DAKOTA PERCEPTIONS OF CLINICAL ENCOUNTERS WITH WESTERN HEALTH-CARE PROVIDERS

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INTRODUCTION

Blumer has written that "the task of scientific study is to lift the veils that cover the area of group life that one proposes to study" (1969: 39). In the process of investigation, a dark side of the human condition may inadvertently be exposed. In the research reported on in this paper,[1] examples of overt discrimination on the part of health care providers surfaced that were embedded in a cultural context. This finding points out the need for a systemic review of medical practice and Native peoples, particularly those living as a visible minority in the rural regions of Canada.

Anthropologists understand that human group life is the essential condition for the emergence of individual consciousness, as well as being a process of formative transaction. What also needs to be remembered is that people do not act toward the intangibles of culture, social structure or the like; "... they act toward situations" (Blumer 1969: 88).

The practice of medicine represents both a social and a cultural activity. That is, it always involves interaction between two or more socially conditioned human beings within a cultural context. Intrinsically embedded in this relationship are the subjective interpretations and perceptions of both client and clinician. This subjectivity extends to both the quality and meaning of the interactions.

Documenting and analyzing issues of discrimination and stereotyping has been a topic of social science research for

several decades. Much of this study owes a debt to the seminal work of Erving Goffman (1962), one of the first objective investigators of dysfunctional behaviour in society.

Many of us have experienced feelings of intimidation in the presence of medical personnel in a clinical setting, regardless of our cultural background. There is a natural tendency to defer to the "experts" to interpret an illness episode. Yet, it is important to keep in mind that there are many behaviors that are deemed socially inappropriate in the clinical situation. These are often in the form of taboos, and are strictly determined by our perception of our relative status within the patient/clinician social relationship.

The purpose of this paper is to examine how these taboos operate; particularly, how the Dakota perceive and interpret the double-edged sword of discrimination and stereotyping in their clinical encounters with Western health-care providers. For the Dakota of southwestern Manitoba, the clinical encounter is all too often just another degrading facet of community life, reinforcing with brutal clarity their subordinate status.

METHODS OF APPROACH

A major alternative to traditional participant observation in anthropology is to gather information second hand from individuals who have experienced the event(s) under study. This methodology is central to this research, as the clinical encounter itself is complex and hidden from direct observation. The procedure is necessarily subjective, conditioned as it is by the selective perceptions of the informants. However, this does not deny the reality of the event for the individuals concerned.

The techniques employed to gather the following narratives included the use of stenographic note-taking and tape recordings during open-ended personal interviews with Dakota informants. This allowed respondents the freedom to interpret and place into context their recollections of past encounters with Western health-care providers.

All of the material was transcribed and then analyzed for content relevant to the research. In all cases formal written consent was obtained from informants prior to interviewing. Interviews were conducted in the Band Council office on the Indian reserve and within private homes. Interviews were restricted to individuals who had actually experienced contact with the Western medical system within the year of the study. This of necessity limited the size of the sample. Questions were directed toward discovering the perceptions held by Native patients of their experiences within the Hospital District.

Random sampling was not employed for two reasons. First, the residential character of the reserve is not conducive to random selection. It is not possible, for example, to select every fourth house on a particular street, as there are no streets. Land is held in common by the band, resulting in homes scattered throughout the reserve. Second, and more importantly, the Band Chief had instructed the Community Health Representative to arrange for interviews with selected informants known to have experienced an illness episode within the specific time frame. In all, data were collected from thirty Dakota informants, out of a total reserve population of approximately 300. These individuals ranged in age from twenty to eighty-one.

The analysis of existing information was a secondary method utilized in this study. Special focus was directed to the literature on ethnic, or minority, encounters with Western medicine. In addition, relevant data from the files of the Manitoba Health Services Commission and the local hospitals were applied to cross-check various aspects of the research. For example, utilization rates, age and sex parameters, as well as actual etiology and treatment plans were compared with patients' reports of illness episodes. Even though official records are usually accurate and reliable, there are drawbacks to their use. For instance, patient charts may not necessarily reflect patient satisfaction.

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of Arts Ethics Committee, University of Manitoba, and the Manitoba Health Services Commission.

Throughout the research there was a concern for, and a sensitivity to, patterns in the responses of informants. Discrimination, stereotyping and stigmatization faced by Natives were central issues that emerged early in the interviewing process. Within the context of any human interaction, the presence of these behaviors can produce a poisoned environment. Within the clinical encounter, they are inexcusable.

RULES OF CONDUCT

Interaction may be thought of as a process; a series of mutually interrelated behaviors on the part of two or more individuals or groups in which each step of the process is designed to arise meaningfully out of the preceding steps. In addition, people will act in accordance with their own predetermined rules which define "how to act" in light of the expected reciprocal acts of others. This "knowing," however, often fails to transfer effectively within the clinical encounter between patient and health care provider, and often fails completely when the patient is Native.

The narratives presented below will show that the unique interaction between physician and Native patient, with its overtones of discrimination and prejudice, is fraught with difficulty and misunderstanding.

VICTIM BLAMING

When the rules governing social behaviour become blurred, as they often do within the clinical encounter, the causal agent is usually found to be a perceived difference in power. Whenever there is a power differential between two parties, real or imagined, the more favoured and dominant group, such as the physicians, has more freedom to cross barriers of conduct and impose legitimate or illegitimate means of control than has the less favoured Indian.

