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## Executive Summary

When governments invite the public to participate in consultations to reform health care and other policies, they generally represent themselves as calling upon citizens to engage in a social, but apolitical process. This study questions this representation by rethinking how policy is formulated and enacted and by rethinking how Aboriginal women are regarded when they engage in the health care system.

This report constitutes the second of two phases of research conducted in collaboration with a First Nation community in north central British Columbia. In the first phase of this study, we explored First Nations women's encounters with mainstream health services, and the unequal power relations that shaped their experiences (Browne & Fiske, 2001; Browne, Fiske & Thomas, 2000). When we discussed the findings from Phase I with the research participants, several of whom were leaders in Aboriginal health, they proposed solutions to persistent inequities in health and health care, which they grounded in notions of health policy reforms. Underlying their policy recommendations was a call for a more representative and responsive health care system that would incorporate greater First Nations input into program design and system management. Critical reflection on the women's recommendations led us to consider how and why their voices are erased in policy reform and how this might be changed. As we tracked the outcomes of Aboriginal women's efforts to change health policies, we became aware of barriers to change that are inherent in policy practices themselves. This led to the second phase of our research, described here, which considers health care policy within the context of government-sponsored policy "reform" consultations with citizens and within everyday encounters in health services where policy is implemented. We are specifically concerned with the paradox of positioning First Nations women as empowered citizens in dialogue with government while First Nations women are elsewhere represented as undeserving patients within health care services. We refer to the latter positioning as the construction of First Nations women as "discredited medical subjects." [1]

**As we tracked the outcomes of Aboriginal women's efforts to change health policies, we became aware of barriers to change that are inherent in policy practices themselves.**

Critical discourse analysis provides the analytical framework for this paper. Such analysis primarily investigates how social power and inequality are produced, contested, and resisted in social and political arenas of society. Rather than "collecting data" from research participants, studies employing critical discourse analysis examine the meanings embedded in various discourses. In their examinations of health policy and calls for policy reforms, political arenas, government dialogues, and the media, researchers

are directed to question what often gets taken for granted in communication and social relations. Drawing on critical discourse analysis in this report, we focus on Aboriginal women's experiences as citizens engaged in policy consultation and how they come to be conceptualized in policy discourses, and in turn how this conceptualization is entangled in other political practices.

**Health care policies produce and are produced by a range of encompassing discourses that shape our suspicions and doubts about particular people or groups of people.**

We have chosen several cases in order to illustrate concrete and detailed examples of public consultations and their outcomes related to First Nations women. The selected cases include: two Royal Commissions, the provincial referendum on treaty settlements, a recent consultation with Aboriginal governors who served on regional health boards, and a key recommendation made by the First Nations women in Phase I of our study, who expressed faith in policy as a mechanism through which to address their concerns related to health care. Analysis of these cases reveals that health care policies produce and are produced by a range of encompassing discourses that shape our suspicions and doubts about particular people or groups of people. By analyzing policy within the contexts of related public discourses, and the historical, economic, and social realities of Aboriginal women's lives, we encounter a "doublespeak"—a paradox involving the construction of Aboriginal women as citizens in dialogue with government in health policy "reform" consultations, and their simultaneous construction as discredited medical subjects without legitimacy or power in health care services.

We conclude that health policy reform is and will continue to be constrained in effecting true social change unless it is accompanied by a significant shift in socio-economic power structures, critical awareness of the powers of discourse, and consciousness of the colonial legacy that underpins notions of reform and consultation. Without these interlocking transformations of power relations, many Aboriginal women, discredited as medical subjects, will find policy itself a barrier to their well-being.

# Introduction

Policy [noun]. 1. A course or principle of action adopted or proposed by a government, party, business, or individual. 2. [archaic] prudent or expedient conduct or action. (late Middle English from Old French *policie* "civil administration" via Latin from Greek *politeia* "citizenship," from *polites* "citizen," from *polis* "city." (The New Oxford Dictionary of English, 1998).

This report constitutes the second of two phases of research conducted in collaboration with a First Nation community in north central British Columbia. In the first phase of the project, we documented how First Nations women's health care experiences were shaped by their social and cultural positions, by health care policies, and by health care providers' perceptions of the women as First Nations patients (Browne & Fiske 2001; Browne, Fiske & Thomas, 2000). Our analysis of participants' narratives identified the kinds of barriers that the women faced when they accessed health care, the unequal power relations that women encountered, participants' accounts of various ways in which health care providers unwittingly conveyed dismissive attitudes towards them, and the onus they felt to transform their appearance and speech to gain respect as medical subjects.

