care professionals do have in the community creates a weak link for elders. Thus, the manner in which doctors are provided (on a short rotation basis) perpetuates segmentation of the community, impairing the physician's role with the elders as a liaison to the community. This contributes to the isolation of the elders from the community.

CROSS-CULTURAL HEALTH CARE

"In working in a cross-cultural setting you will first be accepted as a person and only later as a professional." (Aeschliman, 1973:661)

The health care system in Moose Factory failed to recognize the importance of cultural differences. In this section two issues are addressed. First, communication style influences effective health care delivery. This will be paralleled in the fieldwork experience. Second, lack of awareness of the influence of cross-cultural differences maintains barriers in communication. For health care services to be a liaison for elders to the community, communication with elders is vital. Drawing on the Medical Anthropology literature on this topic I offer suggestions on overcoming these barriers.

COMMUNICATION IN THE HEALTH CARE SETTING

Communication in the health care context between patient and health care worker is fundamental to the effectiveness of the delivery of care. As Hogdson (1980: 62) points out in her study of nursing in the north, "The northern nurse has a doubly difficult task, for she must achieve interpersonal competence 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. Similarly, for the fieldwork experience to be successful sensitivity to styles of communication is necessary.

Communication between health care workers and patients in the western medical system relies on a shared style of communication. The dialogue is usually of a question-

answer structure, which the patient perhaps initiates with the reason for the visit and then the health care worker follows up with a line of questioning relevant to the complaint. The patient expects the questions and responds.

In contrast to this style of communication is the more traditional Cree style of communicating, described here by a diabetes education planning committee member. First, direct questions put people "on the spot." Part of their identity is being peeled off by each question. Natives show respect for the other person by showing interest rather than putting them on the spot by demanding answers to questions. Hodgson (1982) also points out the need to maintain harmony in conversation. Second, natives tend not to hear direct questions. The cue words who, what, where, when and how are not used in indirect questions. There is a tendency to say I wonder or maybe. Third, natives have flexibility with time that non-natives do not. There is a tendency to expect some kind of answer when a question is asked. Natives show respect by leaving it up to the person to respond. Fourth, is the need for balance in interaction. No one must show superiority or put anyone down. Given the differences in communication style between traditional Cree culture and greater western society, sensitivity is essential if communication is to occur.

Before going to the field I wrote a proposal that included questions on the topics that I was interested in. I was advised that these questions should not be asked directly. Cree elders tend to use the more traditional style of communication. But as enthusiasm mounted and I became eager to gather data, I found myself asking direct questions. I was confronted

with the difference between our communication styles. My questions did not elicit a direct response but rather silence or some other comment. I learned to be patient.

Preston (1975:3) demonstrates this point clearly, "Many of the questions I asked received an " I don't know answer" and these minimal replies were appropriate. I had to learn what to ask and how to ask, and even more important, when to just keep quiet and listen patiently. More structured or aggressive questioning sometimes elicits immediate answers, but in the long run the patient approach, with gradually increasing ability to understand answers, is much better suited to the goal of depth ethnography."

Health care workers in the context of providing care are not engaged in deep ethnography, but their awareness of cultural differences such as communication style can enhance their effectiveness as health care workers, especially with elders who tend to communicate in a traditional Cree style.

Yet, awareness of the importance of cross-cultural differences is limited. Reference to this issue was noted only by one health care worker and by one in an administrative position. While I was in Moose Factory, I had several discussions with a medical student working in a summer job position. She recognized that for incoming health care workers there was no introduction into the community or cross-cultural awareness training. On her own initiative she put together a book that provided some information about life in Moose Factory. Included were articles on "nursing in different cultures" and "understanding your native patient." Her intention was to return to Moose Factory during a medical school elective,

begin the development of a cross-cultural training program and investigate the issue of

integrating health care workers into the greater community.

In contrast to this fresh, open mind, were others who refused to acknowledge the

significance of cross-cultural differences. One non-native health care administrator, interested

in hearing what my study was about, suggested people to be interviewed. "Just get on with

it," he said when I explained that I was doing an Anthropological study and this meant

establishing relationships with people so that I could obtain meaningful information. He

suggested I just make the rounds and ask my questions. This comment from the director of

the Queen's University program responsible for sending doctors to Moose Factory

demonstrates a lack of awareness of cultural differences. From our conversation, I concluded

that he did not fully understand the role of establishing relationships with informants and its

impact on the data gathered, nor its effectiveness in cross-cultural health care services.

While "...Anthropologists have traditionally resisted what some people have referred

to as `quick and dirty applied research'" in current Medical Anthropology there is an area

referred to as "Rapid Ethnographic Research" (Pelto and Pelto, 1990:292). When applied in

an appropriate situation this approach can provide some basic data for health care intervention

programs. However, established relationships usually lead to co-operation and interest on the

part of the local residents and it takes time to establish and experience a relationship. In

addition, the time spent also serves the "... tendency to collect a great deal of data about

economic factors, social relationships, cultural belief systems, political processes and other

aspects of the community, even if the research intention is focused on a specific health question" (Pelto and Pelto, 1990:274).

There are those who are aware of the differences. "The Cree need to learn to be direct, make eye contact and answer questions," a non-native health care worker complained, "I can't talk to someone who hangs their head down and won't look at me. They've got to learn the way we do it." (Cochrane Red Cross Unit Representative, 1988) This comment, while it acknowledges a difference in behaviour, demands conformity. This person is representative of many who do not recognize interaction as a negotiated process.

The implications of this attitude with regard to elders in the health care context are vast. Health care workers are in Moose Factory to deliver care, yet implicit in the delivery of their care is a well-defined role for the patient. This rigid attitude works to exclude the patients who do not conform to the health care worker's expectation. This population certainly includes elders who in general tend to use traditional ways of communicating. The experience of not being able to communicate is an alienating one and can only result in elders feeling isolated from these service groups. For elders these services are then a weak link to the community.

SUGGESTIONS FOR EFFECTIVE COMMUNICATION

One of the goals in the health care context is to establish a health care worker-patient relationship where trust and respect are major components. These qualities develop from conveying needs and concerns, and being listened to and understood.

Current Medical Anthropology (as a discipline) offers insight into how this goal may be achieved. Dougherty and Tripp-Reimer (1990) describe the similarities between nursing and anthropology and point out the potential for gaining knowledge and awareness in the context of providing care. "Nurses, participant observers in home and hospital environments, learn the intimate details of health and illness through their physical proximity and temporal relationships with patients; this parallels the fieldwork setting used by anthropologists. For the authors "...the nature of understanding is transformed by the intimacy of the interaction, a function of being there." Nursing and Anthropology rely on observation, on "being with" and "understanding other" (Aamodt, 1982).

Although this "hands on" approach makes sense; its application in Moose Factory is not simple. As an illustration I must describe my own experience as a patient at Moose Factory General Hospital. I sprained my foot playing basketball. Due to the extent of the swelling I went to the outpatient clinic where I first saw a nurse who then had to reach the on call physician. The physician inquired about the problem and stated that she could not attend to a patient now. She instructed the nurse to obtain a x-ray and then she would come over to the hospital. But instead, over the phone, the physician asked the x-ray

technician to read the x-ray and she then decided it was just a sprain. I never saw the physician. Upon inquiry I was told that this was common practice for this particular physician.

While there is the potential for knowledge during contact, in Moose Factory this contact may not occur. From my personal observation, I conclude that individuals with responsibilities have to be held more accountable for their behaviour. Once physical contact is an established part of the health care system, cross-cultural training is necessary. Medical Anthropology and its various subdisciplines (Clinical Anthropology, Clinically Applied Anthropology, Critical Medical Anthropology, and Transcultural Nursing) have shown the western medical system to be a subculture within its own culture and have addressed cultural factors that influence illness and effective medical care in the cross-cultural context (Kleinman et. al., 1978). Capra (1987) sums it up nicely "The health of human beings is predominantly determined not by medical intervention but by their behaviour, their food, and the nature of their environment. Since these variables differ from culture to culture, each culture has its own characteristic illnesses, and as food, behaviour and environmental situations gradually change, so do the patterns of disease." (Capra 1987:138-139) Yet cross-cultural training and education of health care workers is minimal. The very powerful perspective that Medical Anthropology offers has practical application to these problems.

For example the previous description of physician-patient interaction in the western medical system can be examined with regard to the structure of that interaction.

This structure can then be distinguished from the Cree style of communication. The challenge to the health care worker is to negotiate the style of interaction. Fundamental concepts such as world view would teach that the health care worker brings his/her own world view as does the patient. The interaction is not a matter of one dominating the other, as I found in Moose Factory, but rather respect for each other. Cross-cultural training of health care workers will reduce the influence of cross-cultural barriers, enhance communication between health care worker and patient and establish a stronger link with elders that facilitates their engagement with the community.

Personal style and limitation will always be a factor in the success of the cross-cultural context. The dietician in Moose Factory was an exception. She was surprised that she did not receive any cross-cultural training. She also recognized that she did not feel confident about her interactions because she felt the barrier in communication. She felt it was essential in her job to communicate in a way that was agreed upon by both parties. Unlike others she had become active in the community, taking interest in events, and establishing personal relationships with people in the community. She established a context for the relationship outside of the hospital that then fed back on the hospital context. She found this to be an effective method for enhancing communication between her and clients. Similarly, Deagle (1986) comments that cross-cultural differences can be minimized through sharing in the community life of patients. Most health care workers do not participate in the community. I spoke with people who had never ventured past the Hudson's Bay store. They claimed there was no reason to.

