AN EXPLORATORY STUDY
OF THE ADJUSTMENT TO HOSPITALIZATION
OF TUBERCULOUS INDIANS
by
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Date May, 1961
ABSTRACT

An Exploratory Study of the Adjustment to Hospitalization of Tuberculous Indians

The aim of this exploratory study has been to discover and analyze some of the basic problems of tuberculous Indian patients, particularly their adjustment to hospitalization.

The Indians studied are those of the northwest coast, including the Yukon and the Queen Charlotte Islands. The population studied was in Miller Bay Indian Hospital near Prince Rupert. Primary emphasis was placed on the emotional reactions of the Indian's adjustment to hospitalization and to removal from his familiar environment.

Due to the fact that Indian patients show inhibition in communicating their feelings and opinions, it was necessary to use direct observation as the initial technique in gathering data in the first three months of this study. In the fourth month a small sample of staff members and patients were given a semi-structured, non-directive interview. The questions included in the interview schedule covered the following 15 major areas: (1) the patient's attitudes toward life and illness; (2) the patient's acceptance of the diagnosis and understanding of the disease; (3) the patient's acceptance of hospital routine and orders; (4) the patient's
response to hygiene measures; (5) the patient's emotional reactions to hospitalization; (6) the influence of visitors on the patient; (7) the patient's trust in the staff; (8) the acceptance of the patient as an equal by the staff; (9) the expression of aggression by the patients and how it is dealt with; (10) the patient's initiation of social activities; (11) the patient's reaction to social activities planned by the staff; (12) the patient's plans regarding his future after discharge; (13) the problem of alcoholism; (14) irregular discharges; (15) the sexual behaviour of the patient.

Each of these 15 areas was analyzed in an attempt to arrive at common reactions to hospitalization.
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CHAPTER I

INTRODUCTION

Not much research was done on the present state of the Indians until the recent studies by Hawthorn, Belshaw and Jamieson reported in their book, *The Indians of British Columbia*, published in 1958. This book described the demographic, cultural and historical backgrounds of the British Columbia Indians, their occupations and education, and the problems of alcoholism and social control within the Indian community.

The Conference on Native Indian Affairs, University of British Columbia, 1948, mentioned the three Indian hospitals for tuberculosis and their capacities but did not go deeper into this area. No articles on the hospitalization of Indians could be traced in the Canadian Index on Indians.

Since no material on the hospitalization of Indians was available, it was necessary and desirable to conduct an exploratory study in this area. There were certain myths about the Indian adjustment to hospitalization and it was important to investigate whether these peculiarities, of which people who worked with Indians spoke, were true. The writer, herself being a nurse, found this point of great interest in her study, and felt compelled to find out the truth about it.
In the Miller Bay Hospital, many tribes and bands within tribes were represented. These patients having come from various parts of British Columbia, belonged to various tribal groups which spoke different languages. Thus it was not infrequent that one Indian was incapable of conversing with the others. If he had not learned English he was completely cut off from the possibility of verbal communication.

Due to difficulties in communication with the Indian patients this exploratory study consisted of two phases; observation of the patients for three months followed by interviews in the fourth month. The same areas were investigated by both techniques. The following 15 areas were felt to be significant for an analysis of the reaction of Indians to hospitalization: 1) the patient's attitudes toward life and illness; 2) the patient's acceptance of the diagnosis and understanding of the disease; 3) the patient's acceptance of hospital routine and orders; 4) the patient's response to hygienic measures; 5) the patient's emotional reaction to hospitalization; 6) the influence of visitors on the patient; 7) the patient's trust in the staff; 8) the acceptance of the patient as an equal by the staff; 9) the expression of aggression by the patient and how it is dealt with; 10) the patient's initiation of social activities; 11) the patient's reaction to social activities planned by the staff; 12) the patient's plans regarding his future after discharge; 13) the problem of alcoholism; 14) irregular discharges; 15) the sexual behaviour of the patient.
CHAPTER II

BACKGROUND INFORMATION

A. Perspective on the Indians

Historically, Indian people are the indigenous inhabitants of this continent. Perhaps most of the Indian cultures of British Columbia have been in existence for about two thousand years (Hawthorn et al., 1958, p. 8). In the Department of Indian Affairs census of 1954 there were 30,564 Indians of legal status in British Columbia. This number of believed to be on the increase.

Many Indian groups still live in isolated permanent reserves, some of which, like Telegraph Creek and the Naas River villages of Aiyansh, Moberly Lake and Fort Babine, are still in a locale hard to reach. Each Indian reserve is occupied by several bands, based on some traditional residential or cultural grouping, settled in a village. The commonest type of band is 75 to 200. The band is the most significant social and political unit beyond the family.

For administrative purposes the Federal Government has set up regional agencies. Each agency has a Government representative in the person of the Superintendent. The agency boundaries are based upon the accessibility of various bands to a Superintendent in a particular locality.

The geographical isolation of many of these reserves
has favoured the retention of the Indian culture, language, values and way of life. The change of culture from reserve to the hospital is quite abrupt and radical and sometimes results in painful psychological consequences.

B. The Medical Care of the Indians

The Federal Department of Health and Welfare endeavours to supply these isolated areas with public health nurses and yearly x-ray teams as part of its program to control tuberculosis.

Groups who can earn their livelihood by fishing or berry-picking undertake seasonal migration; the berry-pickers from Vancouver Island migrate for a period of time to Washington State, and the groups engaged in fishing migrate with their families to coastal areas where the canneries are located. A more complete medical service is available during this period to all Indian people in the canneries. However, the living conditions provided are fairly primitive.

Tuberculosis is a long-term illness, unknown to the Indians before the coming of the white man. Living conditions on the reserves favour the spread of the disease. Sleeping accommodations in isolated areas where acculturation has taken but little root are extremely crowded and unsanitary. On several occasions it was observed that both parents and two children slept in one bed since it was sufficiently wide. These people readily seek medical help but it is questionable whether many have any understanding of how the disease is
spread. Tuberculosis can easily go unnoticed by the Indian, who, if he is without any understanding of the disease, finds it difficult to believe that he is not well. Hence the response to diagnosis sometimes is opposition and disbelief. On the other hand, when symptoms are easily perceivable in visible damage to the body, the Indians seek assistance wherever possible.

Some areas are more fortunate in obtaining assistance than others. The Fort Babine area is visited by the public health nurse only about once in three weeks. It can be easily understood that under these conditions native medical practices continue. A public health nurse gave an account of an Indian medicine woman, whom she knew to be very sensible and clever, who attended and treated the sick. When asked by the public health nurse in a scientific way what was done for each particular patient, the medicine woman was always prepared to explain and give an account of her treatment.

Among the Indians there is a general preference for modern medical treatment where it is available, but medicine men (mainly women) function also to aid the patient until such help is available. Folk medicine does not seem to be regarded as a substitute treatment, but rather as a stop-gap. Normally, the Indians do not admit this practice to strangers and the fact that it was discussed with the public health nurse demonstrates great trust and confidence in her on the part of the medicine woman. The medicine woman is known to bring
her own grandchildren for medical examinations when she visits her daughter who lives close to the town.

During the fishing season, when Indians from isolated areas migrate to canneries, it is evident that they respond very well to modern health measures, and whenever anything is wrong, immediately turn to the first-aid attendant. Hospitals are fully trusted with the care of their children by parents and occasionally, in a busy season, parents do not come as soon as the child is discharged. It is not that they do not want the child, but they leave him as a matter of convenience, since the child is felt to be in a safe place and well cared for. Parents usually are willing to part from the child when hospitalization is required, on the ground that it is best for the child. The parents are not only truly warm and affectionate, but also well-controlled, and emotional scenes do not occur at times of admission.

The adjustment to hospitalization of younger generation patients is facilitated by agencies favouring acculturation, such as schools in the villages, improved transportation, health teams, technology, employment outside the village and contact with the white people in general.

Although some medical staff do not credit it, the improved medical treatment by powerful antituberculosis drugs has improved overall attitudes toward hospitals and willingness to comply with the treatment program. An influential Indian woman made the following comment: "Years ago people
used to go to Miller Bay to die, now no longer this happens."
One may reasonably infer that the question of the effectiveness of treatment occupies the minds not only of friends and relatives but also of the patients, since their own fate must be to them of much greater importance than it is to an individual not personally involved in the illness. In the writer's experience the improved medical care is a great step forward in gaining the patients' cooperation and willingness to accept hospitalization.

Now antituberculosis drugs have shortened the patient's stay in hospital to a considerable degree. It is not infrequent that a patient is allowed a month or two of leave in which time he continues with treatment at home. The popular drugs used in treatment of tuberculosis are streptomycin injections, para-aminosalicylic acid in liquid or tablet form and isonicotinic acid hydrazide tablets. These drugs are administered two at a time so that one medical weapon remains in reserve to combat T.B. bacilli which may develop resistance to the present drug treatment.

In discovery of new cases and follow-up of those discharged, the diligent care of the Department of National Health and Welfare throughout the country cannot be overemphasized.
CHAPTER III

METHODOLOGICAL CONSIDERATIONS

There are two ways in which human behaviour can be investigated, by observing what people do, and by asking questions about what they do and think.

The original plan in this study was that the main tool of investigation would be the semi-structured interview employing open-ended questions and the "funnelling" approach whenever it appeared useful. In addition, careful observation of patient-patient and patient-staff relationships would be made and recorded.

The first two weeks were spent in observation and investigation of the best approach to the problem. The staff administrative personnel advised that the interview technique would not work; their experiences were that the Indians do not respond well to questioning but smile silently instead of imparting information, and only after long acquaintance will they engage in a conversation that discloses their personal opinions and feelings.

It was therefore decided that it was necessary perforce to use the technique of direct observation. This provided an advantage in that the investigator could engage in gathering data without the patients and staff being aware that they were being observed and that information was being
gathered. Thus the natural setting did not undergo any change. During the last month when the investigator went on midnight shift on the nursing staff, the field of observation became limited, and it was evident that nothing could be lost by trying the interview technique at this stage of research. Some ties of mutual trust between the patients, the staff members and the investigator had at that time been established making the interview more effective and productive.

A. Observation Technique

Observation becomes a scientific technique to the extent that it

(1) serves a formulated research purpose
(2) is planned systematically
(3) is recorded systematically and related to more general propositions rather than being presented as a set of interesting curiosa
(4) is subjected to checks and controls in validity and reliability (Selltiz, Jahoda, Deutsch, Cook, 1959, p. 200)

Observational techniques yield data that pertain directly to typical behavioural situations. Sometimes a study demands that what people actually do and say be compared with what they say they do, in which case two methods would be employed, observation and interviewing. Observation may provide data that an informant would never think of reporting. This technique is independent of the subject's ability and
willingness to report. Observation demands less active cooperation from the subject than other techniques. Even if the subjects do know that they are being observed, it is, in general, agreed that the distortion of the life situation is less than distortion of memory, inherent in interviews (Selltiz et al., 1959).