**Underlying women's policy recommendations was a call for a more representative and responsive health care system that would incorporate greater First Nations input into program design and system management.**

When we discussed the findings from Phase I with the participants, several of whom were leaders in Aboriginal health, they proposed solutions to persistent inequities in health and health care, which they grounded in notions of health policy reforms. For example, when we asked the participants in Phase I about their health care encounters and how these might be improved, they explicitly and implicitly recommended changes in health care practices at all levels of delivery and governance. Acting as citizens, they proposed ways to improve health care encounters through greater awareness of specific barriers and cultural practices, the development of respectful and prudent practices to treat highly marginalized clients, and the development of liaisons between the dominant medical community and their reserve clinic. They proposed concrete changes to local reserve and off-reserve service delivery: for example, greater opportunities for involvement of First Nations peoples in health care planning and delivery, improved mechanisms for communicating decisions affecting health care within their jurisdiction, and progress toward health transfer. Underlying their policy recommendations

was a call for a more representative and responsive health care system that would incorporate greater First Nations input into program design and system management.

**Policy and related discourses are constructed through language that carries implicit political and social messages in a particular political context.**

It is noteworthy that the women expected not only that government would act upon their recommendations in good faith but they were also convinced that policy reform would lead to more responsive and representative actions and conduct in the health care system at the local level. However, efforts by health service administrators to implement some of these policy recommendations do not reflect the women's vision and instead position First Nations women as undeserving medical subjects. Critical reflection on the fate of women's recommendations has led us in Phase II of this study to consider how and why their voices are erased in policy reform and how this might be changed.

The First Nations women's faith in the process of policy reform is shared by the general public who commonly view policy reform as social action grounded in and giving rise to confidence either in governments as "doing the right things" or, when governments fail to do right, in policy as having the capacity to *correct* prior failures and wrongs. Another popular view is that policy originates in citizens' empowerment, such as when citizens speak to government through consultations. These understandings of policy are sometimes taken to be self-evident and not in need of definition. (See, for example, the papers collected in Hylton, 1999 and Brodie, 1996.) However, policy and related discourses are constructed through language that carries implicit political and social messages in a particular political context. In other words, the meaning of policy is not always self-evident, even though its discursive strategies reflect the ways in which the state governs and acts upon citizens' daily lives. This context requires us to take a more critical view of what is understood when governments call for policy reform. By closely examining how language is used in shaping political and social meanings, we learn what the outcomes might be, in particular, for Aboriginal women.

The second phase of our research, described here, considers health care policy within the context of government-sponsored policy "reform" consultations with citizens and within everyday encounters in health services where policy is implemented. We are specifically concerned with the paradox of positioning First Nations women as empowered citizens in dialogue with government and their contrasting positioning as undeserving patients within health care services. In the language of critical discourse analysis, which provides the analytical framework for this paper, we refer

to the latter positioning as the construction of First Nations women as "discredited medical subjects (Fiske & Browne 2006)."

To trace this shift from empowered citizen to discredited medical subject, we have chosen several cases to illustrate concrete and detailed examples of public consultations and their outcomes related to First Nations women. These selected cases include: two Royal Commissions, the British Columbia provincial referendum on treaty settlements, a recent consultation with Aboriginal governors who served on regional health boards, and a key recommendation made by the First Nations women in Phase I of our study, who expressed faith in policy as a mechanism through which to address their concerns related to health care. As we develop our arguments, the following questions guide our analysis:

1. What discursive strategies are deployed by policy discourses that construct Aboriginal subjectivity?
2. How do discursive strategies of national, provincial, and local policies reconstitute First Nations women's health agendas as agendas of client dependency and discredit them as medical subjects?
3. How do the discursive strategies of policy within the political economy of health care treat policy recommendations made by First Nations women?
4. How do health policies resonate with other discourses to displace Aboriginal women as credible, empowered citizens while constituting them as discredited subjects of public policy?

To address these guiding questions, we have organized the report into four sections. We begin by providing a background to discourse and its political implications for health policy. We then analyze selected examples of policy and political discourses. After discussing how health policy in particular constructs First Nations women as discredited medical subjects, we close by addressing the implications of our analysis for First Nations women in their everyday lives and in their roles as engaged citizens and participants in the mainstream health care system. Framed as responses to our four guiding questions, our analysis leads us to conclude that health policy is implicated with other salient political processes that need to be confronted.

**Our analysis leads us to conclude that health policy is implicated with other salient political processes that need to be confronted.**

Because policy is dynamic, both product and process (Taylor et al., 1997), it is not enough to look solely at policy documents. And because the construction of First Nations women as medical subjects occurs within the processes of health care practice and policy implementation, reform at the policy level alone cannot address the complex issues that arise in health care delivery.

This analysis of health care policy confirms the manner in which discourses and the everyday practices they define and support act as powerful social instruments that perpetuate negative stereotypes of Aboriginal women as medical subjects. Our study contributes to an interdisciplinary understanding of policy and its role in the constructions of self and citizenship and in the maintenance of the status quo.

