A TRANSACTIONAL QUEST FOR HEALTH

by

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ABSTRACT

The present thesis is a study of the process of development of specific health care services in lower mainland B.C. The major questions posed are: how does personal experience relate to one's choice of therapeutic service, and how do interacting social factors direct or influence the form and content of a selection of health care services? The institutions examined are family medicine, a feminist health centre and acupuncture. Ethnographic research was carried out through informal, loosely directed interviews with practitioners and patients or clients of these institutions.

The study focusses on the choices made by individuals as outcomes of personal experience; experience seen in the context of transactions. Transactions occur between individuals, between individuals and ideas, between individuals and institutions, and between two or more institutions. Transactions, when successful, reinforce previously established behavioural patterns. When unsuccessful they bring about changes in behaviour and are identified here as articulations. Behavioural patterns develop within individual lives and when these patterns take on aggregate form, new services or modification of pre-existing services emerge.

Decisions and choices are made on the basis of personal and shared

values, values which are situational. Outcomes of transactions reflect a negotiation process between transactors which frequently involves the juxtaposition of divergent values and goals. Personal experience, or transactions, occur within a framework of incentives and constraints imposed by broader, interacting social factors. When these factors are supportive of, or complementary to personal choices they facilitate the development of services. When social factors, external to the actual transaction occuring, are in conflict with personal choices they then restrict the development of services.

Personal choice, mediated by interacting social variables, directs the formation of social structure, the network in which personal experience is enacted, and this very structure in turn affects personal experience. The types of health care services described to me under the rubrics of biopsychosocial medicine and holistic health are examples of services that reflect a highly differentiated social structure and respond to it by attempting to integrate the diversity.

The services examined in this thesis reflect the values of the individuals that were instrumental in their development and consequently of the society of which they are a part.

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Chapter 1 Theoretical Framework and Introduction to Study

Introduction

How does personal experience relate to one's choice of therapeutic service and how do interacting social factors direct or influence the form and content of a selection of health care services? These are the questions posed by this thesis.

'A Transactional Quest for Health' is a study in the development and maintenance of health care services in the lower-mainland area of B.C. The focus of interest will be the 'processes' by which services are sought, implemented and modified. Because these processes are inherently related to the concerns and ideals of individuals within social frameworks it will become obvious that the services resulting from the processes reflect both current social values and the system of social organization.

The theoretical position that I have taken is one that perceives personal experience, in the form of transactions (between individuals or between individuals and ideas), in concert with compatible social factors as embodying a configuration of events and conditions that lead to the development of specific social services. The process involved is not a direct or clear cut cause/effect reaction but a coming together, or a

convergence, of many and often disparate factors. For any service or commodity to be offered or institutionalized, certain economic, political, legal, scientific and cultural or social contingencies must be met. Because these factors are in a continual state of flux the content and/or form of services also change. The services adapt to and therefore reflect social situations and issues.

It appears to me that the process involved is one whereby personal experience mediated by changing social factors is instrumental in bringing about adaptations in the types of health care services offered to a community. Therefore the purpose of this thesis is to identify some specific instances of experience and some of the social factors that have been presented to me as being influential in the development of certain health care services in lower mainland B.C. They can then be analysed as possible examples of a more general situation. I will examine: 1. the relationship between personal experience and one's choice of therapeutic service, from the position of both patient and practitioner and 2. the interaction of social factors that direct or influence the form and content of health care services. In conclusion I will look at how the actual structure of social organization, a structure that develops as a result of people making choices within social frameworks, informs both personal experience and current health care concepts.

It must be stated from the outset that due to the vastness of the subject - the Canadian health care system - this study is intended only as a preliminary one, rather than a comprehensive analysis. I hope this research will provide the groundwork for more definitive statements.

Background

In the past fifteen years or so there has been a tremendous upsurge in the numbers and types of health care services available in the province of B.C. Even though Canada has a strong, well established socialized health care system more and more facilities and therapies are emerging as alternatives to it. Health care has become a topic of interest and concern to all sectors of our community; social scientists are questioning the validity of health care services in society (Foulds, 1984; Jackson, 1981); doctors are asking - what is our role? (unpublished talk at medical conference 1984; Quaggin, 1982); politicians are evaluating the organization of health care systems (Lalonde, 1974; Government of Canada, 1984); alternative practitioners criticise modern medical doctors for their lack of sensitivity and relevance to an individual's everyday life and problems, as well as a perceived domination by the medical establishment (Smith, 1984; informants), and members of the public are left in a general state of confusion over who to turn to in the case of ill health

(informants). It is this above situation that has prompted me to look at what is happening in the field of health care. Why are these new services developing and do they reflect changing personal and social situations?

During the same period of time that many of the new services have been introduced to the British Columbia community the academic world has been publishing literature criticising the validity and organization of modern health care services and systems (Duff and Hollingshead, 1968; Freidson, 1970; Illich, 1976; Minkler, 1983; Navarro, 1976; Reiser, 1978). This literature has focussed much of its criticism on the political organization of health care systems, the role of the medical profession in promoting their own interests and those of the ruling classes, the over medicalization of life and society's dependence on high technology in the medical sphere. Although these studies certainly present issues that are of valid concern, it has appeared to me that they are often very narrow in perspective. They often pose the medical establishment as a self governing, insensitive monopoly that protects its own position and interests in isolation from external social influences. I see the medical establishment as a repository, not a definer of social values; one that is subject to, rather than in control of the fluctuations of changing social, economic, political and cultural values. The medical profession responds to social trends, public demands and environmental conditions (Horrobin,

1977; Mishler et al, 1981; Wertz and Wertz, 1977) just as any other institution in a broad system of social organization (Belshaw, 1970).

It is my frustration with what I perceive as the inadequacy of many critiques to explain the form and content of health care services that has prompted me to undertake this present study. I hope to show, within the limitations of this research, that personal experience within a changing social environment has direct influence upon the types of health care services offered in a community, and that what has happened in B.C. is a response to individual perceptions of need molded by the incentives and constraints of a social system.

Methodology and Theoretical Framework

My ethnographic research focussed on three health care institutions that are currently providing services for this community. I will discuss details of the institutions as provided for me by both practitioners (the proponents) involved and by their respective clients (the recipients). I will use the comments of my informants in order to discuss the types of services that people seek and why; and what practitioners and patients perceive as health and consequently health care needs. I will exemplify how personal experience, with direct relation to health conditions, as well as more general life experience, operates to define one's perception of

needs and therefore one's resort to therapy and therapist.

By understanding the significance of an individual's experiences and the influences under which people have lived we can recognize patterns that emerge in people's lives. When similar patterns develop in the lives of various individuals, or when divergent experiences result in the quest for common goals social trends begin to emerge. These trends generate the demand for specific types of services and when these services are reinforced by patronage, social approval and economic support trends direct or influence the direction of social systems. The comments and statements of my informants help to illustrate this process and point out how and why certain services are currently being offered.

I will begin my study (chapter 2) by presenting a chapter descriptive of the structure of the Canadian health care system. It will provide an overview of the federal - provincial health jurisdictions, medical legislation, the organization of health care services, avenues of access to services and methods of payment for them. These descriptions will point out the options that are available to people and the many social factors involved in providing health care services to a community. It will also acknowledge the position of the health care system in relation to other social systems in this society. I will pay specific attention to B.C. and provide even greater detail of the health care scene of the lower mainland

area of this province.

The study that I have undertaken has been designed as synchronic. I will attempt to explain the existence of three types of health care facilities that are currently operating in this area. I have interviewed both practitioners and clients (see appendix B) in each of the selected facilities and elicited their comments about the services being presented, what is being offered, what they want in terms of services and why. Even though the study is presented in terms of present conditions and environment it became clear that individuals' thoughts, perceptions and ideals reflected past experiences and situations. What is present today is a result of an historical process, in the context of an individual life as well as that of a society. The references to historical background come directly from my informants and therefore are their perceptions of history, not necessarily objective. I have not attempted to do any historical literary review or direct historical research. I have utilized, as supporting evidence, studies published by other researchers wherever the material is relevant to this thesis.

In addition to the observations and comments of my informants in the three institutions I am looking at, I have utilized the statements of speakers expressed at conferences, lectures, in journals and in the media. I have also spoken to a number of other members of the health care

community, in the areas of health education, health care planning as well as critics of the health care system.

The informants that I have selected do not comprise a statistically representative sample as I am not presently interested in quantifying experiences or behaviour but in clarifying the personal understandings and explanations of particular individuals who seek and choose between the health care options that are available to them, either as practitioners or as lay people. It is the process by which individuals make choices and how those choices affect the types of services offered in a community that I am examining.

I will try to understand the "webs of significance" (Geertz, 1973) that cause a person to perceive and react in his environment as he does, to make the choices that he does. Using the information gathered from loosely directed interviews with my informants I will try to determine the import of personal experiences and mediating social factors as the basis for the delivery and patronage of health care services.

The system of social organization in any society directs human behaviour within that society, it offers avenues through which goals may be sought and social interaction experienced. Cultural values define the goals that people seek. But the systems of social organization and of cultural values must not be seen as isolated entities; they are totally

interdependent and integrated.

> "Culture is the fabric of meaning in terms of which human beings interpret their experience and guide their action; social structure is the form that action takes, the actually existing network of social relations." (Geertz, 1973:145)

It must also be understood that cultural, or shared values are not absolute. Human beings are pragmatic; they therefore are evaluative and adaptive in their behaviour and when situations present themselves individuals tend to evaluate the circumstances within their specific context and modify their behaviour accordingly. Studies on ethnicity conducted by Nagata (1974) in Malaysia illustrate how behaviour, in terms of ethnic self identity, is modified. Situational ethnicity, as identified by Nagata, is the phenomenon where an individual's choice of ethnic identity is selected according to the context of the specific situation rather than by any fixed characteristic of heredity or affiliation. This choice will then vary as do situations. Health care seeking behaviour, and even health care servicing behaviour can often be seen to follow this situational type of pattern, as will become clear later in this thesis.

It has been shown that individuals generally follow behavioural patterns that have been initiated by others, as in the case of childhood experience or on the recommendation of a family member, colleague or friend (Barth, 1981). Routine is developed, familiarity established and as

long as faith is maintained with no obvious disastrous results a course of action is formalized and repeated in similar situations. Research into why people resort to specific healers (Frankenberg and Leeson, 1976; Solien, 1965; Young, 1981) supports this concept of formalized patterns in health seeking behaviour and the evidence presented in this thesis also lends credence to this position. Problems arise when established patterns of behaviour no longer bring the desired results. When dissatisfaction occurs behavioural patterns must be re-evaluated and adjusted in order to attain one's goals.

Generally, modification of behaviour fits within the flexibility of the social system, as is the case in Nagata's study of Malaysia or in the case of alternative types of health care services, such as the Feminist Health Centre in B.C. But there are times when values become incompatible with the social system and the system is changed. The most extreme example of this change would, of course, be revolution or a complete overthrow of the system. A less dramatic example, which will be discussed later, is the greater tolerance now being extended to the technically illegal practice of acupuncture in B.C.

Social systems are dynamic, they are on-going and changing precisely because human beings are evaluative and adaptive. Barth (1981) points out that individuals are constantly presented with "different choices

predicated by changing values" (ibid, p.94) as new situations are encountered. Whether values actually change or whether it is that the same values are invoked situationally according to their relevance to specific conditions is perhaps a moot point but it is clear that criteria change as different choices are confronted. Situations, even though they may seem similar from an outsider's position, must be recognized as intrinsically unique within their social and historical context. When social interaction occurs decisions are made which produce outcomes, and new situations are generated. The new situation is then dealt with in its own context. Although a result of previous conditions, the new situation must be evaluated, by the actors, in its own terms and within its own framework of criteria. But social interactions are not isolated events; they are affected by priorities established in other interactions. And because priorities tend to link interaction patterns can be seen developing. It is through this very process of evaluation and decision-making that social systems take their shape.

In order to clarify the process involved in the development and maintenance of health care services I feel that it will be analytically useful to organize my data in terms of Barth's (1966) transactional model. I will use it

> "to explore the extent to which patterns of social form can be explained if we assume that they are the cumulative result of a number of separate choices and decisions made by people acting vis-a-vis one another. In other words, that the patterns are generated through processes of interaction and in their form reflect the constraints and incentives under which people act." (ibid, p. 2)

Transactions occur between individuals, or between individuals and ideas, and just as the outcome of one transaction will influence future transactions, the outcome of any transaction is often, if not always, the result of a configuration of previously unrelated transactions. It is also important to recognize that each transaction is a negotiation; therefore what is present today in terms of health care services is the result of an on-going historical negotiation process. And as transactions take place within a framework of values, the services that emerge as the result of transactions reflect the values of the society of which they are a part.

I would like to apply Salisbury's (1976) contribution to transactional analysis in my use of this model. By recognizing each transactor within a dyad as an individual with his own logic we can avoid the assumptions of a moral community and acknowledge the fact that decisions, or transactional outcomes may be arrived at on the basis of two distinct value systems. It will become clear later in this study that transactors frequently hold disparate values in relation to similar goals. Wood's

(1984) study on intercultural transactions between Euro-Canadian social service agents and Indo-Canadian immigrants also supports this position. Transactions are not merely mechanical processes. They represent the coming together of individuals for interrelated purposes; i.e. to buy and sell as in the case of a merchant and customer or to alleviate ill health as between a doctor and patient. But the ramifications of meaning that the individual transactors possess in relation to that purpose may diverge widely. Only through an investigation into the lifestyle, experiences and values of each transactor can we see how the transactional outcome has been arrived at. Once we have seen how the outcome has been established we can abstract the process and look at how the configuration of numerous outcomes can generate social patterns.

Transactions occur at many levels. They occur between individuals, as in the case of social relations or personal interactions; they occur between different social institutions and they occur between individuals and social institutions. For the purpose of this study I will define one more category of transaction; this category is between an individual, or group, and an idea or concept. I will identify this type of transaction in relation to the introduction of scientific techniques, the influence of a philosophical concept or the emergence of a new therapy etc. where these ideas or notions prove to have had an influence on an individual's or group's

criteria for making decisions. The introduction of new ideas can have a strong effect on people and therefore will in turn affect behaviour in other transactional situations. Although ideas cannot in the strictest sense be considered transactors in their own right, as they have no power of negotiation, they do result from transactional processes and definitely influence future transactions. I will therefore be dealing with them as transactors.

Due to the limitations of this research the transactions that will be referred to in the course of this paper have not been witnessed by the author and therefore cannot be spoken of in a manner as if the transaction had been observed. What I shall refer to as transactions, in actuality, are perceptions of transactions. They are transactions that have been experienced, interpreted and consequently understood by each of my informants. And it is on the basis of their interpretations that decisions and choices have been made. I shall rely on these perceptions of transactions for my analysis.

Relying upon perceptions instead of personally observing transactions is actually not inconsistent with the object of my research. I am primarily interested, not in the mechanical process of interaction, but in the interpretations by individuals that invoke values and direct choices. Therefore it is precisely these perceptions and interpretations that hold

importance for me.

Belshaw (1969) utilized a concept of 'articulation' referring to how "the elements which make up culture react upon one another to bring about a further result." (ibid, p. 52) This concept was used in the context of institutions and offered an explanation for how cultural institutions interact with one another to promote change and consequently influence cultural performance. He defined seven categories of articulation as follows:

1. ramifying - when an alteration in goals or in the effectiveness of their achievement brings about adjustments in a wide range of other goals; the total effect is such that there are profound and widespread reactions within the culture

2. multiplying - when the satisfaction of a goal to an anticipated degree results in the intensification of demand for it

3. complementary - when one goal calls forth others which are closely associated in a complex, usually in something like a means-ends relationship or for the sake of consistency

4. competitive - when all goals are affected and fully accounted for, theoretically, in economic reasoning; it derives from the inescapable condition that all goals cannot be achieved at once

5. inconsistent - when actors perceive that goals they hold are contradictory, or that the goals and values of ego are inconsistent to some of those held by alter; inconsistencies can be ignored, they can be removed by allowing one set of goals to predominate or they can be modified, resulting in innovation

6. incompatible - an extreme form of inconsistency where the means of resolution lies in competition, confrontation and conflict rather than through co-operative resolution; intervention by institutional arrangements such as the legal system may occur

7. dysfunctional - when goals work against the functioning of the polity

I shall incorporate into my use of the transactional model Belshaw's concept of articulation but I shall adapt it in order to apply it to individual levels of transaction. Whereas Belshaw utilized the notion of articulation only in the context of shared culture or cultural institutions, I will also discuss articulation with reference to the movement of value orientations within the realm of an individual's experience.

For the purpose of this thesis all interactions between individuals, between individuals and ideas, between individuals and institutions, and between two or more institutions shall be referred to as transactions. The point at which transactions produce significant change, such as obvious alteration in the behavioural patterns of an individual, shall be

identified as articulation. Articulation is a form of transaction whose outcome calls forth movement in a set of ideas and values. Goals or the means by which they might be realized are altered.

It must be acknowledged that every transaction involves some degree of change. Every transaction occurs within a unique context of time and circumstance, and each transactor is affected by the juxtaposition of his personal value framework with that of the other transactor. This exposure to events and conditions will always produce an alteration of perceptions, however minimal. It is only when significant changes in performance occur that I will identify an articulation. Transactions occurring without articulation work to maintain situations or behavioural patterns; behavioural patterns that are satisfactory to the transactors or whose alternatives are not available or not worth the effort of change. When a transaction is seen to cause an increased commitment to a current behavioural pattern an articulation will be defined.

By utilizing the different categories of articulation one can estimate the extent to which this change will affect performance, of an individual or of a social group. Although beyond the scope of this study, a further application of this concept would be to attempt to predict the kinds of stimuli or situations that might provoke the various kinds of articulation.

If specific stimuli could be identified as producing specific articulations then the process of social change could be better understood.

Institutions Under Study

Chapters 3, 4, and 5 of my thesis will deal with the three institutions that I have chosen to investigate. These chapters will be structured according to the following format. The first part of each chapter will be a descriptive ethnography, outlining the particular institution - its characteristics, its structure, its services and its relationship to my informants and their perceptions of health and health care services. These sections will include the comments of my informants as well as other information that I have acquired. The second part of the chapters will be an analysis of my data in terms of the transactional model. I will examine transactions, define articulations and point out their significance to the process of health care service development. My analysis will address the questions that were posed in the beginning of this chapter; the questions concerning the importance of personal experience and other interacting social factors in the process of development and adaptation of health care services.

The first institution that I will present is the practice of family medicine. The reason that I have chosen this area is that it represents the official health care system in Canada and, in actuality, is the gate keeper for the system. In order to be covered by medical insurance all people must first see a general or family practitioner who in turn may refer a patient on to consult with a relevant specialist. For the purpose of this study, and as is widely accepted, I will use the terms 'general' and 'family' practitioner synonymously. I will present, through the remarks and opinions of my informants, what is now happening in the area of family practice medicine. The opinions expressed may not be representative of the whole medical community; individual practitioners do diverge, within limits, in their approaches to medical practice (Gaines, 1982; Lock, 1982). The practitioners that I have chosen to speak with are prominent in their field; they are all active in the medical school at the University of B.C., as well as being practising physicians. They are involved in teaching medical students and planning medical curriculum in the area of family medicine and health education of the general public. They are therefore, I believe, on the forefront of what is currently being presented as family medical practice. The recipients of family medicine that I have interviewed are patients of these doctors.

I have spoken with three doctors and three patients each of two of

them.

The next institution that I will discuss is the Feminist Health Centre (FHC). I chose this centre because of its development as a partial alternative to the official medical system. It is strongly aligned with the feminist movement. It was designed as a political alternative to the medical establishment and therefore represents individuals who have sought out a different, and in their opinion, more satisfactory form of health care service. The women I interviewed from this centre are all self proclaimed feminists and are either currently active in the FHC or are utilizers of the centre's services. One of my informants has been involved with this centre since its inception and was actually instrumental in its development.

Although the FHC does advocate an alternative political structure for health care facilities, adopts a critical approach to all health services and adamantly encourages individual responsibility for one's health, specifically directed toward women, it still retains a strong foothold in western scientific medical practice.

I interviewed three women who have been active in the FHC for an extended period but as the structure of this centre is different from a traditional doctor/patient format these interviews do not reflect the

same proponent - recipient positions. The first three women I spoke with are not professional health care practitioners but they are involved at the service level in the centre. Under the early structure of this facility two of the women were active in mutual aid and self learning groups; today they plan, coordinate and present programs. I also interviewed three women who are strictly clients of today's centre, unlike the earlier days when their involvement would have been in the context of a shared responsibility for providing and participating in services.

Acupuncture, my third area of interest, poses an alternative to western medical theory and was chosen for this reason. Grounded in ancient Chinese principles of balance and harmony within the body, acupuncture offers patients a different theoretical approach to health care. Although acupuncture is now used by certain western medical doctors it is usually confined to the treatment of pain or as a technique for anaesthesia. I will not be dealing with it in this context. I wish to look at the practice of acupuncture in its traditional form, as a therapeutic technique of Chinese medicine, as practised by orientally trained practitioners in the Vancouver area. I have spoken to three practising acupuncturists and to three clients each of two of them.

As the Acupuncture Association of B.C. has allied itself with the

holistic health movement and is supported by the Health Action Network Society (HANS - an agency that promotes the legalization of alternative health care facilities and individual responsibility for health) I will make reference to the broader holistic health movement and acupuncture's part in it.

I have chosen to keep the identity of my informants hidden out of respect for those who chose to remain anonymous and to prevent jeopardizing any of them as a result of their own statements or those of their patients or clients. I will therefore utilize pseudonyms when referring to my informants.