The observation technique avoids the reporter bias inherent in technique and questionnaires in which the respondent's statements may represent what he would like to be or do, or what he believes the interviewer would approve, rather than a true account of his own behaviour. This became very evident when a young man being interviewed denied any feeling of aggression although a few weeks before the interview he had been observed by the interviewer involved in a fight with another patient, lying on the floor and pulling the other man's hair.

Systematic observation also has the advantage when other techniques are unavailable or inappropriate as in the early stages of the present study.

One disadvantage of this technique is that it is impossible for the observer to foresee the occurrence of a significant event and for him to be there at that moment. Another limitation of the observation technique is that some events and occurrences are not accessible to direct observation, for example, sex behaviour.
The observation may take place in real life situations or in the laboratory. The observer may himself participate actively in the group he is observing; or he may just observe without participation; or his presence may be unknown to some or all of the people he is observing. In the present study the investigator was employed in the hospital and therefore used the technique of participant observation.

Selltiz et al. (1959) suggest that the following information about the observational setting is valuable:

(1) the participants' age, sex, official function and whether they are strangers
(2) the setting - wards, recreation rooms, classrooms
(3) the purpose - what brought participants together
(4) the social behaviour
   (a) what initiated the behaviour
   (b) what is its objective
   (c) toward whom is it directed
   (d) the form of activity entailed
   (e) qualities of behaviour (intensity, persistence, duration and unusualness)
   (f) what are its effects - what behaviour does it evoke from others
(5) frequency and duration

In general, this approach was followed in the present study.

Recording the data of participant observation is best done during the observational process but this is often not feasible since it disturbs the naturalness of the situation.
Making notes may arouse suspicion and even interfere with the process of observation itself. Consequently, in the majority of cases, the recording is postponed until after the observed event when, as soon as possible, a narrative account of everything in the situation is put on paper. This was the procedure followed in the present study.

In recording, an attempt should be made to separate the observations from any interpretations that are made, and this structure also guided the observer in gathering the data to be presented here.

B. The Interview Technique

In the interview, the respondent's verbal expression must be directed toward the interviewer in response to the interviewer's questions. There is a variety of research designs in which the interview may be employed in social psychological research. The interview is considered to be an important instrument of data collection in an exploratory study of any field when little information is available.

In the standardized or structured interview, the questions to be asked of the respondent have been decided upon in advance and are asked in the same order and the same wording for all respondents. In this form of interview it is impossible to change the order of topics to adjust them to the respondent's flow of ideas. The structured interview has the advantage that it makes information comparable from case to case and that it is more reliable. However, the structured
interview was not considered suitable for this study of Indians because it was felt that adherence to fixed questions would have made the establishment of rapport rather difficult; they might have reacted negatively and resented the too obvious attempt to probe their personal feelings.

The unstandardized interviewing technique differs from the standardized technique in that a standard list of questions is not used. It is nondirective and lets the respondent take the lead. Because of this it also has been named a "passive" interview. The unstructured interview has the advantage that it is more flexible and more valid in that it encourages more true-to-life replies. But this technique was not used either because it was felt that the Indians could not have responded well to general questioning and also, because the study required comparability of data in all 15 major areas of interest.

The semi-structured interview, also known as "the focussed interview," makes use of a list of suggested questions giving the interviewer a considerable freedom within the framework. The interviewer directs the respondent to use the given material in a certain way. The semi-structured interview is essentially a compromise between the structured and unstructured techniques. It attempts to maximize the advantages, and to minimize the disadvantages of each. The semi-structured interview was chosen because it did not limit the replies of the Indians and allowed a freer communication than a structured
interview would permit. It did not evoke inhibition, and replies to questions not understood could be traced and clarified. The interview situation was near to a true life situation and facilitated rapport. At the same time, the semi-structured interview provided some frame of reference for the patients to follow and to initiate their thoughts on required topics. The results of the 15 investigated areas yielded comparable data.

C. Open and Closed Questions

In general the questions used in an interview may be "open" or "closed."

An open question gives the respondent very little, if any, lead or direction as to the content or form of his answer. The open questions state a problem without specifying a list of alternative answers, for example, "How do you feel about it?" The open question asks the respondent to recall something. It has the advantages, first, of permitting the interviewer to detect misunderstanding of the question, and second of being unlikely to suggest an answer to the respondent. The interaction between the respondent and the interviewer promotes rapport because it closely resembles an ordinary conversation.

However, the openness of a question remains a matter of degree. Every question limits to some extent the possible range of answers because the subject matter is specified. A closed question limits the respondent's answers severely in that a series of alternative choices is given. In closed questions the answers may fall in the following categories:
two-choice answers as "yes" or "no" or agree, disagree; or a number of alternatives from which the respondent is asked to choose the one that comes closest to his opinion. The closed question asks the respondent to recognize something. The respondent, given a series of alternatives to choose from, will do so even if he has no information or definite opinion about it. The research worker here has no chance of detecting the respondent's misunderstanding or ignorance of the issue, because the answer is suggested. Closed questions are liable to interference with rapport because the already prefabricated alternatives may irritate the respondent by limiting his creative thinking and freedom to express his opinion, especially when none of the given answers properly reflects his thought on the subject matter. In this case, the individual may resent being forced to answer in predetermined categories. The advantage of closed questions is that this produces considerable uniformity of answers among respondents and that it facilitates field coding.

In interviewing individuals from other societies the questions should be as open as possible, for instance, "Tell me about ...," followed by nondirective probes. The interviewer should be able to admit his difficulty with ease if he fails to understand a given response and to clarify the issue immediately. It is also extremely important that he recognize signs of anxiety in the respondent, signs which in other societies are often different from ours. It can be observed among the Indian people that in case of anxiety they "freeze"
and become stonily impassive. This is comparable to the restless activity of white people, as an indication of anxiety and the interviewer has to be able to recognize and release it.

Open-ended questions are used in this study because they have the following advantages: 1) they allow the interviewer to detect misunderstanding on the informant's part; 2) they neither suggest nor force an answer on the respondent; 3) they promote rapport; 4) they do not limit answers; 5) they do not limit the respondent's thinking; 6) they stimulate participation. Other important reasons for choosing open-ended questions were that the individuals interviewed were from a society different from our own and that in such a case it is recommended that the questions be as open as possible. There were no previous studies to give information on possible alternative answers for closed questioning and there was a great necessity that the Indians understand the questions.

In summary, the original plan to use interview first and then do direct observation could not be followed, and had to be revised, the direct participant observation occurring before the interviewing which was postponed until the final phase of the study. The initial approach was thus shifted from interview to participant observation. Because of the characteristics of the patient population and the total situation, the semi-structured interview was chosen and open-ended questions were considered the most likely to be productive.
CHAPTER IV

RESEARCH METHOD

A. Subjects

The subjects for observation and interview consisted of two groups; the patients and the employees at Miller Bay Indian Hospital near Prince Rupert.

Patients serving as subjects covered an age range from infancy to old age. All were Indian residents of British Columbia, coming from various sections of the province. Although the majority of patients suffered from pulmonary tuberculosis, some patients with other diseases were also admitted to the hospital.

The patients belonged to various Indian groups which differ in their native tongues. Due to their isolated living conditions some of the patients had not learned the English language. Differences in the mastery of English were most marked between the various age groups: the school age group and the younger generation were the most advanced. Their skill in the English language also was dependent upon the degree of isolation of their reserves and the amount of their previous contact with white people.

The capacity of the hospital was 140 beds. There were about 30 infants, 40 to 50 children and adolescents, and 50 to 60 adults and old people.
The staff members at the hospital constituted an extremely varied group. There were Canadian Whites from various provinces, British nurses, nurses from Holland, Greece, Germany and other European countries, and nurses' aides among whom were a great number of previously discharged Indian patients. During their convalescent period the Indians had been enrolled in a six-week nurses' aide course offered by the hospital and gained their first experience in nursing through this rehabilitation program.

The 15 staff members interviewed in this study varied in length of employment, objectivity displayed, ability to cooperate and amount of interaction displayed with patients and staff members. With few exceptions, most of the staff members had been employed at Miller Bay longer than five years. Among the interviewed staff members were two medical interns, one doctor, one male nurse, one social worker, five graduate nurses, two orderlies and three nurses' aides. The age range was between 26 and 50 years.

The 15 patients interviewed were chosen in consultation with the matron. Eight female and seven male patients between the ages of 12 to 50 years were interviewed. It was important that these patients speak English well enough to communicate freely and that they be willing to cooperate in the interview situation. Data from patients who did not lend themselves to interview was added as inferred from observable data. The interview data of each was compared with behavioural observation.
B. Procedure

The study took place from May 15 to September 15. Systematic observations were done daily on wards while on duty. The informant worked on two shifts, morning and midnight. Questions covering the 15 areas were kept in mind and every opportunity when an event relevant to any of the 15 areas occurred, was recorded. Since the investigator lived in a residence close to the hospital, occasional observations were also made in the evenings during time off-duty. These observations were concerned with the out-door activities of the patients. Hospital charts were studied with regard to patients' adjustments, age and progress of health, mainly on weekends while on duty; hospital records were perused for patients' ages, chronological time and discharges, mainly in the evenings. Notes of the observed behaviour were written down in a sketchy manner immediately and rewritten after duty the same day.

The interviews of the patients and most of the staff took place in a hospital office in privacy in circumstances which favoured the establishment of a good rapport. The interviews of the staff members who lived outside the hospital grounds took place in the office, but those living in residence were interviewed in privacy, either in their own or the interviewer's room, the time of the interview at the choice of the respondent. The length of the interview varied from 30 to 45 minutes. Prior to each interview the
respondent was assured of the secrecy of his responses. The interviews were usually done after four o'clock in the afternoon when the hospital's offices were available and the interview did not suffer by interference from hospital routine. Each interview was carried out in terms of the 15 areas which were written on a sheet of paper in the investigator's sight:

1) the patient's attitudes toward life and illness; 2) the patient's acceptance of the diagnosis and understanding of the disease; 3) the patient's acceptance of hospital routine and orders; 4) the patient's response to hygienic measures; 5) the patient's emotional reactions to hospitalization; 6) the influence of visitors on the patient; 7) the patient's trust in the staff; 8) the acceptance of the patient as an equal by the staff; 9) the experience of aggression by the patient and how it is dealt with; 10) the patient's initiation of social activities; 11) the patient's reaction to social activities planned by the staff; 12) the patient's plans regarding his future after discharge; 13) the problems of alcoholism; 14) irregular leave and discharges; 15) the sexual behaviour of the patient.