# II Background

"Despite the importance of policy as a key institution of modern society, it remains curiously under-theorized and lacking in critical analysis." (Shore & Wright, 1997, p. ix)

## A. Critical Discourse Analysis

Over the past 25 years, scholars have turned to discourse in a quest to understand the ubiquitous nature of power in our everyday lives.[2] In this paper, "discourse" refers to a public conversation or political dialogue between unequal parties as, for example, between governments and citizens in health reform consultations, with the government holding the resources that determine both the context of the dialogue and the content of subsequent policy. Critical discourse analysis engages researchers in reflections on language use. Rather than "collecting" empirical data, the analyst plumbs texts for meanings located within and between the literary devices employed for rhetorical purposes: semantic reversals, mobilizing metaphors, literary tropes, analogies, tone, and referential strategies that may evoke stereotypical or taken-for-granted assumptions respecting Aboriginal women in the context of their health needs and health care.[3]

A central concern in discourse analysis is to examine who has the "power to define," given that "dominant discourses work by setting up the terms of reference and by disallowing or marginalizing alternatives" (Shore & Wright, 1997, p. 18). In Shore and Wright's terms, discourses are "configurations of ideas which provide the threads from which ideologies are woven" (p. 18). Ideologies, in turn, tend to reflect and perpetuate the normative ideals of the dominant society—in other words, the status quo.

Although definitions of ideology are diverse and shifting (Browne, 2001), what is common among them is that ideologies advance *value-laden claims* about human nature, freedom, science and social justice, among other politically contentious issues (Love, 1998). Dorothy Smith (1987), for example, has advanced the notion of ideology as those ideas and values that organize and maintain the relations of ruling in our society, and as the medium through which our ideas, practices, and social relations are organized and operate in everyday life. As Thorne, Reimer Kirkham, and Henderson (1999) note, "When we refer to social structures as ideological, we invoke an analytical perspective of how certain ideas and beliefs get put together in order to maintain or reinforce privilege" (p. 123). The consensus among critical theorists is that ideology is so deeply rooted in

modern culture as to be almost impossible or at least extremely difficult to recognize, acknowledge, or escape (Heywood, 1992).

**By examining policy as ideological texts, we expose ways in which policy reform exerts power and the ways in which Aboriginal women negotiate their health care.**

By drawing on a variety of discourse theorists informed by postcolonialism, critical anthropology, and educational studies, we examine health care policy in relation to Aboriginal women, and view policy documents, as Codd (1988) has done, as ideological texts that have been constructed in a particular political, historical, and economic context. That is, we take as our starting point that health policy, like all state policy, reflects, reinforces, and advances values that are consistent with social relations and structures that maintain relations of privilege in B.C. and Canada as a whole, as they have emerged from our colonial past. By examining policy as ideological texts, we expose ways in which policy reform exerts power and the ways in which Aboriginal women negotiate their health care.

## B. Health Policy as a "Technology of Power"

Following the work of French philosopher Michel Foucault (whose critiques of power and language in social institutions inform our own), we treat health policy as a "technology of power" that operates through various discourses—"technology" in the sense of a regularity or repetition of actions or techniques and "power" as that which serves "to qualify, measure, appraise and hierarchize… [power that] effects distributions around the norm. A normalizing society is the historical outcome of a technology of power centred on life" (Foucault, 1980a, p. 266). This normalizing, appraising power (e.g., the power to decide who is deserving, who is credible) is not restricted to the state but is dispersed throughout society. Foucault claims that, "in thinking of the mechanisms of power, [he is] thinking rather of its capillary form of existence, the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives" (Foucault, 1980b, p. 39).

Foucault's concepts of power help us to question how health policy directs the public to think in certain commonly unquestioned terms and to seek alternative ways of thinking and communicating in order to reveal relations of power and their consequences. A core feature of this shift in thinking is the search to understand how a sense of identity is attributed to—and taken up by—individuals and collectives as a consequence of dominant discourses, and further, how these identities may either shift over time or co-exist with one another.

## C. Understanding the "Medical Subject"

Discourse theory often refers to "the subject" instead of "the person" or "the individual" in order to indicate that discourses can alter or shift conceptions of the individual. Discourses of citizen engagement, for example, construct the First Nations subject as a citizen with power to shape health care policy. But once policy is implemented in health care services, the First Nations subject is positioned either as having credibility or as lacking credibility as a medical subject, depending upon her compliance with policy expectations.

We understand health care policies as producing and being produced by ideological discourses that increasingly shape the way in which individuals understand themselves and one another as subjects (Shore & Wright, 1997, p. 4). By *subjectivities* we refer to "the contingent and variable sense of self, conscious and unconscious, both as actor and as 'acted upon'" (Ristock & Pennell, 1996, p. 116). As "actor" we may take action, as Aboriginal women have, against specific discourses. But as "acted upon," the knowledge we may have of ourselves and our sense of the possible actions we can take can be constrained or otherwise influenced by discourses.