By utilizing a transactional model to analyse each of these institutions, by themselves and in relation to each another, I hope to have shown how and why these services have taken on the form they now present. I would like in my final chapter to extend the concept that transactions and articulations determine the form and content of health care services, to point out the circular effect of systems development. I will show how the structure of the services that are currently present, purely from an organizational or mechanical perspective, has an effect on personal and shared values; and consequently on transactional outcomes

that in turn produce new forms in response to that structure. Barth (1981:102) points out

> "that these processes cannot be concluded to produce the best of all possible worlds. The relationship which they depict between values and social systems is not one where the latter is designed to maximize the former. Rationality remains associated with micro-level units of decision making, not with overall systems. Thus the separate actors in social systems may repeatedly find themselves in situations where they unilaterally or mutually preclude each other from choosing the options which would be of most benefit to them separately and jointly. This will arise because of frequent discongruities and even antithesis between micro- and macro-levels of systems; but it is also, surely, often the result of misconceived, or indeed noxious, values that are sometimes embraced and confirmed as parts of life styles and praxis."

I will show how the concepts of biopsychosocial medicine, as espoused by family practitioners, and holistic health, as presented by alternative practitioners, are a logical outcome of a highly specialized and differentiated system of social organization.

Chapter 2 An Overview of the Health Care System

The official Canadian health care system is a well established, socialized system of facilities and services that provides care to approximately 99% of the Canadian population. The system is grounded in western scientific medicine and is supported by the governmental, legal and economic institutions of the country.

The constitution states that public responsibility for health services falls under the jurisdiction of the provinces in Canada. Other than areas such as quarantine regulations, provision of health care services in the Northwest Territories, for native peoples and for the armed forces direct federal government involvement in health care has not been possible. The federal government, though, does strongly affect health care policy across the nation. As Blomqvist (1979) points out the federal government has offered the provinces 'a deal they could not refuse'. It has established a system of cost sharing that asserts a federal control throughout the country.

Canadian statistics indicate that the majority of Canadians utilize the official health care services and facilities. Between the years 1978 -

1979 Canadians made more than ninety-four million visits to physicians. That is an average of four visits each. It is important to realize also that these visits were not made by a minority of people. Seventy-five percent of the population made at least one visit to an M.D. during this period (Abelson et al, 1983).

Federal and Provincial Jurisdictions

The federal and provincial jurisdictions in the Canadian health care system have been the source of much controversy. The system of financing for health care services has been maintained over the years by various programs which draw funds from both the federal and provincial governments. In 1977 the federal government instated the Established Programs Financing (EPF) Act. This program replaced the previous method of 'cost sharing' by the federal government to one of 'block funding'. Block funding is a system whereby the provinces receive an allocation of funds from federal sources, the amount of which is not tied to any specific program. The federal government posed it as a more equitable transfer of

health care funding from itself to the provinces and this program allowed the provinces more flexibility in the use of the funds than they had previously experienced. According to the task force (Government of Canada, 1984) this system encouraged the balkanizing of the Canadian health care system. Block funding was tied to the GNP and therefore payments could increase or decrease depending upon whether the GNP increased more or less rapidly than health spending. Tensions abound over the funding arrangements.

The reason that tension is present with reference to health care funding is due to the fact that the B.N.A. Act grants provincial governments primary jurisdiction over most health services. Soderstrom (1978:16) points out that Sec. 92 of the B.N.A. Act stipulates that each provincial legislature

> "may exclusively make laws in relation to ... the establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions in and for the province, other than marine hospitals,".

It also gives the provinces jurisdiction over "generally all matters of a merely local or private nature in the province,". This jurisdiction was partially usurped when the federal government offered to assist the

provinces in funding their health care programs. Federal funding is dependent upon certain specific conditions being met by the provinces and these conditions do undermine provincial autonomy. The conditions are:

1. the plans must be comprehensive i.e. cover all types of physician or hospital services which are medically required with no exceptions or dollar limits
2. they must be universally available to all eligible residents on equal terms and conditions (1)
3. the plans must in effect be portable between provinces
4. medicare plans must be run on a non-profit basis and managed by a public agency accountable to the provincial government (Blomqvist, 1979; Government of Canada, 1984; Soderstrom, 1978)

The provincial governments in turn raise their share of the costs through taxation, premium financing and the implementation of user charges. Premiums must not interfere with the requirements that ninety-nine percent of the population be insured (Evans,1982). User charges are

"a charge that is authorized under a provincial health care

> insurance plan for any insured health service and that is payable directly by an insured person" (Government of Canada, 1983:3).

The medical associations in some provinces encourage their physicians to 'extra bill' their patients also. Extra billing consists of

> "the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province." (Government of Canada, 1984:vii)

In 1984 the federal government passed the contentious Canada Health Act. This act gave the federal government the option of withholding part of their payments to the provinces for medicare. Funding could be withheld to the amount that the provinces received from user fees or extra billing. The federal government feels that these charges undermine the four principles of national medicare.

An article in the Canadian Medical Association Journal (Black, 1983) points out that decisions concerning the allocation of federal funds for health services, the nature of federal reaction to the provincial health care systems and the priority and details of major federal health legislation are made primarily by bureaucratic committees of appointed deputy ministers in Ottawa. These deputy ministers are seldom elected members of parliament or health care professionals but are highly

politicized professional bureaucrats. Health policy in Canada, therefore, falls directly into the political arena and is infused with the tensions of political rivalry. It is not determined solely by doctors or the health care community.

Hospital operating costs are calculated on the basis of an aggregate estimate of the operating costs of each department. Charges are not levied on specific services rendered. The majority of physicians, on the other hand, are paid on a fee-for-service basis. Only about one third of Canadian physicians are salaried (Blomqvist, 1979). On a fee-for-service system physicians bill the provincial insurance agency directly for services rendered. The amount of the fee is established under a fee schedule of the provincial medical association; a schedule that has been negotiated between the provincial government and organized medicine. Doctors fees are determined not on a basis of cost coverage for services but on the principle of providing incomes for physicians (Blomqvist, 1979; Evans, 1982).

The Case of British Columbia

M.S.P. (Medical Services Plan) is the insurance agency for the province

of British Columbia. M.S.P. stipulates the billing procedures and rates for all physicians and health care services in B.C. The fees in the M.S.P. schedule have been negotiated between the B.C.M.A. (British Columbia Medical Association) and the provincial government. The fee schedule lists the various types of services that are insured, the negotiated fee that M.S.P. will pay physicians for their services and the amounts that the B.C.M.A. have set as fees. If a patient is insured under the provincial agency the physician can bill M.S.P. directly at the negotiated rate, but if a patient is not covered by the insurance plan the physician can bill him the higher amount established by the B.C.M.A. (B.C.M.A. Payment Guide, 1985).

The Medical Services Plan of B.C. charges premiums for their insurance plan and it has determined user charges as well. User charges are imposed for hospital stays, for outpatient therapy and for emergency room use.

M.S.P. also restricts the number of billing numbers that it issues to physicians. For instance in B.C. there are areas that are considered saturated; the doctor/population ratio should not increase further. M.S.P. will therefore not issue any more billing numbers to physicians wanting to practise in these areas. As of 1978 the doctor/population ratio reached

its' optimum point of 1:665 throughout Canada. These figures do vary between locations and generally are higher in urban versus rural areas (Abelson et al, 1983). Hospitals play a role in restricting physicians also, by controlling the doctors to whom they grant hospital privileges. Hospitals in Canada, although publicly funded, have remained private institutions and are self governing. In order to get visiting privileges a physician must apply to the Medical Director of the specific institution who will, in conjunction with the medical staff and board of directors, determine eligibility.

Each province in Canada has, as part of its legislation, a medical act which governs medical practice in the respective province. This act controls medical practice and determines who can legally practise medicine. In the province of B.C. medical practice is restricted to physicians who are registered with the College of Physicians and Surgeons. Exceptions to this requirement are persons who are licensed to practise medicine under another pertinent act, such as: chiropracters, dentists, naturopaths, optometrists, pharmacists, podiatrists, physiotherapists, dieticians, psychologists, nurses or anyone performing emergency procedures as authorized by the Health Emergency Act.

(Government of B.C., 1979)

The national organizations that establish the norms intended to govern professional behaviour are the Canadian Medical Association, The Royal College of Physicians and Surgeons and the Canadian College of Family Physicians (Blishen,1969; Crichton et al, !984) The first two of these institutions are incorporated under a provincial act in each of Canada's provinces. Their responsibility is to prescribe qualifications for practitioners. The Royal College is in charge of training for specialists. A physician, upon successful completion of his specialty examinations receives automatic membership in this College. The Canadian College of Family Physicians is a voluntary body that sets standards and certification exams for family practitioners.

The Canadian Medical Association has published a Code of Ethics which outlines the following principles of ethical behaviour for all physicians:

1. Consider first the well-being of your patient.
2. Honour your profession and its traditions.
3. Recognize your limitations and the special skills of others in the prevention and treatment of disease.
4. Protect the patients secrets.
5. Teach and be taught.
6. Remember that integrity and professional ability should be your

best advertisement.
7. Be responsible in setting a value on your services.

> "The complete physician is not a man apart and cannot content himself with the practice of medicine alone, but should make his contribution, as does any other good citizen, towards the well-being and betterment of the community in which he lives." (Canadian Medical Association, 1982)

At a provincial level there exists the B.C. College of Physicians and Surgeons which prescribes qualifications for practitioners, licenses annually those who qualify and investigates and disciplines those who violate the standards or practise medicine without a licence. All practising physicians must be members of this college. The B.C.M.A. (British Columbia Medical Association) is a voluntary association that takes care of the interests of doctors. It is a political body that negotiates the fee schedules with the provincial government, investigates abuses of the billing schedule and provides public relations services for the profession.

Territoriality

As becomes clear upon investigation, the Canadian health care system is inherently tied to the political and economic fluctuations of the country and consequently is fraught with the tensions and conflict that relate to economic and professional control of services. But tensions do not all

originate outside of the system. Apart from the issues and controversies over the financing and regulating of health care services there exists a problem of conflict between the actual levels of health care providers. Due to the high level of technology and the current complexity in health care there has developed a distinct system of boundaries and division of labour between health professionals.

As Crichton, Lawrence and Lee (1984) point out, the years since World War II have brought with them enormous technological advances. These advances have included automated laboratory testing and improved radiological and ultrasound scanning techniques for the use in diagnosis. Superior invasive investigative procedures have been developed and new levels of pharmacological knowledge and expertise have made it possible to control many conditions which could not have been managed before. These advances have aided the general practitioner in many ways but they have also brought about an increase in the numbers and types of specialists now practising in the health care system. The development of specialization has meant that the general practitioner can now refer patients when they require more specialized knowledge and care. Some physicians, though, have been reluctant to acknowlege the limitations of

their own levels of competence and to refer their patients to specialists (ibid). There is definitely a battle of territoriality being fought and it does not end with the problems between general practitioners and specialists. It extends to the domain of nursing and other support health care workers in this highly differentiated system. An example of inter-professional wrangling exists with the current controversy between nurses and doctors.

> "The nursing profession claims that nurses are well able to perform many of the duties currently practised by doctors, and at considerably less cost. Observers claim the nurses are prevented from expanding their roles because of the profound consequences for medical manpower, and because of the power of the medical profession." (Government of Canada, 1984:82)

Another level of this same problem exists between nurses and nursing assistants. The assistants feel that their profession should be recognized as a separate entity from that of registered nurses because they perform special and important functions in the health care system (ibid). Even though the health care system is based on the division of labour disputes over jurisdications and boundary definitions abound.

Another problem that is often cited among health care professionals is the lack of communication between the various branches of

responsibility within this diversified health care system. For example, the psychologist will complain that he does not understand exactly what it is that the family practitioner does, nor does he understand the jargon that the medical professional uses. With the growing number and types of allied health care workers this situation appears to be increasingly significant. (Grams and Grantham talk:1985)

From a patient's point of view entry to this system begins with the general or family practitioner. In order to be covered by the provincial health insurance plan an individual must first consult with the general practitioner. Such a physician is usually the person who interprets the system and directs the patient to the services that he requires, if they happen to be beyond his own expertise. If a physician refers a patient to a specialist then the specialist fees are covered by M.S.P., but if the patient goes directly to a specialist with no referral he must pay the difference between the general practitioner's fees and those of the specialist.

Within this system roles are defined (i.e. G.P., specialist, allied health workers, patients) and behaviour is controlled (i.e. professional group expectations, rules for patient access to expertise) but the presence of conflict, as noted, indicates that acceptance and complacency are not

exhibited. Individuals and groups of people continue to evaluate their positions and work to bring about changes. Transactions take place throughout all levels of the system and articulations continue to alter goals or the means by which they can be achieved.

The dispute over territory extends to the area of responsibility for decisions concerning the treatment of patients, and the boundaries of jurisdiction for some decisions reach beyond the actual health care system. Who holds the authority to decide on issues such as abortion, euthanasia or utilization of life support techniques?

A controversial case that sparked much public concern in B.C. (Kluge, 1983; Ross, 1983) illustrates the many levels of transaction involved in deciding upon some services, and how opposing values are juxtaposed when such decisions are faced.

Stephen Dawson was a severly handicapped, hydrocephalic child who faced brain surgery in order to survive. His parents, after consultation with, and agreement of the attending physicians decided to withhold surgery on the grounds that it would amount to extraordinary intervention. Doctors stated that the surgery would not improve the overall quality of his life, which was deemed to be poor, only prolong it. The Ministry of

Human Resources (MHR) intervened and demanded that the courts over-rule the parent's decision. MHR's case was lost and the parents were legally granted the right to allow their son to die. MHR took the case to a higher court, appealed the decision and had the ruling over-turned. MHR was granted custody of the child and surgery was performed.

According to the media reports transactions and articulations occurred between parents, doctors, lawyers and social workers, and were enacted on the basis of values relating to the morality of prolonging life, the right to die with dignity, the economic viability of supporting the chronically ill and the medical judgements concerning outcome of surgery and future status of health. The final articulations indicated incompatible goals between the concerned parties, and subsequently the courts intervened.

This one case illustrates the myriad of interacting factors involved in the making of a single decision - surgery or no? Although located in the health care arena this case involved the interaction of medical science, religion, economics, law and social service. It also showed how transactions between the parents and the physicians, based on the personal and professional values of each, failed under the constraints of

broader social influences. If the actual transactions could have been observed and the transactors questioned I suggest that we would have seen how personal choices are arrived at on the basis of values derived from previous experience, i.e. religious affiliation, medical training or legal expertise. We would also see how personal choices, in this case, for therapeutic services, are mediated by the interaction of broader social factors i.e. law, religion, and economics.

Health Status of Canadians

The health status of Canadians reflects the health status of the citizens of most developed nations of the world. The predominant health problems lie no longer in the areas of parasitic or infectious disease but in the areas of degenerative, chronic, environmental and lifestyle illness (Abelson et al, 1983; Government of Canada, 1982; Lalonde, 1974). The successful control of parasitic or infectious disease reflects environmental improvement, economic development and stable food supplies (McKeown, 1976). Although these diseases have been virtually eliminated, environmental and social changes have incurred other health hazards. A rise in life expectancy and an increasingly older population

contribute to the higher incidence of chronic and degenerative disease (see appendix A).

LIFE EXPECTANCY AT BIRTH, BY SEX, BY PLACE, BY DATE

	1931			1976		
	M	F	DIFF.	M	F	DIFF.
Canada	60.0	62.1	2.1	70.2	77.5	7.3
B.C.	62.2	65.3	3.1	71.0	78.4	7.4

(Statistics Canada, Blomqvist, 1979)

The Alternative Health Care Scene in B.C.

The descriptions given to this point of the health care system of Canada, with special reference to B.C., does not account for all the health care services available to the public. In the lower mainland area of B.C. many new facilities and services have been introduced. The theoretical validity and effectiveness of these services are openly questioned and often negated by the official health care establishment. The practice of many of the alternative therapies is also illegal. Except for those practices specifically acknowledged by the health act, any practitioner

utilizing a therapeutic technique which can be identified as 'practising medicine', as defined by the health act, is liable for prosecution. Alternative services are not covered by M.S.P. insurance. Therefore any practitioner of an alternative medical therapy is open to prosecution and any individual patronizing such a practitioner must personally accept the responsibility for the payment of that service.

In the B.C. lower mainland a number of organizations and agencies have set themselves up to promote and advertise alternative health care services. Most of these agencies and practitioners consider themselves a part of the 'holistic health movement'. They oppose the current health legislation and they often oppose western scientific medicine as well. Their opposition to western scientific or allopathic medicine is grounded in the perception that allopathic medicine, with its intrusive surgical and pharmacological techniques, is harmful to good health. It is also opposed on the grounds that western scientific medicine has an unwarranted monopoly on medical services perpetrated by the medical associations and supported by our legal and economic institutions (Smith, 1984; informant's comments).

A study (Bryan, 1982) commissioned by the Health Promotion

Directorate of Health and Welfare Canada presents the author's research into the holistic health movement in B.C. and Alberta.(2) He outlines the philosophical orientation of 'holistic health' and he identifies a number of the various alternative practices that are being offered in B.C. A few of these practices are being utilized by M.D.s or licenced practitioners and in that context are legal. The list of therapies that he describes includes: acupressure, acupuncture, autogenic training, ayurveda, biofeedback, chiropractic, herbalism, holography, homeopathy, traditional North American Indian medicine, iridology, meditation, midwifery, naturopathy, orthomolecular medicine, osteopathy, podiatry, reflexology, rolfing, and stress management techniques. This list does not cover all the practices being offered to the community.

There are agencies and publications which actively promote the practice of alternative therapies and a few of these are: the Health Action Network Society (HANS) who believe that the "freedom to consult practitioners of one's own choice is a fundamental human right." (HANS pamphlet), Banyan Books which distributes advertising for numerous alternative practitioners, the Aquarian Network (1982) that publishes a directory of "Healing, Holistic and Spiritual Resources" and Common

Ground newspaper that regularly publishes articles and advertisements by varied types of practitioners. The range of services being offered covers areas from spiritual or religious healing, to traditional medicine of other cultures, to numerous philosophical orientations, to fitness and relaxation techniques, to the use of herbal and/or vitamin therapies and many nutritional programs.

The purpose of this chapter has been to present an overview of the health care system in a manner that is relevant to the objectives of this thesis. I have outlined the structure of the health care system, the public's access to services, supporting social institutions and some of the conflicts that result from the interaction of many and varied interested parties.

Footnotes:

1. The percentage of residents to whom services must be available is actually quoted by Evans (1982) and the Government of Canada (1984) to be 99%. Native peoples are provided for separately.

2. It should be noted that Bryan's report (1982) has not been released by Health and Welfare Canada and only a limited number of copies have been printed. The report clearly states that the views expressed are those of the author; they do not reflect the official policies of Health and Welfare Canada.

Chapter 3 Family Practice - Gateway to the Medical Establishment

I have chosen to look at the institution of family practice because of its unique position in the health care system. It is, for most people, the first point of contact between an individual seeking health care advice or consultation and the medical profession. It is also the point of greatest contact between the public and the health care community, due to the regulation that in order to be covered by medical insurance a general or family practitioner must be consulted before a referral can be made to any specialist. Because of this position the institution of family practice is, I feel, an essential part of the decision making process for an individual seeking health care. It is also likely to be a significant option when making choices concerning therapeutic service.

Family practice is the gateway to the health care system and therefore is imperative to examine when dealing with the questions of how personal experience affects the choice of therapeutic service, and how interacting social factors influence the form and content of health care services.

Although I am concerned in this thesis with the lower mainland area

of British Columbia, the family practitioners of B.C. are certified by the College of Family Physicians of Canada and subsequently adhere to the policy statements and objectives of the national body. I shall therefore be including statements issued by the Canadian College.

Dr. Robert Peterson

My first informant is Dr. Robert Peterson, a faculty member of the Department of Family Practice at the University of B.C., and a practising family physician. He has provided his interpretation of what is currently happening in the field of family medicine and how he feels that what is now being presented is the result of a changing medical paradigm that has responded to changing public need.

Dr. Peterson began by explaining that traditional doctors have been trained as allopathic physicians to diagnose and treat instage disease. Their practice relies heavily on technology, surgery, pharmacology and on increasingly sophisticated investigative techniques. He pointed out that biological medicine has served humanity well when "digging bullets out was what was required on the western frontier" and "when conquering infectious disease was the major health problem". It continues to be useful when cutting out the disease through surgical extirpation is a

worthwhile technique. But, he continued, this model is becoming less satisfactory as those diseases have been conquered and as the spectrum of illness problems which are being brought to doctors by their patients is changing. This general framework for medical practice he designated as paradigm 1 or 'biological medicine'.

Within this century, Dr. Peterson noted, the relationship between mind and body was recognized and the biological model, whereby one looks at an individual as a mechanism and as a system of enzymes and intracellular enzymatic reactions, was shown to be inadequate to explain all problems. The biological model cannot be used to solve all the difficulties people develop. So an awareness grew up out of psychiatry, in part, and out of other people's perceptions that there was more to illness than just the biological problems, and that there was indeed a relationship between the mind and the body. Around the period of World War II the term psychosomatic medicine made its appearance. This era of medical practice, where the physician is aware that what goes on in your head can and indeed does affect what goes on in the body and vice versa, my informant referred to as paradigm 2 or 'biopsychological medicine'.

Dr. Peterson stated that it has become increasingly evident that biopsychological medicine is still not a broad enough basis for medical

practice, probably because the problems people are taking to physicians are mainly to do with behaviour. It is much more appropriate to look at a person, "not just as that organism, physical and psychic, but as part of a larger organism." In other words looking at a person in their milieu, in their environment, in their context is crucial.