The semi-structured interview with open-ended questions, employing the "funnelling" approach whenever it was useful, was used. Answers to questions were funnelled into pertinent areas as suggested by Kahn and Cannell (1957). Because the attitudes of Indians were unknown prior to the interview, the opening questions were given in general and
unrestricted words which were followed with successively restricted questions, narrowing the content to objectives. "The funnelling sequence is especially useful when one wants to ascertain from the first open questions something about the respondent's frame of reference" (Kahn and Cannell, 1957, p. 158). Thus an attitude evoked does not become biased through the form of the questions but leads to the desired goal. The interviewer strove for a natural form of communication in which the respondent would be inclined to express himself in the way he would do in every day conversation. At the outset of each interview, permission to take notes was asked of the respondent. All respondents agreed to this.

In order to understand the patients and their life situations more fully, the investigator accepted invitations to visit the patients who were discharged and made several visits to some distant reserves such as Fort Babine, Kitwancool, Smither's Landing, and to the canneries ten miles distant. These visits facilitated understanding of their ways of thinking and the hygienic measures they use in every day life.

C. **Analysis of Data**

The data contained in the observations and interviews were carefully organized under the 15 categories. The material within each area was analyzed in order to discover common beliefs, attitudes and problems of adjustment in regard to hospitalization among the Indian patients.
The data did not lend themselves to precise quantification. Rather, quantification is conveyed by words like "more," "often," "always."

It should be recognized that such terms are just as "quantitative" as such terms as 37 or 52%; they are only less exact and precise (Berelson, 1959, p. 489).

During the coding of data, it was found that often the categories merged and that it was difficult to code certain statements as belonging to one category exclusively. These were included in the categories toward which they leaned most heavily. Also, ambivalent feelings were often expressed in that a patient would state that he liked the hospital routine and then start citing the things that bothered him about it. When asked to clarify his statements, such a patient would typically continue to maintain both statements, perceiving them as two separate items rather than a contradiction. The same applied to some adolescents who claimed that they did not want to miss school and in the same breath continued that they would like to get a job and be independent. In such cases the replies were coded in both appropriate categories.

In the next section, each of the 15 major areas is discussed separately in order to provide a fairly detailed account of the Indians' reaction to hospitalization.
1) The patient's attitude toward life and illness

The results in this area are largely drawn from interview data since it was not possible to obtain them by direct observation.

The patients' attitudes toward life, just as in our society, are very varied. To many it appears a hard struggle against difficult circumstances. A few others grasp for what they can get out of life in the way of whatever pleasures are available. A few had a vegetative existence and to them nothing matters much. Altogether, some display quiet acceptance, most of them fight for improvement.

Illness, when it appears outside the hospital's walls, is, on the whole, perceived the same way as our society perceives it. However, it seems that illness is, to the Indian, somewhat more mysterious and less understood. Help is sought whenever needed and where available. To the hospitalized Indian, tuberculosis appears less serious than to the average white person. This may be accounted for in two ways: first, the Indians have been less exposed to educational material regarding illness, and second, they do not, in fact, feel very sick.

There was a distinct difference in the descriptions
of the patients' attitudes given by the Indians in comparison with those given by the white people. On the basis of observation, it would appear that the Indian account of their attitudes corresponds better with their behaviour.

The patients' responses fell into three categories; passive acceptance, giving up, and fighting it out. A great number of patients claimed to have gone through all three of these attitudes during the time of hospitalization. The observation data supported these three areas.

"Many of them have no special attitude toward life and illness," said one white informant who has worked as a doctor in Miller Bay for six years. This could be taken as acceptance of fate on the part of the native. The social worker felt that, on the whole, the attitudes of Indians are very good, and quite philosophical: "They are not disturbed, though mothers are anxious about children in quite a normal way." Because the Indian patients do not give much consideration to this question, or else are unable to verbalize their feelings about it, most of the white respondents said that as far as the Indians' attitudes to tuberculosis goes, "They have none." One of the staff members expressed an opinion that most Indians wish to fight the disease and to return to normal life, but that a few curse the white man for being the cause of this malady and have no other thoughts than that. It was claimed by the respondent that this type of patient occasionally displayed vengeance by attempting to cough into the nurse's face so that she, too, would get the disease.
This, however, to the interviewer, appeared to be a misjudged conclusion, since bad manners are more likely the cause of such behaviour. A few staff respondents reported that most patients were aware of being ill, but they did not ponder over the causes, and only took care that they would get well again. A medical interne's reply to this question was:
"Take F.S., he likes it here; first decent meal he ever had; can't postpone pleasures -- candy, food, sex -- they want it all and gulp it."

Typical feelings on the part of the Indians were expressed by an Indian ex-patient, now an orderly. He was able to communicate his feelings because, after his recovery, he had spent about ten years in the white society and had acquired freedom to express his feelings. This Indian had been hospitalized previous to the recent advances in medical treatment. He put his feelings and his attitudes to his illness very differently, saying: "These are sad things; you were told you would be a year on strict bed ward. The worst is after you are in bed. You think of all the things that are happening outside the hospital. You have an attitude toward life as if you had been hurt, as if somebody had taken something away from you. It seems like everything has caved in on your future plans. If you thought before that some day you might be on top, now you have to give up everything."

The above case reflects the data from interviews with the patients who said that in the beginning there was a
stage of passive acceptance of fate, then, during early hospitalization, a feeling of giving up, out of which generally emerged a determination to fight the disease.

2) The patient's acceptance of diagnosis and understanding of disease

The results for this section are mainly based on interview data. The patients themselves stated that they understood the disease and accepted the diagnosis. The data from the staff interviews was quite contradictory on this issue and it was not possible to come to firm general conclusions. A doctor felt that most of the Indians accept diagnosis and understand the illness. The opinion of a young medical interne was that they do not understand the disease too well; when it is explained to them, they say "yes," they do understand, but the answer should be "no," they do not understand. A few refuse to accept the diagnosis. Another staff informant claimed that 50 per cent of the patients do not understand the disease because they do not feel sick. A few staff informants felt that simple people feel themselves as either sick or well and that they cannot visualize themselves in between the two or accept the fact that they are half-sick.

The patients get a review and explanation by their doctor every three months which keeps them up to date on the progress of their health. Many patients think of what the disease means and that not following instructions may have
unhappy consequences. The more intelligent patients therefore follow doctor's orders and do not get too friendly with those patients who fail to do so. It is true that the treatment is not pleasant; streptomycin injections are very painful and para-amino-salicylic acid given in liquid is certainly bitter and revolting. From staff reports and observed stains on the outside wall, it is evident that the less responsible individual who lacks understanding of disease, pours his medicine out of the window.

The reports of the Indian respondents on this question were very varied but the majority tended to support the view that most of the Indian patients understand tuberculosis. There were a few patients who were convinced they had tuberculosis, even though the doctor failed to diagnose them at the beginning of the disease. A few patients who have had tuberculosis in their families, claimed to have been aware of having it and to have stayed away from their children until the diagnosis was confirmed, when they gladly left their homes for the sake of the family. Most patients said that when the diagnosis was explained they understood and accepted the fact of being ill. There were a few patients who claimed that they had no explanation given but had to learn about the disease from other patients.

It seems worth while to quote an Indian orderly who once was a patient himself, on the understanding of illness and acceptance of diagnosis: "To me it was a very interesting
thing, I have never heard of tuberculosis. It was a great help to have the x-ray explained, it boosts one's morale as it [the x-ray results] improves. If you do as the doctor asks, you have a good chance to recover before the planned time, which is encouraging. If you do not understand, tell the doctor and he explains again, but some patients may not admit they had not understood."

In spite of the fact that the interviewed patients claimed to understand the disease, the observations show that a few patients found it very difficult to believe that they had tuberculosis. There is also the rare case in which a patient, although hospitalized for several months, still did not accept the diagnosis nor understand the disease regardless of the doctor's efforts to help him understand. There was one patient in particular who almost regularly once a week fought the staff and argued that he was not sick and wanted to go home. This man developed emotional problems, became suspicious of the other patients, and sometimes it seemed that a breakdown was not far off. He often refused to take his medication and became depressed.

The following is an example of a 23 year old male patient who initially did not understand the disease but later gained understanding only too late to avoid tragic consequences. He was first admitted in 1947 with tuberculosis of the bone. The doctor told him that the hospitalization would take two years. At that time being only a
child, he did not understand the implication of the disease, and apparently his parents were no wiser. He wanted to be home with his family and was discharged against medical advice. Two years later he was readmitted and had to be sent to the Nanaimo Indian Hospital where his leg was amputated. The patient emphasized that he had made a very big mistake about which he was very concerned. At the time of interview this patient had tuberculosis of the urethra and the kidney, and further operations were pending. His personal comment was that people should contact a doctor immediately and obey his orders, not wait until it is too late.

In a few cases it was hard to tell whether it is lack of understanding of the disease or fear of surgery which prevented acceptance of the diagnosis. An example of this was a patient who went for lung surgery all the way to Sardis only to refuse to sign her consent for operation. She returned to Miller Bay and discharged herself against medical advice.

3) The patient's acceptance of hospital routine and orders

In this category, refusal to take medication has already been mentioned. The problems of alcoholism and irregular discharge will be discussed separately.

Interviews with the staff members showed general agreement that the hospital routine is accepted very well by adult patients, except for staying in bed, although women do
better at this than men. The Indian patients do not like the routine when it means having to rest and go to bed. There are three rest periods a day from nine-thirty to eleven a.m.; from two to three p.m., and from six to seven p.m. All patients must be in bed by nine o'clock in the evening and the lights go off at nine-thirty for the night. Regarding patients going to bed, one nurse said: "We have to drag them in and keep on nagging. The other routines they do not mind." A few patients are reported by the staff to follow the routine with great negligence and to ignore everything that limits their freedom. This applies more to the male patients than to the women.

One respondent who had a deep insight into the problem thought the Indian patients took the routine very well. She called attention to the fact that white women would fight among themselves if they had to live so closely and mixed with different social strata: "We put people together in one room who would normally never be together, and yet, they get along well." She noted that in spite of the fact that the routine puts difficult demands on them, they still follow regulations and get along well. Also she pointed out that Indian people live more by the sun than by the clock. This puts a stress on them when following our routine. Also by routine they are forced to eat very different food, as we do not serve seaweed, fish oil, berries and tree bark. We do many things that offend them without knowing it. For an elderly man it may be devastating that women order him around.
Several respondents made the statement that the patients like to come to the hospital to get cleaned up in a physical sense; they especially enjoy the baths. For the women it may be the first vacation they have ever had: they get a chance to get washed, do up their hair and be away from their babies. But it was claimed by all white respondents that when the patients returned to the reserve, they regressed to the previous state of grooming.