As an Anthropologist you find comfort in "otherness", but for others this often induces fear. The fear is evident in the rejection of alternative ways of being. Deagle is one of the few to recognize that "Examination of other cultures leads to increased self-awareness," With this "There is pain in finding out things about oneself and in becoming aware that our own cultural "glasses" have in fact been a perceptual screen that distorted what we perceived as reality. It is painful to acknowledge that other cultures are not better or worse, not richer or poorer than ours; they are just different."(Deagle 1986:1318) The dietician at Moose Factory and the director of the care at the nursing home were not afraid to recognize others as different from themselves. Instead of defending against the difference, they were confident enough within themselves to embrace the difference. They recognized that the failure to acknowledge differences would create barriers in effective communication. They will be less effective in their role as health care providers. Deagle writes, "The study of other cultures is a powerful tool to increase self-awareness. Such self-awareness will vastly improve the effectiveness of care-givers even *within their own cultural group* (Deagle 1986:1318).

CHAPTER 4

INFORMAL CARE AND LONG TERM CARE

This chapter examines the everyday care of elders, which rests with the informal

support system. Stresses on this system make it difficult to always provide adequate care.

Suggestions are made with regard to improving the informal system. The issue of long

term care demands sensitivity to the growing generation gap between elders and younger

generations. Placing elders in a long term care facility will physically isolate them from the

community and make cultural continuity increasingly difficult for the Cree.

THE INFORMAL SUPPORT SYSTEM

The formal support system described in chapter 3 refers to services organized and

administered through a government agency (Chappell et al., 1986). In Moose Factory this

includes the organized service agencies such as home care and home support as well as

hospital and physician services. Home care, home support and public health contribute to

maintaining elders at home. The other support system that plays a major role in care of the

elders is the family and neighbours; (Table 4.1) referred to as the informal support system.

Definitions of the informal support system vary. Bienvenue and Havens (1986) define it as

"...help from the primary group for such activities, as personal care, meal preparation, and

house repairs." For the purposes of this study this informal network will be examined with

regard to maintaining elders at home.

TABLE 4.1

ELDERS RESIDENCE PATTERNS

	With Family	With Grand children	Couples	Alone	Hospital Resident	TOTALS
# Elders	26	13	20	2	5	66
#House holds	17	7	10	2	--	36

Table 4.1 shows that fifty-nine out of the sixty-six elders whose residential status I became aware of live with someone. This informal support system may include a spouse, unmarried sons, daughters and grandchildren; married sons, daughters and grandchildren and their spouses and children. Of the couples, two are sisters and two are friends. This residency pattern shows that elders normally have physical proximity to kin.

This pattern of residency is similar to other native groups, although in Moose Factory a very small percentage of elders lived alone. Murdock and Schwartz (1978) looked at native Americans in North and South Dakota and found 28.8 % (40) living alone, 13.2 % (21) part of a household with an elderly couple and 58% (93) living in a household with an elderly person or couple and one or more children. Bienvenue and Havens (1986)(n=2410 non-natives and 110 natives) looked at residence patterns of natives and non-natives in their

comparison of the 2 populations use of formal and informal networks. In the native sample, 79% live with 2 or more people in a household. Similarly, a smaller percentage of native elders live alone or with a spouse (35%). They point out that they are not sure whether this pattern is linked to tradition or simply due to overcrowding, given that there is a housing shortage on most reserves. While physical proximity may make it easier to provide care, in some circumstances it may also be a source of stress.

FACTORS INFLUENCING ELDER CARE BY THE INFORMAL SUPPORT SYSTEM

Kin dominates informal networks. (Stoller and Pugliesi; 1988: 499) In Moose Factory where most elders lived with family, it was the family who provided care. Responsibilities and constraints in the home context impacted on the availability and role that family can play in the care of the elders. Among these were the health of caretakers, the role of women, the housing shortage, unemployment and employment. When the elders needs are not met this contributes to their social and physical isolation.

For an elderly couple independence is maintained through spouses helping each other (Fischer, 1984, in Stoller, 1989). As the health of one declines, the burden of responsibility rests with the other. This role as caretaker can be very stressful and result in the declining health of the caretaker. In Moose Factory, there are several couples who rely heavily on each other for help with daily activities. In the most extreme case the husband needed supervision and basic caretaking, and his wife had her own health problems. She found it very stressful

and was not able to look after him adequately. (R. K., 1988) There were no kin available to remove the burden of care. The M. F. G. H. took this elder into the hospital for 2 weeks at a time re-establishing his health and giving her a break.

Women have always played a major role in caretaking. In larger society when there is no spouse to care for an ailing elder or the level of care is not adequate, the most likely person to care for an ailing elder is a daughter. Traditionally women are the primary caretakers, but now more than ever women are working outside of the home (MacLean and Bonar, 1983). The Report of the Women and Work project (Blythe et al., 1985) supports this observation as applying in Moose Factory: "Historically, the number of women working outside the home has increased over the years. Long term residents generally noted a trend toward more involvement outside the home, but it is clear from the interviews that women - native and non-native - have always carried responsibilities for family support." (Blythe et al., 1985:122)

This expectation no doubt puts women in a bind; as a primary caretaker of others and as a source of family income. Brody (1981) uses the term "woman in the middle" to describe daughters and daughter-in-laws in the middle of the demands of various roles: the traditional value of caring for the elderly and the more current trend that sees women fulfilling their potentials in the work force (Robinson, 1988:240).

A secure financial base can allow women to take on the role of the primary caretaker. Several years ago a woman's father was living alone and became ill. His daughter wanted to

take care of him and was able to quit her job because of her financially secure position with her husband (D. G., 1988).

Regardless of the additional responsibilities shouldered by the working woman, the expectation that women will be the caregivers has not disappeared. Two elderly sisters who lived in their own house were neighbours to one of the woman's daughters and her family. In addition to these elders receiving home support twice daily for water supply, this daughter checked in on them daily. These elders proposed that when they needed more care the daughter would quit her job at the hospital and care for them. In general when elders were speaking of caretakers they always referred to a female; a daughter, daughter-in-law or granddaughter.

The housing shortage in Moose Factory created stressful living conditions. There was a shortage of houses, and a long waiting list due to limited funds that only allow the building of ten houses per year (R. E., 1988). The shortage of houses meant that people live in overcrowded conditions; sometimes 4 generations live in one small three bedroom house. In some instances inadequate sewage, plumbing and heating systems were a source of stress. Additional stresses included alcohol addiction and high rates of unemployment. For some residents the home situation was already stressful and was added to by the increased responsibilities of meeting the needs of an elder.

Employment can make it difficult for family to be adequate care-givers. For example, I encountered a couple who had been left for the weekend by their two adult sons with no food, money nor the state of mind to obtain any. The father is somewhat forgetful; the mother

is confused and incontinent. I had already met one of the sons early on in my visit to Moose Factory. He seemed responsible and concerned about his parents, but unaware of the extent to which they needed supervision. When I talked with him about what had happened on the weekend, he said that he and his brother were away working and that there was no one to look after his parents.

The above mentioned constraints that impair the informal network's ability to be effective in supporting the elderly are fuelled by the varying needs of the elders themselves.

THE ELDERS' NEEDS

The capabilities and needs of elders vary. One population of elders was those in need of nursing care (12). The home care nurse provided necessary nursing care. The home care aide attended to the environment if there is no one else to help out. Responsibility for the everyday needs of the elder rested with the family. In most cases, these needs included seeing to meals, medication, and personal care.

A second population of elders (approximately 5) was not in need of nursing care but in need of basic-care taking, usually because of the loss of their mental faculties. Four of these elders resided at home with family who was faced with providing supervisory care. Many residents were aware of the need for care of this vulnerable population as evidenced by these comments: "It doesn't matter if most elders live with their children- that does not mean they are being taken care of. ...there's neglect (S. E., 1988). "They won't tell you about that-

starving and they can't get out. Many are in okay health but they're senile and left alone." (G. S., 1988)

Mental impairments create added difficulties for care-givers. Unlike physical impairments that make it possible for others to recognize tasks that the elder cannot perform, mental impairments such as confusion or memory loss show only subtle signs to begin with and are even less evident if one is inexperienced in recognizing an elder's decline in mental functioning. Mental decline evident in behaviour is often intermittent. Memory loss is an excellent example of an intermittent occurrence. An afternoon of confusion can be followed by days of clear mindedness.

Often elders with mental impairments were left with duties that they had difficulty performing. One elder who was usually able to get his lunch could not remember if he had eaten or not. Many residents of the community told me of situations where younger generations go to work and leave grandma and/or grampa to baby-sit young children. In his letter to the Chief, re: concerns about home support services, the C. H. R. mentions that "Drug compliance is not followed.... Some are taking too much medication...." (letter to Chief re home support, 1988:2) He also noted with regard to the laundry that his wife brings home (she is a home support worker) "Sometimes the elderly's clothing is full of human waste and urine." (ibid, 1988:1) These problems suggested a need for more care-taking.