**The complex and contingent nature of subjectivity is revealed through the disjuncture between ascribed labels of identity and public responses to and perceptions of them.**

In the past, through legislation and policy, the Canadian state controlled the discourses that named the original peoples of Canada. Today Aboriginal peoples insert their own identifying terms into public dialogues and policy (the most commonly used term being First Nations). As defined by the Royal Commission on Aboriginal Peoples (1996a), the term "Aboriginal peoples" refers generally to the indigenous inhabitants of Canada including First Nations, Métis, and Inuit peoples, without regard to their separate origins and identities. To highlight the diversity and multiple subjectivities that exist within social and cultural groups, we use the inclusive terms "Aboriginal women" and "Aboriginal peoples" with full recognition of the cultural, historical, and political distinctiveness inherent therein. When referring specifically to the participants in our study and/or to peoples included under the health policies of the First Nations and Inuit Health Branch of Health Canada, we use the term "First Nations women" in keeping with the women's own usage and with the practice of the federal government, whose legal and fiduciary obligations differ in relation to specific groups of Aboriginal peoples. (We do not reveal the specific First Nation identity of our participants in order to protect their confidentiality.)

The complex and contingent nature of subjectivity is revealed through the disjuncture between ascribed labels of identity and public responses to and perceptions of them. For example, the B.C. government is currently engaged in treaty negotiations with First Nations, whose rights and entitlements have

been clarified in the Canadian constitution. Nonetheless, the government presents these negotiations as "native land claims," a phrase that draws on colonial labels of racial difference and fails to highlight either the treaty or inherent rights (i.e., arising from the land through original occupation by organized societies existing prior to European contact and colonization) that underlie constitutional relations between First Nations and Canada. This is one example of how subjectivities arising from public policy can embrace more than personal or collective sense of identity or neutral shifting positions of citizen and subject.

## D. The Moral (and Moralizing) Dimension of Policy

"Policy is how government governs us."
– *Research participant*

Policies can be viewed as "narratives that serve to justify or condemn the present, or as rhetorical devices and discursive formations that function to empower some people and silence others" (Shore & Wright, 1997, p. 7).

**The moralizing capacity of health policy... has ramifications for the relationship between self, other, and society because it gives rise to questions about who are 'deserving' recipients of health care.**

Because health care policy is typically portrayed as a market-based product in current U.S. and Canadian discourses, terms such as "efficiency" and "the consumer" are common. Malone (1999) finds a particular moral dimension in U.S. health policy because it requires decisions about "how to act toward affected others who are not involved (or only indirectly involved) in actually deciding what to do about an identified problem" (p. 18). A market-based portrayal of policy implies that our moral capacity and conduct toward others with regard to health care is "something up for sale" (p.18).

The moralizing capacity of health policy—its power to define the medical subject in moral terms—also has ramifications for the relationship between self, other, and society because it gives rise to questions about who are "deserving" recipients of health care. In considering this dimension, we understand health care policies to encompass much more than specific documents or prescriptive texts; rather, we view them as producing and being produced by political discourses that increasingly shape our suspicions and doubts about particular people or groups of people.

Health policy exists within the larger context of public dialogues and government actions. To return to the example of treaty negotiations, the use of the word claim in "native land claim" suggests that Native demands are contestable and raises the spectre of First Nations laying claim to

lands rightfully held by someone else. Indeed, in 2001, the Union of B.C. Municipalities (UBCM) forwarded a resolution to the federal and provincial governments urging expedience of "the First Nations Land Claims process" with just this spectre informing its rationale. The union characterized the issue as "creating uncertainty and prejudicing economic activity in the province as a whole." The implication here is that "natives" carry responsibility for undermining the provincial economy. In its response, the provincial government accepted this moralizing construction of the consequences of treaty negotiations and agreed it had to find "solutions that …lead the Province to economic stability" (UBCM Resolutions Data Base 2001, Resolution B33). Through its characterization of treaty negotiations, the province sets up terms of reference that spill into public consciousness about Aboriginal issues and moral culpability, all of which can resonate with popular stereotypes that emerge in health policy.

**When women enter the health care system as patients, they may lose their positions of strength.**

## E. Obstetrical and Epidemiological Policies and Aboriginal Women

Several researchers have analyzed the capacity of health policies and discourses to shape perceptions and assumptions about Aboriginal women. These studies illustrate the flow of political power underlying health policy discourses and how stereotypes about Aboriginal women can be perpetuated.

John O'Neil and Patricia Kaufert draw on Foucault's concept of discourse to understand diverse issues that have ramifications for Aboriginal women as citizens and medical subjects (Kaufert & O'Neil, 1990; O'Neil & Kaufert, 1990; 1995). They found that obstetrical policies enacted in northern Aboriginal communities, which required women to travel long distances to southern communities to reduce risk during childbirth, disrupted women's lives, undermined cultural identity, and negated women's positions as active contributing members of their communities. However, at the same time the women were experiencing the negative effects of these policies, they were also galvanized into resistance to these same policies through collective political actions. The women therefore renewed the legitimacy of their role as leaders and social activists within their communities.