> "This approach brings in then their culture, their religion, their heredity, their family, their socioeconomic status, their value system, their environmental concerns, where they work and all that kind of stuff",

explained Dr. Peterson. 'Biopsychosocial medicine' is the term used to refer to this third paradigm, or in more popular vernacular, holistic medicine.

The concept of holistic medicine is believed by Dr. Peterson to be an excellent one but he feels that today this term has become totally disreputable because of

> "entrepreneurs and physicians in the United States who have set themselves up as practicers of holistic medicine based on economics rather than on anything that is more scientific than that. The other thing that has gone along with that has been a propensity to discard the 'bio' and indeed often the 'psycho' part of that biopsychosocial definition and to focus exclusively on the person's culture, environment and spiritual side."

There has been a tendency to throw out the science, according to Dr. Peterson, and this is the point with which he, as a physician, has great

difficulty and it is also the reason that he prefers the more cumbersome label of 'biopsychosocial medicine'. The concept represented by either of these terms he feels is a very appropriate one and one that he espouses for the practice of medicine, but he disapproves when he perceives that science is being discarded. He stated that "afterall physicians are primarliy scientists, or should be".

Along with the changing medical parardigm that provides the theoretical basis for practice Dr. Peterson also noted a change in the way physicians actually conduct their practices. Working within a strictly biomedical model the physicians' role was a therapeutic one,

> "that's where the doctor cuts out, or gives a pill, or treats, or sticks a needle in or does something very therapeutic and very overt and obvious".

This mode of treatment is 'disease oriented'.

About the time that psychosomatic medicine became popular the medical profession and other people believed , said Dr. Peterson, that the prevention of illness was a more responsible role for physicians rather than to sit and wait for instage disease to present itself and then try to pick up the pieces. This phase of practice became known as 'preventive medicine'. It was still disease oriented only now it dealt with the prevention of disease.

More recently there has been an "enlightened" attitude, in parallel with the concept of looking at the whole person in his context; "a desire to get away from illness and disease entirely", explained Dr. Peterson. The term wellness has now begun to creep into people's vocabulary and the concept of health promotion is being seen as a more admirable approach than prevention. "It is much more positive in its orientation."

Reflected in Dr. Peterson's perspective of what is now being promoted in the practice of family medicine are the following statements and objectives of the College of Family Physicians of Canada:

> "The physician shall be able to define health as the state of physical, emotional, and social well being."
> "The physician shall be aware of the effects of the patient's total environment upon his health."
> "The physician shall consider health maintenance as part of his professional responsibility." (College of Physicians and Surgeons, 1981)

Also the goals of the Family Practice residency program at the University of B.C. elaborate even further upon the ideas of Dr. Peterson. The Residency Objectives Booklet (1983) states the following:

> "The prime goal is to enable the residents to acquire and gain experience and confidence in using the appropriate skills necessary to provide the best possible health care for their patients.
> In order to achieve this the following objectives must be

met:

1. First Contact Management
   The resident will serve as the physician of first contact and become skilled in the initial management of any presenting problem including life support measures, managing emergency situations, relieving or minimizing suffering, and managing acute medical, surgical and emotional problems.
2. Continuing Comprehensive Care
   The resident must understand and be capable of providing continuous health care to all ages of people in an ambulatory and appropriate hospital setting; be able to manage chronic diseases on a long term basis; know how to prevent diseases by the use of periodic screening techniques; be able to act as a counsellor and educator for patients, their families and the community in ways of preventing disease, prolonging life and making life more enjoyable; act as a coordinator of the health care team when necessary.
3. Community Medicine
   The resident must understand the current concepts of screening, health hazard appraisal including environmental and occupational health, applied epidemiology, such as prevalence and incidence of disease in the community, be aware of the community resources available and be able to apply this knowledge to the maintenance of health and well being of the patient in a cost effective manner.
4. Behavioural Medicine
   The resident must gain self understanding; perceive patients as individual people who are ultimately responsible for their own health, life style and health care; understand the interrelationship of health and disease with the patient, the family and the community.
5. Medical Economics
   The resident should gain an understanding into the financial aspects of medical care...
6. Medical Legal
   The resident should have a clear understanding of the medico-legal aspects of patient care...
7. Research and Continuing Medical Education
   The resident will develop lifelong habits of enquiry...
8. Problem Solving

The resident will develop a problem solving technique..."

It is clear that today's physician, as Dr. Peterson pointed out, is expected to perform a much broader range of duties than had once been expected under a strictly biological, disease oriented model. These goals effectively outline the expectations the medical school has for its residents and our future doctors. A family physician is expected to be, not only a medical technician but a competent communicator, a counsellor, a teacher, a community resource expert, a business manager who can run his office and hospital routines, and someone who has an extensive awareness of cultural and social issues. And according to Dr. Peterson this changed role has come about due to changing environmental and social factors that affect patient needs. The major concern of doctors is no longer battlefield wounds, nor infectious or parasitic disease. The problems being presented to doctors are degenerative and lifestlye type illnesses (Government of Canada, 1982; Lalonde, 1974; Abelson et al, 1983; informants), and according to all the physicians that I spoke with 70 - 80% of their patients come to them for behavioural or stress related problems rather than pathological disease. Social and personal conditions have changed and these changes have caused physician/patient transactions to be

unsuccessful; inconsistent articulations have developed between patient and physican. According to the doctors with whom I spoke they felt an inability to deal with these new problems being presented to them on the basis of their medical training, therefore they are developing new approaches toward patient care. Other researchers have also pointed out how changing social trends and subsequent patient demands have caused an evolution in health care practices (Horrobin,1977; Wertz and Wertz, 1977).

A newspaper article (Casselton, 1985) quoting Dr. Peter Grantham, Head of the Department of Family Practice, points out that "Formal medical education lags behind the sharp, in-focus, current needs of the physician, and the physicians' focus lags behind public demands." This comment was in reference to the new Division of Behavioural Medicine that has been established within the family practice department. "Its three-point goal", said Grantham, "is to teach doctors and professionals the limited amount of scientific information available about alternative medicine, to develop research programs to discover new ways in which human behaviour can be altered to help with problems and, ultimately, to establish the clinics for patients."

Dr. Peterson's model of evolution presents his opinion of how medical practice has adapted to environmental conditions, and social and academic

trends. It does not describe how personal experience fits into this process of development. Therefore, after listening to Dr. Peterson's views I asked him if and how these paradigms are reflected in his own personal practice of medicine, how he relates to his patients and how he makes choices concerning therapeutic techniques.

Dr. Peterson stated that the change in medical paradigms has influenced the way in which he spends time with his patients compared to when he was a young doctor and compared to how his predecessors spent their time. "I now spend more time exploring the patient's concerns, the patient's situation in life, in society, in the family."

I continued my line of questioning in order to discover what it was that caused this doctor to adopt a biopsychosocial (BPS) model of medical practice. It became apparent that many levels of transaction had occurred and articulations had resulted from patient interaction, professional and colleague interaction, the emergence of new scientific knowledge and public demands.

With respect to his patients, Dr. Peterson spoke of a personal recognition,

> "an awareness that I'm not meeting this person's needs very well here. Sure I send them for the right lab tests but he's still worrying, I sent him to the right consultant but he's still

complaining or he's still unhappy."

He says that he feels the people are more satisfied with a BPS approach to health care and he gets positive feedback from his patients. "They say things like, - that's helpful, the cardiologist didn't help me but now that I've seen you again I feel more satisfied ". I pursued the issue and asked him to explain more fully how this new model developed and he replied:

> "Doctors feel that it has arisen to a great extent from their patient substrate, from patient's demands and expectations. It has arisen to some degree by thoughtful people, including physicians and critics of medicine, and other people who study the health care system - writings, lecturing and teaching."

Dr. Peterson's comments illustrated the situation of how transactions occurring at various levels of experience - between doctor and patient, between colleagues, and between doctor and the media or general public- create articulations and generate patterns that bring about changes in performance. He also pointed out the difficulty in identifying the exact point when awareness and articulation occur. "The reasons are all so infinitessimal when you try to identify 'the' point in one's life where interest is sparked". Even though he did not identify any specific points that could be considered articulations in the process that shifted his allegiance to the BPS model of medicine he did offer the example of an incident that he was involved in which depicted another important level of

influence for a doctor. It was an example where an identifiable pattern developed, articulation occurred and a change in behaviour resulted. He spoke of a level of experience which differed from patient demand and could not be considered standard medical knowledge. This level lies in a more vague area best described as personal or professional wisdom. Dr. Peterson related the following account.

> "There was a very, very esteemed and still, I think, highly respected, and shoud be, physician in this town when I was an intern, just out of medical school and knew everything; which interns tend to believe. He had been in practice many years at that time and he was routinely using chloramphenicol for otitis media. Now he happened to be the doc in B.C. or in Vancouver who looked after all the native Indian population. He was the Indian doctor, and recurrent and chronic otitis media is almost endemic among native Indian children, or was then and still is to a degree. And chloramphenicol is not the drug of choice. At that time it was a new drug and still fairly popular but it had been already described as producing aplastic anaemia and its indications were narrowing ... He was using it on nearly every kid he had in the hospital because almost every kid he had in the hospital had runny ears. All those children he had in the hospital at that time were all on chloramphenicol. I came up to him in my fresh faced innocence, bursting with knowledge and said 'Doctor don't you know that chloramphenicol is a dangerous drug and can cause aplastic anaemia?' And he said "Of course I know that.' And I said, 'Don't you know that penicillin is ... the drug of choice for otitis media in children?' 'Yes', he said, 'I know that but, he said, I've had three people die from anaphylactic reactions from penicillin in my practice in the last two years. I haven't had anyone die from aplastic anaemia from chloramphenicol. So don't tell me to use penicillin.' ... And I would support that. So that is what I mean by personal experience. It would take a pretty brave man to go on prescribing bushels full of penicillin, and yet the experience of

other doctors and science would tell us that penicillin is the proper drug."

It is clear from this account that three transactions with dying patients brought about an incompatible articulation with the medical knowledge that this doctor possessed and caused him to rethink his approach to treating children with otitis media.

I also asked Dr. Peterson if he has developed any particular interests in his private medical practice and if so how they came about. He replied that sports medicine had for a long time been a special interest of his and that it developed largely because his practice had grown up around a number of his rugby playing friends. An articulation with the special needs of his athletic patients caused him to develop this area of his practice and it proved to be complementary to his broader goals of health care.

He has also become a vocal advocate of smoking cessation due not only to his articulation with scientific data that shows smoking to be harmful, but also due to his experiences of witnessing the suffering and death of his smoking patients. His articulation with these dying patients complemented his goals of health in that it reinforced his previously intellectually based values and created an even stronger position.

Other remarks of this informant exemplify how choice of therapeutic

technique varies according to fluctuating values. I asked Dr. Peterson if he had experienced all three of the medical paradigms that he had described. He answered that he had but not in the progressive manner in which he had described them. Even though he personally espouses the BPS model he admits to not always using it.

> "You already asked me if I think I've changed. Yes, I think I've changed, but I still see people because of their presentation or because of my personal feelings, or my temporal limitations, or whatever they might be that are dealt with in what my kindest critic might consider to be in a purely biological sense - 'Don't worry you've got essential hypertension, take these pills, come back in six months and I will look at your blood pressure again' ... One uses whatever one can. There are people that aren't interested in talking about their family, who aren't interested in talking about how they feel or what they're worried about. They don't expect their doctor to do that ... You can try, you may or may not, and if you're rebuffed you'll probably, because of limitations of time and personal impatience and dislike say - 'alright, OK come back in six months and I'll measure your blood pressure again' - or 'I'll have my nurse measure your blood pressure' - or 'I'll send you to the hypertension clinic and they can measure your blood pressure every six months'.

Dr. Peterson's comments support the concept that values are often situational and governed by the context of time and condition. Transaction with a disinterested patient, or with his own fatigue, may provoke an inconsistent articulation causing him to change from using a BPS approach to treatment to a strictly biological approach.

Dr. Heather Carlton

The second doctor that I spoke with is also a faculty member and a practising physician in the Dept. of Family Practice at U.B.C. She adheres to the biopsychosocial model of health care described by my first informant and espoused by the College of Family Practitioners and the U.B.C. Department of Family Practice. I asked Dr. Carlton how and why services come to be offered within family practice. She replied that it is a twofold situation; a response to both patient needs and to physician needs. She said that "when I got out into practice I found that I didn't know what I needed to know to deal with the patients that I was seeing". She worked for a number of years in a multi-ethnic community health centre and was confronted with patients of a different socioeconomic level than she was familiar with. They were people who she saw as "underprivileged, victims of the system". She felt that there were many things that she should have been taught in medical school that would have prepared her better for working in such a setting, but were not. "What kinds of things?", I asked.

> "Bioethics, economics of medicine, politics of health ..., a number of feminist issues in terms of women's health issues which have been instrumental in terms of making changes in sex abuse legislation",

she replied. These specific issues she felt "have all grown out of broader social movements." Because of her personal experiences and feelings of inadequacy with respect to helping her patients she has been instrumental in the development of two major programs, one being the division of behavioural medicine within the Department of Family Practice and the other a sexual abuse clinic. The articulations that promoted changes in her practice and development of these two interests are ascribed to insufficient or inadequate training, training that was inconsistent with the means necessary for maintaining the health of the patients whom she was dealing with.

The behavioural medicine program has the goal of controlling, or helping to control, disease and illness by controlling behaviour. It will provide specific advice on how to lose weight, stop smoking, ease chronic pain, control stress and solve other non-physiological problems within the context of family practice, according to Casselton (1985). Some of the techniques offered are hypnosis, autogenics and biofeedback therapy. This program offers clinical services to the public as well as educational facilities for medical students. Dr. Carlton itemizes the core educational areas of this program as being: 1. interactional communication 2. cross cultural issues 3. growth and development and 4. stress and impact of

stress. She adds that " it seemed to me that a lot of that material should have and must be transmitted to people who are being trained to be health professionals". There is now a much broader social science component to medical training. In agreement with Dr. Peterson she admits that people want a broadening number of things from doctors.

I raised the question as to whether any one physician could possibly do all that is being demanded, as she sees it. She responded, "one person can't do it all BUT one person has to coordinate it". She says that perhaps physicians should be treating disease and other professionals should look after health but she asks the question "who is going to pay for it?" And she responds by saying that "at this point in time the G.P. is the cheapest source of health care for the average person". The majority of people are covered by the provincial medical services plan and this plan does not cover alternative types of practitioners. (except those listed by the medical act)

It becomes clear from Dr. Carlton's discussion that unsuccessful personal transactions, current social issues and financial criteria are all articulated and provide impetus for changes in the content and form of medical services. Dr. Carlton spoke to me about, and referred to an article concerning the health centre that she had previously worked in; the one

that had spurned her concern for changes in medical training programs. This centre she explained had developed a structure that responded to the needs of the clients and of the staff that worked there. It became a more egalitarian, unstructured, untraditional health care facility.

Articulations with scientific developments or new knowledge will also bring about changes in health care practice. This informant related a personal experience with one of her patients that led her to become very active in the area of sexual abuse work. A child was brought into her office with a vaginal infection which turned out to be gonorrhea. She immediately became alarmed and suspected a case of sexual abuse. A subsequent investigation could not confirm her suspicions and according to medical information of the time gonnorrhea was believed to be passed on bedsheets. It was not until a number of years later that an encounter with the girl's sister revealed that Dr. Carlton had been justified in her suspicions. Both girls had been sexually abused. By that time the medical community had also reversed its position and new information indicated that gonnorrhea was only passed intimately. Recalled Dr. Carlton,

> "I was personally devastated by it. I found it shattering that we had absolutely blown it and we blew it by doing the right things for the time, knowing what we thought we knew."

This experience for her triggered the development of a whole new

component to her practice. Her multiplying articulation with new medical knowledge combined with the recognition that her previous encounters had been inconsistent, or perhaps even dysfunctional, for her patient prompted her to develop her expertise and facilities for the treatment of sexual abuse victims. An interest in broader women's health issues also proved to be a complementary articulation with respect to her new direction.

I spoke with three of Dr. Carlton's patients and one important point that emerged was the fact that none of the three seemed to hold entirely the same model of expectations and values as expressed by Dr. Carlton. There certainly were overlaps in what they perceived as the role of a family physician but there were also discrepancies. This fact, of course, has, as earlier mentioned, been documented by other researchers (Salisbury, 1976; Wood, 1984). Individuals can reach their desired goals on the basis of divergent value frameworks.

Mr. Arthur Lougheed

Patient number one, a Mr. Lougheed, attended Dr. Carlton's clinic originally because of its proximity to his home. He had had another G.P. who had retired and when his place of employment requested a physical

examination he consulted with her. He explained that he received a "reasonably good and solid exam" so he "just got in the habit of going there".

I asked him what he expected from a family practitioner and his major concern was for "some expert help". He likes the fact that the clinic is affiliated with the University hospital where there are specialists if he requires them. He also feels that a doctor should provide reassurance either on the basis of his own expertise or through his willingness to refer to a specialist when the problem goes beyond what he can deal with. This perspective is consistent to that of Dr. Carlton. Mr. Lougheed looks to his doctor mainly as a technical consultant and although he does feel that a doctor should educate his patients he feels that should happen only with direct relation to a particular ailment.

> "If there is something you can do to alleviate some condition instead of coming to her all the time, she should tell you",

he said. A more general health education, he feels, is not within the role of a personal physician. He does appreciate the fact that his doctor does take a personal interest in him, but when asked if he would go to her for counselling he replied "that may be asking too much, their medical requirements are so heavy".

Mr. Lougheed is a scientist by profession, a highly trained specialist, and this background has clearly influenced what he expects from other professionals. He said that

> "the basic strength of a good G.P., or a good specialist in any field is their knowledge and awareness of specialists in other fields and almost a personal contact with them."

His satisfactory childhood experience with a family doctor has also directed his choice as to what type of practitioner to patronize; behavioural patterns were established and there has been no need to alter them. Although his frame of values does not encompass as wide a range of criteria as that of Dr. Carlton he has had successful transactions with her and continues to consult her. He does not see any other types of practitioners.

Jennifer Jones

The second patient of Dr.Carlton's that I spoke with was a woman with a young family. Jennifer's model of health care expectations fitted perhaps more closely that of her doctor than those of either of the other two informants. The major discrepancy in her case was the inclusion of values not expressed by Dr. Carlton. Whereas Dr. Carlton suggested that medical students be given a much broader education to enable them to

understand and deal with the problems of people from backgrounds and socioeconomic conditions distinct form their own Jennifer looks for a physician who is as much like herself as possible, someone that she can relate to, "like a neighbour" with a similar family arrangement as her own. She thinks that in order to relate effectively with a physician both individuals should be socially and culturally as alike as possible. She likes the fact that Dr. Carlton is a woman and can consequently understand women's issues; she feels more comfortable with her.

Another factor, or perhaps just an extension of the above, that became apparent while speaking with Jennifer was that she would not be happy with someone who she thought had a different sense of personal morality to her own. She related an experience about a lecture series that she had attended. The subject was child rearing philosophy and she was very intrigued by the man, a psychologist, who was giving the program. She felt he was an extremely competent, reasonable and intelligent man. Jennifer was so impressed that she finally convinced her husband to accompany her after he had previously refused. He too was impressed. One day she encountered this lecturer while on an outing with her family, he did not see her. She saw him speak on a public telephone and believed he must be speaking to a 'girlfriend'. This man she knew to be married and

she was very shocked at his apparent behaviour. Jennifer refused to attend any more lectures or to have any further contact with him. She appears to want a doctor who is very like herself only without any personal, or physical failings. She says that she would not go to a dermatologist who had a rash, for instance; he would lose his credibility in her eyes. She does want a doctor who is competent biomedically, who will educate her on health matters, and who will counsel her if need be.

She grew up with a family doctor and has maintained this behavioural pattern when looking for a health care practitioner. She explained that they originally consulted with Dr. Carter while her husband was in attendance at U.B.C. It was a question of convenience and they have been satisfied with the care they receive so continue to patronize this clinic. She feels that her personal transactions have been successful even though her framework of values relating to her expectations of her practitioner are somewhat different to the values expressed by her physician. She does not attend other types of practitioners although she feels that alternative practitioners should be allowed to practice.

Mr. and Mrs. Williams

The next informants that I interviewed were a young couple; the wife

was of Oriental descent. Mr. and Mrs. Williams first became patients of Dr. Carlton while Mr. Williams was a student at the university. The clinic was convenient for them. This couple had a less demanding expectation of Dr. Carlton than did my last informant. They wanted a doctor who would be a good medical technician and an educator. They felt it was very important to them that their physician be willing to explain things to them, someone who will offer information. "They should tell you what's happening, not just what to do" expressed Mr. Williams. His wife had her first baby with Dr. Carlton and they were very happy with the level of education, support and care that she received. Unlike Mr. Lougheed, the Williams expect a doctor to teach them about health promotion, they want a general outlook on how to maintain good health - nutrition, excercise etc. They also feel that a doctor may be a counsellor also, but it is not crucial.

The Williams' concern was mainly that their doctor had a high level of biomedical knowledge and that she was willing to share her ideas with them, negotiate care and share responsibility for health care. I asked if they would patronize an alternative practitioner and they replied that Mr. Williams has been to a chiropracter and they both have used acupuncture therapy. They were of course culturally familiar with acupuncture but were emphatic that they would only patronize an orientally trained

acupuncturist and that they would not consult their G.P. about it because western doctors are not well enough versed in acupuncture.