The responsibilities of a home care-giver are often more demanding than others recognize. On the basis of personal experience as a care-giver and coordinator of home care services for an elderly woman at Shalom Village (Hamilton, Ontario), caring for the elderly

is a draining experience. A care-giver that lives in the same environment is constantly confronted with the need to be in proximity of the elder. Furthermore, unlike children who move from a position of dependence to one of increasing independence, the elder is likely to decline further into a state of greater dependency.

The informal support system attempts to maintain elders at home. The task may be demanding depending on the available resources in the home environment and the needs of the elders. When the elders needs are not met, they become physically and socially isolated.

TOWARDS A MORE EFFECTIVE INFORMAL SUPPORT SYSTEM

Being maintained at home as long as possible is important given the traditional Cree values of competence and independence (Preston 1976). To make the informal network more effective in caring for the elders, several issues should be addressed. They include the elder's need for supervision, caretaker's relief of supervision responsibilities, and the need for educating the population on elders' issues.

An extension of the informal network is necessary. The example of the two parents left alone by their two working sons demonstrates this. The sons must work and are therefore not available to provide the supervision necessary. The informal support network must then be extended to include others in the community, such as neighbours and/or kin. Given the divisions characteristic of the community, and the lack of coordination between service groups previously discussed, the support these sons need for their elders may be difficult to

achieve through the intervention of a formal service. Working on a more informal level may be a more successful method in Moose Factory. This means that individuals have to reach out into the community to find solutions to the problematic situations. The sons could be advised to seek out neighbours or friends from the community to look in on their parents when necessary. Similarly, for relief from the role of care-giving, others in the community need to be involved.

While the one son was aware that his parents needed supervision, he did not realize the extent of that need. People need to be assisted to recognize problematic situations. Teaching people about the signs of mental decline can help them avoid unsafe or stressful situations. Once people acquire some basic training they can request guidance from the formal support system. In my own experience at Shalom Village, I recognized some behavioural changes in my client but needed to convey these behaviours to professionals familiar with the client's situation. I was then instructed on the amount of supervision necessary and other signs of disturbance to look for. Sometimes strange behaviours result from a new physical basis. Stroke is a good example of this.

Robinson (246; 1988) suggests that providing elders and care-givers with a list of community resources would help the care-giver access the appropriate agency to provide service. The C. H. R. revealed that the Moose Band would provide emergency food and money. In the example above, neither the elders nor the sons were aware of this service.

Extending the informal network through community involvement will allow elders to be better maintained at home. It will also draw the community together through their common effort to maintain elders in their homes.

AN ELDERS RESIDENCE

The Moosonee apartment complex provides a good example of self contained units for elders. Residents of a facility such as this must be able to live on their own. No nursing care is provided.

Most residents of the community and Moose Band administrators supported the building of an elder's residence. Elders viewed the building of a residence as necessary and many looked forward to moving into it. Further investigation into their actual reasons for this include living in an abusive environment where drinking is a problem, being left to babysit children on a regular basis and living in overcrowded conditions.

The building of the residence would relieve these stresses on elders and their families. The concern was that this physical separation of the elders from the community makes social interaction less likely. A native administrator suggested that given the changing concepts of personal space, (that is, younger generations want their own space), people could build an addition onto their house so that everyone would have their own living area, but this closer proximity would reduce the isolation that may occur from a completely separate residence.

LONG TERM CARE

MOOSE FACTORY'S NEED FOR A LONG TERM CARE FACILITY

Families were attempting to meet the needs of elders while the health care system had yet to resolve the issue of caring for elders who need either hands-on nursing care (beyond what the home care nurse can offer) or constant supervision. In general most health care workers supported the building of a long term care facility. A long term care facility was a top priority for public health (Moose Factory Public Health unit, 1988). A concern for the home care nurse was that, once she can no longer maintain the elders at home, the options for care are limited. Elders who are senile and not taken care of at home were likely candidates for a long term care facility, as were the five residents of the hospital.

Elders in general demonstrated overt resistance to becoming a resident of a nursing home. They were aware that they may get to the stage where they cannot be cared for at home and then may have to become residents in a long term care facility.

THE 1988 STATUS OF LONG TERM CARE IN MOOSE FACTORY

Elders who needed nursing home facilities had three options. The Moose Factory General hospital would unofficially take in elders for 2 weeks at a time as mentioned above. If necessary they would keep the elder as a resident. The alternative was residence in a

different community. Attawapiskat, a community located north on the west coast of James Bay, has a nursing station which includes an 8 bed extended care unit. Actual nursing homes are located in Cochrane and Timmins, two in Timmins and one Extendicare nursing home in Cochrane.

While the hospital keeps elders in the community and therefore accessible to family and friends, it is not an adequate solution to the issue of long term care. At the time of this study 5 elders were residents of the hospital. One Moose Band administrator said that "they (elders) aren't being cared for at the hospital either...I get complaints... ."(S. E., 1988) The Chief was frustrated by his attempts to investigate these issues but never get a clear story from various health care workers. His frustration with the state of the hospital was clear in a meeting between the federal government's Assistant Deputy Minister of Health and the native government in which the discussion of the temporary closing off of a wing of the hospital culminated in a temporary breakdown in communication between these two groups. Also many informants seemed to feel that becoming a resident of the hospital had more to do with politics than with need. The example above of the elder and his wife was commented on by one informant. "He returns home and the same cycle starts all over again." It's clear that he needs full time care and his wife can't do it. It's politics." (K. R. 1988) In addition to these political issues, the hospital was a fire hazard (Moose Factory Fire Chief, 1988) and plans were to replace it. As a temporary measure it provided care to some elders who could not be maintained at home, but it was not thought to be a long term solution.

Residence in another native community is preferable over residence in a non-native community. Many commented on their awareness of others that had gone to a nursing home in another community and died shortly thereafter. However most preferable was residence in Moose Factory. In a long term care facility, such as the one at Attawapiskat, cultural continuity would be present but residents would be without the support and comfort of family and friends. Physical distance is a barrier to providing community and family support. One resident of the Cochrane nursing home, originally a resident of Moose Factory does not receive any contact with friends or family. The importance of community and family support is paramount to native elders and other residents of the community. It must be considered in finding a solution to long term care of the elders.

FINDING A SOLUTION

In the early 1980's it was thought that the nursing residence was no longer going to be used as a nurses residence. Attempts were made by the community to secure it as a residence for the elders. However it remained as a nurses residence (C. E. 1988).

The provincial government is responsible for chronic care. On this basis, the Mushkegowuk Council put a proposal to the provincial government in 1986, outlining the problem of not having chronic care accommodation and suggesting that for a cost of $200,000, a wing of the hospital could be renovated into a chronic care wing. If the wing could be converted as a temporary measure, it could be used as a model for the new hospital.

As of the summer of 1988, the provincial government had not yet responded to the proposal. Native officials were angered by this lack of acknowledgement and understood it as an avoidance of the provincial government's obligation to provide chronic care (S. E., 1988).

The widespread support for an elder's nursing home was a practical response to elders who need constant supervisory and nursing care. As we shall see in the following examples, other communities have turned to institutionalization as a solution to the long term care issue.

For a native group, such as the Navajo, nursing homes are looked upon with distaste because many have died there. In addition, admitting elders to nursing homes is in conflict with the highly valued concept of autonomy. Regardless of how frail and needy an elder might be, one cannot decide for another. Further, elders have ensured their care in old age through their relationship with their grandchildren. Although these cultural values work to discourage institutionalization of the elders, the Navajo own and operate two nursing homes (Shomaker, 1990).

The Iowa Old World Amish like to consider themselves "more responsive to the needs of elders than are other groups of people." "...others don't want the responsibility to take care of their parents;..."(Tripp-Reimer et al., 1988:194) The Amish take care of their elders at home as long as they can. Although at first the extended family will respond to an ailing elder's needs the ultimate long term responsibility and care will be left to a single unmarried daughter. When the resources of the community can no longer care for the elders, they reside either in a Mennonite nursing home in the community or a mental health institution. These

individuals tend not to have any kin and/or are severely confused and disoriented. The institutionalization of these elders is a practical response to needs that cannot be filled by being incorporated into the community's everyday activities.

ISSUES IN INSTITUTIONALIZATION OF THE ELDERLY

In any move of an elderly person to an institution there is the stress of an unfamiliar environment and a loss of everyday support systems at a time when the elderly person's personal resources are low. This often influences his/ her mental health. This reorganization of his/her life is under conditions of great stress and requires support from all those involved in the move - family, friends, community and the staff and administration of the institution (MacLean and Bonar 53:1983). With the trend toward institutionalization, ethnic minorities are being placed in facilities that are not culturally sensitive to them (Ujimoto, 1987). Being introduced to another cultural environment is an added stress to the usual stresses of being uprooted.

My visit to the Cochrane Extendicare nursing home confirmed that residents of Moose Factory would be better suited to an institution in their own community where there is greater potential for cultural continuity. The Cochrane nursing home is oriented towards non-native residents. The cultural programs and cross-cultural skills of nurses are limited to greater white society. I met with the Director of Care who was very enthusiastic about providing some cultural programs through the Cochrane Friendship Centre. My efforts to

engage the Centre and the Chief of the New Post Band raised awareness of the need for some cultural input at the Cochrane nursing home. Although responsive to my concerns, the Friendship Centre was overburdened with grant requests, programs and staff limitations. Any outreach project with the Cochrane nursing home would have to wait.