In spite of the fact that most patients did accept the routine, a few staff members felt that they did not accept the routine as well as they should. For example, a male nurse reported that the majority of male patients do not like the routine and that the rest period is the greatest breach. He also felt that many of the men had a "chip on the shoulder," an antagonistic attitude from the beginning. This again was explained by the fact that the patients do not like their freedom limited.

The interviews with the patients provided strong agreement with several points cited by the employees. Although they all agreed that the liquid medication para-amino-salicylic acid was difficult to take, and it took them a number of months until they got used to it, they took it without much complaint. In spite of the fact that they claimed to miss their home cooking of Indian food, they took hospital cooking without resistance. Generally they found the rest period to be a restriction but they followed it in spite of that.
Although there was general compliance with the demands of the hospital routine, the Indian patients did voice complaints about minor irritations. Many patients felt badly about the nurses removing their books during the rest period since reading helps them to go to sleep. Opinions were voiced against the lights being turned out too early in the evening, a routine occurrence at 9:30 p.m. A few patients felt that they were rushed with their meals: "If we do not eat right away they take our trays away." This, however, is not fully true because in the morning the patients are hard to wake up for breakfast and at noon they like to continue for a while with what they are doing at the time the trays are brought in, even though the staff works according to the clock. There were a few complaints against the rule that the hospital clothes have to be worn and the Nanaimo hospital was mentioned as a place where patients could wear their own clothes. They also complained that if patients did wear any of their own clothes they were not allowed to do their own washing and it was claimed that the hospital laundry ruined the articles. There were no complaints by the up-patients against having to make their own beds. A few patients found the routine very boring; the same thing was done over and over. In spite of these complaints most patients expressed agreement with the present routine.

Direct observation suggested that a considerable part of these difficulties is due to our concern with clock and routine. Rest periods, meals, medications are given at
certain times of the day. Quite often these interrupt what the Indians are doing and they have difficulty understanding why they should follow the clock and interrupt their casual activities. Their habitual way of life is not compatible with it. Thus the patients have to be called in for their meals and rest period while playing or walking outside. The change of food also appears to be a difficulty. A few have seaweed sent to them by mail or other food brought in by visitors. They like fruit but dislike vegetables, liver and canned beef. The fish on the menu is always enjoyed.

However, it was also observed that the personality of the nurse has a lot to do with the patients following the routine. If the nurse is understanding, she is liked and there is hardly any refusal to take medication, to eat the meals on time, or to rest.

Acceptance of routine is much harder for infants and small children. This topic could also be discussed along with the emotional reactions to hospitalization, but since it has to do with the hospital routine, it will be discussed here. For the one-year old infant, who has not been toilet-trained at home, the routine of being placed on the toilet regularly is upsetting. This routine within the first few days of hospitalization for untrained babies is marked by a dreadful fear that almost approaches panic. When seated on toilets, especially in the early morning, there is hysterical crying, trembling, hanging on to nurses' skirts,
holding on to nurses' legs or the bed for fear of falling over. Although they are tied to the leg of the bed so they cannot fall, this does not provide a sufficient feeling of security and sense of balance. Quite a few of the two and three-year olds protest against the routine of being tied into their cribs. They are tied in such a fashion that they are able to stand and may move halfway across a crib but when climbing over could not fall to the floor. Most children get used to this routine very quickly but a few continue to pull out of the harness as long as they are in hospital.

The three and four-year olds have a different problem; they are in a separate ward in low beds and are no longer tied. Partially dressed in the morning they are expected to remain in their beds. This is an outstanding problem for both the child and the nurse. There is no playroom nor adequate toys to occupy the child's time and the struggle is undesirable. Very few nurses are capable of handling this situation without loss of temper which is a rather unfortunate experience for both sides concerned. This age group also is one that suffers the separation from home most; they miss their parents, miss their freedom and have difficulty in adjusting to the different food. They favour dessert, but find it difficult to take milk, vegetables, and certain kinds of meat. To make the routine tolerable for the children and for themselves, the nurses are known to buy and bring in candies, balloons and other toys. The older children also
dislike the routine of rest periods and of restricting their freedom from being outdoors when they would wish to be.

Generally it may be concluded that the hospital routine was accepted quite well by adult patients, with some difficulty by infants and even more difficulty by young and older children. It seems likely that any comparable group of children in a white community would have similar problems under similar conditions.

4) The patient's response to hygienic measures

The staff respondents agreed that the majority of patients responded to hygienic measures well. Sometimes they go to extremes just as the Whites do. Those better educated were thought to show a better response. If patients are re-admitted, no matter how ill they are, they demand a bath. Women try to get more than two routine baths a week; men are always found in the shower at nights and when called out they remark that they did not get a chance to get into the tub during the day. If they happen to drop a towel they hand it back to the nurse and ask for a clean one because they have been taught that anything that drops to the floor is contaminated. Children consider washing and brushing their teeth a treat rather than a chore. The patients never need to be told that they need a bath and sometimes it is hard to get them out. Their hands are always clean. Some respondents thought that the patients are more fussy while in the hospital than they would be at home; this, of course, can be understood
in terms of available facilities and time. Apparently some of the patients carry home a good knowledge of hygiene and practice it after being discharged.

The patients' general attitude was that they enjoy cooperating with the hygienic measures required by the hospital. A few patients in their interviews voiced an objection to the tuberculous patients being mixed with the non-tuberculous; they felt that it was not right because contagion was possible. In general the patients refrained from criticizing the hospital, although a few mentioned that the windows were not cleaned and the table tops were neglected.

Thus it can be gathered that cleanliness depends mainly on the facilities available. In hospital, where these are available, the patients respond very well. Even the blind 90-year old woman enjoyed the struggle to get into the tub immensely and made sure that the nurse had washed her clean.

The tuberculous women who deliver their babies while at the hospital are permitted to keep their new-born infants at their bedside and are taught to take care of the babies themselves. These women deserve a great deal of credit as their babies, without exception, are very clean and well cared for. The patients took excellent care of their sputum containers and at no time was a patient seen or known to spit on the ground. Head lice on the new admissions are not often found. The discovery of this condition should not be a surprise in view of the generally unsanitary living conditions
in some Indian homes.

Observations by the investigator support some of the criticisms voiced by the patients that the hospital did not always set a high example of hygienic measures. Sometimes the bedside tables were dirtier than desirable. The patient's response to maple syrup with cockroaches in it was a refusal to eat breakfast. Many of the patients have a great sense of cleanliness. For example a patient who received 'clean' pyjamas of which the pants were heavily blood-stained, asked for an exchange. The next pair was the same. The housekeeping department had not done its job, but the head nurse's response to this incident was most remarkable: she adopted a helpless voice, facial expression and posture, and said: "Yes, we cannot do anything about that." This sheds bad light on both sides, on the patients for putting pants into the wash without taking care of them first, and on the staff for negligence and forcing dirt onto a patient who was not likely responsible for it.

5) The patient's emotional reaction to hospitalization

The interview responses of the staff indicated that hospitalization upsets patients when they are first admitted. Many patients lack the spiritual strength to cope with the change in their lives. Sadness, restlessness, depression, loss of appetite and withdrawal seem to be dominant symptoms which last for a number of months for most patients. Gradual acquaintance with other patients and adjustment to hospitalization helps them out of these states. The degree to which
hospitalization upsets a patient depends to a great extent upon the patient's home conditions; those patients who have families at home long for their children, and married people are concerned about the fidelity of their husbands or wives. A few patients may try to leave the hospital when emotionally upset.

The patients themselves state that these difficulties last for several months. They are worried about their homes, children, husbands, or parents. Crying continues sometimes as long as into the fifth month of hospitalization. Lack of money to buy cigarettes, soft drinks and other things available, increases the misery. Although the Social Service helps, a few patients object to its "digging too much into one's personal business." A few patients report having felt withdrawn for two months until other patients helped them come out of it, whereas the staff was of no aid. The first few days after admission on most occasions are characterized by bitterness against the whole world: the typical patient "Did not want to see anybody, nor hear anything."

The emotional reaction to hospitalization is greatly depend also upon two additional factors: whether the patient understands and accepts the fact that he is sick, and whether the patient has come willingly to the hospital, or has been forced to come. In cases where the disease and danger of contagion are understood, adjustment problems are much simpler than where hospitalization is thought to be unnecessary as an
alternative to treatment at home. The most severe reaction is displayed by the very few who are brought to the hospital by the Royal Canadian Mounted Police. When the disease is first discovered, the patient is called into the hospital. Sometimes the hospital waits for a patient as long as a year and when he does not arrive the Police are finally required to deliver him at the hospital. Such people, forced into hospitalization, often get a feeling of being jailed.

The observation records show that children around the age of three to five years react with marked withdrawal for a whole week; they are very quiet and show no attempt to climb out of their beds. The absence of the mother does not appear to evoke fear in the young child, although occasionally a child goes into a fit of crying when the nurse leaves the room.

A somewhat atypical case concerned the hospitalization of a 12-year-old girl who was brought to the hospital because of pregnancy and suspected incest. She was depressed, very quiet and fearful. She broke into tears periodically and would not speak for the first few days. Instead of being up and about she took to bed and would not leave it. She did not communicate with other patients for four days and when her home was mentioned she cried. This child was in an extremely painful position since she was not allowed to see her parents and relatives, nor to receive any phone calls. One of her relatives was hospitalized at that time too, but there was no
communication of any kind. There was a rumor that this girl's sister had four children by their father. Among the native people it holds fast that the girl must not give this secret away, or else she would make her return to the reserve impossible. When forced out of bed by two nurses to have a walk, the patient got gradually accustomed to talking with other patients and felt somewhat happier. To keep her occupied she was assigned to the rehabilitation program in which she spent one or two hours a day working on the ward. Her homesickness did not ease. With trembling hands and heavy pounding heart she came to the investigator and handed her the following letter:

I was just wondering if you will let me if I asked you to go home for a week or two. I'll feel better when I come back if you let me. I won't be as lonesome as I am now. I don't want to stay here all these months without seeing mom and dad. It will give me more exercise.

B.

Although she filled out an application for special leave she did not get the leave. Later, when the visiting restrictions were lifted, the girl made a good emotional adjustment.

On the whole, it appeared that the reaction to hospitalization was most severe for girls around the age of puberty. There was one occurrence of soiling by a 12-year old girl. In our society, the response of other children to such behaviour would be rejection and withdrawal. But the Indian children made friends with the girl and offered her
their moral support. Because of the genuine sympathy they receive from the other patients, these children recover from their first reactions remarkably quickly and in a few days are completely absorbed by their own age group of patients.