Again the Williams' have followed behavioural patterns established during childhood. They both had family doctors as children and Mrs Williams also had a childhood familiarity and experience with acupuncture. Mr Williams had learned of acupuncture and had been to an acupuncturist while living in Japan. Their articulation with acupuncture, chiropractry and also massage therapy, or shiatsu, is definitely complementary to their health care goals.

Dr. Philip Roy

Dr. Roy is the third doctor that I interviewed with respect to family practice. He has similar ideas to those of Dr.s Peterson and Carlton and reiterated many of their sentiments and perspectives. It is clear that with these physicians, all members of U.B.C.'s department of family medicine, a basically common view of a family practitioner's role is espoused and this perspective is congruent with the objectives of U.B.C.'s residency program and the College of Family Physicians of Canada. They all show an interest in new and alternative approaches to health care, they share a willingness and desire to learn more ways of helping their

patients. They also share the idea that the Family physician should remain the primary consultant and the coordinator for health promotion. One basic difference appears to be in the extent to which these doctors utilize or are willing to incorporate into their own practice, or affiliate themselves with, alternative therapeutic practices and practitioners. After all, commented both Dr. Peterson and Dr. Carlton, they have been educated as allopathic physicians and are products of the ways that the have been trained. This comment would support Barth's (1981) belief that behavioural patterns develop and are not abandoned unless shown to be unsatisfactory. Medical socialization should be seen as a process that develops distinct behavioural patterns.

Dr. Peterson says that if a procedure can be scientifically proven he will use it. Also if he has nothing more to offer a patient and if he thinks something might help he would not object to a patient seeing an alternative practitioner. Dr. Carlton has incorporated certain behavioural medicine techniques into her practice (autogenic training) and has the names of a couple of types of alternative practitioners in case a patient requests them; she herself does not usually suggest an alternative practitioner. Dr. Roy seems to be somewhat more receptive to trying therapies or referring to alternative therapists. He has a longer list of

therapists to whom he will refer a patient. His willingness to try alternative methods is expressed by himself and his patients. He also structures his practice less traditionally than most physicians do. Dr. Roy says he does not practise on a fifteen minute appointment basis as is common in most doctors' offices. He must be available for the time a patient needs to discuss his problem. Consequently he sees about half the number of patients that a regular G.P. will see in a day.

Dr. Roy has a very broad view of what factors contribute to good health - a clean environment, a controlled market place and the lifestyles of previous generations are just a few. He agrees with my previous informants and other health care researchers (Lalonde, 1974) that the conditions being presented to G.P.s today are dramatically different to what was seen in the past. What is being witnessed now are the diseases of "modern civilization, degenerative diseases and those caused by unhealthy lifestyles". His approach to medical practice strongly reflects this view and is oriented towards lifestyle counselling. He says

> "people come to physicians to help them but all the things they have to do to get well they have to do themselves, so we depend entirely on them to get them to do the things they look to us to help".

He goes on to say that

> "Dr. bashing is because doctors are vulnerable. People expect us to walk on water; they expect to get better yesterday. They have heard about wonder drugs that work in some instances and they're expecting a lot of things that we can't deliver. And of course it's fair to say that today medical science is baffled by the cause and cure of all major disorders."

He also cites the market place as being very harmful to people's health.

> "The market place has been invaded by powerful clever commercial organizations that were nonexistent one hundred years ago when people abandoned the production of their own food supplies due to urbanization. So into the vacuum that was created massive commercial organization came; into the market place and filled it with all sorts of highly desireable and dangerous or useless products. Therefore the uninformed, self indulgent citizens can walk into the market place and get into real trouble."

But he adds

> "to a large extent each of us is a creature of ignorance so we have to say that the market place is not the real danger, our ignorance is - if you don't know what you're doing you shouldn't venture into the dangerous market place."

It appears that Dr. Roy's exposure to incurable conditions along with his transactions with environmental and political issues have produced a complementary articulation which has made him a proponent of education, counselling and coordinating health care for people. He seems to feel a personal responsiblity to protect people. "Doctors should teach and work themselves out of a job", says Dr. Roy.

> "Lifestyle appears to be one of the most promising approaches to health care there is... we need fixers, those who fix other peoples problems but more and more we need health promoters and even

> more so, we need health promoters that work well in advance of the prospects of disorder."

Dr. Roy also acknowledges the complementary relationship possible between many of the alternative techniques that are now being offered by practitioners and western medicine. But his training as an allopathic physician shadows the level at which he publicly acknowledges efficacy. He says,

> "I think that they have an awful lot to offer because of the fact that some of them may be effectively using the placebo effect and that some of them may be supporting the spirituality of a patient - something they don't get from doctors."

He adds that there needs to be communication,

> "I think that the ideal situation would be where paramedicals and other people with healing impulses, healing skills and techniques should communicate freely with the doctor who may have more access to information about the person than they have."

He does refer patients to certain individuals who practise acupuncture, psychologists, hypnotists and marriage counsellors but likes to remain party to the treatment. He, like Dr. Carlton, would like to be the coordinator when not actually administering treatment. They both expressed the need for continuity of care and the responsibility the family practitioner has in providing that service.

One problem he encounters with respect to counselling is that he does much more counselling than the medical plan would like. MSP now

restricts billing for more than four counselling sessions per patient per year. Dr. Roy feels that is "quite unrealistic" considering that 70 - 80% of his patients have functional disorders that have no organic basis. The articulation between his goal of health promotion is therefore inconsistent with that of the MSP at the level of a need for counselling. Both previous doctors also expressed their dissatisfaction with the restrictions on billing for counselling.

Nancy Smith

The first patient of Dr. Roy's held very similar concerns about health care to his. Nancy is herself a public health nurse and stated that:

> "I expect a lot more in prevention... I'm looking to a doctor not just for the average type of cultures and blood tests and counselling in that way but I'm really interested whether or not he can fill me in any more on areas that I don't know about which have to do with lifestyle... he's just not looking in medications, he's looking or I'm looking with him at anything he can teach me in human lifestyling ... This is Dr. Roy who thinks about vitamins, who's studied, who's in the formal mold which I respect because I think people tend to go off in medicine which may or may not have some answers and I'm willing to listen to them, but perhaps when I go and have a problem I look at Dr. Roy as someone where I would respect his training, I would respect the number of years he's been in the community and I would respect the amount of reading he has done."

Apparently Nancy went to Dr. Roy on the recommendation of a colleague after having had a falling out with her previous physician. She

felt he had over filled his practice and did not have the time to spend with her to discuss matters. Their divergent values created an incompatible articulation and she consequently sought out another physician; one with whom she had a complementary articulation concerning health care philosophy. The qualities she looks for in a doctor are:

> "a diagnostician, because he will stick with you longest, he will be able to sort out things I'm not able to; an approachable individual, someone who's a listener, the sorter."

Nancy has also been treated by both an acupuncturist and a chiropracter, who provide a complementary articulation to her goals of health maintenance.

Charles Carter

Charles was the second patient of Dr. Roy's that I spoke with. He first consulted with Dr. Roy while he was acutely ill in hospital. He had been under treatment for about six to seven years with one physician but was extremely dissatisfied by the lack of results and the persistence of his ill health. On the recommendation of a relative he decided to try an alternative therapist and went to a naturopath. His negative transactions with his previous doctor led to an incompatible articulation with the practice of family medicine and for a time he abandoned traditional

western medicine. The naturopath took him off medications he had been prescribed by his former physician and he suffered an acute attack of his condition and a withdrawal shock to his body. He contacted Dr. Roy while in this condition and has since been his patient. Due to a dysfunctional articulation with naturopathy, one which almost resulted in his death, he returned to the system of medicine that he had previously rejected.

Charles' value sytem strongly indicates situational characteristics. He will utilize the services that he perceives as the most beneficial within the context of his current situation. Even his choice of patronizing Dr. Roy reveals a process of selection because he appears to share only a few of Dr. Roy's expectations of a physician. "I like a doctor to be thorough and if you still have a problem not to hesitate to send you to a specialist", says Charles. When asked if he thought a doctor should be a counsellor he replied adamantly.

> "No, I think he's there to practise medicine, he's not a psychologist. I think you can talk over with a good friend, you get more off your chest because you know a person. I was into compulsive gambling, but things like that you have to admit to yourself, then you discuss it. I went to Gamblers Anonymous for a year. See, a G.P. can't help you with something like that."

When I asked him why he replied,

> "Well can you go up to someone and say, I'm betting $20,000.00 a day? I mean they have no... how can they understand it? They just say 'you're crazy'! Really... when you go to a place like Gamblers Anonymous everyone in there knows, so they understand. That's one good thing now there is a self help group for everything - alcohol, drugs, abuse..."

Charles feels, as a result of his own personal experiences that in order to counsel someone you must have an intimate knowledge of the problem. He says a doctor "should be there for the technical, to be a doctor, not a psychologist, he shouldn't be able to bill for counselling." His complementary articulation with a support group over the means for achieving health has made him a great advocate of such groups.

Although Charles does not admit to sharing Dr. Roy's view that a physician should be a lifestyle counsellor he does benefit from the qualities that result from Dr. Roy's perspective; for instance, the personal interest and time spent with Charles as a patient. He likes the "personal contact." He respects his ability as a biomedical technician and he shares his concerns about good nutrition, although he does not expect the doctor to be a nutritional educator. Once again we can see how divergent values can produce a satisfactory achievement of goals.

Lawrence Underhill

"Why are you a patient of Dr. Roy?" I asked my third informant in this

category.

> "I got his name from somebody who recorded a medical conference which he was attending. I got his name and called him on the phone. I had about an hours talk with him late one night. I was very impressed that he would take the time to talk to me."

Lawrence explained that he had had a physician before this but had been dissatisfied with his services. He felt that he had been "put down" because he was not sympathetic to "orthodox" medicine.

> "Let's put it this way, most physicians aren't sympathetic to alternative therapies and specifically in cancer; in cancer treatments. So I sort of lost confidence in them and I was impressed with what Dr. Roy told me on the phone and I also saw his name in a directory, 'Common Ground', so I ended up going to him and he's quite good."

Lawrence continues,

> "Dr. Roy doesn't seem to have all the answers either but at least he's open minded and willing to look into some things and discuss them. And I have been to a naturopath. I lost interest in going out there because it was just too far, so I'm sticking with Dr. Roy because he is a medical doctor and at the same time he is openminded."

As a child Lawrence lived in Africa and never had a family doctor, his family depended upon their own resources. "We lived in the bush in West Africa and were forced to cope with these things in our life." Perhaps these early experiences generated patterns of self responsibility that have endured and have enabled him to research and seek out health care services

in the independent way he has. He has taken the initiative to look for alternative techniques and sympathetic practitioners when faced with an unwanted surgical procedure to remove a brain tumour.

When asked what he thought the role of a doctor is he explained that a doctor should be a biomedical technician, he should treat your symptoms but also he should be trying to help you prevent them. "He should be like Dr. Roy, in preventive practice and treatment." Lawrence thinks public education is essential but feels that a family doctor should not necessarily be a counsellor. "Maybe he can recommend you to someone who specializes in that." I asked Lawrence if he would go to another type of specialist for stress related problems. He replied,

> "Sure, just like I would for anything else in medicine, if I had a heart problem I would go to a heart specialist and the doctor, the family physician is the one to help me decide who I am going to see and he'll arrange it. You can carry that same idea into many fields, not only actual medical fields but other fields, if you're working with the family doctor on it I think that's a good idea."

"So he's there to sort of advise you and direct you to...?", I prompted.

"Right", he said. "Rather than supply all those services himself?" I asked.

> "That's right , I don't see that he has to supply all those services, there are so many needs these days, people have so many needs there are a lot of people there to take care of those needs and I think a doctor should be able to direct you."

I asked Lawrence if he felt from his experiences that doctors were

restricted in the ways that they practice medicine or if they have a fair degree of leeway within their private practices. He feels that they do have a considerable flexibility but they must be cautious.

> "I know of any doctor that I have talked to that does anything a little bit different has cautioned me to be quiet about it. But they still go ahead anyway."

This individual difference in medical perspective and practice has also been pointed out in other studies (Gaines, 1982; Lock,1982). Dr. Peterson acknowledges, as well, that practitioners do excercise a considerable amount of flexiblity in their private practices.

Lawrence and Dr. Roy seem to share many of the same values with respect to health care and there interaction has been a successful one. Certain general behavioural traits of Lawrence's seem to be a carry over from childhood experiences of behavioural patterns. Even though his parents never seemed to have patronized doctors on any regular basis they did have, according to Lawrence an ability to rely upon their own resources and to accept personal responsibility for the care of themselves and their family. Lawrence also expresses self iniatitive in his search for health care. As a result of his experience with cancer, and his transactions with many health care theorists and practitioners a multiplying articulation has been produced between his health care goals and the new ideas that he

has encountered. His perspective on health maintenance has changed; a change that has prompted increasing alterations in his lifestyle. Lawrence says that he pays much more attention to lifestyle factors, such as nutrition, excercise, good habits, no smoking etc. than he ever did before. He also says that he feels that his condition probably could have been preventable had he begun a healthier lifestyle at a much earlier age. This new perspective can be interpreted from Lawrence's position as the result of a dysfunctional articulation with carcinogenic cultural factors -smoking, poor dietary habits and generally poor lifestyle that were undermining his health and life.

The data in this chapter illustrate how personal experience affects one's choice of therapeutic service. Mr. Lougheed and Jennifer Jones have spoken of successful transactions that have produced a maintenance of behavioural patterns established early in life. They have always consulted a family practitioner and continue to do so. Dr. Peterson indicated that transactions that he experienced with dying smokers produced an articulation that reinforced his previous medical stance on health care and caused him to become an adamant advocate of smoking cessation. A change in choice of therapeutic service as a result of dysfunctional

articulation with naturopathy was described by Charles Carter, and Lawrence Underhill commented on an alteration in his behaviour after experiencing a multiplying articulation with new ideas concerning lifestyle and the maintenance of health.

Personal experience interacting with broader social influences have also been noted as influencing the form and content of health care services. Dr. Peterson's descriptions of the evolution of the biopsychosocial model of health care, Dr. Carlton's development of behavioural medicine and Dr. Roy's belief in the dangers of the market place all exemplify situations that have brought about modification and redirection of medical services that are being offered to this community.

Chapter 4 The Feminist Health Centre - Choosing a Political Alternative

The Feminist Health Centre (FHC) was chosen as a focus of study because of its role as a type of health care facility that espouses a system of political organization that differs from the established Canadian health care services and facilities. According to my informants,it is a feminist centre that promotes the position of women in society, encourages education of the public and advocates self responsibility. Much of its concern is directed to teaching people how to be informed, critical consumers of health care products and services. My informants feel that by being informed and aware the onus of power can be shifted from the health care provider to the patient or consumer.

Because of the distinctive structure of the FHC my informants are not of the same patient/practitioner categories as those in other chapters of this study. The first three informants are members of the FHC and they participate actively in the organization and distibution of services. The latter three are consumers of the services offered. The women with whom I spoke discussed the experiences that led them to choose to participate in the activities of this centre. They spoke of their ideas on health care and why they were involved in this particular facility. Their experiences, as

they recounted them, reflect both personal constraints and incentives as well as influences from the broader social milieu.

Margaret Haliburton

Margaret, my first informant from the FHC, spoke very personally about her involvement with this women's centre.

"Revenge", was the reply when I asked Margaret why the Feminist Health Centre was established. She went on to describe the sequence of events that led up to the inception of the centre.

It was 1969 and the Dalcon shield was being promoted as the ideal form of birth control for women who had not had children. Margaret was interested in having one inserted, went to a local physician and "demanded" it. The experience was extremely unsatisfactory for her. She felt that the physician was unduly insensitive and callous in his treatment of her, she was in severe pain during the insertion and suffered pain for the entire two months that she had it in. Margaret described it as a "terrible experience" and decided to have the IUD removed. Obviously her body could not tolerate it, was her reaction.

> "So I went to a different doctor to get it removed and ... what I left out and this is important, the doctor who put it in, it was excruciating getting it put in... I think I actually fainted ... it was horrible, and I couldn't get up after he put it in ... and he said "do

you want me to take it out?" He was a very cruel person who did it, he was off hand and didn't pay much attention but I was determined so I continued on and then I went to someone; I was never going back to this guy again, so I went to someone else who took it out and told him about getting it in. Any how in this whole three month period I felt extremely isolated except that I had these two fairly awful experiences with these two doctors and I ended up feeling like a failure in maintaining the thing and really disappointed. And both of them indicated they had never seen a problem like this before".

I asked if these were both male doctors.

"Oh yes, I think at the time there weren't many women doctors ... So I had had this horrible experience, that was the point. And I went on a trip, right after I had this IUD out, to California. And the whole way down, it was a car trip, I ruminated about how upset I was with this experience because I don't think I'd ever felt quite so angry and humiliated and mystified. I just felt terrible, and I was also disappointed because now I didn't know what to do for birth control... The climax of the story is I met this woman in California and told her my story because what I had concocted on the trip was I wanted to black list these doctors. She thought it was a great idea and she said "I've got a book you've got to read." What it was was the original format of 'Our Bodies, Ourselves' and I read it and I couldn't believe it because it was taking up; just putting it into some form, a lot of the stuff I had been thinking about on this trip.

So anyway, when I came back from California I wrote this article for a women's newspaper in Vancouver, called the 'Pedestal'... I thought women should know what doctors, they should have some idea of what they wanted and they should know that not every doctor is going to give you what you want. You know they - uh - in other words, in other words it was like being critical etc, and I had lots of other ideas about how you develop it - you'd - we would all learn about our bodies and maybe we could even have our own clinic. You know, where we could educate people etc etc, and called for a meeting and a whole bunch of people came to this meeting. And that was where it started."

The above scenario, as presented by Margaret illustrates the transactions and articulations that occurred and led up to the inauguration of the Feminist Health Centre. The earliest mentioned, influential transactions recalled by this informant were those enacted between herself and the physician that inserted the IUD and then between herself and the physician who subsequently removed it. These two encounters, coupled with her negative experience with the IUD itself were totally unsatisfactory and produced an incompatible articulation with the doctors involved and subsequently with the whole medical establishment. They were "two fairly awful experiences" stated Margaret. But it was precisely these experiences that provided the basis, or perhaps reinforced earlier felt sentiments, for her disillusionment with the medical profession. The process had begun, the unsuccessful outcome of these transactions left her open to search out new avenues for health care.

Margaret has described herself as a 'feminist' or in the jargon of the late 1960's, a women's liberationist. It was the articulation with this political movement that led her, during her trip to California, to talk with women of the same persuasion. These women had ideas which were compatible with her own and they supported her dissatisfaction with what

they saw as a male dominated, authoritarian medical establishment. They offered suggestions for a feminist alternative to health care; a cooperative, female oriented centre where women would help one another take responsibility for their bodies and their lives. This encounter, or transaction, in California provided direction for Margaret's feelings of frustration and for her desire for a different type of health care system. Her articulation with feminist ideology and her transactions with the feminist women in California were complementary to her goals for health care and for her life in general.

Once back in Vancouver transactions with local women who also shared the same feminist ideology and visions of something different provided the necessary support and encouragement to open the Feminist Health Centre. The formation of this centre was the culmination of a transactional process that originated in disillusionment with existing facilities. It progressed due to articulation with an ideological movement and through the association with similar minded people.

The centre that opened was of course fashioned according to the dictates of the women involved and those dictates reflected the issues and values of that time. They were relevant to the women's liberation

movement and therefore were strongly influenced by the feminist literature that was appearing. As Kleiber and Light (1975) point out, it was also designed, not only as a centre that catered to women, but as a political alternative to the traditional hierarchically structured medical establishment. It was committed to the concepts of education, sharing information, power and responsibility. There were no formal leaders but members who could all have equal right to speak for the organization and to take part in the concensus decision-making process (ibid). The above concepts were developed to combat what was seen as health care professionals, mainly doctors, who have a monopoly on information and on decision making about consumers' health care. Consumers were seen to be uninformed and uneducated about their health and care. Except for certain doctors who were brought in to consult in the clinic, education, information sharing and clinic services were provided by lay health workers. Women were encouraged toward active consumer participation and to take personal responsibility for health and health care.

The report by Kleiber and Light, along with statements from my informants, indicate that the women who participated in the formation of this collective did so after some kind of negative experience with other

more traditional health care facilities, and very often with doctors themselves. As Margaret pointed out " everybody was totally disgruntled." As time went on women were attracted by recommendations from people who knew of the centre, by women who were involved, or even by referrals from physicians. They came not solely on the basis of dissatisfaction with previous experience but on the basis of positive recommendation. Also new clients and members were not all women's liberationists, or even politically conscious upon their arrival, but as there was a strong political orientation at the centre along with the service orientation, members soon became aware, even if not politically active (ibid).

Although it was designed as an alternative to the traditional health care facilities, the Feminist Health Centre was not and could not be a complete alternative. The medical theoretical basis still rested in Western scientific medicine and the major focus of the centre, in the early years, was gynaecological. Therefore other health concerns and problems had to be taken elsewhere and more serious gynaecological problems were beyond the scope of the centre's clinic. The service in fact articulated in a complementary fashion with the goals of the official medical system; even while it openly opposed it and presented a competitive articulation at certain levels.