The goal in such a project would be to establish a liaison with the native population in Cochrane and at the nearby New Post band reservation to bridge the cultural gap at the nursing home. An example of the type of input that would be helpful to the residents of the nursing home involves residents from the reservation visiting the nursing home with traditional meals or beading materials. My suggestion for visits by members of the native community is in keeping with Maclean and Bonar's (1983) suggestion in their examination of the ethnic elderly in long term care facilities. They proposed that volunteers from different ethnic groups improve the quality of life through visiting these institutions. Since most staff are limited unless they come from the same ethnic background, these visitors would be providing a service the staff could not. The role of these visitors would develop from the particular needs of the elder. They may range from simply providing conversation to playing the role of advocate (Maclean and Bonar, 1983:58-59).

MacLean and Bonar (1983) address three main issues the ethnic person would face: the loss of family, the loss of culture and the loss of community. With regard to the loss of family, Markson (1979 in MacLean and Bonar, 1983) proposes that the need for respect and intimacy is most likely provided by the immediate and extended family. The elder may develop feelings of isolation, rejection, disrespect and dishonour. My experience in Moose Factory

revealed that elders do not want to leave family and perhaps associate this with a feeling of isolation, but the role of rejection, disrespect or dishonour is not clear.

The loss of culture experienced was evident in their daily existence, organized by a different culture. The loss was apparent in the different foods and drinks prepared loss of music, literature and folklore. Any part of their heritage that had been significant was no longer available. The language of communication may be different. When language becomes a barrier to communication, it is difficult for one to communicate needs, express wants or just make idle talk. The issues discussed in Chapter Three in the section on cross-cultural barriers in communication apply to this situation where the potential for misunderstanding and misinterpretation of behaviour is likely. This experience can be very isolating (Maclean and Bonar 55:1983).

Although Maclean and Bonar separate family, culture and community, they recognize that community is tied to culture. In a new institutional setting, the players in the group are certainly different and play by different rules. For the ethnic elders in a nonethnic institution there are no individuals who share common rules, behaviours, or history. The development of new relationships is limited by the lack of social, physical and emotional support available to most in an institution (Maclean and Bonar 58:1983).

The importance of this continuity of culture is emphasized in Holzberg (1982). Drawing on the work of Zay (1978 in Holzberg, 1982:254) this extreme view proposes that "...all Native Peoples share a common opinion about institutionalization in a hospital or a home for the aged. Irrespective of the group's identity institutionalization is viewed with

distaste not only because it makes them feel transplanted in a totally foreign environment but also and above all because it forces them to abandon their natural environment." Similarly, Guttmann (1979 in Holzberg 1982:254) reports responses of a similar nature from white ethnics from Eastern , Central and Southern Europe. These groups preferred to use informal and formal support systems to remain in their familiar surroundings. In my own experience working with the elderly in many settings, the above attitudes are confirmed. "That everyone irrespective of cultural origin finds a preference for familiar surroundings merely emphasizes the importance of ethnicity as an instrument of continuity with past habits, associations, and preferences." (Holzberg 1982:254)

ISSUES TO BE SENSITIVE TO IN A LONG TERM CARE FACILITY IN MOOSE FACTORY

A long term care facility physically isolates elders from the community, making social interaction between elders and others more unlikely. This would create another division in the segmented community. Most importantly, exchange between the elder and younger generations becomes less likely. But elders play an important role in cultural continuity. Sharing between these groups is important given the growing generation gap between young and old and the resulting reduction of cultural continuity. If a long term care facility is the solution to the care of elders then it must be done with sensitivity to the importance of maintaining elders as part of the community.

Such a facility will ultimately have a negative impact on Cree elders if careful planning does not take into account factors that can influence the environment. "While policy makers must meet the basic needs of the elderly, emphasis should not be placed exclusively on physical resources...The socio-emotional needs of the elderly must not be neglected and the cultural context in which individuals have lived their lives must be respected" (Zimbabwe,1987). As one native leader commented, "Models from the south don't necessarily apply here. We are free to make our own choices about the housing of our elders." (K. R.1988)

In my own experience at Shalom Village nursing home, not all residents need nursing or supervisory care. Sometimes elders are placed into a long term care facility prematurely. The fact that elders are an added stress to some home situations in Moose Factory may make them premature candidates for nursing home residency.

A long term care facility in Moose Factory needs the cultural input of the community. But the divided nature of the community makes it more difficult to get community involvement. Hendel-Sebestyen (1979) looks at the importance of the community aspect of an institutional setting in her paper on the Sephardic community. "The cultural tradition that links residents, staff and governing body has important implications for the style of interaction in the home because sharing a cultural tradition enables individuals to have congruent expectations and interpretation in any set of complementary roles, including doctor-patient, patient-patient and patient-therapist." (Zborowski 1952 in Hendel-Sebestyen 1979:22)

Continuity of culture is possible when some of the characteristics of the community are duplicated in the home. In Handel-Sebestyen's example the residents are Orthodox Jews, who adhere to the calendar of activities and eating rituals. The community involvement in the home is extensive. The family of residents governs it. The home is considered to belong to the residents and community, the old and young. Many of those in the community volunteer personal time. The commitment to and involvement in the home, while it reflects a continuity of traditional values, also encompasses acculturative changes occurring in the second and third generations of Sephardim in the community (Hendel-Sebestyen, 1979:24). A similar situation exists at the Shalom Village retirement and nursing home in Hamilton where the Jewish community and family members of the residents of the homes play a significant role in governing and maintaining tradition.

In Moose Factory, a long term care facility may rely on the non-native governments expertise, but it is essential that residents of the community be trained to operate the facility and implement programs that allow for cultural continuity and involvement, given the gap between generations.

THE IMPACT OF THE ISOLATION OF ELDERS ON CULTURAL CONTINUITY

THE ROLE OF ELDERS IN CULTURAL CONTINUITY

The report of the Women and Work project highlights the difference in "...the cultural context in which language, discipline and authority were once transmitted... ." (Blythe et al., 1985:155) Elders have different views on the role of leaders, family and community.

Originally hunting territories played a major role in the political structure of Cree society. Leaders demonstrated abilities and assumed responsibilities without interfering in people's lives. This was in contrast to government officials and missionaries who basically told people how to live their lives. Today leaders do not take a familial role towards residents by providing guidance and support. This is in contrast to the elder females expectations, who still "...to some degree expect the leaders of the group to take care of them and maintain their houses."(ibid:111) A Cree hunting community provided discipline. Children were allowed to learn through experience and encouraged to be independent. Self control and self discipline were quickly acquired. The present community does not provide the external authority that the bush environment once did (Blythe et al., 1985:155).

The elders have understandings about the discipline of children and leader's responsibilities that reveal a generation gap between them and their grandchildren (Blythe et al. 1988:156). Many elders that I spoke with confirmed this: "When I was a kid my mother said I couldn't do something, we did not think anything- nowadays they don't listen. It was

much quieter then, peaceful."(S. A., 1988) "They (children) spend too much time in front of the television when they should be reading."(C. E., 1988)

Even the younger generations feel the gap. "Elders feel that they have been pushed aside...they are concerned with what is going to be but the young people do not want to listen."(C. V., 1988)

In an effort to overcome this generation gap older women "... hope for more continuity and communication between generations than is sometimes present."(Blythe et al , 1985:111) They propose that recreation be used as a way to overcome this gap. They feel that recreation will draw the community together and at the same time direct the energy of the young. Families will regain some control over their children (Blythe et al., 1985:109-110).

Elders "...are the link between the past and future, they are the connections their children and grandchildren have to the old way of life. They are very interested in the kind of environment the community can provide for their descendents...they want younger people to learn Cree ethnicity; this represents a stake in the community for them. They want the girls to adapt to a modern life successfully, but they want them to use the older models of a good and competent life to guide them in doing this, in integrating family and community." (Blythe et al. 1988:111)

The gap between generations lessens the influence elders have on younger generations. Physical separation in view of this generation gap will work to erode the role that elders have in this capacity, making their job as teachers of cultural history and native ways even less likely. In the model of cultural continuity the goal is to increase the shared

knowledge space between elders and younger generations. There are cultural pathways that encourage this, but they must be reinforced to overcome the ease with which they can slip away.

OPPORTUNITIES FOR INVOLVEMENT

Amoss (1981) in her study of the Coast Salish Indians claims that elders as repositories of traditional knowledge were perceived as playing a major role in the maintenance of Salish identity. Vanderburgh (1988) proposes a similar role for the Anicinabe elders in the Georgian Bay area. Canada's native communities are actively involved in maintaining native identity. Vanderburgh (1980) describes government effort and the organization of various groups to facilitate the role of elders in maintaining identity. The extent of participation is not clear. In Moose Factory and other native communities along the James Bay coast events such as Indian Days attract some residents but not many. Few elders attended the Moose Factory or the Attawapiskat Indian Days celebration during my fieldwork.