Being examined in the doctor's office is another difficult experience for a few adolescents. Typical of these was the fear reaction of a 12-year old girl who was brought in for physical examination on the first day after her admission; she became rigid with fear. Her whole body stiffened and the focus of her eyes became immobile. Fortunately she was brought out of this state immediately by the nurse who asked her an inconsequential question unconnected with the examination. Nevertheless, tightening of the muscles continued to be observable until the girl returned to the ward.

A few patients develop psychosomatic symptoms and complain to the doctor about heart palpitation, headaches, sleeplessness etc. One patient, realizing that her symptoms were due to worry and anxiety, sought help from the social worker. This woman had developed an anxiety reaction because she had nine children at home left in the care of a 16-year old girl while her husband worked at the canneries away from home. She felt that conditions at home were not satisfactory. Her parents could not help as one of them was blind and the other was crippled. Upon the patient's admission to the hospital her son had left high school and destroyed her future plans for him. She was worried because she could no longer help her family's progress.
A very severe reaction to hospitalization was observable in a 28-year old woman, a mother of ten children who was expecting her eleventh child. She cried wherever she went and admitted openly that she was lonely. She said that the other two women in her room would not talk to her. Although she followed the nurse's suggestion, and tried to talk and make friends with other patients, it was difficult because she spoke Cree which the other Indians did not know and her English was very limited. For a whole week she cried and spent sleepless nights and confused days. Her roommates were not very sympathetic and were annoyed at her bumping into their beds at night as she got up. This patient's main problem was that she did not feel sick and felt deprived of her family role for no good reason. She was admitted June 15 and continued to have problems as long as the investigator was in the institution, although latterly she began to engage in occupational therapy and made moccasins. Although the radio is a comfort and joy to many patients, it did not work out that way with this particular patient whose five-year old boy was sending a message to the hospitalized mother and started to cry during the broadcast. No doubt this set the patient back to where she was two weeks before when she was admitted. After receiving letters which carried the news that her father was very ill, this patient was found one evening outside the hospital grounds on her way to town. Most of the time she used to go for a walk in solitude, and, although the staff was concerned about the possibility that her baby would be
delivered in the bush, she could not be kept away from it. After her baby was born her behaviour stabilized, and she occupied herself looking after her baby. Also contributing to her adjustment was the admission of a new patient who could speak Cree; in him she found someone to whom she could speak.

An 11-year old girl displayed an unsatisfactory emotional reaction to hospitalization during her whole stay of 18 months. She often was lonely and reduced to tears, finding comfort only if she was allowed to visit an adult patient to whom she was attached. Since her admission, the nurses' records contained the following remarks:

<table>
<thead>
<tr>
<th>Date</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted February 12, 1959</td>
<td>A good child.</td>
</tr>
<tr>
<td>July 13, 1959</td>
<td>Displays fits of temper, otherwise a happy child.</td>
</tr>
<tr>
<td>October 13, 1959</td>
<td>Hysterics and crying.</td>
</tr>
<tr>
<td>October 29, 1959</td>
<td>Unruly, changing bedroom from two to eight, not permitted.</td>
</tr>
<tr>
<td>November 10, 1959</td>
<td>Temperament improved, but still has stubborn spells.</td>
</tr>
<tr>
<td>November 27, 1959</td>
<td>Refused food. Tray removed - wanted it, but not given; cried herself to sleep.</td>
</tr>
<tr>
<td>December 27, 1959</td>
<td>Improved, playing with other children, a good child.</td>
</tr>
<tr>
<td>June 19, 1960</td>
<td>Lonely to tears. Settled after visit with P.Q.</td>
</tr>
</tbody>
</table>

This child came to the nurse with three different complaints in eight hours; she complained of cold, then of painful eyes and finally of stomach ache. The next day she was crying and complaining that other children called her names. The following day she attempted to get the nurse's attention by
complaining of headache. This child was extremely happy when the discharge order was obtained, and said she would be lonely no more.

Indian parents show good judgement and consideration of their hospitalized child's feelings by taking care not to upset the child with their visits. On one occasion the parents had an 18-year old son and a four-year old son in the hospital. When they came to visit, they went into the older son's room, but did not show themselves to the little boy. They looked at the young child by hiding themselves behind the door and watched him through the glass of the door or window at a distance. They explained that they did not want the child to cry when they went away.

Correspondence, as mentioned once before, also has a lot to do with the patient's response to hospitalization. Letters frequently report a rumour upsetting to the patients, making them restless and drawing them home. Mothers receive the wrong information about the state of their homes and children; wives receive information that their husbands are faithless or drunken. Sometimes it takes weeks for the patient to get evidence which will confirm what is true and allow him to reject what is false.

It is not infrequent that Indians show little emotional expression even when deeply moved. This can be illustrated by an incident in which the investigator after her trip to Fort Babine was to bring greetings to a seven-year old
girl from a brother to whom the child was strongly attached. As the child was met in the hospital corridor, the investigator gave her the greetings and told her of seeing her brother and sister. The child stood immobile like a rock and just stared. No word was said. To the white person such a reaction is something unusual. Since it could not be believed that nothing went on within the child, the investigator put her head against the child's chest and became aware of an extremely forceful beating of the heart. A dry looking tear stood in her eyelashes, the only visible evidence that the child who had been for two years away from home was deeply moved. It cannot be said that such inhibition is typical of all Indians, but it occurs often enough so that emotional expression alone cannot be used as a reliable guide to the depth of emotional arousal.

6) Influence of visitors

No doubt all patients love to have visitors. If the Indian patients' people live a long distance away, visits are infrequent and separation brings unhappiness. During the summer when the canneries are operating, many of the patients' relatives and friends are employed there and are much closer to the hospital. At this time visits are more frequent, especially on the weekends.

Visitors, like letters, bring in good news, bad news, and gossip. Quite frequently a patient becomes worried on receipt of a visitor's news, and the hospital has to wire
his home to have the Indian Agent find out what the truth of the situation is. There are occasions when seeing visitors increases a patient's feelings of isolation and restlessness, and creates in him a wish to leave the hospital. Although infrequently, it has even happened that visitors have brought clothes to the patients so they could run away. Similarly, alcohol is occasionally brought into the hospital. Most husbands are sensible and enjoy regular visits with their wives, but a few keep persuading their wives to come home. One such patient goes home regularly, about every six months, without permission.

On the other hand, visitors keep the patients from becoming too lonesome and boost their morale. It means a great deal for the patient to have someone from the world outside the hospital come and see him. One patient said in the interview, "When my husband comes we talk about the future and it gives me more faith. It makes me feel that I have got to accept the time in hospital until I get well. It makes me happy. Often though when visitors leave it makes me want to go home too." About half of the patients' interviews gave an account of visitors making them homesick. Patients who often saw visitors reported that their departure did not arouse any emotions but joy that they had come. There are a few patients whose families live a great distance away, but they understand the situation, and, as a rule, do not fret about not getting visitors.
7) **The patient's trust in the staff**

When a new patient arrives, or when a new nurse comes to the hospital, there is a great deal of "sizing up" done by the patients. A stranger is not trusted immediately. But once a patient decides that the new person can be trusted, his opinion holds firm. The staff member is trusted in a shorter time if the patients are not looked at "from above," but rather accepted as equals.

Observations suggest that the patient's confidence is gained if the staff member takes the trouble to reason with the patient when certain of his wishes cannot be granted. The Indians are very sensitive people and if their query is answered with a very short "no," they suspect that there may not be a sufficient reason for the refusal. The proper and truthful explanation of a given situation leads to trust.

Most patient informants felt that they trusted those on the staff who deserved to be trusted. The observations show that, in general, patients trust the staff once they come to know them. There may be certain people whom they do not like as well as others, but as far as work is concerned, there is no distrust displayed. Only on one occasion did a patient display a general distrust of the white staff. This occurred when the patient and the nurse discovered that some other patient's specimen had been poured into the bottle which bore the patient's name. The patient was quite indignant about this mistake and said: "As always, anything is good enough for the Indians."
The Superintendent of the hospital is one important person in establishing and maintaining the patients' trust in the staff. One staff informant commented that the present medical Superintendent is wise because he never criticizes the Indian medicine. He lets the Indians take their own medicine but says the new medicine is stronger. The patients may not trust the medicine as much as they trust the medical Superintendent. There was no observable evidence to support the report that the patients were taking their own medicine in combination with that prescribed by the doctors.

Trust is a phenomenon which is not easily observable, nor does anyone like to display distrust openly. This was demonstrated when the investigator went to a distant village to visit a patient to whom a promise was given to do so. When the patient received the investigator in the house she was very pleased, but the first words she uttered were, "I did not think you meant it when you said you would come."

8) The acceptance of the patient as an equal by the staff

The staff members were very varied in their attitudes toward Indians. Prejudice ranged from high to nil. Those who were prejudiced put forth an effort to convince new white staff members to see things their way. The investigator did not escape this; an old nurse tried to point out how wrong and bad the Indians, in her opinion, are, but when no reinforcing response came forth, ended by saying, "You will see, you will see."
One possible indication that the staff regard the Indians as inferior, was the practice of calling all Indians by their first names. It was always Walter or Mary, never Mr. Brown or Mrs. Wesley. This was done regardless of the patient's age, whether 20, 40 or 80 years old. The only person who called his patients by their surnames and addressed them as Mr., was a registered male nurse who had spent a great number of years in the far north working with Eskimos and Indians. The practice implies perhaps a parent-child, superior-inferior relationship. The Indians, however, did not show any resentment of it.

It is also revealing to examine the relationship between the white employees and the Indian employees, a great number of whom have been patients in this hospital. Even though they have recovered, have been taught their work, and carry an equal load, they are not accepted as equals by nearly half the white people on the staff. This observation is confirmed by the interviews.

The registered nurses, who are all white, live on the second floor in the residence and have their own entrance. The nurses' aides live on the ground floor and share their baths, pantry and other facilities with the Indian maids and nurses' aides, who occupy the same floor. One of the white nurses' aides made the following statement: "What are we? Second class citizens that we have to live on the same floor where their rooms are?" A few of the white nurses' aides
objected to the Indian nurses' aides getting the same salary. Dirty bath tubs, food disappearing from the refrigerators, excess noise, none of which the investigator ever happened to observe, all were blamed on the Indian staff. In the registered nurses' quarters the same complaints were heard and shortcomings observable, although Indians never used the facilities on the upper floor. Bath tubs were left dirty, food disappeared, and, although considerably fewer people lived on that floor, a few occupants still complained of noise. The Indians were blamed behind their backs for stealing fruit juice in the hospital but there was no evidence to support that fact.