The members of the centre devised a method to monitor physicians. Obviously the medical community could not be changed or controlled and as their services were still required the women wanted some means by which they could advise one another on the attitudes and practices of the physicians they consulted. The idea of a reporting system provided a complementary articulation with the political goals of the FHC centre. They set up and maintained a file containing women's comments on the doctors they had been to. They encouraged women to fill out an evaluation form describing the behaviour and attitudes of the physicians they saw, and to generally describe their experiences with these physicians. The members of the FHC then placed the forms in the file and made them available as a resource to all interested parties. The file remains a central part of the centre although now the FHC staff scrutinize all forms in order to prevent statements appearing that could be considered legally libelous. Next to the files a sign clearly states that the opinions expressed are not those of the centre itself but of the various women who have written them. These modifications had to be introduced after an incompatible articulation with the legal system that prompted allegations of libel. Interestingly though, according to my informants, the files have been consulted by lawyers who are investigating physicians with respect

to legal cases, and also by the College of Physicians and Surgeons. Physicians occasionally drop in and peruse the files but do not themselves enter comments.

The services offered by the centre in the early years were based on self help or mutual aid concepts. Again, these ideas stemmed from or were, at least, reinforced by other mutual aid movements which were currently popular and provided a complementary articulation with the political and health care goals of these feminist women. The women felt that because they were disturbed by their experiences with doctors they needed to get together, share their complaints and offer support to each other (ibid, p. 47). There were three levels operating within this self help model: 1) an individual level where a woman helps herself by learning about health and by participating in the centre's activities as a member or a client 2) the group level where members help one another and 3) a level at which members provide self help services to non-members. It was felt that working together within this model gave members, clients and other women the feeling that by taking responsibility for health care and health maintenance they could shift power from the provider to the woman herself.

The centre offered a health information phone line and drop-in service, abortion counselling, birth control counselling and diaphragm fitting, and health information resources that included a library, the doctor directory, health information groups and a community education program. It also ran a self help clinic where doctors participated under controlled conditions, and gynaecological examinations were performed.

The health education groups included workshops on self cervical and self breast exams where women got together and taught one another how to do these kinds of examinations themselves. The introduction of these exams, as reported by Margaret, was the result of influence from the feminist movement in the United States where in 1971 self cervical exams were first publicly done. In 1972 women from the Vancouver centre visited a similar clinic in Seattle and learned how to do the self cervical exams. They returned to their own centre and instructed their members. It became an important focus of this Feminist Health Centre and resulted in another complementary articulation between their political and health care ideologies. The women of the centre believed that

> "the relationship between body ownership and health care is an important one. If a woman feels that the care of her body 'belongs' to her doctor, she will all too easily abandon control of that body to the medical profession. On the other hand, if she feels comfortable with and in possession of her body in states of both health and illness, she is much more likely to take responsibility

> for herself. She will feel motivated to gain the knowledge about her body that is necessary to care for herself. And, confident in her own acquaintance with her body, she will be less likely to feel intimidated by medical expertise." (Kleiber and Light, 1975:54)

Women were encouraged to develop a familiarity with their bodies and to take responsibility for their health. Integral to these workshops and educational programs were discussions of female sexuality, and issues of sexuality were dealt with in terms of their personal, social and political context. The women of the centre (ibid, p. 55) felt that sex had been a source of "fear, pain and shame" for many women and one of the aims of the centre was to get women to perceive their sexuality as "a source of pride, strength and joy". Through such an understanding a woman's sense of her own power was seen to be enhanced and she could accept a greater responsibility for herself. As is clear, issues of health were seen as being inextricably related to body image, social role and political awareness.

As pointed out in Chapter 1 transactions occur at many levels, the most basic being the dyadic transaction enacted between two individuals, i.e. between a patient and a practitioner. The outcome of dyadic transactions can be negligible when, for example, dissatisfaction occurs on the side of either party, but not to the extent as to motivate any other specific direct action. On the other hand, as in the case of Margaret,

dissatisfaction led to an incompatible articulation with the goals of the individual doctors concerned. Her disillusionment related to, not only the specific physicians with whom she had transacted, but to the whole medical profession; to the attitudes and behaviour that she saw as inherent to the established medical system. We have seen how these incompatible articulations provided the necessary motivation for Margaret to actively search out an alternative means for attaining the type of health care that she desired. We have also seen how the initial dyadic articulation, reinforced by the second, became the pivotal points that initiated a pattern of subsequent positive and supportive transactions, or complementary articulations, that culminated in the opening of the centre. This pattern that Margaret established through her own personal transactions would be expanded if one could also view the transactions and articulations experienced by the other women who shared her disillusionment with the medical establishment. It is the synthesis of previously unconnected transactions, that defines the ultimate pattern. Margaret's ideological perspective and her multiplying articulation with the women's liberation movement provided the inspiration needed to formulate a vision of a possible alternative to traditional medical facilities. Her association, or complementary articulation with women of

the same political persuasion, the same concerns over health care and the status of women, as herself, offered the support that enabled her to concretize her goals. The feminist health movement was only one area of the broader feminist movement which, during the seventies was gaining widespread attention and support.

Another level at which transactions occurred was between the Feminist Health Centre and the government. Beginning in 1972 (Kleiber and Light, 1975:21 -22) the centre received funding from federal government grants and in 1976 when federal funds terminated the provincial government came forth with money. These funds enabled the centre to hire permanent staff and to cover the costs of rent and supplies. Certain community organizations also donated funds for the centre. The transactions that resulted in the funding of the centre obviously were crucial to the existence of the FHC and facilitated the delivery of a new and viable service for women. Within the framework of Belshaw's analysis one can identify a complementary articulation existing between the provincial government that originally provided funding and the FHC. The provincial government at this point in time was a socialist government and it was supportive of facilities and institutions that operated within this political ideology. It supported equality for women and delegated

funds in this area. In furthering its own political priorities or goals it enabled groups such as the FHC to establish themselves. Political goals coincided with health goals and provided a complementary articulation between the government and the FHC. Had it been possible to witness the actual transactional process we might have found that the values that supported the goals of each transactor and motivated their decisions may have diverged significantly.

The Feminist movement which we have seen as one of the major influences that contributed to the development and functioning orientation of the FHC can be looked at in terms of a ramifying articulation, one that created widespread reactions and changes through-out the social order of that day. The FHC was only one example, one in the field of health care. As well as being a ramification from the feminist movement the centre's specific articulations with the various elements of women's liberation were complementary; they shared the basic goal of improvement of women's position in society and consequently they supported one another's actions.

Even though a transaction may be incompatible, preventing the attainment of specific goals, on one level, as in the personal experiences of Margaret with the medical profession, it may in a broader scheme

produce a complementary relationship. Barth (1981) points out that there are frequently discongruities between micro and macro levels of systems. With the establishment of the FHC women were able to receive and offer care in an environment of mutual help and sharing. They also gleaned the information and attitudes which enabled them to be more assertive, take more responsibility and to demand more information when they were compelled to seek the services of a physician. The centre has never been a complete alternative to the established medical system, even though, at the level of political goals, there definitely exists a competitive articulation. In fact the articulation between the FHC and the medical establishment is one of complementarity with respect to the common goal of health attainment. There were physicians working, in controlled conditions, in the clinics held by the FHC and today when the centre is almost strictly a counselling and educational service this relationship has strengthened. Without the actual clinic services women must now resort to other medical facilities, but also certain doctors are utilizing the services of the centre by referring patients to them for specialized kinds of information and help. A few doctors have also actively supported the centre through direct donations of money, according to my informants. The centre is seen as offering services that physicians have neither the time

nor specialization to do.

It becomes evident in examining the transactions and articulations that led to the establishment of the FHC that transactions occur within a framework of values and it is these values rather than the actual goal being sought that create incompatibility within transactions. Obviously the goal of 'health' is equally held by both physicians and the women of the FHC but it is the manner in which services are delivered and controlled that proved to be the unnegotiable factor. The success the women had in setting up the FHC indicates that they were not unique in the values they held, that in actuality their attitudes and values reflected those of other women and groups in society.

As the progression of transactions that have been described led to the formation of the FHC, further articulations throughout the years have led to modifications in its services and foci of interest. The study that I have referred to (Kleiber and Light) was undertaken between the years of 1972-74 and describes the centre up until that time. The informants with whom I have spoken are still involved with the centre. Margaret, of course, has been associated with the FHC since its inception and my other informants, Annabel and Eunice have been actively involved for the last 3

1/2 - 4 years. Their observations and comments reflect the entire history of this centre and what is presented today is the result of the transactions and articulations that have occurred throughout this history.

Eunice Johnston and Annabelle Murphy

The FHC of today, 1985, still adheres strongly to the feminist perspective and the political ideology that directed its policies and activities when it first opened but according to my informants it has expanded its concerns. The major directional changes have occurred with respect to the type of service that is now offered and a swing from strictly gynaecological issues to more generalized health issues. Services presently being targeted are almost entirely of an educational nature. The FHC no longer operates any clinical service, there is still some abortion counselling available and diaphragm or cervical cap fittings are now done by affiliated groups. The abandonment of clinical services can be seen as leading to specialist segmentation, in that services previously provided through the clinic are now referred to other centres.

After speaking with my informants it has become evident that some controversy, or perhaps just confusion, exists over the reasons for the switch from a clinical service to an educational facility. Eunice assured

me that the switch was a definite political move; a move that would enable the FHC to reach more women and consequently have a greater influence. With the operation of the clinic they were restricted logistically in the number of women they could see, due to limitations on their own manpower and time available. As an outreach educational facility, with resource services and counselling available, the number of people they could come in contact with was greatly expanded. Annabel, though, felt that the move had been due to financial restraint. Because funding has been cut from the FHC they are now unable to hire permanent staff. Their programs are run almost entirely on a volunteer basis whereas before they had a staff of seven working in the centre. Financial restraint must play a part in their abilility to offer certain services and obviously affects their viability as an organization but the decision to cut clinical services happened approximately seven to eight years ago, according to the informants, and the major financial cuts did not happen until 1983. It appears therefore that with financial limitations it was felt to be more prudent to offer the services that would benefit larger numbers of people. A competitive articulation existed between their economic status and their political goals producing a compromise or redirection.

The funding cuts by the provincial government reflect both a changed economic situation as well as a changing relationship with the provincial political system. In 1983, when the final provincial grants were cut the province was experiencing an economic recession and many such institutions were facing similar cuts. As Eunice pointed out "everybody else was getting the axe, that's when we got it too, and completely". On the other hand, the provincial government had also changed, the socialist NDP was no longer in power and the more conservative right wing Social Credit party held different political priorities from those of its predecessor. The articulation between the present government and the FHC became one of inconsistency with respect to a goal of health and consequently the FHC would not receive ideological support. When the economic situation deteriorated their funding was quickly cut. Had the articulation been of a more directly competitive nature the Centre might have been forced out of business entirely.

It becomes clear in reviewing the developments of this centre that the personal experiences of my informants have strongly inlfluenced their values, decisions and choices. Their work towards and involvement in the FHC has been a result of their many personal transactions and articulations. But their ability to set up and manage the direction of the

centre has been influenced by mitigating social factors such as political, economic and health care trends.

As mentioned, the services now being offered by the centre are mainly educational. Programs range from offering workshops, lecture series and public speaking engagements. They operate a library and resource facilities, publish their own research, as well as that of others, and produce educational videos. The doctor directory still holds a prominent position in the centre and it now includes evaluations of alternative practitioners and therapists.

A significant change that has occurred over the years is the shift from a strict gynaecological focus to one that encompasses wider ranging health issues. When questioning Eunice about this shift she assured me that they "absolutely" are still politically motivated as a feminist group, "that approach hasn't changed, our analysis keeps broadening". She also stated that

> "we started off with a real gynae.cological focus but we have information on anything - occupational health, allergies, things that are not necessarily specific to women even though a lot of it , of course, is."

These sentiments were fully shared by Annabel as well.

Reasons for this broadening interest can probably be accounted for at two levels; the radical feminism of the seventies has quietened and the

holistic health movement has gained both momentum and support. The fading of the radical feminism can be detected in the comments of the informants. Annabel described how the self examination workshops have lost most of their intrigue and support, she feels that many women now are "intimidated" by this public examination. They are therefore now developing video programs that women can watch instead of having to "take off their clothes" and participate in a group setting. The political significance seems to have lost its relevance to today's issues.

Annabel also pointed out that there is a far less "anti-doctor" sentiment present now than there was in the early days of the centre. This more tolerant attitude probably reflects the fact that more women are now attending and participating in the centre on the basis of positive recommendations from individuals that are familiar with its services and not necessarily because they are disgruntled over previous experiences with doctors. Even Eunice explained that her articulation with the FHC was motivated by her search for a job and her interest in the health care field. She holds no past resentments or hard feelings with respect to the experiences or transactions she has had with the medical profession. Margaret mentioned that the reasons women became interested in the idea of the FHC were usually of a personal nature but they all shared negative

feelings toward the medical establishment. This situation is no longer the case. I do not mean to imply that the FHC is now fully supportive of the medical establishment, it is not. The level of criticism appears to have changed from one of being critical of "sexism" in the practice of medicine to one that also incorporates a questioning of "the basis of western medical theory". "That has been an evolution", remarked Eunice when discussing the critical focus. She went on to state that

> "in a lot of ways we've increased our knowledge of the possibilities of the alternatives to western medicine and our knowledge of the damage that can be done by the over-prescription of drugs for example, - the scandalous levels to which drugs are prescribed, unnecessary surgery, that kind of thing. And we are also so much more informed about the potential of the alternatives".

It seems clear that the association of the FHC with the feminist movement has continued but the issues and the means of pursuing them have altered. The increasing interest in the holistic health movement has now entered the picture and been incorporated into the goals and concerns of the centre. Eunice, as a massage therapist prior to her involvement with the FHC, brought with her an interest in alternative therapies. She also patronizes a naturopath as well as her regular G.P. The doctor directory has expanded to include alternative practitioners and members

in the centre will sometimes suggest alternative therapies to clients who they feel might benefit from them.

My data is unclear as to the nature of the transactions and articulations that produced the change in perspective. But Eunice stated that her personal interest in alternative health care developed because she happened to be in a place, at a time, when "new wave, body oriented therapies" were part of what was happening. It was in Toronto during the late sixties that she became involved. She articulated with a new idea and became a massage therapist. Possibly the women participating in the centre also had similar experiences and incorporated their new perspectives.

In examining the services offered by the FHC and how they have altered since the centre came into being one can see, from a transactional analysis, the various levels of transaction that influence the self presentation of a facility such as the FHC. The very personal transactions between Margaret and her private physician led to an incompatible articulation with the medical system and eventually to the establishment of the FHC; a centre based on radical feminist perspectives. Eunice's transactions with the holistic health movement as a massage therapist have proved to be a complementary articulation with respect to the

present goals of health maintenance in the FHC. The original strongly political position of the early participants that required communal self examinations has become an inconsistent articulation with the broadened view of health in the centre, one that has responded to a complementary articulation with the holistic health movement. As Eunice pointed out her involvement with the idea of holistic health came about due to her exposure to friend's involvement with, and media presentations of alternative types of healing practices. She then learned massage therapy. Her interest was not due to an incompatible or dysfunctional articulation between her personal goals and those of the medical establishment, nor to unsuccessful transactions with individual physicians. Family physicians in her memories were family friends. Her articulation with holistic health concepts was one of competition only with some areas of traditional medical practice. She sees her values relating to the use of natural healing techniques as competitive with certain drug therapy and surgical intervention techniques; therefore she consults with a naturopath for specific conditions. Eunice's involvement with the FHC came about because of her stance as a feminist, her interest in health care at a level that was compatible with that of the FHC and her search for a job.

It is clear from Eunice's discussion, and that of my next informants,

that values are situational. The type of practitioner or service sought often depends upon the circumstances of a particular situation. As has been said individuals are evaluative and pragmatic. Therefore when a situation arises it must be analysed and decisions made according to the most appropriate course of action. Even though the concern may be 'health' it is obvious that people have different routes for seeking help.

The majority of clients of today's FHC are in actuality 'clients' rather than participants or members as women had been in the past. There is not necessarily any personal involvement in the centre. People will come to the centre for information or to request the services offered by them; they come when they want something. Although there is no longer any particular commitment to share responsibilities in the FHC itself, the women with whom I have spoken all feel an identification with the feminist movement and a sense of affiliation to the concerns of the centre.

Mary Campbell

Mary, one of the women whom I interviewed, works in a family drop-in centre and has utilized the services of the FHC both as a personal resource and as a resource for her job. She was quick to point out that,

although she intends to, she has never actually been into the centre. She does receive bulletins and pamphlets regarding their facilities, resources and programs. She explained that she has known about the FHC almost since its inception as friends of hers were involved with it. She has also heard many people speak about the centre. With respect to her work she has frequently requested speakers from the FHC to give educational programs to the participants of her drop-in centre. She says that she will often refer people to the centre for information or counselling on matters such as birth control, abortion, premenstrual syndrome or menopause. Mary feels that the information offered is "very direct" and that there is "no morality attached"; it is objective unlike other places that might impose a moral stance.

This informant identifies herself as a feminist and states that the FHC portrays to her "the idea of women caring about other women". She says, "it is important to me to know that they are there".

At a more personal level she identifies her main source of health care as coming from a family physician that she and her family have patronized for twelve years. She attests to being very satisfied with the attention that they have received from him, but she does not expect him to know everything and therefore says that "I always go beyond that for

information". In one instance when she had problems with premenstrual syndrome she consulted her G.P., requested a booklet from the FHC to read herself and then passed it on to her physician. She values the time her doctor takes to discuss matters with her and feels that he has also been very supportive of her. She states that she would leave a doctor if she felt he was patronizing, did not respect her or was incompetent. She did in fact stop going to one physician because for twelve days while her daughter was hospitalized he never once came into the hospital. The doctor's means of attaining health care goals produced an incompatible articulation with hers.

Mary's choices for seeking health care services reflect a merging of her personal experiences with health care practitioners and her identification with a feminist ideology. She has had family physicians since she was a child and even though she has been dissatisfied with a couple of them she has not broken with the behaviour patterns established in her early years which included the patronage of a family doctor. There have been incompatibilities between her goals of health care and those of individual physicians resulting from unsuccessful transactions but these incompatible articulations have been resolved by finding another doctor with whom her transactions have been successful. She has not lost faith

with the institution of family medicine.

Mary's articulation with feminist ideology has prompted her to accept more personal responsibility for her health and that of her family. She will seek out information on her own wherever she perceives the best source. This habit has led her to depend upon the FHC for information concerning women's health issues and to resort to a specialty bookstore for information on nutrition. She goes to the bookstore because she "knows" doctors are not trained in nutrition. Mary's articulation with these sources of information are complementary to her goals for maintaining good health, a condition she describes as "feeling good".

Sheila Montgomery

My next informant was a young woman whom I shall call Sheila. Sheila has on a number of occasions gone to the FHC for information concerning women's health issues. She says that in reality she has not felt the need to go to many health care practitioners and most minor problems she deals with herself. She does have a family doctor but goes to her only if she has a specific physical ailment. Sheila feels that doctors do not have the time to deal with a lot of problems. She feels that the clinic she attends is "fast paced and very busy". Therefore Sheila likes

to do research or to seek out information on her own. She says that she does not feel comfortable in libraries and because of her "leaning" towards the feminist movement she goes to them for information. When asked how she knew about the FHC she replied that she had found their name in the phone book while looking up another women's resource centre. But she added that she has also heard her friends talk about it.

Sheila has one small child and took the baby to a health clinic for her inoculations, again because she felt the doctor was too busy. I asked her if there was any particular reason that she had chosen a woman physician over a man. She said that actually she had started out with a male doctor but he did not do obstetrics work and she therefore had to find another doctor. The doctor she chose and has been with for about two and a half years is a woman because she feels that women "spend more time talking and explaining" and that perhaps they are "more aware, more careful".

In choosing a health care practitioner Sheila also has followed behavioural patterns established in childhood. Her family always had a family doctor. She changed doctors only because of an inconsistent articulation of goals but she did stay within the same system when choosing another practitioner. Although she was hesitant in calling herself a feminist it is her interest in that ideology that led her to the

FHC when she sought information. Her feminist interest has developed into a complementary articulation with her health care goals.

Phylis Davis

Phylis explained to me that she now maintains a loose connection with the FHC, "I recommend it and I've been with clients". But in the past she was deeply involved with certain of their mutual aid groups. Her interest stemmed from her concerns over menopause at a time when there was little public discussion about it. She also felt very little support from her doctor who when she asked him about heavy bleeding responded "Oh, it's menopause". She then asked what she could expect and he said, "almost anything". Phylis recalls feeling very uncomfortable with both his response and the fact that she really did not even know what she wanted to ask. At that time she was friendly with some of the founders of the original FHC. She knew them from work she was doing with other women's groups and parent's classes, so she attended a lecture series on "midlife" put on by the FHC. From there she, along with a number of other women, formed a mutual aid support group. They met weekly, researched and shared information. Phylis said that she found this to be an excellent group, extremely supportive and nonjudgemental. This group met for four

to five years and they also were instrumental in establishing other such groups.

Phylis is emphatic about her role as a feminist and feels that she has a strong sense of responsibility for the health of herself and her family. Her association with the feminist movement provided a complementary articulation with her health care goals at a time when she was experiencing an inconsistent articulation with her physician. The inconsistency, or dissatisfaction, with her physician's attitude was resolved by her involvement with the mutual aid group at the FHC.

Although she did not share all the same ideas of her family doctor she stated that she did respect his competence, his willingness to refer when necessary and she trusted him completely. He would come when they needed him, he would talk to her and respond to her questions. Phylis also "respected that he had a different view of the world than I but he respected me and was interested in me". Even though some individual transactions may not have been successful their overall relationship was good. Salisbury's (1976) position that dyadic transactors possess their own logic and outcomes may be arrived at on the basis of two distinct value systems is well illustrated by Phylis's comments. She and her family were patients of this doctor for over thirty years; until recently

when he retired.