A natural and perhaps more rewarding way to increase the shared knowledge space between generations is in the relationship between grandchildren and elders. Grandchildren play a significant role in the lives of the elders. In seven households, thirteen elders live with grandchildren alone. These elders were very capable of functioning on their own but the grandchild provides companionship, someone to care for, and help with household chores (D.

G. 1988). The Women and Work project also notes "the pattern of a particular grandchild being brought up by and then taking care of the grandparents ..." (Blythe et al., 1988:53). In general, my observations of elder-grandchild interaction were characterized by kindness and extreme fondness.

Weibel-Orlando (1990:110) in her article on the role of grandparents in Native American culture describes the cultural conservator grandparenting style as a general practice of ethnic minority groups. "Grandparents as cultural conservators constitute a role in cultural continuity in that responsibility for the enculturation of the youngest generation was traditionally the role of the grandparents across American Indian tribal groups" (Amoss 1981).

In addition this practise serves to ensure care in old age. For some Navaho grandmothers clearly stated that they encourage close relationships so that they will be cared for in old age (Shomaker, 1990:28). They teach that reciprocity and caring are important and work well with the concept of autonomy. Those elders who are isolated are those who did not establish warm, loving and longlasting relationships with their grandchildren. The result is isolation in old age (Shomaker, 1990; 28). Similarly, Wentowski (1981; 605) in a study on reciprocity in the urban southern United States reports that although many factors that are beyond the control of the individual influence the care that the elderly will receive in old age, in a review of the life histories, security in old age is related to how personal resources were managed in creating relationships. The anthropological literature points out the need for reciprocating to maintain a feeling of self-worth (Jonas & Wellin, 1980).

One elderly woman who lives with her grandson commented on their situation, "I raised him and now he is looking after me." (H. L., 1988) Similarly one informant commented "My mother was living in her own home when a number of young relatives moved in. I felt that they were overtaking her. So I asked her to come and live with us. She has her own room and her own space and she does not have to baby-sit. She had done her thing for me and now it was my turn to return what she had given me."(W. N. 1988)

SUMMARY

Formal health care services in Moose Factory need to provide an effective support system for the elders in the community. A centralized coordination of services could ensure communication between groups, ensuring the effective delivery of services to meet the needs of the elders. Team meetings that involve all possible groups could review each elder receiving care case by case so that each team member was informed of current status and needs. Cross-cultural sensitivity can be enhanced through a training program designed not only to facilitate communication, but also to encourage health care professionals to participate in the community. Such a program will help to reduce the impact of the short term residency of most health care providers.

The issue of long term care is also of concern to the community. Although the informal support system is an incredible source of care for the elders, it is unable to provide for all of their needs. While the building of a long term care facility will provide physical care to elders, the challenge is to overcome the potential for social isolation once elders are

physically separated from their families. The model of cultural continuity describes the impact of isolating elders from the younger generations. Reducing physical proximity may impair social exchange and thus lead to a growing gap between generations. A community based approach to the building of a long term care facility, with a sensitivity to maintaining and enhancing the role of elders may overcome these barriers.

A similar approach is needed for the building of the apartment complex. It will alleviate the stress of living in overcrowded conditions and allow people to live more comfortably in their own space. If designed so as to facilitate interaction as a community centre there will be incredible potential for generations to mix and for elders to help one another. The staff provided could also facilitate these situations.

Health care services, as a central institution in the community, can work towards integrating elders. In the "Profile of Liaisons" model, health care services can be examined with regard to a role in strengthening elders' ties to the community. Ultimately the broadening of the informal network, and the bridging of the gap between the informal and formal network can lead to better approaches to elder care, resulting in a balance of the needs and resources of each generation.

APPENDIX A

Guideline for Interview with Group A

1) Find out about existing family, and the role they play in care. Are there

   tasks that family help out with? Tasks that you would like them to help out with?

   What tasks do you perform everyday? These questions are aimed at functional

   ability and the traditional role of family.

2) Do they receive Home Care or Home making? How often? What services do they

   perform? Are you satisfied with the services?

3) If you got to the point where you could not care for yourself what choices are

   open to you? Would you move in with family, go to a long term care facility?

   Under what conditions would you go to a long term care facility? If you would

   not go, what alternatives would you suggest?

Guideline for Interview with Group B

1) What were the conditions under which you entered this facility? Did you have a choice?

2) Do you have any children and /or relatives with whom you would have liked to live? What were the reasons for not living with them?

3) Do you like living here? How long have you lived here? How do you spend your time? How would you change it here if you could?

4) Do you have any ideas about alternative ways of caring for elders?

Guideline for Interview with Group C

1) How would you like to be cared for as an elder? Do you think you would like to remain at home or go to a long term care facility? Can you imagine conditions under which you would enter a long term care facility? Would you prefer that the facility were close to your family?

2) Do you have any ideas about alternative ways of caring for elders?

APPENDIX B

A BRIEF HISTORY OF HEALTH CARE TO NATIVE CANADIANS

This section describes the major trends in the development of native health care services in Canada.

THE PROVISION OF HEALTH CARE

Political hegemony, the fur trade and the desire to convert natives to Christianity brought Europeans to native territories. Outposts provided a context for cultural exchange, depicted in the literature as a two way exchange with natives showing the white man how to survive in harsh conditions and the white man introducing their own form of education, spirituality and health care.

Traders and missionaries were first to introduce "western" health care to the natives of Canada. The Hudson's Bay Company possessed it's own medical officers (Blythe et al., 1985). Many northern hospitals were initially managed by missionaries (Graham-Cumming, 1967).

The first nursing station in the north was established by the Roman Catholic mission at Fort Providence in 1867. It was still functioning in 1969 , operated by the Order of Grey Nuns under contract arrangements with the federal government (Brett, 523;1969). The

Catholic Hospitals of James Bay began operation in 1902 with the opening of the first hospital at Fort Albany. Others followed including one at Fort George in 1930, one at Moosonee in 1942 and one at Attawapiskat in 1952. This system of hospitals became a provincial concern with subsidized funding from the federal government for services to status Indians. Similar situations occurred throughout northern Canada.

The government stepped into a niche established early on in the history of contact. Government organization however was to become an elaborate structure designed to manage Indian affairs.

THE GOVERNMENT

In 1755 the Imperial British government established an office to administer Indian affairs. The Crown Lands department of what was then the Province of Canada took over responsibility for Indian Affairs in 1860. Then in 1867 the Dominion of Canada came into existence and the Office of the Secretary of State administered Indian Affairs. Responsibility shifted in 1873 when the Department of the Interior was established. This was followed by the establishment of the Department of Indian Affairs in 1880 where responsibility remained until 1936. These early departments were not much concerned with Indian health (Graham-Cumming 1967). The Department of Indian Affairs was absorbed into the Department of Mines and Resources in 1936 and was from that time responsible for Indian Affairs including the Indian Health Services Division.

In 1945 the Indian Health Service Division of the Department of Mines and Resources was transferred to the Department of National Health and Welfare where it remains. All other services - land, housing, education, welfare, remained with the Indian Affairs Branch of the Department of Mines and Resources, then with the Department of Citizenship and Immigration and finally with the Department of Indian Affairs and Northern Development. The restructuring of native health to Health and Welfare Canada in 1945 resulted in the establishment of a network of Regions and Zones. The nine regions are: Yukon, Northwest Territories, Pacific, Alberta, Saskatchewan, Manitoba, Ontario, Quebec and Atlantic. Within these nine regions are 25 zones, each possessing professional, administrative, technical and operational staff.

In 1962, Indian health services disappeared as a separate entity and Medical Services Branch of Health and Welfare Canada was created. Its purpose was to provide services to Canadians whose health care services fell outside of provincial jurisdiction. Its focal points include: maternal and child health, communicable disease control, accidents and alcohol abuse, dental health treatment and prevention, health education and promotion.(Young 1984)

The government's initial role was fairly limited. "Treaty" day was an annual opportunity for the Indian agent, accompanied by a medical doctor (if he was not one himself) to visit reserves and provide minimal care. The first Indian Agents were often also medical doctors by training.

This was to change as a result of disease, especially tuberculosis (TB), reaching

epidemic proportions. While initially hesitant to provide health care, the government would

come to play a significant role in providing health care services to native communities.

EPIDEMICS

Various diseases spread rapidly through native communities. At the time of European

contact the estimated number of Eskimos and Indians was 200,000. By the year 1871, the first

Canadian census reported 102,358 (Frideres, 1974). By 1961 the population had returned to

precontact levels (Wherrett 1977 in Hodgson 1982). Small pox, measles and influenza as well

as others contributed to this decline in population but tuberculosis (TB) had an immense

impact not only as the leading cause of death for natives and Eskimos until 1952, but also in

establishing the role the government would play in native health care (Hodgson, 1982).

As early as 1880, annual reports of Indian Affairs field administrators made reference

to TB as the major cause of death among prairie Indians, although the Deputy Superintendent

General first made reference in 1885. TB was a concern, but attempts to ignore its importance

continued. In 1898, the Deputy Superintendent claimed that TB was lessening its impact, yet

that year the death rate remained very high (Graham-Cumming, 1967). Graham-Cumming

(1967) notes that references to TB are hidden away in the end of government documents

(133:1967).