Although the white staff are instructed not to provoke or argue with the Indian patients, a few behave with subtle hostility. Indian people, sensible as they are, observe this with tolerance. Hostility is displayed by a few nurses toward the patients if the slightest occasion is provided. For example, once a patient was given a permit to leave the hospital with extended time if necessary, due to a death in the family. Before this patient had a chance to return, a few of the staff were talking about her having run away. The patient returned in due time. The staff who do not accept the patients as equal show very little tolerance toward Indians for happenings which in our society although not approved of, nevertheless occur. Thus one nurse, when she reported in the book that a newly admitted child had head lice, went into an unnecessarily forceful description:
"Very lousy + + + + + + + + + + + + + + + + + + + + + "
It looked as though she tried to put down a cross for every louse. Another nurse shouted a loud warning all through the ward when the investigator went to visit a child who was having a treatment for head lice. It sounded as if the child had leprosy.

One important factor standing in the way of acceptance of these patients as equals, may be the value system that the white people hold and their lack of understanding of the Indian way of life. For example, the patients may be looked down upon for common-law marriages regardless of the fact that what we call common-law marriage is the old Indian custom of marriage. They took their wives without ministers and formal ceremony. We frown upon incest and so do the Indians in spite of being "cooped up in one room." Incest occurs in both societies, but, because we have laws and a higher standard of living, we look at it with a much stronger revulsion.

The perception of the patient as less than an equal by a few of the staff probably results in lowering the quality of nursing care. Those nurses who already had sloppy work habits probably allowed themselves to become more careless. It was observed when children were given medicine that the majority of nurses took no care whether the child swallowed it or spat it back.

The superiority felt by a few of the staff also prevents sympathetic understanding in such cases as the
following. A patient weighed herself and expressed the wish
to take some medicine to improve her appetite and so gain
weight. When this was referred to the head nurse she affected
a helpless expression and said: "We have done everything.
In the beginning when she came she would not cooperate and
now there is no more hope. It is too late. She will not get
good." It also happened that a girl of approximately six
or seven years of age did not receive slippers for more than
a week after the order to let her out of bed was given. The
slippers were all the time in a cupboard in the ward office
and the head nurse was reminded almost every day that the
child must stay in bed because of the need for footwear.
However, the child got them on the day of discharge.
Similarly there were times when the older children were kept
by the nurse in charge from going outdoors when the weather
was suitable. The investigator observed in them some aggressive
feelings towards the nurse who would not grant the permission.

One patient respondent reported the following:
"My husband took me out for a ride and I was reported by the
night nurse. The charge nurse threatened me with Oakalla if
I ever do it again. She called me out right in front of my
husband and he scared to come now and has not been here for a
whole week although he is only eight miles away. They do not
call me to the phone when he calls - say I am busy, and when
we talk they tell us to hang up after a few words. Mrs. -
took my new sweater away to the clothes closet without
telling me or asking for permission. Also the girls run away
because they treat us that way. Each time Mrs. — comes she just throws the tablet at me; shakes her finger at me."
Another respondent reported that the nurses sometimes are not kind enough in the way they ask the patients to do things. A 12-year old respondent stated that sometimes they are forced to eat up all their food even though they cannot eat any more or else they do not get permission to go outside.

As to the nature and level of prejudice, it can be concluded that it varies widely among the staff members both as to quantity and manner of expression. Many staff members are widely tolerant but a few are intolerant. This prejudice conveyed to the Indian patients causes some difficulties in the patient-staff relationships and reduces the quality of nursing care.

9) The expression of aggression by the patients and how it is dealt with

A survey of all the data gathered shows that overt aggression is not too common. When it occurs, its expression differs with age; the younger male patients once in a while fight with their fists; the elder groups complain. If there is an argument between the patients in one room, the patients involved are separated by being placed in different rooms. A few show aggression by being uncooperative and moody. One respondent reports that very occasionally an Indian patient calls the staff names and curses them.
The staff are under orders not to antagonize the patients and not to get involved in disputes, but to report differences to the doctor. Habitual trouble-makers, if they are not too sick, can be discharged. In the rare fist fight the patients are separated; nothing else needs to be done.

One way of expressing a mild aggression among the adolescent group is talking and being noisy during rest periods or at bed-time. This occasionally happens when they get a dominating nurse. Such a nurse usually resorts to some sort of punishment, such as prohibiting them from going to the movies or some party that occupational therapy has planned for the group. Sometimes the removal of clothes so that the adolescents cannot go outside was used as punishment. In an extreme case, the investigator observed a nurse pulling down the blinds in midafternoon and forcing the whole room of youngsters to lie down in their beds in the dark.

An employee who had formerly been a patient felt that should a patient become aggressive toward a staff member for a good reason, it is always wise for the staff member to apologize, as that brings the patient out of the aggressive state very quickly and to a ready belief that the staff will do better next time. This general philosophy is used by most of the staff. Mild forms of aggression are usually permitted and are best ignored.

One respondent cited a rare event where a girl was dumping bedpans at the staff. This could not be ignored,
and since the patient was not a tuberculosis patient, she was discharged. Just as rare as the above-mentioned case was the aggression of a patient who wanted to go home. This old man trembled with anger, his eyes filled with tears, his voice was threatening and tearful, trying to convince the staff that he was kept in the hospital although he was not ill and deserved to be discharged. He further showed his aggression by pushing his medicine away and refusing to take it. This initiated arguments with other patients who were sensible and understanding of the situation and tried to reason with him. Since reasoning was impossible they became involved in arguments and finally the uncooperative patient was transferred to another room. Aggressive adolescents are occasionally moved to the ward of a younger age group, which to them is a great "loss of face."

One way of expressing aggression is leaving the hospital for a brief period. This behaviour was mentioned by the respondents of both groups as well as being directly observed. It occurred twice during the period of four months needed to make this study. A very few patients when they ask for leave and do not get it, become angry and go away without it. A female patient previously described (the patient who was threatened with Oakalla jail) left three times and had to be brought back by police, however her sputum was positive. Two of the staff respondents stated that the patients are "right now" people in that whatever they want must happen immediately. If their wishes cannot be granted immediately,
the patients respond very well to reasoning or to the use of humour.

A rare burst of emotion by a 12-year old child during the interview on the afternoon of the same day on which she ran away went as follows: "People say it's good here, that's why they put me in here; instead, they are mean to me. Miss - pushes me around too much, that's why I don't want to obey her, she was pushing me into bed, lights out, blinds down since six o'clock. She did not let me go to the show. This for talking in rest period, threatened me with Dr. -. All trouble starts when she is on; she always puts us to bed. Mrs. - always takes my housecoat away when I do little things she does not like. Nurses just keep on talking, never let anyone explain, just you and Miss - never scold me once, the rest are too mean. Sometimes we are forced to eat up all the food even though we can't eat any more, or else, they don't let us out. Too strict, don't let us walk around; sometimes in the morning when we could go out they keep us in. If they will not do something [about that] I will tell everybody, we will run away." There were a lot of tears shed during this interview and the child appeared to be homesick. The very same night at about 9:15 p.m. this girl with three other girls of approximately the same age and four male patients of the age of about 20 years, walked out. All the girls had been involved in the same situation of punishment that afternoon, but the men were not. The girls left in their housecoats, walked up the pipeline to Oliver Lake three miles
distant and returned on their own at 2:45 a.m.

This was a very unpleasant experience for the staff and it was agreed that there was sufficient reason for the patients to rebel. After such occurrences there is an investigation by the matron on the next day and the doctor has a talk with the patients if it is considered necessary. Thereafter the issue is dropped.

A few years ago, before the coming of the present Superintendent, the Miller Bay hospital had two detention cells. The relationship between the patients and staff was said to be remarkably improved since this Superintendent eliminated these detention cells. A doctor stated that since the abolishment of the detention cells the running away of patients has dropped very sharply. In general, the new Superintendent has remarkably improved the atmosphere in the hospital. Figure illustrate the drop in the rate of patients running away (see Appendix A).

10) The patient's initiation of social activities

The general opinion of the staff was that the patients initiate few social activities. This could easily be understood because many factors are against it; their lack of contact with other people and other communities who might give them some stimulation; lack of financial resources; lack of recreational facilities in the hospital; differences in their educational and cultural backgrounds. This rather negative view by most of the staff members was not confirmed
by direct observation.

The patients who attend school edit a monthly journal called *The Golden Hawk*. It contains jokes, stories, riddles and information about current events. The first issue of it was a senior class project. It contained about ten typewritten long-format pages.

One of the patients owned a record player and on Saturdays the patients' requests for certain songs were collected and played over the broadcasting system within the hospital. Songs were played for friends and sometimes also for a favorite nurse.

A great number of patients engage in letter-writing. Reading books and magazines is a favoured pastime. Quite a number of the patients appear to be subscribers to the Indian newspaper *The Native Voice*, and they seem to read it carefully from cover to cover.

The male patients tend to be more engaged in group activity than the women. They like games and music, and have a great feeling for rhythm. Often one of them would play a stringed instrument and others would gather around and sit and listen or sing.

Although there are wide differences among them in terms of age, education and language, at one time the patients managed to initiate the organization of a band. They made their instruments by making use of a washtub, a pot and a
waste paper basket; one respondent communicated that it was "a good show." On another occasion two boys who played guitars got together with others in a sing-song, found someone else to play a different instrument, and finally organized a band.

The men do jigsaw puzzles, play cards, cribbage, checkers, croquet, and do leatherwork. The women pass their time making moccasins and gloves and sewing, crocheting and knitting. Both sexes love to go for walks, but the weather does not offer many opportunities, since the summer is very short with few sunny days. Miller Bay is a sanatorium in a very rainy and wet area.

In spite of the critical attitude of the staff, it appeared to the investigator that the Indians indeed showed considerable initiative in organizing social activities. When they lack this initiative it is partly due to their illness which makes them become temporarily depressed.

11) The patient's reaction to social activities planned by the staff

Once a month the patients are responsible for organizing a radio program: they are encouraged to select songs which are broadcast to their friends in 'Radioland' (their friends and relatives at home). The program is selected with the help of the teachers, taped the evening before, and put on the air at 9:30 a.m. on Sunday. This program started in May 1959 and the patients are very proud of it.
All respondents expressed the opinion that the patients are very responsive to social activities planned by the staff. They enjoy bingo and all movies, good or bad. In the preparations for Christmas parties, everyone catches the spirit, becomes involved and does something.

Several respondents stated that the staff are too busy with their routine work to help and organize social activities for patients. Except for children's birthday parties, the occupational therapy department is fairly inactive in this area. There are no dances and no dining-rooms for the patients, and these are two circumstances that might facilitate exchange of ideas and encourage some social activities. An orderly reported that he used to put on a musical entertainment once a month but that it was hard to find staff interested enough to help him. Consequently he was forced to drop the show.