Phylis also remembers a family doctor as she was growing up, in fact there were a few of them. Her father was a dentist and some of his friends were doctors, they consulted back and forth on a very informal and friendly manner. She only remembers twice formally going to a doctor, once when seventeen to have her tonsils out and then when she married and wanted birth control information. In recollection of this time of her life she mused that this relationship with doctors must be the reason that she now likes to think of her doctor as a peer, as a friend; she likes "no social distance" between them. And she says that the physician they patronized for so many years also treated other families in their neighbourhood and was part of their community. As Barth (1981:100) points out "Generally, actors are guided by their own previous routines in similar situations, if they were not obviously disastrous".

On examining the thoughts, the comments and the experiences of the women presented in this chapter one can detect how personal experience has influenced the choices relating to resort to therapy. One very strong case is that of Margaret Haliburton. Margaret's values that dictated her choice of health care service were directly related to her personal

experiences and her beliefs in feminist ideology. The opening of the FHC was facilitated by mediating social factors such as a compatible political system and the availability of funds. The centre evolved under the constraints of diminished funding and the incentives of supportive feminist women. It was also influenced by the alternative health movement. The women who work in the centre and utilize its services have been directed there by personal experiences that proved to be conducive to a feminist ideology which promotes self responsibility and personal knowledge in the area of health care.

Chapter 5 Acupuncture - An Emergent Form of Health Care Service

Acupuncture is the third and final area that I have chosen to examine for the purpose of this thesis. It was chosen as an example of a therapeutic technique based in a medical system that is a theoretical alternative to western allopathic medicine. In this chapter I will discuss the presence of acupuncture in the Vancouver area, a little of its theoretical foundation and some of the social factors that relate directly to it. I will examine its legal status, its relationship to the official medical system, as well as the experiences of specific individuals with respect to it.

According to my informants the practice of acupuncture has become increasingly visible in the lower mainland area of B.C. since about 1972. They cite the fact that it was around that time that U.S. president Nixon visited China and one area of interest that developed in the West as a result of the visit was the therapeutic technique of acupuncture.

Acupuncture is part of the traditional medicine of China. It is a method of using fine needles to stimulate invisible lines of energy running

beneath the surface of the skin. (Acupuncture Association of B.C.) This practice has been utilized throughout the Chinese culture area for some 2500 years. Chinese medical theory rests upon rational premises that are very different from those of scientific western medicine. It relies upon an inductive and synthetic mode of cognition, one that has concentrated attention upon dynamic processes, or in other words, upon the biological, psychic, social and cosmic functions. Western medicine, as a consequence of its causal and analytical orientation, focusses primarily on the material substratums; on the somatic support of functions. Its main interest lies therefore, in the concrete body and its components. (Porkert, 1979)

Acupuncture, as a therapeutic technique derived from Chinese medical theory, is utilized to re-establish balance within the body.

> "By inserting needles (acupuncture) or burning small herbal cones (moxibustion) at these sensitive points on the body the Chinese physician attempts to restore the proper phasing of the energetic flow and restore it to that dynamic balance, which for the Chinese defines health."(ibid, p. 161)

At this point in time the practice of acupuncture in British Columbia by anyone other than a licenced M.D. is in contravention of the Medical Act. According to Bryan (1984), the Acupuncture Association of B.C. was established in 1974 in order to further the knowledge and training in

acupuncture and to encourage the legal recognition of this practice. The association has, since its inception, carried on an on-going dialogue with the Ministry of Health of the provincial government. There has been no change in the legal status of acupuncture and since 1974 seven acupuncturists have been prosecuted. The last prosecution was in November of 1983. The association currently has seventy-five members, up from 16 members in 1980. A registry of members is kept, the association has regulations, rules of practice, a code of ethics, established qualifications and standards of practice and a disciplinary committee. Not all practising acupuncturists in B.C. are members of the acupuncture association.

Officially, practising acupuncture in B.C. by anyone other than a registered M.D. is an incompatible articulation with the laws of this province. It is a practice for which one can be prosecuted by the courts. But, at a more individual or informal level acupuncture can be seen as being a competitive or a complementary articulation with the health care system. Based on the comments of my informants acupuncture is being widely practised throughout the lower mainland area and it is being offered and used as an alternative, total or partial, to western therapeutic techniques, or as a complement to them. It does appear from the

increasing number of practitioners who openly practise acupuncture, and the few who are prosecuted for it, that at this point in time the legal system is displaying a considerable amount of tolerance towards the practice.

My informants for this chapter are three traditionally trained, practising acupuncturists in Vancouver. Two of them are westerners who trained locally and then studied in Taiwan and China. The third is Chinese, educated and trained in China. I also spoke with three patients each, of two of them.

Ron Bishop

My first informant is a man by the name of Ron Bishop. He explained to me how he learned about acupuncture and then how he himself became a practitioner. In the early 70's Ron was suffering from high blood pressure. He had headaches and sought relief for them. He was not a believer in drug therapy and that was all the traditional medical system had to offer. At this time he happened to hear a radio open line show on which an acupuncturist was speaking. He had to this point known nothing about acupuncture but he was curious about the prospect of controlling his high

blood pressure without drug intervention. Ron tried to get an appointment with the acupuncturist whom he had heard speak but the man was extremely busy and unable to see more patients. Very shortly after that he noticed a newspaper ad for an acupuncture college in Vancouver and he decided to enroll.

Still Ron had not yet had any treatments with acupuncture but he explained that he "just had a good feeling about it, the way the guy described it on the radio." And he began to go to the library to read about it. He decided that

> "it made a lot of sense, it was kind of practical and it was worth a try. And it's natural, the body heals itself so you don't have to take a lot of chemicals."

He started taking the course and after about one year he began to give himself some treatments. The blood pressure began to drop quite dramatically said Ron and he felt much better. During this period he was not consulting a medical doctor as he felt it was a waste of time.

Ron's initial transaction with the concept of acupuncture came as a result of his hearing the radio broadcast. The effect that this transaction has had on his life is one of dramatic and long term change. It was a clear example of a multiplying articulation at the level of the increasing demand for it in different areas of his life. It has been used as a personal health

care service, as a professional outlet and as a political focus. Acupuncture, for Ron, is also a competitive articulation. He sees it as being in direct competition with western 'drug therapy'.

The interest in acupuncture therapy began due to his concern over a specific health problem that he was experiencing. When unable to get the treatment that he wanted he started to study the technique himself. He treated himself successfully and his interest gradually developed from a personal concern to a professional directive. He trained first in Vancouver then moved to California to continue studying and later did further studies in Taiwan. Ron changed careers from being a high school teacher to become a practising acupuncturist, and he currently teaches acupuncture as well. He now is a vocal advocate for the legalization of acupuncture therapy and an ardent opponent of the medical establishment which he sees as being a body of drug therapists who are inextricably linked to the pharmaceutical industry, and primarily concerned with making money. Ron also views allopathic medicine as being seriously detrimental to the health of the population. From his perspective allopathic medicine, with its armamentarium for promoting health, would be considered a dysfunctional articulation with his ideas of health care. He sees western trained physicians as undermining the health and well-being of their

patients.

Ron's experiences during childhood can be seen as having established behavioural patterns that have influenced his choices in adult life. As a child Ron remembers that most health problems were dealt with by his mother with 'natural' remedies, such as putting warm oil in an aching ear. He said that if someone was more seriously ill then his mother would consult a chiropracter. The chiropracter at that time, he recalled, had a similar status to today's acupuncturist. Even though the articulation with acupuncture was something new for Ron and happened as a direct result of his high blood pressure, the behavioural pattern of self responsibility for health care and the use of 'natural' therapy that led him to an alternative type of practice was a pattern that had been established early in life and was being maintained.

Today Ron offers his services as an acupuncturist to treat all types of ill health and sometimes he does include nutrition and excercise counselling in his practice. He does not see acupuncture as a complement to modern scientific medicine because in his view allopathic medicine is dangerous and should not be used. Through it people are exposed to unnecessary surgery and potentially hazardous drug therapy. He aligns himself with the holistic health movement when he sees alternative

techniques as being 'natural treatment'. He works closely with chiropracters and herbalists and he sees much value in reflexology. At a political level Ron believes that anyone should be legally allowed to offer any type of service to the public. The public in turn will judge the legitimacy of each service.

Betty Walker

My second informant, Betty Walker, is a practising acupuncturist in Vancouver and she is a member of the Acupuncture Association of B.C. Betty has for most of her life been associated with the health care community due to the fact that a number of her relatives are doctors. Her introduction to acupuncture came about fifteen years ago. She explained to me that a friend of hers had dropped out of medical school for a year and one evening he came by for a visit.

> "He said, it's incredible, I'm just learning about a new kind of medicine. Because we're brought up in the west to think there's one kind, that's it. And it sounded interesting and I was ready to do something new so I continued on and he went back to western medicine."

In 1972 she entered a local college that was giving instruction in traditional Chinese medicine. In 1974 the instructor from this college was charged with operating a medical school and the college subsequently

closed. Betty went on to study in China and become qualified as an acupuncturist.

Betty's association with acupuncture began with the initial transaction with her friend. Her interest was an academic one but like Ron her transaction with the concept of acupuncture became a multiplying articulation in her life. It changed not only her personal approach to health care but also her career direction and her political activity. Unlike my previous informant, Betty's articulation with acupuncture from a health care perspective was a complementary one. She has not discarded western medicine, she sees acupuncture as a complement to it. She also restricts the types of conditions that she will treat with acupuncture. For instance Betty will not treat contagious diseases such as venereal disease or hepatitis, and she will not accept being the primary therapist for a cancer patient. She will recommend that such a patient remain under the care of a physician. If she also treats a patient suffering from cancer it will be as a secondary therapist in the area perhaps of pain relief. Betty cites the case of a woman who came to her with a complaint.

> "I had one woman who came to me and she had been in the hospital for about three weeks and she had no diagnosis. And she had been sent home and she was just progressively getting worse and acupuncture wasn't doing anything for her. So I recommended that she go to - uh - to one of Vancouver's leading neurologists, I mean, to get a diagnosis. She had been led around the bushes with

> whoever she was seeing. And I try not to get involved to that point but you can't help it when something like that happens.

This informant appears to have a good relationship with at least a portion of the established medical community. She even receives referrals from some doctors.

Betty sees her role as a health care practitioner as including lifestyle counselling, "I can't see not doing that, that's where it becomes more than a technician's role". She says that

> "In traditional Chinese medicine so many different aspects come into play when making a diagnosis of a person, of a condition. It's important to ask what kind of working conditions they have, who they live with, what they do, what their habits are, what they eat, the way they sleep. All those things are all parts that play a role in the whole thing. I just can't imagine treating somebody without those aspects being involved."

She also believes that the amount of time she spends with her patients is important. Each of her appointments takes one hour and she spends that whole time with the patient. Some acupuncturists, she points out, run assembly line practices, they have a number of patients at one time and run between them. This type of service she does not see as conducive to good practice in a Canadian community.

From an organizational or political position Betty sees a need to legalize the practice of acupuncture. She is an active member of the acupuncture association and is involved with the negotiations between the

government and the medical establishment. She feels that acupuncture's association with the holistic health movement is twofold. At one level it is a complementary articulation. The holistic health movement and the associations that are part of it provide publicity and political support. They facilitate a public awareness of alternative healing techniques and the importance of the legal system giving people an legal opportunity to choose between therapeutic options. But Betty believes that acupuncture must be recognised on the basis of its own merits. Clumping it together with other alternative techniques can be detrimental and could result in an incompatible articulation because it can confuse the public as to exactly what acupuncture is and what it can do. She says that

> "as a group we haven't aligned ourselves with other groups. Our objective is to have legislation in the province and to establish standards and have acupuncture grow in a healthy, legal environment. Our feeling has been that each group has to stand on its own and each group has to get its act together."

Therefore at a political level acupuncture's articulation with the holistic health movement, through its association with groups like HANS, is complementary but at a medical theoretical level the articulation may be inconsistent or even incompatible. Acupuncturists do not necessarily recognize the efficacy of other alternative techniques just on the basis of their association with the holistic health movement.

Connie Simons

Connie was first introduced to acupuncture while experiencing problems with menopause. She recounted how about six years ago she had been prescribed medication to control hot flushes. This medication seemed to work for awhile. She then became severely ill with diabetes and decided to change physicians. Connie explained that her doctor, who was a man, behaved in a very patronizing manner towards her and she felt he talked down to her. She remarked that she just did not need that kind of an attitude from her doctor so, on the recommendation of a friend she consulted another family practitioner. She recounted

> "When I became ill I found this wonderful female physician. A Japanese lady in Burnaby ... anyway she and I were sort of on the same wave length, you might say. And I appreciated her advice and she sounded more like a woman of the world than someone on a pedestal and so I really appreciated what she had to offer in her care."

When Connie once again began to have hot flushes her new doctor changed her medication. She found relief for awhile but then again her problems returned. At this point the doctor offered two suggestions. They could either increase the dosage of medication or Connie could try acupuncture treatments. This doctor, being Japanese, was therefore culturally familiar with acupuncture. Connie considered the situation and

because she believed that high doses of that particular medication could be carcinogenic, because a close friend had already been treated by an acupuncturist successfully and because she trusted the opinion of her new doctor she opted for the acupuncture.

Connie has been extremely satisfied with both the results of the treatments and the attitude and manner of Betty, the acupuncturist. Her menopausal symptoms have been controlled and she has had tennis elbow treated successfully as well.

For Connie the transaction with her doctor when she suggested acupuncture was what caused the complementary articulation with acupuncture. She was faced with a situation where traditional western medicine was not successful and she feared using stronger medications. Acupuncture offered a potential solution and she tried it. She still consults her family physician and she has consulted a physiotherapist and a chiropracter. Connie also learned to meditate a number of years ago and considers meditation as an integral part of her health maintenance program.

As a child Connie remembers always having a family practitioner. She remarked that she would never go to an alternative practitioner and when a friend suggested that she try meditation she said

> "I just about lept off my chair. I couldn't possibly do that. I was raised a Presbyterian. And there's just no way, I mean that's just not part of my world."

Naturopaths, homeopaths and chiropracters were all seen as quacks. These behavioural patterns changed for her only after she found herself in a state of complete desperation. Connie was experiencing a very difficult, stressful time in her marriage. She explained that she had been using tranquilizers, sleeping pills and had even begun to drink to a point that it was worrying her. She did not know where to turn and then a friend suggested that she attend a workshop on meditation. Meditation, she was told, could help her control stress and would teach her how to relax. After much consideration and out of great desperation she did attend the classes and did experience tremendous relief.

Connie's previous behavioural patterns that she had learned through her 'Presbyterian' background proved to be an inconsistent articulation when confronted with her new problems. She therefore developed a new pattern which incorporated consultation with alternative therapists. Her articulation with a holistic health philosophy was a multiplying one, in that it facilitated her awareness and her willingness to utilize new approaches to maintaining her health and it produced changes in her lifestyle. The successful transactions with the practice of meditation produced a complementary articulation with her health care goals and

promoted a willingness to try other types of therapy which she felt were inconsistent with her childhood training. Acupuncture was one further complementary articulation.

Pat Wallace

My next informant has known about acupuncture for a long time but it was only recently that she consulted an acupuncturist. Pat had been getting severe headaches for many years and says she

> "had been going to many different doctors trying to get to the bottom of the headaches... I think I had probably tried everything".

She then heard about Betty from a friend who had been successfully treated by her. Pat consulted Betty and had a number of acupuncture treatments. She remarked that she was

> "quite impressed, it was not a five minute procedure in her office. You go in there and you get an hour of her personal time and she's with you the whole time."

Pat was very impressed by the "quality of time" spent by Betty with her patient. She also reported having received considerable relief from the headaches. Previous to the acupuncture treatments Pat was experiencing headaches approximately two weeks out of every month but since the treatments she has had very few headaches. She has also taken other complaints to the acupuncturist and been successfully treated.

Because of suffering from headaches for so many years Pat has tried many types of therapies. She says,

> "Oh I tried everything - right down to faith healers. When you're miserable and you're suffering and you're not getting help anywhere you're going to try anything and anybody you feel you get some relief from."

Pat has been to a naturopath, various massage therapists and a reflexologist. She also still consults a family practitioner and a gynaecologist. As a child she does not recall visiting a general practitioner very often, her mother provided most of their health care needs. It is a result of her chronic health problems and resultant distress that she has consulted alternative practitioners. The visit to the acupuncturist came as a result of a recommendation from a friend who knew her condition. The articulation with alternative therapies is a complementary one to her health care goals. Pat utilizes the various therapies within a framework of values oriented to the relief of distress. She also prefers to try 'natural therapies' because she is distrustful of drug use.

Marjorie Lawford

Marjorie is a woman who has had the same family practitioner for the last twenty-five years. Her doctor is a man she trusts and has confidence

in. The reason that she consulted an acupuncturist is because she was suffering from menopausal problems and the medication her doctor prescribed for her worked only for a short time. Marjorie said that she was not anxious to resort to heavier medication and when her friend told her that she had been to the acupuncturist for similar complaints and experienced good results Marjorie decided that she too would go. She explained that after about the fourth treatment her symptoms began to subside slowly and by the end of her course of treatments the symptoms were practically gone. After about four months the symptoms began to reappear so she returned to the acupuncturist for another two treatments. Since then her complaints have virtually disappeared.

Marjorie's experience with acupuncture is a complementary articulation with respect to her health care goals. She still regularly consults her family practitioner. Her use of acupuncture was the result of her menopausal problems, her belief that overmedication can be harmful and the transaction with her friend who recommended the acupuncturist.

James Koo

The third acupuncturist whom I interviewed was James Koo. James was originally from Australia but received his schooling in China. He

explained to me how he became involved with acupuncture and how it developed into a career for him. In many respects James' choice of profession resulted from a natural progression of events. Educated in a boarding school in China James was "taught to share, to help other people". He explained that sharing and helping was "part of our philosophy, part of our training, so it's always been a part of me". After leaving school he returned to his family home and for about ten years he spent his time helping the older people of his community. During this time he developed his natural skill in massage therapy as he looked after these people and gave them massages. He points out that he never studied massage, "it comes naturally for me". At about age thirty James decided that he wanted to do more with his life. He quickly discovered that with anything he wanted to study he would be required to show a grade twelve certificate and he does not have such a certificate as he studied under a Chinese system. It became clear to him that he would have to study in an area that Chinese had to offer. About this time he had begun to learn Tai Chi, a Chinese excercise program that promotes good health, and he used to spend time with a friend who was an acupuncturist. They would discuss acupuncture treatment. The friend suggested that he might study acupuncture and James thought that was a good idea. He returned to Hong

Kong and China and completed his studies to become an acupuncturist.

On his return to Australia James discovered that he would not be permitted to get a license to practise. In Australia at that time it was not legal to practise acupuncture. He decided that it was time to leave and he emigrated to England to work with a relative who was a practising western physician. He worked in England for five years but found the practice there fairly restrictive. Working under the auspices of a western doctor he was controlled in the type of patient he could treat. The doctor screened all his patients.

James recalled learning two things in England. The first thing was that he learned "what things to do, what not to do - what things to say, what not to say" when working with western trained medical professionals. The second thing that happened was that he began to develop what became the second major part of his profession. He learned many other traditional Chinese relaxation techniques. He says that when he saw patients for acupuncture treatments they invariably had come to him as a last resort, when all other sources had failed. They also came with a fear of the needles he used. They would say "Oh needles, what are they going to do to me?" Consequently James began to utilize the relaxation techniques with his patients in order to reduce their anxiety

prior to starting the actual acupuncture treatment with needles. He found this procedure to be very successful. Becoming frustrated that his practice was being restricted to mainly pain relief therapy he decided that he should leave England and he this time emigrated to Canada.

Upon his arrival in Canada he started to look for a job but was told that "I don't have a degree they want, I don't have all sorts of things they want". He was also told that he could not practise acupuncture here. He was sent to speak with a local doctor who was interested in Chinese medical techniques. She was impressed with his abilities and suggested that he teach some classes in relaxation techniques. "So that is how I began. I started teaching them a workshop and also teaching Tai Chi." From there James began receiving patients.

As Barth (1966) pointed out, people make choices on the basis of a framework of values that are influenced by specific constraints and incentives present in their lives. The development of James' career can be seen to fit clearly into Barth's perspective. James' introduction to acupuncture through the transactions with his friend produced a complemetary articulation with the basic philosophy that he had been taught; the belief that he should help other people. It also developed from the more specific activities that he had already become involved in; the

activity of massage treatment that he said 'came naturally to him'. The constraints he felt as a result of his Chinese education were exemplified in the transactions that he described when trying to choose a career. He would be asked for certificates that he did not possess; therefore his attempts to study within a western system were an inconsistent articulation with his educational background. Acupuncture again proved to be an articulation complementary to his academic qualifications. The developmemt of relaxation techniques also proved to be an articulation complementary to his philosophical position as well as with his career orientation. To be able to put his patients at ease produced a more satisfactory interaction with his clients. Upon his arrival in Canada his resort to teaching provided one further complementary articulation to both his personal philosophy of life and his career direction.

James now practises and teaches in Vancouver. All his patients come to him on referral, either from a doctor or a physiotherapist, or on the recommendation of a friend. He also points out that almost all his patients come to him as a last resort; they are new to the practice of acupuncture. I asked him if he had any Chinese patients who were culturally familiar with Chinese medical practice and who would come directly to him. He replied that these patients he usually refers to other Chinese

acupuncturists who often do not speak english and need more patients.

Once people are familiar with his treatments they then tend to sometimes come to him more quickly rather than go the western medical route first. He spends one hour with each patient and tries to encourage good health maintenance programs.