Maundrell (1940 in Graham-Cumming 138:1967) wrote a history of health care to native Canadians from 1867 to 1940. In it he writes of the Pacific coast Indians. The Indians represented one quarter of the national TB death rate yet they were only one twentieth of the population. Concern warranted a health survey which showed that consumption (TB) was 5 times more common among natives than whites of British Columbia.

Contact with Europeans at Hudson's and James Bays began as early as 1611 with Henry Hudson's visit. By 1670, the company (HBC) had the rights ..."to trade, explore, colonize, and exploit Rupert's Land, the James and Hudson's Bay watersheds..." In 1668 Charles Fort was built at the mouth of the Rupert river and in 1673 Moose Factory a second outpost, was established at the mouth of the Moose river (Long, 44;1985).

In the opinion of one medical attendant to the Indians with commissioners for Treaty 9 writing in 1905 "...35% of the Fort Hope Band, 20% of the Albany Band, and 45% of the Martin Falls Band were tubercular. At Moose Factory only 20% of the Indians were suffering from phthisis (Maundrell 1940 in Graham-Cumming 1967;137). These alarming statistics were apparently not enough to move government to provide adequate aid to the Indians.

Services were eventually provided, however there has been much speculation on the reasons for it. First, the governments' legal obligation is not clear.

Of the many treaties signed between the natives of Canada and the Federal government, only one made any reference to health care. Negotiations prior to the signing of the treaties 8, 10, and 11 contained appeals by the natives for the furnishing of medicines. However these requests were omitted in the final treaties. Treaty Number 6 was signed in

1876 between the Federal government and the Cree of central Alberta and Saskatchewan. These are the "medicine chest" clauses of Treaty 6:

"In the event hereafter of the Indians being overtaken by any pestilence, or by a general famine, the Queen...will grant to the Indians assistance sufficient to relieve (them) from the calamity that shall have befallen them. A medicine chest shall be kept at the house of each Indian Agent for the use and benefit of each Indian at the direction of such Agent."(Morris 1880 in Young 257;1984)

The clause invited interpretation. The court defined the "medicine chest" in Dreaver vs. R (1935) as " all medicines, drugs or medical supplies which might be required by the Indians.... And further that medicines "were to be supplied to them free of charge."(Young, 258;1984) In R. vs. Johnston (1966) the court made a similar decision (Young, 1988). Later the Saskatchewan Court of Appeals ruled that the "medicine chest" did not include the whole range of medical services (Cumming and Mickenberg 1972, 129-130, in Young, 83;1988).

The Indian Act also defines the government's responsibilities for native health care. The Indian Act, first implemented in 1874, received its last major revision in 1951. The Minister is empowered to "prevent, mitigate and control the spread of diseases on reserves; to provide medical treatment and health services for Indians; to provide compulsory hospitalization and treatment for infectious diseases...; and to provide for sanitary conditions... on reserves."(Indian Act, 1970 in Young 1988;83)

The British North America Act states that "while Indians, and Lands reserved for the Indians fall within the exclusive legislative authority of the federal government, health and

social services were considered to be provincial responsibilities." (British North America Acts 1972 in Young 1988;82)

Other forces motivated government intervention. According to Young (1988) the provision of health care services was done on humanitarian grounds. Graham-Cumming (1967) (in his History of Health Care to Native Canadians 1867-1967) expands this point. "Malignant epidemics were decimating the Indians and, of greater significance to even the most unsentimental, non-humanitarian pragmatist, the Indians were becoming a dangerous health hazard to the rest of the population. Increasingly, public opinion on the question of Indian health was making its voice heard in Ottawa. Belatedly and, it must be admitted, somewhat reluctantly the government began to make sporadic attempts to deal with the problem, not from any sense of legal obligation of responsibility but on humanitarian grounds and chiefly for reasons of practical politics" (Graham-Cumming, 117;1967). In an earlier paper Young (1984;260) argues "...that those services were provided grudgingly, and were not altogether altruistic in intent. Epidemics were raging through Indian reserves, putting the health of contiguous white communities in jeopardy."

A reason cited less often was that, under the then prevalent philosophy of civilizing the Indians, health services were seen as an integral part of the policy of total assimilation and elevation of Indians from "wards of the nation" to full citizens. This is indicated in an article by Brittain (1959) (Assistant Director, Directorate of Indian and Northern Health Services, Department of National Health and Welfare) "It is apparent that hospital insurance marks another milestone in the advance of the native people toward self sufficiency and

independence; it is another important advance toward the point where Indians and Eskimos can enjoy, if they wish, a full measure of citizenship in a community -at-large which will be ready to accept them as equal."(Brittain, 1959:634)

The dominant philosophy was benevolent paternalism. "A permanent medical officer at this point would be a great benefit to the Indians: nothing has a more civilizing effect upon them than a display of the white man's skill in healing, nothing convinces them more readily of the white man's interest in them."(Canada Sessional papers, 1913,130; Young, 1988,90 note 17) Whatever the self-serving motivation is or was behind providing health care services, the federal government has continued to provide them, at times trying to change its role.

ORGANIZED SERVICES

Government intervention increased with the appointment of Dr. P. H. Bryce to General Medical Superintendent of Indian Affairs in 1905. He was central to the public health movement in Canada, involved in provincial legislation on vital statistics, the reporting of communicable diseases, the importance of sanitation and controlling epidemics (Hodgson, 1982). He had implemented the building of temporary tent hospitals towards the end of the 1900's, to isolate TB and smallpox patients. It was not until 1917 that department hospitals were built (Young 1988).

Bryce obviously felt that more could be done. Bryce continued to bring the state of the Indians to the attention of the government. In 1922 he published The Story of a National

Crime: An Appeal for Justice to the Indians of Canada. In it he points out the neglect on the part of the government to attend to what had been reported about the frequency of TB in children (Bryce, 10;1922).

During this period however, Bryce's conception of the mobile visiting nurse was finally realized. Nurses visited reserves and residential schools performing public health functions. The limited number of personnel required each nurse to cover extremely large territories. It was not until 1930 that the first government nursing station opened at Fisher River, Manitoba.

Although Bryce made efforts to implement coordinated efforts on a national level, he was unwillingly retired in 1910, and his post was not re-filled until 1927. The medical division functioned without a director (Graham-Cumming, 1967).

According to Maundrell (1940 in Graham-Cumming, 125;1967) in this period without a director, some medical care was provided but services were disorganized. Tension between field doctors and administrators was increasing and to alleviate it another superintendent was finally appointed. Colonel Stone was appointed and it was from this point on that the organization of health care services to the Indians expanded.

As proposed earlier by Bryce, Indian Affairs was transferred the Federal department of Mines and Resources in 1936. Stone was Medical Superintendent of the Indian Health Services division (Graham-Cumming, 1967).

The Indian Agent was responsible for all aspects of native life, including maintaining law and order, directing projects such as agricultural or industrial enterprises, and the

administration of medical and health services. The medical officer was responsible to the Indian Agent, in that he first consulted with the Indian Agent in the admitting of a native to hospital and then he obtained the permission of Ottawa to send the patient to a sanatorium (Stone, 1935).

Under Stone's direction services to Indians employed 11 medical officers, 8 who served as Indian agent and medical officer, and 250 employed on a part time basis. Dental services were limited to adults and clinics in schools. Field nursing services included 11 nurses, 6 attached to large districts and the remaining 5 to smaller groups. In addition, the Victorian Order of Nurses, the provincial and missionary organizations provided the services of 12 nurses in total.

At the time of Stone's 1935 report there were 7 government hospitals ranging from 8 bed capacity to 40. The government also built additions for natives onto two northern Ontario public hospitals. Three nursing stations provided limited bed capacity and 15 hospitals were operated by missionaries or other community organizations.

By 1943 the number of Indian hospitals was 14. The Department had taken over 17 hospitals from the Department of Mines and Technical Surveys and expanded others. Indians were admitted to provincial sanatoria and Departmental hospitals. By 1949, the Department was operating 20 hospitals with 1,756 beds, 18 nursing stations, and 13 dispensaries.

By 1960 the facilities available were as follows: 22 hospitals providing 2,172 beds, 30 clinics, 37 nursing stations and 83 health centres. The number of acute care hospitals declined leaving only 9 operational in the provinces by 1976. The number of nursing stations and

health centres increased from 37 and 83 in 1960 to 51 and 100 in 1976 (Young 1988:88-89). The Departmental hospitals were gradually phased out and Indians and Eskimos were treated in provincial hospitals (Graham-Cumming 1967:140).

Funding declined throughout the 1930's with just over $1 million provided in 1931-32 and just $793,000 in 1933-34. In 3 years the per capita decreased from $10.00 to $7.20. This is in contrast to $30.00 per capita for Ontario citizens. In 1934 the per capita cost was $9.60, close to the same in 1930. The per capita cost for the white population was $31.00. This does not include hospital or physician services.

In 1945 the cost of Indian health care services was $2,329,163. In 1947 $4,103,309. By 1960 the total cost was 23 million , 10% of the total Health and Welfare budget. In 1963 the total cost for Indian health service was 27 million and by the end of the 60's it was close to 28 million (Graham-Cumming 1967).

THE ROLE OF THE GOVERNMENT IN HEALTH CARE

The government was obviously involved in providing health care to the Indians, but later began to change its position on its responsibility.