For those patients whose health has considerably improved, there is a rehabilitation program. The women engage in nursing for up to four hours daily; the men work part-time in the laundry or housekeeping department, or work as orderlies for four hours a day. Uniforms are provided by the hospital. It is not only a social activity but also a healthy way of releasing excess energy.

Boys from the age of 8 to 14, if they are ambulatory patients with negative sputum, are allowed to join the Cub organization. The main objective is to give them enough
Cubbing so that they would be able to start Cub groups on their own reservations. All the boys enjoy it. The membership of the group varies from four to ten patients. The boys are allowed to leave the hospital about three times a year and join the events of the Cub organization at Prince Rupert. Their weekly activities consist of hikes and meetings. They learn the Cub manual, campfire sing-songs, games, exercises, first-aid, growing of plants, telling the time, making book covers and other useful things. Their uniforms are bought with money from the Cub Fund. This fund in the hospital is financed by the district Cub council, local donations, mostly industrial, and the returned Coca-Cola bottles from the hospital. The Cubs do not raise funds themselves, nor do they pay fees. The uniforms belong to and are kept by the hospital. Only the badges belong to the boys. The boys are proud of their membership in the Cubs. They wear their uniforms to the meetings weekly. There is stress upon good health and hygiene so that they can carry on when they get home. Belonging to this organization makes them realize that learning takes effort, especially when they see their fellow Cubs with their achievement stars.

The Girl Guides follow the same pattern, except that they do not participate in outside activities in the community. There is a differential training in manual skills and learning with the emphasis on safety, child care, and home-making. The girls, like the boys, attach great value to belonging to this organization.
All those attending school are divided into two groups. The junior group includes pupils from grades one to six and attends school from 9 to 12 o'clock; the senior group, grades seven to twelve, attends school from 12:30 to 3:30 p.m. The number of pupils in each of these grades varies and at the time of observation the junior school consisted of 14 patients and the senior school of 9. The study period suffered interruptions sometimes when the pupils were taken away for x-rays or arrived late because they had to wait for their injections. A few of the pupils have a double task, having to learn both the curriculum and English at the same time. The teachers attend each child separately, although some illustrations are given to all on blackboards. Both teachers feel that the instruction in the English language is extremely important. Observations suggest that these pupils did not have a very long attention span. Even though they had a recess, they showed several signs of restlessness, like dropping pencils to the floor on purpose, biting pencils, and foot-stamping. Thus it can be seen that teaching these children requires patience and an objective attitude on the part of the teacher. Their handling requires great skill and tact. The curricular emphasis is on mathematics and English: spelling, reading, grammar and comprehension. Sciences, too, are taught, but because in the normal schools to which these children will return there is repetition of this subject and an overlap between years, the loss during hospitalization is not so great it could not be made up for in a regular school,
and less emphasis is placed on Science. Teaching equipment is provided by the hospital and the teaching program is based upon the provincial curriculum. Discipline involves no punishment of any kind, the teachers feeling that children lose faith in education if they are scolded.

One pupil may work on different grade levels in different subjects. The objective is to make sure that the patients do not slip back from the level which they were working in when they arrived in hospital. Both teachers appear to be very interested in their pupils and are able to motivate them very well. Homework is difficult to assign and to expect since there is no room where the pupils can study after school hours.

The privilege of going to school is not limited to the school age group alone. Anybody who wishes to continue his education may attend. There have been instances where older people who were illiterate, enrolled in school and learned to read and write during their stay in hospital. The children go to school willingly and there was no observable encouragement needed to get them off to the classroom.

12) The patient's plans regarding his future after discharge

Most patients do not have any specific plans for their future after discharge. They expect to return to the reservation and continue their previous way of life. The younger ones return to school. Mothers return to their families and continue to keep house and look after their
children. A few patients wish to go on the staff of the hospital after they are discharged. Although there are not enough vacancies to accommodate them all, some are hired and the high turnover of the white staff opens up the possibility that, in time, most of the positions not requiring registered nurses may eventually be filled by Indians. Although the patients learn leather-work and carving, very few choose these skills as future occupations.

The future of the man depends upon his education. If a man has had a chance to go to school, it is easier for him to get the less strenuous sort of job which is desirable following the treatment of tuberculosis. For those men who return to reserves the Government provides relief, allowing a certain amount of money for groceries and heat until the man is able to work again. The Social Assistance rate is $22 a month for a man, $15 a month for his wife, and $12 a month for each of the other family members. Most of them return to fishing and logging, and despite the strenuousness of the work, continue in good health. About 50 per cent of the patients who are considering changing jobs following discharge, discuss their plans with the social worker. The latter commented that a growing number of patients like to go to school and that the Vocational School in Vancouver is becoming extremely popular. However, it is hard for many of them to enrol there because most only have education up to grade 8 while the Vocational Institute requires grades 10 to 12. For those who have passed the age of 16 and are out of school, it is hard
to re-enter because the Indian Affairs Branch is not enthusiastic about sending them back to school. A few girls would like to do typing but most of them are not competent enough in English. Some patients have been successful in securing a job delivering mail; some work on the railway; and some have obtained positions at the cellulose plant. A very bright Indian patient, after discharge, worked for a few months as an orderly, then sought work with the cellulose plant and received a promotion fifteen minutes after being hired. He was removed from hard labour and was put on a salary of nearly $5,000 a year. The whole white staff at Miller Bay were very happy for this patient's unusual good fortune.

The social worker said that Indians have difficulty in changing jobs also because of prejudice: white people are hesitant about hiring them without knowing them.

13) The problem of alcoholism

In the hospital there is no real problem of alcoholism to speak of. When patients go on leave, they may return drunk but their behaviour is under control. Some staff respondents stated that although it happens very seldom, once in a while visitors bring in some alcohol, typically a small amount. When it is found by the staff, it is removed, if the patient agrees. If not, the doctor has to talk to the patient from the point of view of his health. Usually when liquor is smuggled in, the fact is discovered only after it has been consumed. The records show that if some patients
do get drunk they are noisy, but outside of that there are no real problems. Patients well enough to continue their treatment at home, who repeatedly return to the hospital from leave in a drunken condition, are discharged.

Several white respondents reported that alcoholism is dependent upon the area from which the patient comes. Patients who come from Hartley Bay would not take a drink, but others from Moricetown and Babine would never refuse a drink. There was no evidence from observations to support this statement.

14) **Irregular leaves and discharges**

A doctor reported that since the present Medical Superintendent has taken his post, and instituted a permissive attitude towards the patients' coming and going, discharges against medical advice have dropped suddenly and sharply. It also seems likely that modern effective treatments of tuberculosis requiring much shorter periods of hospitalization, encourage patients to stay in hospital and get well.

Under the present system, to lessen the burden of isolation and to relieve restlessness, the patients who have negative sputum, and are allowed out of bed, and are not given streptomycin injections, may receive permission to go on leave from one to three days. For some patients the leave may be granted for as long as several months.

A respondent reported that seven or eight years ago
the patients would run away and hide in the canneries to return when hungry. Now this does not happen any more. Now, only a few patients misuse their leave and do not come back on time. On rare occasions, the police have to bring them in if they are active cases. Any unauthorized absence that still occurs, takes place after some punishment or refusal to grant leave. The patients, as a rule, return very shortly and real desertion rarely occurs.

Another kind of running away seems to be due to the adventurousness, irresponsibility and carelessness typical of the adolescent group. For example, a 17 and a 20-year old patient went, without permission, to meet their girl friends in the town. They were discovered to be missing at 12:30 a.m. and returned at 4:30 a.m. They were happy for having had a good time and could not stop giggling like a couple of children, the whole of the next day. One of them, who had come for tuberculosis review, was discharged, but the other patient whose sputum was positive was moved to a room closer to the nurses' station. It is suspected that clothes for these escapades were brought in either by friends from outside or by some Indian employee not on the nursing staff. When this happens the doctor always speaks to the patient and discusses the situation fully from the standpoint of the patient's health and the potential danger to those with whom he may come in contact. The doctor is respected and the situation does not repeat itself.
One instance of a more serious intent to run away was planned by four girls; one 14, one 13, one 12 and one 9 years old. The 13-year old girl encouraged the three others to come along and at 11 o'clock in the evening they set out for Port Edward. The youngest of them became frightened while on the highway, the two others felt guilty and afraid of their parents and the three decided to return. The initiator lacked the courage to stick to her plans and returned also.

In another case a patient encouraged by her husband, discharged herself against medical advice. The certificate signed by the patient contains the following:

This is to certify that I am leaving Miller Bay against medical advice. It has been explained to me that by so doing I may develop complications from my disease and also may spread it to others. I will do the best I can to take good care of myself and to protect other people from my infection.

..................  ..................
Witness
Date ...........

This patient was found working in the fish cannery eight miles distant from the hospital. A visiting interne recognized her and told the Indian population that she was contagious and should be in a hospital. When her condition became known, the other workers in the cannery completely ostracized her. Working under such circumstances became
unbearable to her and she returned to her home in Hazelton. The doctor decided that she should be brought back to the hospital when her husband finished his work in the canneries and could no longer easily reach the hospital to demand that she leave.

15) **Sexual behaviour of the patients**

Reports from the staff gave contradictory data about the Indian patients' sexual behaviour. About one half of the interviewees stated that the patients' sexual behaviour was conventional. Either they did not know of or had not observed any abnormal or excessive sexual behaviour. One respondent, on the contrary, said the following: "As soon as the men and women are together they are at it; husbands come here for that purpose and they go to the bush. They have also been found in the wives' beds, therefore they are not allowed to visit patients in bedrooms. Outside, any shack will do. Usually another patient is on guard. This may be due to the lack of privacy in their own homes." A few staff respondents stated that the staff tried to keep the two sexes apart. The majority of the answers pointed to the fact that although some kind of sexual behaviour surely goes on, it was not observed by the investigator in the hospital. The social worker stated that sexual activities are one of the chief recreations among the Indian people normally and that they are much less inhibited than we are. The investigator's observations could neither confirm nor deny it.
Since the Indian people have received many criticisms and accusations regarding their sex life from the white people and appear to be sensitive to it, the patient interviews did not include this question, in order not to jeopardize the cooperation of the patients and their willingness to be interviewed. If any of the patients had been questioned regarding sex, it was clear that the news would have circulated immediately to other patients and subsequent interviews would have suffered. The sexual behaviour of the Indian patients had therefore to be inferred from such observations as follow.

"Passion marks"* were observed on a number of patients' necks and also on the necks of Indian employees. A girl may try to cover these marks while on duty but will not rub them out saying that her boy-friend "may get angry." Thus it appears that "passion marks" among the Indian people may be a kind of labelling or symbol of proprietary interest.