When women enter the health care system as patients, they may lose these positions of strength. For example, O'Neil, Reading, and Leader (1998) show how epidemiological constructions of risk factors for diseases or adverse health conditions contribute to increased surveillance of Aboriginal women's lives in the health care system and run the risk of contributing to "an understanding of Aboriginal society that reinforces unequal power

relationships; in other words, an image of sick, disorganized communities can be used to justify paternalism and dependence" (p. 230). A case in point is found in epidemiological constructions of risk factors for cervical cancer among Aboriginal women. Linking the risk of disease to women's so-called lifestyles (e.g., smoking, age of first sexual contact, history of sexually transmitted diseases) involves moral judgment of Aboriginal women (Browne & Smye, 2002; Browne, Smye & Varcoe, 2005). Removed from their historical, social, and economic contexts, discourses about reproductive risk factors or at-risk groups have the potential to produce negative stereotypes about Aboriginal women as lascivious or as lacking will power, judgment, or moral fortitude. Browne and colleagues' analyses illustrate the manner in which discourses such as these, and the practices they define and support, can act as powerful social instruments.

## F. Related Public Discourses

Public discourses such as those that occur in the justice system, the media, social services, and debates and negotiations about the sovereignty of First Nations saturate our consciousness and shape the public's view of Aboriginal peoples and their behaviour as moral or immoral, and deserving or undeserving, both as citizens and as medical subjects. A particularly powerful example of public discourse's capacity to shape how we perceive Aboriginal women is found in McConney's (1999) analysis of the murders of Aboriginal women in Saskatchewan. This work explicates how state and media discourses perpetuate and permit suspicion of and negative attitudes toward Aboriginal women, which in turn deprive First Nations women of justice and equality. Whether the violence against Aboriginal women is "virtually unnoticed and certainly uninvestigated" (McConney, 1999, p. 212) or brought to trial, stereotypes about Aboriginal women interplay with the racist privileges of white men. In separate but related research, Razack (1998) conceptualizes "the culturalization of sexism" (p. 68) whereby legal discourses misconstrue Aboriginal men as culturally entitled to be violent toward Aboriginal women and thereby render Aboriginal women vulnerable to sexual violence (LaRocque, 1993; 1997; McConney, 1999). These studies help to illustrate how various discourses, including policy, can shape people's identities in the eyes of the public, health care providers, and powerful authorities.

Deborah Rutman and others (2000) show how pregnant, substance-using women are constructed within social and health policies as necessarily "indigent, welfare-dependent, possibly homeless, marginalized, and more than likely Aboriginal" (p. 85). With these images in mind, prudent,

principled policies aimed as protecting "the best interests of the child" can thus inadvertently construct substance-using women as discredited medical subjects and paradoxically discourage them from approaching the very services that are designed for their "affected" and "targeted" population (Rutman et al., 2000, p. 85). Caroline Tait (2000a) argues further that images of "the drunken pregnant and the violent fetal-alcohol-affected youth" discredit Aboriginal people as being unwilling or "unable to govern their actions in ways that are morally acceptable" (p. 95).

**The Aboriginal subject created by discourses on land claims and the need for equality does not exist in isolation from the discredited medical subject.**

Collectively, these researchers demonstrate how social and health-related discourses create or erase credibility. They also make clear that Aboriginal health and social policies are inherently political. Thus health policy is implicated in a larger political agenda that is marked by a tendency to deny the power of systemic racism and to reject Aboriginal claims to sovereignty and land title as violating principles of equality and tolerance (Furniss, 1999). Since the advent of the "modern day treaty process" in British Columbia in 1990, tensions have marked the provincial and, to a lesser degree, the federal political landscape over the obligations of government with regard to inherent and constitutionally protected Aboriginal rights and entitlements. The settlement of Aboriginal rights and entitlements includes, among other issues, negotiation of self-governance, the settlement of rights to traditional territories, and the mandate from the Supreme Court of Canada to the B.C. government to consult with First Nations respecting economic development and resource appropriation in their traditional territories. In 2002 the provincial Liberal government held a referendum on "treaty principles," the outcome of which they claimed affirmed their goal of limiting the scope of Aboriginal self-government and "raised awareness of land claims." The province's reassurances that it seeks "affordable" treaties that provide for "equality" not only reflect back to the dominant society its perceptions that First Nations seek the opposite but also sanction such dominant perceptions. In other words, "today's colonial practices are arguably more respectful and inclusionary than their historical counterparts, drawing as they do upon the liberal notions of tolerance and respect for diversity. Yet, they also reproduce many of the processes of oppression" (McConaghy, 1998, p. 351).