In 1964, Young reports that the government of Canada stated in the Health and Welfare annual report that it did not provide free medical services to natives (DNHW 1964:96 in Young 1988:84). Similarly, in 1966 it refuted the assumption that the Federal government had any special responsibility to the natives of Canada and that in fact it was concerned with the public health of all people in Canada. Given the Indian Act of Canada, however, the government had undertaken the health care of natives in the far north where health services were not available (DNHW 1966:84 in Young 1988:84).

The Hawthorne Report, released in 1966 is a comprehensive scholarly review of the political, social, and economic conditions of natives across Canada. Young suggests that the Report conveys a conflict between the Treaty's referral to the "medicine chest" and the Federal government's actual role in the provision of health care to natives. The most famous of all documents of this nature is the Chretien White Paper of 1969. In addition to suggesting the withdrawal of health care services , it proposed the complete removal of all existing structures, such as the Department of Indian Affairs. The implications were vast, as was the native response.

Universal medical care, introduced in the 70's, made the issue of responsibility for native health care services obsolete. The government provided assistance to Indian Bands for

payment of premiums. In some provinces the provincial government assumed some responsibility of health services for their northern Indian population. Non-insured benefits however, remained an issue with native governments and the Federal government.

In late 1978, the Medical Services branch released a new policy directive on uninsured benefits to Indians. The government felt that the system was being abused in the area of drugs, glasses, dental care, and medical transportation. Indian groups responded and the guidelines were suspended for 6 months. A new government in September 1979, the Progressive Conservatives, led to a new policy on the issue. The guidelines were scrapped. They also presented the "...three pillars of truth: " (1) importance of socioeconomic, cultural and spiritual development in attacking the underlying causes of ill health. (2) reaffirmation of the traditional special relationship of the Indian people to the federal government. (3) recognition that Indian health services are part of the Canadian Health system and the encouragement to participate in it fully.

Efforts to consult with Indian organizations followed in the late 70's. The National Indian Brotherhood established a national commission of inquiry on Indian Health in 1978. In 1979 Justice Berger led the commission to determine a methodology that would ensure the participation of natives. This led to the health liaison workers at the regional and zone levels to bridge the gap between providers and consumers.

The Community Health Representative program was implemented in the 80's, as well as the native alcohol and drug abuse program, and funding was provided for community based

health demonstration projects across the country. Native representatives participated in planning of exercises and on selection boards for health service workers and managers.

The Penner committee was responsible for a special report on Indian Self-Government (1983). It recommended health care be considered for transfer to Indian "self-government health structures" through constitutional changes, legislative action, administrative and policy reform within existing legislations. The interpretation and transfer process differ with respect to the parties involved. Native leaders want the structures changed before transfer, while the Medical Services Branch wants to transfer ownership with the already existing structures. The Medical Services Branch created a "program transfer and policy development directorate" to facilitate transfer. Currently, the process has been put on hold, but native officials are interested in re-establishing negotiations (Personal communication with Pat Chilton, Executive Director of Mushkegowuk Council, December 16, 1991).

BIBLIOGRAPHY

Aeschliman, D., 1973. Guidelines for Cross-Cultural Health Programs. *Nursing Outlook*, vol. 21, #10, 660- 663.

Aamodt, A. M., 1982. Examining Ethnography for Nurse Researchers. *Western Journal of Nursing Research* 4:209-221.

Amoss, Pamela, 1981. Cultural Centrality and Prestige for the Elderly: The Coast Salish Case. In *Dimensions: Aging, Culture and Health*. C. Fry (ed.) New York: Praeger.

Becker, M. H., R. Drachman, and J. Kirscht, 1974. A Field Experiment to Evaluate Various Outcomes of Continuity of Physical Care.

Bienvenue Rita M., and Betty Havens, 1987. Structural Inequalities, Informal Networks: A Comparison of Native and Non-native Elderly. *Canadian Journal on Aging*.

Blythe, J.M., S. Preston, and P. Brizinki, 1985. *Women and Work: I was never idle in Moosonee and Moose Factory*. Taso Report # 21.

Brett, H. B., 1969. A Synopsis of Northern Medical History. *Canadian Medical Association Journal*. March 15 vol 100 521-525.

Brant, Clare C., no date. *Understanding Your Native Patient*. editorial from Sioux Lookout Rep.

British North America Act 1972 In *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto: University of Toronto Press.

Brittain, W. B., 1959. The Impact of Hospital Insurance on Indian Health Services. *Medical Services Journal of Canada*. 15:632-634.

Brody, E., 1981. Women in the Middle: and Family Help to Older People. *Gerontologist* 21(5), 471-479.

Bryce, P. H., 1922. *The Story of a National Crime: An Appeal for Justice to the Indians of Canada*. Ottawa: James Hope and Sons.

Canada, 1908. Sessional Papers no. 27 In T. K. Young 1988 *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto: University of Toronto Press.

Capra, F., 1982. *The Turning Point*. New York: Bantam

Chappell, N. L., L. A. Strain, and A. A. Blandford 1986. *Aging and Health Care: A Social Perspective*. Canada: Holt Rhinehart and Winston.

Chen, P. C., 1987. Family Support and the Health of the Elderly. *Journal of Cross-Cultural Gerontology* 2 187-193.

Chrisma, Noel J. and T. W. Maretzki 1982. Anthropology in Health Science Settings. In *Clinically Applied Anthropology* N. J. Chrisma and T. N. Maretzki (eds.) Holland: D. Reidel Pub. Co.

Counts, Dorothy and David Counts, 1985. Introduction: Linking Concepts Aging and Gender, Aging and Death. In *Aging and Its Transformations: Moving Toward Death in Pacific Societies*. Dorothy Ayer Counts and David R. Counts (eds) ASAO Monograph No. 10. Lanham, MD: University Press of America.

Counts, Dorothy, and David Counts, 1992. "They're My Family Now:" The Creation of Community among RVers. *Anthropologica* volume 34.

Cowgill, D. , and L. Holmes 1972. *Aging and Modernization*. New York: Appleton-Century Crofts.

Cumming, P. A., and N., Mickenberg, eds.1972. *Native Rights in Canada*. Toronto: Indian-Eskimo Asssociation.

Darnell, R., no date. *An Essay on Management of Respect; Greeting and Approach in Cree Interactional Style*. Unpublished manuscript.

Darnell, R., 1981. Taciturnity in Native American Etiquette: A Cree Case. *Culture I* (2), 55-60.

Deagle, G. L., 1986. The Art of Cross-Cultural Care. *Canadian Family Physician* Vol. 32 June 1315-1318.

Dietrich, A. J. and A. Lolson, 1981. Political and Cultural Factors in Achieving Continuity with a Primary Health Care Provider at an Indian Health Service Hospital *Public Health Reports* 96(5) 398-403.

Department of National Health and Welfare 1964. Annual Report In Young 1988 *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto: University of Toronto Press.

Department of National Health and Welfare 1966. Annual Report In Young 1988 *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto: University of Toronto Press.

England, Joyce B., 1986. Cross-Cultural Health Care. *Canada's Mental Health* December p. 13.

Fischer, L. R., with Hoffman, C., 1984. Who Cares for the Elderly: The Dilemma of Familly Support. In *Research in Social Problems and Public Policy, A Research Annual*. M. Lewis & J. Miller (eds.), Vol. 3. Greenwich, CT: JAI. Referenced in Stoller, E. 1989 Formal services and Informal Helping: The Myth of Service Substitution. The Journal of Applied Gerontology Vol. 8 No. 1, March 37-52

Foster, George M., 1982. Applied Anthroplogy and International Health: Retrospect and Prospect. *Human Organization* 41 (3) Fall.

Frideres, James, 1974. *Canada's Indians: Contemporary Conflicts*. Scarborough:Prentice Hall.

Graham-Cumming, G., 1967. The Health of the Original Canadians, 1867- 1967. *Medical Services Journal Canada* 23: 115-166.

Guttmann, D. 1979. Use of Informal and Formal Supprots by White Ethnic Aged. In *Ethnicity and Aging: Theory, Research and Policy*. D. E. Gelfand & A. J. Kutzik (eds.) Springer Publishers New York. Referenced in Holzberg, C. S., 1982 Ethnicity and Aging: Anthropological Perspectives on More Than Just the Minority Elderly. The Gerontologist. 22(3) 249-257.

Hagey, R. 1986. The Indirect Approach *Nutrition Newsletter* Department of Health and Welfare Canada, Summer/Fall.

Hendel-Sebestyen, G., 1979. Role Diversity: Toward the Development of Community in a Total Institutional Setting. *Anthropological Quaterley* 52, 19-28.

Hodgson, C., 1980. *Sitting on an Island: Nurses in the Canadian North*. Unpublished Masters thesis. McMaster University, Hamilton, Ontario.

Hodgson, C., 1982. The Social and Political Implications of Tuberculosis Among Native Canadians. *Canadian Review of Sociology and Anthropology* 19(4) 502-524.

Holmes, L. D., 1980. Anthropology and Age: An Assessment. In *Aging in Culture and Society: Comparative Viewpoints and Strategies*. C. Fry (ed.) New York: J. F. Bergin. Holzberg, C. S. 1982. Ethnicity and Aging: Anthropological Perspectives on More Than Just the Minority Elderly. *The Gerontologist* 22(3) 249-257.