Martha Robinson

Martha was the first of James' patients whom I interviewed. She explained to me that she had lost faith in allopathic physicians. She said that they do not understand her ideas concerning health. She is looking for someone who practises preventive medicine and holds her view of the mind, body, spirit interaction. She believes that eighty percent of all illness is caused by emotions.

Up until six years ago Martha, who is sixty-two, had patronized a family physician for her whole life and in her own words "did everything he said". Six years ago she injured her knee and was told by her physician that she needed surgery. Martha was nervous about the surgery and refused to comply. While she was "out of commission" and "could not race around" she saw a workshop on meditation advertised. Out of curiosity she went to hear the speaker and to participate in the workshop. She

comments that she had amazing results and from this experience discovered that she has a healing talent. This experience changed her life. She says that her priorities changed from the social activities of sports and entertaining to meditation, Tai Chi, kinesiology and numerous other alternative healing techniques. Martha says that these practices were "energizing, peaceful, you feel grounded instead of scattered". It was through these activities that one of her instructors referred her to James Koo and he taught her Tai Chi. James later taught her moxibustion, blossom needle therapy and acupressure - all techniques that are designed to stimulate one's own energy to promote healing.

Martha's experience with her knee was the factor that was responsible for changing the priorities in her life, she said. Her transaction with meditation proved to be a powerful multiplying articulation. It was an articulation that was also inconsistent with her former beliefs and practises in the area of health care. She now goes to her family physician for only specific conditions such as fractures, or an eye infection that she recently had, and for routine diagnostic exams like a PAP smear. Her use of allopathic medicine is complementary to her new perspective for these restricted problems but as a general approach to health care it is inconsistent. Her articulation with these alternative

techniques and beliefs has brought about major changes in her life, not only in the area strictly related to health. As she pointed out the direction of her life has changed from one oriented largely towards social functions to one that now focusses on spiritual and healing endeavours. She currently uses her abilities to help other people.

Alison McDougal

Alison went to James for acupuncture treatments out of "desperation". She had been suffering from migraine headaches for twenty-five years and they were getting worse. She explained that between the period from last August to February of this year she was experiencing headaches on the average of six days out of a week. She says that she awoke with headaches and she would arrive at work drugged to enable her to manage. Alison is an executive in a large corporation and she said that she has sacrificed her career for health. She believes that health is "probably the most important thing we have", it is "being able to enjoy everything we do to the fullest".

Due to her chronic headaches and her attempts to find relief she has patronized various types of therapists. In the past she has been to massage therapists, reflexologists, spiritual healers as well as western

trained dieticians, allergists, neurologists and general practitioners. She had varying degrees of relief from them but there were never long term results. After suffering so greatly for the time between August and February she was in complete desperation. Coincidentally three people within a very short period of time recommended acupuncture to her. The first man who spoke to her was a colleague who had recently consulted an acupuncturist in New York. He was very pleased with the results that he obtained. The next person was a girlfriend who had also had successful acupuncture treatments. When the third person, another friend, explained that she had been treated by James, Alison felt maybe it was time that she try acupuncture. But, she explained, she was scared to death of the needles. After four treatments Alison recalls feeling considerable relief and after the eight treatment series her headaches were reduced by more than fifty percent.

Alison's history of health problems had already caused her to develop a pattern of trying different therapeutic techniques so her resort to acupuncture was consistent with her previously established behavioural pattern. The articulation with acupuncture was a complementary one that fitted in with her health care goals. The three transactions that she described with her colleague and friends, together with her state of

desperation were the actual precipitating factors that led to the articulation with acupuncture. She still patronizes her family practitioner when she feels there's a real emergency but she adds that she goes only when she has to because she does not have much confidence in doctors. They give too many pills, they overbook their schedules and they do not appear to really care, according to Alison. She expressed a great confidence in James and feels that the time he spends with his patients and the quality of service he gives are excellent. So it also becomes clear that the articulation with acupuncture that Alison experienced was not only complementary to her search for relief from distress but also it was also complementary to her ideals of how a health care practice should be run.

As was earlier mentioned people are pragmatic and situational. They may, for instance, try a therapeutic technique whose theoretical or philosophical basis is not in agreement with their own, or when the manner of the practitioner does not coincide with the image they hold of a practitioner, if relief is their ultimate goal. This pattern appears to be true of Alison. She states that she does not have faith in regular physicians nor does she agree with how they run their practices but when she feels it necessary she will consult a doctor. Within a broad

framework of values the doctor does complement her goal of relief even if his manner does not complement her values concerning caring and competent practice.

Sally Graham

Sally, my final informant on acupuncture, was twenty-one years old when she was diagnosed as having multiple sclerosis (MS). She recalled that up until that point she had had very little contact with the medical profession. As a child her family had a family physician but she did not remember much contact with him. She remembered being very healthy and not worrying about her health. Prior to the diagnosis she was a university student and she described herself as living "the high and good life". When she received the diagnosis she says that she had as negative a reaction as could possibly be. She was in a state of deep depression and was more or less waiting to die. At one point when she was in hospital she was paralysed, she could not speak and she was losing her memory. Over the next few years Sally was treated by eight different doctors, three general practitioners and five specialists. She said that the worst part was that no one could offer her any hope. She joined the MS association and was given aids, like walkers, to help her get around. She explained that they

helped her to live with the day to day reality of her illness but there was no hope forthcoming. For four years she lived like that until a friend of her brother's suggested that she consult James Koo. This friend had been in a car accident and had been badly injured. His doctors told him that it would be at least six months before he would be on his feet again. After one treatment from James he recalled standing. He credits the acupuncture treatments with his much more rapid recovery than predicted.

Sally was nervous to go for acupuncture but she said that she rationalized it by convincing herself that because MS was a condition of the neurological system and acupuncture was also supposed to be concerned with the same system it was a logical decision. She went to see James. Sally now credits James for changing her life. She says that she became totally dependent upon him for a period of time and dreaded the day that she might not see him again. When he first spoke with her he gave her no guarantees but, she says, he did offer her hope. He told her that there was something that she could do to help herself. He gave her acupuncture treatments, he taught her Tai Chi excercises, massage techniques and taught her some basic Chinese medical philosophy concerning body energy and the necessity to balance her life. Today Sally appears, to an outsider, to be a normal healthy person. She says that she

is one of the lucky ones. She is now independent of James although she adheres strongly to what he taught her and she still goes back to him for a treatment about every six months.

The recounted transaction with her friend that occurred because of her illness led to an articulation with acupuncture that was both complementary and multiplying. It was complementary to her health goals and remains so. Although she still practises the techniques that James taught her and she does return for a treatment periodically, she also patronizes her family practitioner. Her attitude towards her family doctor has changed though, to being less accepting and more critical than it once was. At a broader level in her life Sally's articulation with acupuncture was multiplying. It brought about changes not only in her health but in her total orientation to life. Her philosophy towards life has become one of balance, of living in harmony with her body, her spirit and her environment instead of the hedonistic approach she described prior to her illness.

The comments in this chapter as expressed by my informants exemplify how personal experience affects one's choices and directs one's actions when resorting to therapeutic technique. Ron described how health

conditions sparked his interest in acupuncture therapy and how for Betty it was an academic interest that intrigued her. For James it stemmed from a philosophical position and the search for a career. Many factors are involved in a decision making process and a lot of them are social factors over which we have no personal control. James' choices were restricted because of his educational background and when he began looking for jobs he was not allowed to practise in Australia because the law prohibited the practise of acupuncture. Even once he was in England where acupuncture is legal the conditions of his immigration made it impossible to treat the patients he would like to have treated. He had been sponsored for emigration by his relative who then became the authority over his job. Again in Canada the law has made it difficult to practise openly and without fear of prosecution. In the cases of Betty and Ron the law was the factor that cut both their educations short within Canada. They went on to study in China. They also practise under the threat of prosecution.

The reports of the patients that I interviewed indicated that a major reason for deciding to consult an acupuncturist is one of desperation. The people in this study were new to acupuncture therapy and resorted to it because of health conditions. Even though acupuncture is illegal to practise, within the context that I have described, situations and patterns

develop in peoples lives that lead them to make choices they might not have otherwise made. When similar patterns develop in the lives of different individuals a demand is created and services are offered. The statistics indicate an increasing number of acupuncturists in the lower mainland area even when the law prohibits such practice and the individual must pay from his own pocket to obtain the service.

Decisions are made by people on the basis of their value frameworks, but also on the basis of the options that are available to them. These options are presented in the form of transactions as I have already described. The transactions can reinforce the course of action or the behavioural patterns previously established by the individual or they can produce an articulation that will alter their behavioural patterns. In this chapter I have tried to identify the transactions that my informants have told me about in order to illustrate how this process operates. I have attempted to point out the transactions that have caused these informants to make choices in favour of the practice of acupuncture. I must reiterate that I have not witnessed any of these events, so the my description of transactions is based on the perceptions of my informants.

Chapter 6 Personal Experience, Choice and the Integration of Diversity

I have attempted, in this thesis, to point out and illustrate how personal experience in the form of transactions leads people to make choices affecting resort to therapy, and how these choices in turn affect the form and content of health care services in this community. Drawing from the comments of my informants I have discussed how individuals transact when seeking or offering health care services. They transact with practitioners and patients, they transact with friends, family or colleagues when seeking advice or opinions and they transact with literature, the media and with public speakers. These transactions tend to reinforce the patterns of behaviour already established, or transactions become articulations that promote a change in behavioural patterns.

My informants have expressed to me that childhood experience provided most, if not all, of them with behavioural strategies for seeking health care. Some of my informants were taken to a family doctor when ill as a child, others were taken care of at home, one was taken to a chiropracter and another received care informally from physicians who were family friends. These strategies have led to transactions with

health care practitioners that have proven either to be satisfactory and have therefore been maintained over the years, or to involve dissatisfaction and the development of new strategies.

Barth (1981) has noted that patterns of behaviour are established in life and they are usually maintained unless proven to be unsatisfactory. Other studies (Frankenberg and Leeson, 1976; Solien, 1965; Young, 1981) more specific to the area of health care have also supported this position by showing that established behavioural patterns are evident when individuals seek therapy. Evidence has emerged from the statements of my own informants that shows this perspective to have legitimacy. Mr. Lougheed is one of my informants who expressed a satisfaction with his health care seeking patterns. He patronizes a family physician and has done so for most of his life. He has been pleased with the type of care that he has received and has not attempted to change his approaches for health care consultation. Jennifer Jones also stated that her patronage of a family physician has remained constant throughout her experience. These individuals have stated that they do not consider alternative routes to care when ill but follow a pre-established pattern that involves a family practitioner.

A pre-established routine does not imply the patronage of only one

practitioner; it may mean a compartmentalization of illness categories and the subsequent resort to various practitioners. Beals (1976), Press (1978) and Solien (1965) have all recorded the phenomenon whereby individuals designate the treatment of specific conditions to specific types of practitioners. This practice frequently occurs in societies that have plural medical systems. Some of my informants also display evidence of this behaviour. Martha Robinson has established certain categories of complaint that she will take to her general practitioner, other categories that she feels respond to acupuncture therapy and yet other categories that she deals with through resort to stress therapists. Eunice Johnston also indicated that she patronizes a family practitioner, an acupuncturist and a naturopath; all for specific kinds of complaints.

Not all of my informants showed a contentment with previous behavioural patterns. Some described dramatic changes in their patterns of behaviour relating to health care; these changes have been the result of dissatisfaction. Martha Robinson speaks of her articulation with meditation at a workshop she attended as being the beginning of a completely new approach to her personal health maintenance as well as to her ideas about health and healing. She became interested in meditation and other alternative healing techniques after a disagreement with her

physician over his advocacy of surgery for her knee. Sally Graham also spoke of profound changes in lifestyle and patronage of health care practitioners after unsatisfactory transactions with western trained physicians. They offered her no hope for the improvement or management of her condition. The articulation with an acupuncturist offered her a new and more satisfactory approach to her health care.

Even if the actual care giver has changed in a person's life, attributes of those early strategies often remain. My informant, Lawrence Underhill who grew up in Africa and whose family was left to its own resources, now consults a family practitioner for medical help but he also researches medical literature, alternative therapies and any new ideas that might help him. He has consulted a number of physicians and he likes to be kept informed about a doctor's ideas and rationale for treatment. This man still displays self initiative, responsibility and innovation when confronted with a health problem but he also describes articulations that have caused him to redirect his efforts for seeking help. He has changed practitioners when dissatisfied with their approach to medical practice and has sought out individuals willing to try alternative therapies.

This phenomenon of re-evaluating behavioural patterns and making adaptations does not have to entail a total rejection of all previous values.

In fact it probably seldom does. What usually happens is that through a selection process certain values are discarded while others are retained. It is the retention of specific values that establishes the priorities that link transactions. In Lawrence's case one of the major links between transactions in his health seeking behaviour involved innovation and self responsibility.

The development of behavioural patterns with respect to therapeutic choice is not restricted to the patient community. Studies, such as that undertaken by Light (1980) discuss the effects of socialization of medical students. It is apparent that doctors are the products of the institutions in which they were trained and it is difficult for them to alter their ingrained behavioural patterns that were established in medical school. All three physicians that I spoke with commented on the difficulty of abandoning the scientific model under which they were trained. Their behavioural patterns reflect adherence to what they learned as scientific method.

Some informants have expressed dissatisfaction with health care practitioners and a desire for change, as coinciding with an articulation with a political or philosophical concept. Margaret Haliburton described her affiliation with the feminist movement as providing her with the

necessary support to actually implement change in the health care system. She and her associates opened a new facility, the Feminist Health Centre.

Practitioners have also pointed out articulations that have prompted them to change behavioural patterns relating to the ways in which they treat and care for patients; their development of interests and new approaches. Dr. Carlton described the situation where one of her patients had been misdiagnosed. When new scientific information was developed it became apparent that the child in question had been a victim of sexual abuse. An articulation with this new medical knowledge along with the remorse of not adequately helping this patient led Dr. Carter to develop her special interest in the area of sexual abuse. James Koo explained how he developed techniques of relaxation in order to better deal with patients who were not familiar with the techniques of acupuncture and who came to his office frightened of needles. His articulations with nervous patients prompted him to implement new techniques of treatment. Also Dr. Peterson spoke of his rugby playing patients who required health care services for their athletic injuries. Transactions with these patients provoked an articulation with sports medicine and a subsequent development of expertise in this area.

Some specific articulations have been noted by the informants that I

have spoken with but often the exact point of articulation is vague. It appears from my data that patterns of transactions proceed even when they may not be totally satisfactory to the parties involved. This occurrence perhaps relates to the fluctuating value framework of individuals whereby certain issues are not of enough significance when other goals are being met. For instance the personality of a practitioner may be annoying but if he can cure your problem then his attitude may be overlooked. The point at which his treatments become less satisfactory may also be the time at which his attitude becomes patronizing to the point of redefining a previous pattern of transactions into an articulation that causes one to seek a different practitioner. In the case of a practitioner, Dr. Peterson pointed out that he has changed his approach to smoking patients but is not sure exactly when that change occurred. He had always been aware theoretically that smoking is harmful to one's health but he never pursued the issue very fervently with his patients. After watching a number of his patients die from lung damage a degree of urgency set in and he became an aggressive advocate of smoking cessation. The point at which articulation took place is difficult to recognize but there has definitely been a change in the approach that this doctor takes toward his smoking patients.

Transactions are occurring all the time and articulations either occur overtly and suddenly or they slowly develop and sometimes occur without conscious awareness. Patterns develop in our modes of behaviour as a result of these transactions and articulations, and when these patterns coincide with patterns in the lives of other individuals new services develop or the form and/or content of older services change. The Feminist Health Centre is a good example of how new services are created when individual actions and goals take on aggregate form. Also the comments of my physician informants show how developing patterns at the doctor/patient level and at the professional and scientific level have coincided to create the biopsychosocial model of medicine now being espoused by family practitioners.

I have pointed out that the value frameworks of transacting parties are not necessarily mutual. For a transaction to be successful certain criteria must be met and at least minimal goals of each party must be realized; but these goals are often distinct. A speaker whom I heard at a conference in support of alternative therapists illustrated this point well. He expressed great sympathy with the plight of alternative practitioners who are being refused the legal right to practise their healing modalities. The speaker publicly espoused a political orientation that would support

their right to openly practise and he adamantly opposed the medical establishment for holding a monopoly on the practice of medicine. He disagreed with any kind of licensing of practitioners. When questioned at the end of his talk he was asked what his attitude was toward the restrictions governing the sales of certain types of health food products. After he replied that he disagreed completely with such restrictions on health food products a member of the audience spoke up and suggested to him that he might, in that case, support a ban on cigarettes. He, of course, disagreed with that also. His concern and his level of support were political; his interest had nothing to do with the health issues that were of concern to his audience. Social factors must be complementary but all goals need not, and generally are not, the same when an new institution is created or when new practices are implemented.

Interacting social factors, external to actual transactions, directly affect the form and content of health care services. Even when there exist merging patterns of personal experience in specific transactional processes they must coincide with favourable external social factors, such as the availability of funds or the backing of political organizations, in order to result in a development or change in services.

All transactions occur within conditions of constraint and incentive

and sometimes the incentives are strong enough to promote articulation and subsequent change, but sometimes the constraints are significant enough to prevent change from occurring. The current situation whereby the Medical Services Plan of B.C. restricts the ability of doctors to bill for counselling sessions for their patients is one case where articulation and subsequent open change cannot happen even though there appears to be concensus between many physicians and patients that counselling should be allowed. Social factors in the form of economic considerations, at the level of the overriding structure that finances health care, prohibits billing for more than four counselling sessions annually for a patient (BCMA Payment Guide, 1985). Even though the experiences of doctors and patients have created a desire for counselling, economic factors limit access to this kind of service. Counselling still occurs but it cannot be billed as such.

The case of acupuncture is yet another instance of constraint being imposed by social factors external to the actual transactions between practitioner and patient. The acupuncturist, without an M.D., can face prosecution if caught practising. His practice of acupuncture could result in an incompatible articulation with government sanctioned health care goals. Laws have been enacted to prohibit the non-M.D. from practising

acupuncture even when these services are being demanded by the community.

Legal status and financial support are major and often unresolvable constraints placed upon transactions but these same kind of factors when occurring in favourable contexts will facilitate the change that has been initiated through articulation. The opening of the FHC illustrates a situation whereby personal experience and choice were supported by the interacting social factors of economics and politics and resulted in the development of a feminist health care service. (1)

The type of articulation that occurs will determine the extent and direction of that change. A ramifying articulation, such as the introduction of feminist ideology, will produce widespread changes throughout society, not just in the area of health care services. An inconsistent articulation that occurs between a practitioner and his patient may cause the introduction of a new technique to his practice but is unlikely to affect society much beyond the sphere of the personal lives of the transactors. James Koo's use of relaxation techniques for nervous patients is an example of such articulation. If his techniques were to become widely known, valued and implemented a multiplying articulation could occur and then the extent of influence brought about by his

articulation would be much greater.

If one could identify specific stimuli that would produce the various kinds of articulation one could foresee the effects of articulation on society and better understand the process of social change. This is one direction that future study could take.

I have attempted to show how personal experience in the form of transactions creates the need for making choices and how the choices that are made can affect the development of specific health care services. I have identified specific transactions and articulations as described by my informants and I have attempted to show how these transactions have developed into patterns that have influenced the form and content of the health care services that I have described. I have also pointed out the importance of understanding the interaction of the numerous variables that comprise the social structure surrounding these transactions, transacting with them and exerting influence upon them. I have pointed out various instances where specific factors either supported or undermined the choices of service desired by individuals.

As this is only a preliminary study with limitations of time, access to actual transactional situations and larger numbers of informants, there are gaps in my methodology and I suggest that further study be conducted

in order to substantiate my arguments. I would recommend that the analytical model that I have utilized in this thesis be applied to other social systems, such as education or social service, in order to test the conclusions of this study.

It would be useful to examine the role of personal experience in relation to making choices in the area of educational philosophy and attendance at educational institutions. The questions of how the personal experience of students and educators affects the development of school curriculum, how individuals make choices between public and alternative schools and how these choices are mediated by political, economic, legal, religious or moral reasoning could be dealt with. The conclusions of such a study, if supportive of my present research, would complement the existing body of literature on social development.

If, as I suggest, individual expressions of behaviour can influence larger social forms such as health care facilities it would follow that individual behaviour also affects the overall structure of our social systems. Our behaviour reflects values that are relevant to specific situations and our ensuing actions are what guide and direct the formation of social structures. This perception is neither new nor original, it has

been the basis for Barth's (1966; 1981) transactional model that I have utilized for the purpose of this study and it has informed the work of Belshaw (1969) relating to the performance of social systems, and whose ideas I have also used.

But it is not sufficient to allow things to remain at this point. Social development is not unidirectional. It is a circular process. Individual behaviour can affect social structure and in turn that very structure affects future behaviour. Even though individual action can be seen to influence the direction of social forms it must be recognised that the structure of those same forms holds considerable influence over individual experience and action. It has been discussed how all transactions respond to certain incentives and constraints. It is now important to identify how the actual structure of the system in place exerts influence upon any current transactions. Social systems are dynamic and continuously changing, bowing to the influence of individual action and to the restraints of established structure.

The structure or system of social organization present in B.C. is reflective of any modern, highly developed, complex society. It is a highly specialized, differentiated environment dependent upon technology and industrialization. The individual is trained to do a job in a very specific

sector of this society; his skills are usually specialized. Isolation, alienation and lack of personal identity are often cited as problems associated with the style of living in any such environment (MacCannel, 1976).