The Aboriginal subject created by discourses on land claims and the need for equality does not exist in isolation from the discredited medical subject. Rather, in a political climate fraught with competing claims, unquestioned negative constructions of Aboriginal women in health and social policy work with "land claims" discourses to undermine Aboriginal people's assertions that they are capable of taking on responsibilities of self-

government. In everyday life these constructions emerge as justification for the status quo.

## G. Deconstructing Health Care Policy

**Health policy may associate specific diseases with "life-styles" while avoiding references to colonial legacies that shape either personal life choices or health care practices.**

Discourse, as we have suggested, positions human beings as subjects, not only through placing them in particular roles or relationships but also through negative and moralizing constructions. For Aboriginal women, their position as medical subjects depends on health policy and other social discourses that are inadvertently mobilized as "technologies of power" that "qualify, measure, appraise and hierarchize … [and effect] distributions around the norm" (Foucault, 1980a, p. 266). "Deconstruction" of health care policy entails exposing internal contradictions and logic within the context of interrelated political discourses. Deconstruction has among its goals not only an exposure not only of what is said but also of what is not said. Thus, just as discourses of land claims may exclude references to Aboriginal rights and entitlements, and thereby negatively construct Aboriginal subjects as threatening the province's economic well being, so health policy may associate specific diseases with "lifestyles" while avoiding references to colonial legacies that shape either personal life choices or health care practices. Deconstruction of health policy means to reveal how particular medical subjects are established in relationships of dominance and subordination and offers a way to undo this distinction.

By deconstructing health care policy, discourse analysis exposes its power and ideological bases and points the way for a new kind of health policy that is created and enacted with the participation of Aboriginal women. In the next section we locate health care policy within the context of other discourses from which and to which it provides shared meanings and political implications.

# III Paradoxes of Policy Reform: How First Nations Women are Discredited as Medical Subjects

## A. Citizens Called to Dialogue

**When social problems are complicated by potentially divisive moral, ethical, and/or racial and gender issues, it is not unusual for the federal government to mandate a Royal Commission.**

When citizens and governments alike find themselves faced with social problems that need multiple policy interventions, governments eventually respond with initiatives for policy reform. Although the public is invited to participate in consultations to reform government policy, such gatherings are never social, apolitical engagements by the citizens. The outcomes of policy reform attest to its underlying political nature: policy can establish or reinforce unequal social relations. Aboriginal women, in particular, find themselves in a discursive contradiction when they participate in policy consultations—they are citizens in dialogue with government only until their recommendations for changes to health care are transformed into subsequent policy and practice. Then Aboriginal women are constructed as discredited medical subjects, without legitimacy or power.

To trace this pattern we look at two Royal Commissions, return to our analysis of the Referendum on Treaty Principles, and deconstruct a consultation with Aboriginal governors of regional health boards and the outcome of a key recommendation made by women who participated in our study in northern British Columbia.

## B. Royal Commissions

When social problems are complicated by potentially divisive moral, ethical, and/or racial and gender issues, it is not unusual for the federal government to mandate a Royal Commission. Commissions hold public gatherings, call for research, and issue position papers to unearth and define socio-cultural relations that are seen to be shaping the problem. Royal Commissions call upon a broad sector of interest groups, governmental and non-governmental groups, and private citizens to participate in fact finding and policy recommendations. Commissions' appeals for the participation of groups that hold contrary views and interests are meant to signal the government's commitment to tolerance and respect for diversity.

The Royal Commission on Aboriginal Peoples (RCAP) was a five-year process (1991-1996) that followed upon several provincial inquiries addressing the most severe problems that Aboriginal people experience with the justice system, and the federal government's reviews of the impact of the *Indian Act* on Status and non-Status First Nations women.

The RCAP was meant to investigate the root causes of these and other social, economic, and political crises affecting Aboriginal peoples.

Aboriginal women demonstrated their good faith in the Royal Commission when they undertook research, gave public addresses, and submitted position papers on the need for reforms that would alleviate their social denigration and the incidence of domestic and sexual violence; they also spoke of the need for personal protection through the application of the Canadian Charter of Rights and Freedoms (RCAP, 1996b). They offered numerous solutions that were recorded by RCAP in its comprehensive 1996 report. The commission's willingness to consult with Aboriginal women (and the government's extensive funding to make this possible) along with the commission's subsequent endorsement of the women's policy recommendations and political stances at first suggested that the federal government was willing to shift its policy reform practice from "doing to" or "doing for" to "doing with" Aboriginal women. By writing a chapter specifically addressing women's concerns and calling upon all governments at all levels to redress social, economic, and political constraints that women encounter, the RCAP positioned Aboriginal women simultaneously as citizens holding Charter entitlements and as a special needs group. However, nearly seven years after receiving the multivolume RCAP report, the federal government has failed to act on most of its recommendations; it's also failed to initiate meaningful changes in governing relations with Aboriginal peoples, in general and, more particularly, with women (Aboriginal Rights Coalition, 2001).