Honigman, John J., 1981. West Main Cree In *Handbook of North American Indians: Subarctic Volume 6*. William C. Sturtevant (gen. ed.) pp. 217-243 Washington: Smithsonian Institute.

Indian Act, 1970 In Young, T. K., 1988 *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto: University of toronto Press.

Jacobson, David 1988. The Cultural Context of Social Support Networks. *Medical Anthropology Quarterly*,

Jonas, K., and E. Wellin, 1980. Dependency and Reciprocity: Home Health Aid in an Elderly Population. In *Aging in Culture and Society: Comparative Viewpoints and Strategies*. C. Fry (ed.) New York: J. F. Bergin.

Kaufman, S. R., 1986. *The Ageless Self: Sources of Meaning in Later Life*. Madison, Wisconsin: The University of Wisconsin Press.

Keith, J., 1980. "The Best Is Yet To Be": Toward an Anthropology of Age. *Annual Review of Anthropology* 9: 339-364

Kleinman, A., Eisenberg, L., and Good, B., 1978. Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. *Annal of Internal Medicine* 88: 251-258.

Kunitz, Stephen J., 1981. Underdevelopment, Demographic Change and Health Care on the Navaho Indian Reservation *Social Science and Medicine* ???175-192

Ledbetter, Elizabeth K., no date. Non-Directiveness: An Orientation to Life at Taos Pueblo. Unpublished manuscript.

Long, J., 1984 Born and Brought up in the Country. In The New Peoples: Being and Becoming Metis in North America, J. Peterson and J. Brown eds, Winnipeg; University of Manitoba Press.

Long, J., 1985 The Reverend George Barnley, Wesleyan Methodist, and James Bay's Fur Trade Families. *Ontario History* 70(2):75-89.

MacLean, M. J. and R. Bonar, 1983. The Ethnic Elderly in a Dominant Culture Long-Term Care Facility. *Canadian Ethnic Studies*, XV 3 51-59.

Markson, E., 1979. Ethnicity as a Factor in the Institutionalization for the Ethnic Elderly. In *Ethnicity and Aging: Theory, Research and Policy*. D. Gelfand and A Kutzik (eds.), New York: Springer Publishing Co. Referenced in MacLean, M. J. and R. Bonar 1983. The Ethnic Elderly in a Dominant Culture Long-Term Care Facility. Canadian Ethnic Studies, XV 3 51-59.

Maundrell, C. R., 1942. Indian Health: 1867-1940. Unpublished M. A. thesis. Queen'sUniversity, Kingston, Ontario. Referenced in Graham-Cumming, G. The Health of the Original Canadians, 1867- 1967. *Medical Services Journal Canada* 23: 115-166 1967.

McPherson, B., 1983. *Aging as a Social Process*. Toronto: Butterworth and Co.

Mianscum, R., 1988. Letter to the Chief re: home support.

Morris, A., 1880. *The Treaties of Canada with the Indians of Manitoba and Northwest Territories*. Toronto: Belfords Clarke. Referenced in Young 1988 *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto: University of Toronto Press.

Murdock, S. H., and D. F. Swartz, 1978. Family Structure and the Use of Agency Services: An Examination of Patterns Among Elderly Native Americans. *The Gerontologist* 23(1) 475-481.

Nishnawbe-Aski Nation, 1985. *Position Paper Regarding the On-Reserve Accommodation and Care of Our Elders*. Unpublished manuscript.

Noble, Gaile P., 1978. Social Considerations in Northern Health Care. *Canadian Nurse* October 16-22.

Paine, Robert, 1977. The nursery game: colonizers and the colonized. IN *The White Arctic*. Robert Paine, ed. pp 77-106. Toronto: University of Toronto Press.

Peckham, Agnew, 1987. Patient Advocacy Through Ownership of the Health Care System. Toronto: Agnew Peckham Health Care Consultants.

Pelto, P. J., and G. H. Pelto, 1990. Field Methods in Medical Anthropology. 269- 297. In *Medical Anthropology: Contemporary Theory and Method*. T. M. Johnson and C. F. Sargent (eds.). New York: Praeger.

Porcupine Health Unit, 1988. One Stop Access. Draft January 25

Preston, R., 1976. Reticence and Self Expression: A Study of Style in Social Relations. Pages 450-494 in *Proceedings for the 7th Algonquin Conference, 1975*. W. Cowan (ed.), Carlton University

Rathbone-McCuan, E. and J. Hashimi, 1982. *Isolated Elders: Health and Social Intervention*. Rockville, Maryland: Aspen Systems Corporation.

Resource Management Consultants, 1986. *Study of Health Care Service Needs in the Moosonee/Moose Factory Area for the Cochrane District Health Council*. Toronto.

Robinson, K., 1988. Older Women Who Are Caregivers. *Health Care for Women International*. 9:239-249.

Rogers, Edward S.,1983. Cultural Adaptations : The Northern Ojibwa of the Boreal Forest 1670-1980 In *Boreal Forest Adaptations: The Northern Algonkians*. A. T. Steegman (ed.) p. 85 New York: Plenum Press.

Rubenstein, R. L., 1986. What is Social Integration of the Elderly in Small Scale Society? *Journal of Cross-Cultural Gerontology* 1: 391-409.

Rubin, Joan, 1976. How To Tell When Someone is Saying "No." *Topics in Cultural Learning* August 61-65.

Shanas, Ethel, 1979. The Family as a Social Support System in Old Age. *The Gerontologist* 19(2) 169-174.

Shomaker, D., 1990. Health Care, Cultural Expectations and Frail Elderly Navajo Grandmothers. *Journal of Cross-Cultural Gerontology* 5:21-34.

Shubin, S., 1980. Nursing Patients from Different Cultures. *Nursing* June 27-29.

Stoller, Eleanor Palo and Karen L. Pugliesi, 1988. Informal Networks of Community-Based Elderly. *Research on Aging* 10(4) 499-516.

Stoller, E. P., 1989. Formal Services and Informal Helping: The Myth of Service Substitution. *The Journal of Applied Anthropology*. vol. 8 No. 1 March 37-52.

Stone, E. L., 1935. Canadian Indian Medical Services. *Canadian Medical Association Journal*. July 82-85.

Stuart, Paul, and E., Rathbone-McCuan 1988. Indian Elderly in the United States. In *North American Elders: United States and Canadian Perspectives*. E. Rathbone-McCuan and B. Havens(eds.) Connecticut: Greenwood Press pp. 235-254.

Tripp-Reimer, T., B. Sorofman, B., G. Lauer, M. Martin, and L. Afifi, 1988. To Be Different From the World: Patterns of Elder Care Among Iowa Old Order Amish. *Journal of Cross-Cultural Gerontology*, 3 185- 195.

Ujimoto, K. V., 1987. The Ethnic Dimension of Aging in Canada. In *Aging in Canada: Social Perspectives*. V. Marshall Ed. Fitzhenry and Whiteside: Markham, Ontario.
Vallee, F. G., 1962. Kabloona and Eskimo in the Central Keewatin. Ottawa: Northern Co-ordination and Research Centre. Referenced in Hodgson, C., 1980. Sitting on an Island: Nurses in the Canadian North. Unpublished Masters thesis. McMaster University, Hamilton, Ontario.**

Vanderburgh, R. M., 1987. Modernization and Aging in the Anicinabe Context In *Aging in Canada: Social Perspectives*. V. Marshall Ed. Fitzhenry and Whiteside: Markham, Ontario.

Weidman, H., 1979. The Transcultural View: Prerequisite to Interethnic (Intercultural) Communication in Medicine. *Social Science and Medicine*, Vol. 13B, 85-87.

Wentowski, Gloria, 1981. Reciprocity and the Coping Strategies of Older People: Cultural Dimensions of Network Building. *The Gerontologist* 21(6) 600-609.

Wherrett, G. J., 1977. The Miracle of the Empty Beds. A History of Tuberculosis in Canada. Ottawa:James Hope and Sons. Referenced in Young 1988 *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto: University of Toronto Press.

Williams, G. C., 1980. Warriors No More: A Study of the American Indian Elderly. In *Aging in Culture and Society*. C. Fry (ed.) Preger : New York. 101-111.

Young, T.K., 1983. The Canadian North and the Third World: Is the Analogy Appropriate? *Canadian Journal of Public Health* 74 July-August 239- 241.

Young, T. K., 1984. Indian Health Services in Canada: a Sociohistorical Perspective. *Social Science and Medicine*. Vol. 18 No.3 257-264.

Young, T. K., 1988. *Health Care and Cultural Change: The Indian Experience in the Central Subarctic.* Toronto: University of Toronto Press.

Zay, N., Old Age and Aging in Canada's ethnic population. Paper presented at the National Symposium on Aging. Ottawa, 1978. In Holzberg, C. S. 1982 Ethnicity and Aging: Anthropological Perspectives on More Than Just the Minority Elderly. The Gerontologist. 22(3) 249-257.

Zborowski, Mark, 1952. Cultural Components in Attitudes Toward Pain. *Journal of Social Issues* 8: 16-30 In Hendel-Sebestyen, G., 1979 Role Diversity: Toward the Development of Community in a Total Institutional Setting. Anthropological Quarterly 52 19-28.