The health care system in B.C. is structured in basically the same way as the broader society. It is divided into highly developed specialties, and these specialties correspond to distinct parts of the human body. Specialties range from neurology, to gastroenterology, to gynaecology, to psychiatry to urology etc. The patient is dealt with and treated by specialists in terms of his relevant parts rather than in his totality, except by the family or general physician. He is also seen and treated in a highly impersonal hospital environment governed by high technology and division of labour. This type of highly specialized and differentiated system of health care services has been referred to by critics as being depersonalizing, alienating, sterile and basically unhealthy for the overall well-being of a patient (Foulds,1984; Illich,1976; Reiser,1978).

Ivan Illich (1976), a strong critic of industrialized society, blames technology and the subsequent over medicalization of society for creating what he identifies as clinical, social and cultural iatrogenesis. He sees these conditions as arising out of a kind of social, cultural and clinical

organization that promotes the expropriation of individual responsibility for health definition and maintenance. Iatrogenesis, as described by Illich brings about longterm destruction of the human condition. He sees man as having been forced to become overly dependent on an institutionalized health care system leaving him almost totally without personal resources and in the hands of insensitive and uncaring medical technicians. These same kinds of complaints are expressed by other critics such as those discussed in the Mishler (1981) volume.

From the data that I have collected I can determine basically two trends developing among health care givers in the lower mainland area of B.C. Both of these trends relate to concepts already described in this study and I suggest that these concepts and the services that are designed to correspond to them provide both a reflection of and a response to the structure of social organization present in this community.

The concepts that I refer to are the biopsychosocial model of medical practice espoused by the family practitioners and the holistic health model subscribed to by the advocates of the holistic health movement. Basically, as earlier described, these two models are more or less identical. Unlike areas of specialized medcine, they claim to view the individual in terms of his whole person, an individual who is made up of

body, mind, emotions and spirit in the context of a complete social and cultural environment. These concepts reflect the differentiated social system in their acknowledgement of the various integral parts of both the individual and his environment; they respond to the social structure by attempting to integrate the parts.

Two health care models have been described in terms of political organization by Jackson (1982). She portrays them as being opposing systems of power structure. The biopsychosocial model of health care represents a centralization of power where the medical profession has complete control. The structure is "hierarchical and authoritarian" (ibid, p.221). A patient enters the system at the family or general practitioner's doorway, or in a hospital emergency ward, and is then directed by the practitioner to the appropriate part of the system for his care. The practitioner sees the patient, evaluates him and then coordinates his movements within the system from then on. The holistic health movement is based on a de-centralized system of power; one that is "heterarchical and interactive" (ibid, p. 222). Power ideally resides with the individual and his family to decide what avenue of resource they wish to pursue. Through education and community resources the individual is made aware of good health care programs and the facilities that are available to him.

He then accepts responsibility for his actions.

What Jackson does not describe are the cultural identities held by the practitioners and the patients within each of these systems; the meanings attached to these various roles. The general or family practitioner certainly does hold power within the system of biopsychosocial medicine, he holds the power of understanding. He understands the complexities of the 'complete' person, plus he understands the intricacies of our highly specialized social and medical systems. By understanding, and by being able to communicate efficiently between these various parts he holds the power of integration. He is able to understand the individual in terms of the entire social and cultural environment and to make the individual understand his own position. Not unlike the shaman of band societies today's family physician crosses boundaries of a highly differentiated society and interprets for the individual the meanings of the world in which he lives and the worlds that he does not have access to. As stated by my informants and by the pertinent literature, the family physician sees his role as one incorporating treatment with education and counselling. He must understand the 'whole' person in terms of biology, psychology and sociology, he must know how to communicate efficiently and he must be knowledgeable of the broader community and its resources,

its problems and its issues (Berube and Woods,1983). The patients of these physicians have also stated that they want a physician who cares, one who can treat their ills and can also understand their feelings, one who can teach them and can counsel them. Even the critics state that people want to feel less alienated and more integrated with the world of social life; a good family physician in this model should do just that.

The holistic health movement also addresses the problems of alienation in a highly complex environment but it places the power of integration on the individual. The holistic movement sees the individual as having a unique place in the whole universe, as being an integral part of the universal process (Ferguson,1982; Jackson, 1981; informants), and as having a responsibility to maintain good health. Health implies the ability to function well on all levels; biologically, psychologically, emotionally, spiritually, socially and culturally (HANS brochure). By associating with like-minded individuals people become aware of their potential and aware of the resources available to them. By having personal contact with or knowledge of facilities in one's environment one becomes familiar with the 'whole' and their part in it. Even semantically the 'holistic' health movement attempts to unify an extremely differentiated system.

MacCannel (1981) discusses his concept of 'touring' that

familiarizes an individual in a complex, highly industrialized society with the history and the diversities of his own world. Touring can be done as a typical tourist visiting historical and contemporary sites, or through reading about them. Touring provides an overall view of the world and offers the individual the opportunity to authenticate his place within it. Like the advocates of the holistic health movement, MacCannel places the responsibility for integration on the individual. Knowledge and self responsibility become the instruments to integrate the diversity of our environment.

Involvement in the holistic health movement can be seen as 'touring' in the sense that it is the individual that must take responsibility for increasing his knowledge of the system of health care alternatives and by doing so he integrates the diversity and identifies his place within it.

Conclusion

This study was intended to examine the process of development of specific health care services in lower mainland B.C. It has focussed on the choices made by individuals as outcomes of personal experience; experience seen in the context of transactions. Transactions sometimes become articulations and promote changes in behaviour. Behavioural

patterns develop within individual lives and when these patterns take on aggregate form new services, or modification of pre-existing services, emerge.

But personal experience or transactions do not happen in a vacuum, they occur within a framework of incentives and constraints imposed by broader, interacting social factors. When these factors are supportive of, or complementary to personal choices they facilitate the development of services. When social factors, external to the actual transaction occurring, are in conflict with personal choices they then restrict the development of services.

I have used my data and illustrated specific instances of personal experience affecting choice of therapeutic service, and I have shown how certain broader social factors have mediated these choices and influenced the form and content of health care services. This process can be seen as the convergence of micro and macro levels of interaction.

I have also pointed out that personal choice, mediated by interacting social variables, directs the formation of social structure, the network in which personal experience is enacted, and how this very structure in turn affects personal experience. The types of health care services described to me under the rubric of biopsychosocial medicine and holistic health are

examples of services that reflect a highly differentiated social structure and respond to it by attempting to integrate that structure.

I have shown how services that I have described reflect the values of the individuals that were instrumental in their development and consequently of the society of which they are a part.

Footnotes:

1. A study (Wertz and Wertz, 1977) that came out of the United States illustrates well the phenomenon of how health care services change in relation to the constraints and influences of the surrounding social trends. This study does not look at the role of the individual as such but does give a good description of how childbirth practices and maternity care, in general, adapted to the pressures of urbanization, the breakdown of extended family networks, medical professionalization and the development of technology and pharmaceutics.

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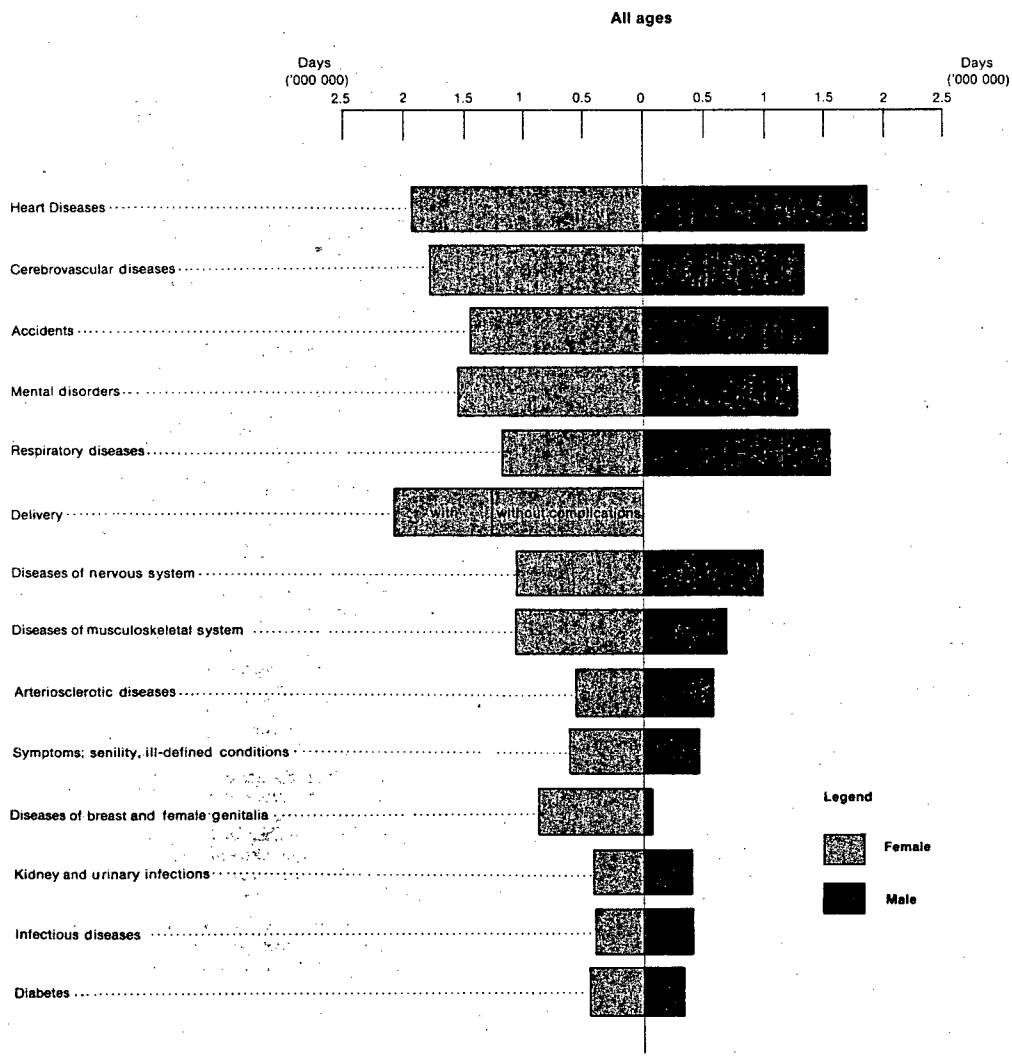
Appendix A

Patient-days by Major Causes, General and Allied Special Hospitals, by Sex, Canada, 1977



Source: Institutional Care Section, Health Division, Statistics Canada

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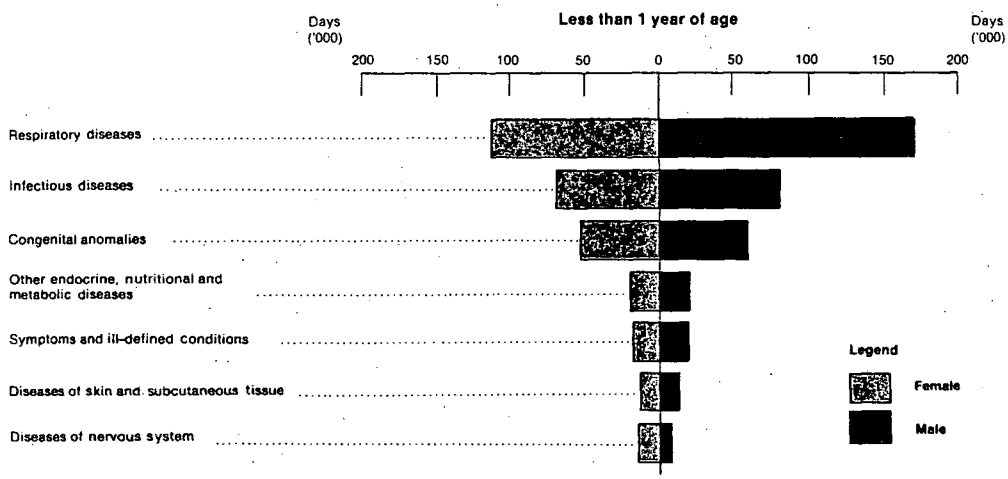

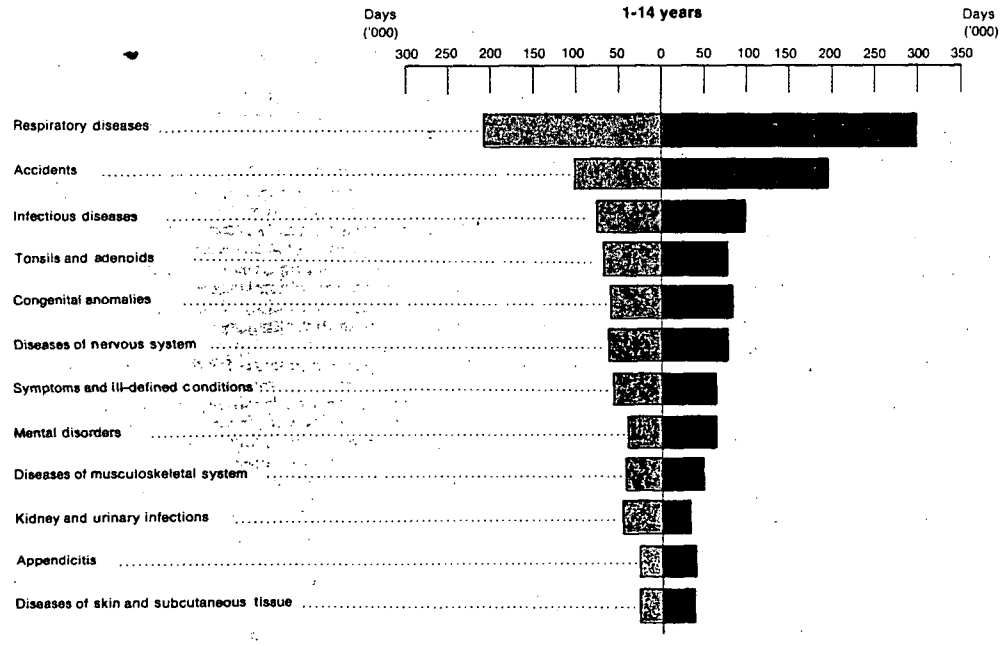

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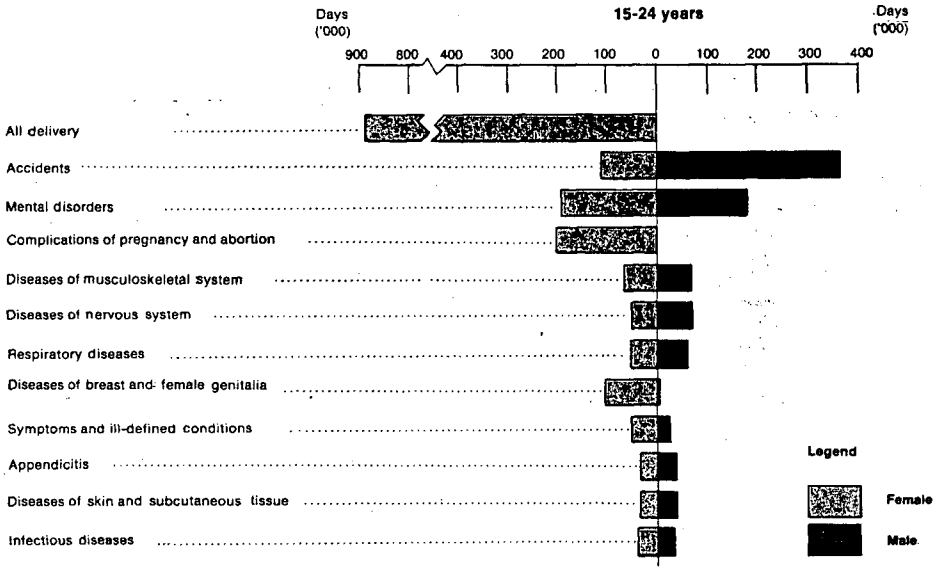

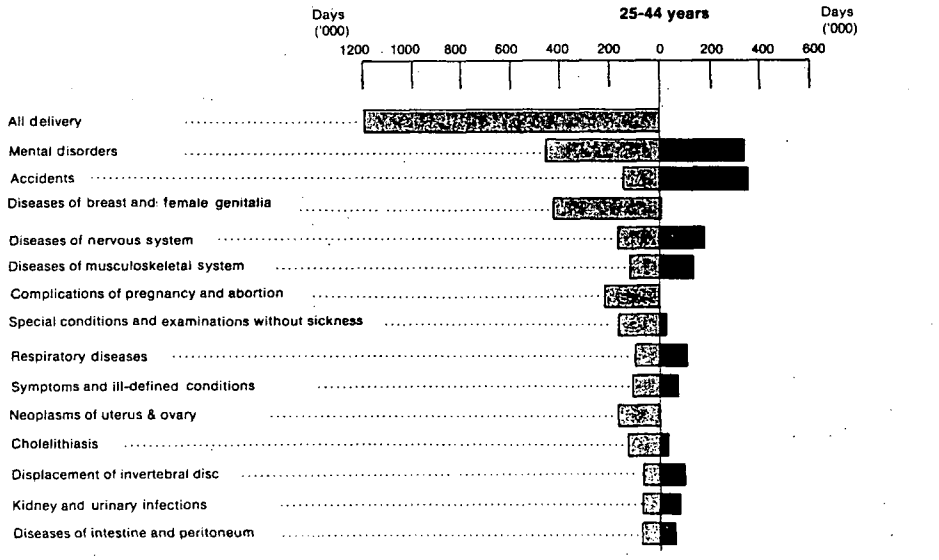

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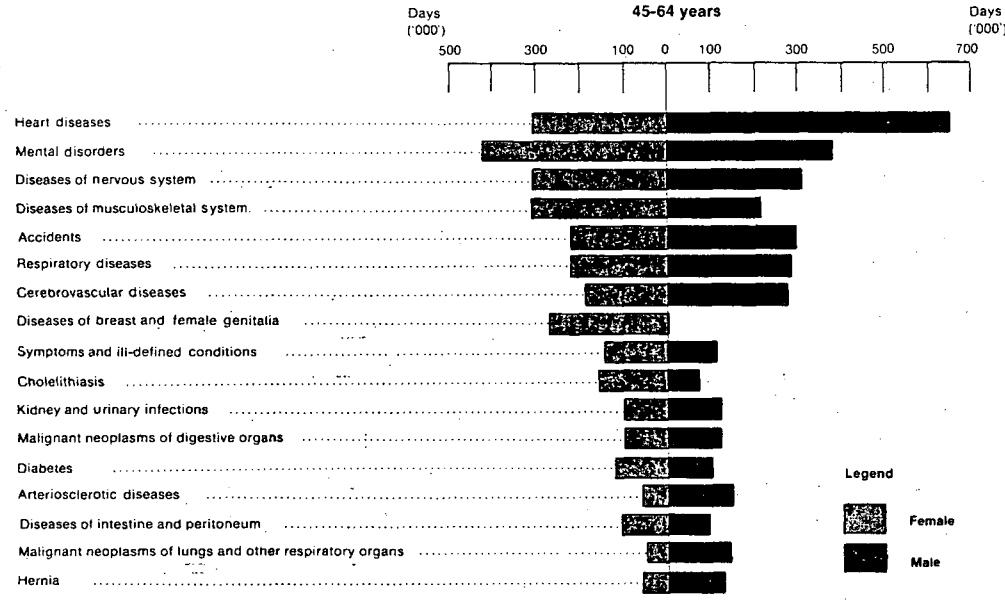

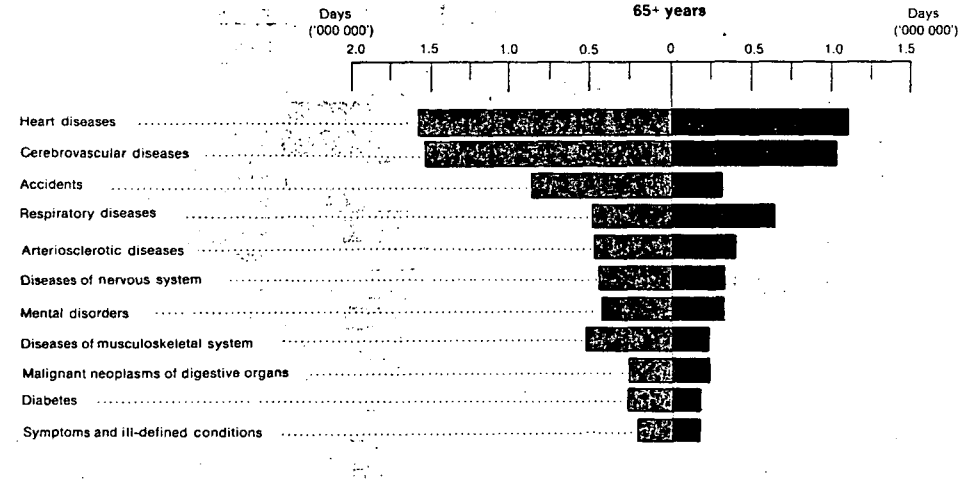

Source: Institutional Care Section, Health Division, Statistics Canada.

Appendix B

Subject Areas for Questions:

1. Definitions of health, health care, therapy

   (i.e. What does it mean, for you, to be healthy?)

2. Health care experience as a child

   - modification of these values?

3. Health care education

   - formal or informal

4. Responsibility for health maintenance

   (i.e. Who do you think has the responsibility to promote good health for Canadians?)

5. Resort to therapy

   - when?

   - why?

   - who?

6. Government intervention in health care

   - legal constraints

   - funding

   - political issues

7. Official v.s. alternative system

8. Thoughts on the future of the health care system

9. Personal experiences with the patients, practitioners, the health care system

   - level of satisfaction with services