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The federal Romanow Commission on the Future of Health Care, constituted in 2001-2002, is a recent gesture of tolerance and respect for diversity on the part of the federal government. Calling itself "a citizens' dialogue," the Romanow Commission generated interim reports "to frame issues so that Canadians [could] participate in public consultations in a meaningful way" (Commission on the Future of Health Care in Canada, 2002). When the Romanow Commission joined with the National Aboriginal Health Organization (NAHO) to hold a forum on Aboriginal health, Aboriginal women were specifically called on to exercise their citizenship by engaging in consultation on health policy and related issues. When Aboriginal participants in the Romanow-NAHO joint forum were asked to identify what they viewed as successful interventions in policy reform, they spoke of their "optimism" and the government's "willingness to rise to the challenge of designing and delivering culturally appropriate services" (National Aboriginal Health Organization, 2002).

We do not know if the women's optimism was well placed. The commission's final report, released late in 2002, does contain two recommendations pertaining to the consolidation of funding for Aboriginal health services and the use of these monies to fund new "Aboriginal Health Partnerships" that would be responsible for "developing policies, providing services, and improving the health of Aboriginal peoples" (Romanow, 2002, p. 223). However, as is always the case with government commissions, it is difficult to predict if or how the recommendations in the final report will be implemented, or if they will reflect the intentions of the submissions from Aboriginal women. As the National Aboriginal Health Organization reminds us, "if governments are to be taken seriously in their efforts to address Aboriginal health disparities, policy responses such as RCAP or the Commission on the Future of Health Care must be sustained and accountable, incorporating outcomes that can be both measured and evaluated" (2001, p. 21).

## C. Referendum on Treaty Principles

The Referendum on Treaty Principles provides one of the clearest examples of the reciprocal relations between commonly held perceptions of First Nations peoples and the political discourse of government. Throughout its tenure as opposition in the provincial legislature, the Liberal party of B.C. expressed strong dissatisfaction with First Nations' legal and political struggles to have their Aboriginal rights to land, resources, and self-governance recognized; the party especially objected to what it called a 'third order of government'. The views of the provincial Liberal party reflected the position of many British Columbians, in particular individuals and organizations who perceived themselves to be competing with First Nations for resource rights and wealth in the mining, fishing, and forestry industries. To this end, the Liberals promised that, when elected, they would hold a referendum on the principles for negotiating land claims—in fact their election platform guaranteed a so-called democratic voice for all. In May 2002, the newly elected Liberals held a referendum on treaty settlements that they claimed would guide them in conducting future negotiations. Signaling their purported commitment to democracy, they were also mirroring public discontent. The B.C. Liberals adopted a rhetoric of "equality" but remained virtually silent on issues of inherent and constitutional rights and Aboriginal title. They also engaged in fear mongering by raising questions of Aboriginal expropriation of citizens' private property—a possibility excluded by the extant treaty negotiation principles. The referendum included issues that lay strictly within federal

powers and asked the voters to affirm the government's goal of restricting First Nations governance to a limited form of delegated authority. It then went even further in establishing distance and difference between First Nations and non-First Nations by inserting questions that called for protection of "all British Columbians," a suggestion that First Nations' claims would erode the rights and every day practices of citizens at large.

**The referendum's discourse reflected back to the public both discontent and misunderstanding of the treaty process and suspicions and distrust of First Nations peoples and their political and legal aspirations.**

This gesture toward citizens' participation — by a government that has become known for ongoing unilateral cancellations of social welfare policies, labour agreements, and health care provisions — was opposed by human rights, labour, and environmental groups and churches (Anonymous, 2002; LeMoal, 2002a; 2002b) and criticized for being racially divisive (LeMoal, 2002a; 2002b). Only 35 percent of the province's registered voters mailed their ballots back to the provincial government, "the lowest participation level ever for a provincial vote" (LeMoal, 2002b, p. 1). Although First Nations people vehemently rejected both the substance of the referendum and the implications of its outcome, in particular the province's desire to constrain the scope of self-governance, the government still claimed the results favoured their stance on treaty negotiations to limit self-government to a municipal style of government (LeMoal, 2000a, 2000b).

The referendum played to social and political difference by appealing, on the one hand, to "equality" through the erasure of Aboriginal rights and entitlements and, on the other, by insinuating that treaty principles should lead to clear and conclusive containment of First Nations governance and resource use by constraining governance and use rights to provincial authority, thereby replicating a discourse of irresponsibility and incapacity within First Nations leadership. In these appeals, the referendum's discourse reflected back to the public both discontent and misunderstanding of the treaty process and suspicions and distrust of First Nations peoples and their political and legal aspirations. This is the wider context of other public discourses within which health policy unfolds and by which it is influenced. As we shall see later, similar constructions of Aboriginal women's so-called irresponsibility shape health policy. And the practice of governments appealing to Aboriginal peoples as citizens, followed by policy and practices that discredit these same peoples, emerges as a pattern in policy reform and implementation.