In an attempt to understand why Dakota patients are often reluctant, or uncomfortable, in seeking out the services of western physicians, we must turn to actual cases. As one young Dakota mother notes:

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

An elder expresses his frustration that his people are unable to escape from a classical double-bind situation:

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

One mother of four small children speaks bitterly of her experiences with local physicians:

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

The harsh economic reality of being an Indian on a poor reserve in Canada impacts directly upon the quality of health care that he or she can expect. As one elder comments:

> One doctor in particular doesn't treat us very nice. He yells at us, and tells us we are bad parents because our kids seem to get sick more often than white kids. That

> is what he says. He tells us we don't know how to take care of our children. That really makes me mad. Children are very special to us. They always have been. But, what do you do when you don't have enough money to buy food that is good for them, or have a warm enough house in the wintertime, and don't have running water to keep them clean all the time? It is really hard being an Indian mother with little kids.

These four narratives illustrate how "victim blaming" occurs in this study within the clinical encounter between western physician and Native patient. In particular, it is the mothers of Native children who find themselves labelled as being in the "wrong" when their children become ill. Somehow, in the eyes of some physicians, the child's illness is directly correlated to the mother being a bad and/or irresponsible parent. In addition, the onus of responsibility is placed on the shoulders of the mother to decide if their child is <u>really</u> sick or not. The major defect in this approach by physicians is that it places the mother in a "double-bind situation:" that is, they are damned if they bring the children in for medical consultation, and damned if they don't.

STEREOTYPES AND STIGMATIZATION

A stereotype is a complex set of personal characteristics and behaviors attributed to a person who occupies a given social position. It is a process of naming or labelling persons that is full of hidden pitfalls and ramifications. In this research the primary social position in question is that of Native patient. Classification of the stigmatized group is, in itself, a social act, and as such entails the participation of at least three different types of persons: the classifier (health care practitioner); a person or group to be so classified (Dakota patient); and the public (the non-Native community) called upon to accept or reject that particular classification. Whenever a group proposes to exclude others from their midst, they create the objective "they," which carries with it the requirement to attach a range of stigmatizing labels in order to support the illusion of not belonging.

Stereotyping is perhaps the best example of that peculiar ability of the human mind to believe fiercely and emphatically in whatever it wants to believe, even when one can demonstrate empirically and repeatedly that the belief is inaccurate. For instance, understanding becomes displaced in the situation where a Native patient is automatically assumed, by virtue of his symptomatology, to be "just another drunk Indian," rather than, in fact, the victim of a heart attack:

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

This ethnic stereotyping extends to all Native peoples, including those with significant official status. A member of the Dakota-Ojibway Tribal Council Police notes:

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

A middle-aged band official introspectively reflects upon the fact of being Native:

> You know, some people are quite open about not liking me because I am Indian. One of the first questions I asked myself when I was growing up was why did I have to be Indian? The second question I asked myself was what can I do to help myself when people treat me

> like dirt? Once I had a doctor tell me that most Indians were alcoholic. It is a stereotype that every Indian is a drunk Indian. I can feel pain too. Prejudice hurts me just like it does anybody else. I guess Indians aren't supposed to have feelings.

The special ritual of the clinical encounter reinforces the dominance of the expert. For the socially disadvantaged, the ritual is subtly changed, exacerbating an already delicate situation:

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

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

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

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

The impact of stereotyping and stigmatization is especially pernicious when found within the realm of health care, for it not only leads to overt acts of discrimination, but it also exacerbates the social distance between Native patient and health professional, thereby reducing communication and patient satisfaction. Moreover, the efficacy of medical treatment becomes suspect under these circumstances.

CONCLUSION

The selected narratives presented illustrate that psychological support and respect for the Dakota are two vital attitudes missing within the practitioner/Native patient relationship in the Hospital District under study.

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

Depersonalization and discrimination are serious matters, and not to be taken lightly, for when meanings of illness episodes are not shared by physician and patient, incongruities in definitions and expectations arise. These lead to conflict and dissatisfaction for both parties. This is consistent with Kleinman's theory of "explanatory models" (EM) (1980).

These EMs, a mnemonic for the patient's perception of illness, are a device which serves as a system of explanation that allows the patient to interpret the illness experience. Explanatory models are reflections of individuals' belief maps, both consciously and unconsciously formulated. They function to govern one's attitude towards illness episodes. The essence of Kleinman's work is that we need to be more sensitive to the impact of social, cultural and psychological factors upon that matrix of complex variables that constitute each unique person (Spiers and Sherley-Spiers 1986: 36).

It would be dangerous to look at these incidents in isolation, for the Dakota are victims in a vicious circle of structural poverty, unemployment and discrimination. To compound the

issue, they are blamed for situations over which they have no control. A case in point is when the physicians blame the Dakota patient for utilizing the emergency room instead of coming into the clinic during office hours. They are blamed when their children become ill, and told they are irresponsible and bad parents. They are verbally castigated when they fail to keep an appointment with a physician and when they do not comply with a medical regimen. They are berated and psychologically abused by their health care practitioners. Their perception is that they are being treated stereotypically. Consequently, their feelings of outrage are understandable.

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

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

NOTES

[1]The data reported here were collected as part of a larger project undertaken during 1984-85 (Sherley-Spiers 1987), designed to explore the nature of cross-cultural health care in rural Manitoba.

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