The male patients are often observed to flirt with the maids. One night at one o'clock the orderly discovered two maids on the balcony in a patient's bedroom. They had brought in some liquor and were drinking. When sent away, the maids continued the drinking in another room with some other male patients. These girls were dismissed the following morning; the patient on the balcony was discharged until the

* Blood under the skin caused by suction from kissing.
time he was to return for lung surgery; and the two young men in whose room the party continued were transferred to quarters closer to the nursing station.

The affection of the 15 and 17-year olds is sometimes observable in that they take walks hand in hand around the hospital buildings and order records of love songs for each other on Saturday morning broadcasts. The girls of 12 to 16 years of age are observed to write erotic love letters to the male patients and to give them to the nurses to be delivered. It was observed that the nurses sometimes read these letters previous to delivery and if they found the contents too exciting, did not deliver them. The investigator wondered whether the adolescent girls did not do this intentionally to shock the nurses, because it would have been just as easy for the girls to deliver the letters by other patients who would not destroy them.

One female patient was reported to have been very much in love with a male patient who had another girl. The unrequited lover lost her appetite; could not sleep, and used to watch his window attentively and jealously. One night she was found on the male ward in bed with this man. The girl was discharged but he remained until the two mentioned above were found in his room.
CHAPTER VI

CONCLUSIONS AND SUGGESTIONS

A. Conclusions

It is evident that the patients' adjustment to hospitalization is not a one way process. It depends not only upon the individual patient and his personality but also upon external factors. Some of these are: the patient's previous contact with white people or degree to which acculturation has taken place; and the conditions that the hospital offers, including the personnel, cleanliness, regulations and physical facilities.

The patients' attitudes toward life and illness showed as great variety as they would in our own society. Some patients were extremely upset by the knowledge that they had tuberculosis and their early reactions on the whole were to become depressed and give up the struggle. In a few months they changed their philosophy of life and began to organize their energy to fight the disease so that they could eventually return to a productive way of life or start their life anew. Some other patients had no special feelings about life and illness but took things and events as they came and were reconciled to the disease without special reactions. Few among them led a vegetative existence.

The interview data of the white respondents on the
Indians' acceptance of the diagnosis and understanding of the disease was quite contradictory. One of the doctors felt they understood and accepted the diagnosis once it had been explained, but an interne was convinced that although the Indians said they understood, actually they did not. The nursing staff interviewed expressed the opinion that the understanding of the disease varied with the intelligence of the patient. The patients themselves stated, with few exceptions, that they did understand the disease and accept the diagnosis. The observation data revealed a discrepancy with this generally voiced opinion in that some patients did not take their medicine every time it was given and that sometimes it was found out the window. However, on the whole, it was true that the patients did take the medicine willingly. The explanation of the illness by the doctor and the x-ray films shown to the patients appeared to give them some sense of responsibility and willingness to cooperate with the doctor and to do their best to get well.

The acceptance of hospital routine and orders on the whole was good. Small breaches were tolerated by the staff as they had no serious consequences to the patient's health. The greatest difficulty was presented by the rest periods which most of the patients did not like, but on the whole when reasonable and firm demands were set by the staff, the patients complied. Another area of struggle was that of keeping the patients within the hospital limits. Young men were occasionally seen to take short distance walks beyond
the hospital property on the highway but on these occasions they returned promptly when they met staff members and were asked to return. This probably happened because the hospital did not have sufficient grounds for the patients' walks. Going on leave without permission happened, but not too frequently and the patients always returned on their own. On the whole the patients conformed and accepted the hospital routine very well.

The patients' response to hygienic measures was good. The better educated patients showed more understanding of hygiene and as a result showed a better response. In such cases they expressed objection to being mixed on wards with non-tuberculous patients. They all enjoyed their baths and kept themselves clean. The new-born infants were well taken care of by their mothers. The patients' adjustment to hospitalization in this area was favourable.

The patients' emotional reaction to hospitalization was one of the most difficult areas to investigate. Although most of them tried to hide their emotional difficulties, in a good number of cases it could not be concealed. Sleeplessness, palpitation of the heart, tears and withdrawal were the observable symptoms. It required quite a long time to overcome the emotional difficulties which were perceivable as a barrier to a sound adjustment but these were the most difficult to cope with. Establishment of friendships with patients who had been in hospital for a longer period was
reported and observed to be the most helpful act. The most severe reactions to hospitalization were observed in the patients who were at the age of puberty, but these were not long-lasting as adolescents make friends quicker than adults do. Infrequently it happened that some children could not adjust emotionally during their whole stay in hospital. Some show it openly but others conceal it and it takes a special event to bring it to the surface.

The influence of visitors favoured adjustment to hospitalization. It lessened the feeling of isolation and reassured the patient that his home was functioning adequately in his absence. But rumors also were brought to the patients and upset them at times, but this, on the whole, did not diminish the value of visitors. The negative results of having visitors were to cause restlessness and to ask the married partner to return before the treatment was completed. However, this did not happen too frequently. Most husbands encouraged their wives to stay and get well.

The patients' trust in the staff was a function of time. Indians do not trust a stranger immediately but first observe him. Observations and interviews show that the staff members who deserve to be trusted, are trusted by the patients. The Superintendent of the hospital was an outstanding success in establishing trust in the institution as such by the patient. His wise leadership was of indispensable value.
The acceptance of the patient as an equal by the staff was a sensitive area. Superficially the staff members tried to demonstrate that they accepted the patient as their equal, but it was quite evident in many cases that they did not. The fact that all the patients were addressed by their first names was the most open and obvious evidence of discrimination. That the feelings on the white employees' part must have been strong can be deduced from the fact that the hospital administration had set a rule that the employees were not to engage in arguments with the patients. The non-acceptance of the patient as equal was best observed in off-ward situations where the employees felt more or less at ease and able to express their opinions with no danger of being overheard by Indians. It was suspected that negligent work by nurses was stimulated by their difficulty in accepting the patient as an equal.

The expression of aggression by patients was infrequent and when it appeared, it was in a mild form. On most such occasions it was felt wise to ignore it and the patients would come out of it on their own. If the patient became aggressive toward the staff for a good reason, it was found wise to apologize. Aggression showed the greatest discrepancy between observational and interview data. The verbal accounts of the Indian respondents showed the effect of socialization and striving for acceptable behaviour within white society. From the observational data and the reports of the staff it could be gathered that the commonest form of
expressing aggression was ignoring the rest periods and running away from the hospital for a period of hours during late evening and night. This also appeared to be an open demonstration which followed some misunderstanding with the staff. The situation of leaving the hospital was always investigated the next day. If the patients were found to have a reason for being aggressive, they went unpunished or else the doctor in charge had a talk with the patients. Adolescents expressed their aggression by crying when their wants were frustrated.

Despite the information by the staff that the patients' initiation of social activities was small, observations showed that it was considerable. When it took place it favoured greatly the patient's adjustment to hospital. Group activities were hindered by lack of financial resources, facilities in the hospital, differences in social background, and to a certain extent the hospital routine itself was an interfering factor in the patients' activities. For this reason the self-initiated activity groups were usually small and informal.

The patients were very responsive to social activities planned by the staff. They enjoyed all shows, broadcasting, school and the rehabilitation program. The adolescents took great interest in the birthday parties planned for them by the occupational therapist and the Girl Guides and Cubs were proud of their membership in those
organizations. All these activities help to fill the patient's day and help him in adjusting to hospitalization.

The patients' plans regarding their future after discharge were dependent upon their role in a family setting. Wives planned to reassume their place in the home, children planned to return to school. A few patients entertained the hope of joining the staff in the same hospital. Due to the turnover of the white staff it is possible that most positions not requiring registered nurses eventually may be filled by Indians. Lack of education and prejudice of the white people was mentioned as a barrier to the Indians in finding employment in the white society. Most men therefore return to their previous jobs of fishing and logging. If they intend to get less strenuous work, which is desirable after the treatment of tuberculosis, they discuss their plans with the social worker. The Vocational Institute in Vancouver is becoming increasingly popular but many are hindered from entering it because they do not have the required education.

Alcoholism did not create a problem. The consumption of alcohol was very infrequent. Sometimes a patient who was on leave, returned in an intoxicated state, causing no trouble within the hospital. It rarely happened that alcohol was brought in by visitors. If the patient returned from home repeatedly in an intoxicated condition he was discharged if the condition of his illness permitted the doctor to do so.

Irregular discharges can be considered as an
indicator of poor adjustment to hospitalization. Discharges against medical advice happened but much less frequently than they did in the past. The present Medical Superintendent with his permissive and humane attitude, is said to be the cause in the drop of irregular discharges. Another factor that encouraged the patients' stay in the hospital until they are well is the improved, modern medical treatment which has shortened the hospitalization time.

Young, irresponsible patients were observed to desert the hospital for a few hours during the night to date their girl friends. If their sputum was negative, these patients were punished by discharge; if their sputum was positive, the doctor had a talk with the patient, pointing out the danger to the patient's health and the health of those with whom he came in contact. Thereafter such patients were watched more carefully. A few irresponsible husbands encouraged their wives to sign discharge papers against medical advice. This was permitted, but if the patient's sputum was positive, the patient was brought back to the hospital when favourable conditions for compliance with treatment arose. Although seldom, it did occasionally happen that adolescents formed a group of three or four with the intent to run away. Usually they did not get very far as the uncertainty of the situation and fear brought them back.

The sexual behaviour of the patients was hard to observe. White respondents gave contradictory data about the
patients' sexual behaviour. Most of them claimed it to be conventional. A few respondents stated that sexual behaviour was going on. A few others stated that the staff tried to keep the two sexes apart. Observation of "passion marks" indicated that some sexual behaviour took place. The male patients flirted with the maids but this is not characteristic of Indians alone since the same happens in the hospitals of Whites. Although the adolescents wrote erotic letters to the male patients and gave them to the nurses to deliver, these may have been produced with the intent to shock the nurses rather than bear sexual significance.

B. Suggestions

There was a considerable amount of prejudice found among the white staff members. This prejudice was a subtle problem to the Indian patients' adjustment to hospitalization. Future studies of the adjustment of Indian patients to hospitalization might profitably focus on prejudice, in order to work out how to avoid it.

Although the language barrier is an area of difficulty in adjusting to hospitalization, it does not seem to be worth further investigation as the younger generations are improving in their ability to communicate and further progress is expected.

The patients' emotional reactions present many problems. This is an area which will be especially hard to
free from difficulties. A long-term hospitalization will inevitably affect people's lives and they will react to it. It may be worth while to investigate how these patients should be dealt with and whether besides the work done by the social worker, occupational therapy and rehabilitation program, anything more could be done by the staff.
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## APPENDIX A

### Yearly Number of Discharges

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