## D. Regional Health Authorities and the Role of Aboriginal Governors

"Many Aboriginal peoples," according to the Romanow Commission, "find themselves relying on provincial health programs that are designed to meet the health needs of the general population and may not reflect their specific needs" (National Aboriginal Health Organization, 2002). Romanow is not the first to have noticed this. Across Canada, Aboriginal peoples have addressed this issue by calling for policy reforms that would, as Romanow repeats, "allow for meaningful governance and control of health services" (National Aboriginal Health Organization, 2002). The Aboriginal Health Association of B.C. argues that "among the barriers to improving health, Aboriginal British Columbians consistently have identified a lack of access to services, the lack of meaningful participation or control in how services are delivered, and the absence of working relationships with health service providers" (2003). Hospital boards, health authorities, and other levels of service delivery have responded by creating mediating positions for Aboriginal people within the administration of health services. Most of these positions are held by Aboriginal women.[4]

**The governors recommended that health authorities establish anti-racist education, cultural awareness, and holistic health programs integrating Aboriginal health knowledge with Western delivery systems.**

In 1998 the British Columbia Ministry of Health (in the government then led by the New Democratic Party), through its Aboriginal Health Division and in conjunction with the Aboriginal Health Association of B.C., called together 31 Aboriginal governors of the regional health authorities' boards to discuss Aboriginal health needs (Aboriginal Governors Working Group [AGWG], 1999). This discussion led to the formation of a subgroup of Aboriginal governors who brought forward 50 recommendations that focused on the accountability of non-Aboriginal health authorities to look to their own role in perpetuating colonial relations of power. They argued in the spirit of broad responsibilities of all board governors for Aboriginal citizens. In this instance, the non-Aboriginal governors agreed; they shared the goal to have all governors and others in authority take responsibility for health service reform. Subsequently, both the New Democrat government and the current Liberal government took formal actions on some of the recommendations. However, even a cursory look at a few key recommendations suggests that the outcomes of this citizen-engagement process are not what they could have been.

In an effort to address reforms within the health authority itself and most particularly at the level of the board, the governors recommended that health authorities establish anti-racist education, cultural awareness, and holistic health programs integrating Aboriginal health knowledge with Western

delivery systems. The governors emphasized that "boards and councils have responsibilities to educate and orient themselves on Aboriginal issues," noting that "this is not the sole responsibility of Aboriginal representatives" (AGWG, 1999, Appendix C). "All governors would benefit from mandatory training in: Aboriginal history, health issues and traditional practices, and antiracism and cross-cultural awareness training" (AGWG, 1999, Appendix A, p. 3). Official responses to this recommendation brought mixed outcomes. Significantly, in 1998, the health authority board chairs themselves accepted the recommendations from Aboriginal governors in the spirit in which they were originally delivered. For example, they specifically recognized "the need to provide culturally specific and relevant training on boards and councils on Aboriginal health issues and this training needs to include anti-racism and cross-cultural awareness training" (AGWG, 1999, Appendix C). Although a handbook on Aboriginal health was developed as a reference for health authorities (Aboriginal Health Association of British Columbia, 1999), to date the provincial government has failed to offer clear direction regarding mandatory training in the areas originally recommended by the governors.

**Aboriginal governors recognize that, in order for specific health needs to be addressed at the community and provincial levels, health authorities must provide a range of women-specific services.**

To ensure greater equity in decision making between Aboriginal and non-Aboriginal governors, the Aboriginal governors recommended that health authorities "establish policy requirements to ensure that Aboriginal representation reflects the proportion of Aboriginal population in the Health Authority areas" (AGWG, 1999, Appendix A, p. 1). In response, the health authority chairs reiterated the Aboriginal governors' position that "where the Aboriginal population is significant, the representation should be similar to the population of the Region" (AGWG, 1999, Appendix C). Despite this endorsement, the B.C. Ministry of Health required health authorities to have merely "a minimum of two Aboriginal governors" (Government of British Columbia Ministry of Health Services, 2002a).

The Aboriginal governors also recommended that the health authority "establish government-to-government relationships between health board/councils and First Nations councils with formal protocols" (AGWG, 1999, Appendix A, p. 1). In this, as in other recommendations, the Aboriginal governors voiced their objectives in the language of citizenship, identifying governance issues as the primary means of improving health care delivery. But to date the call for governance reform has been ignored by the provincial government.

Aboriginal governors recognize that, in order for specific health needs to be addressed at the community and provincial levels, health authorities

must provide a range of women-specific services. Pressing concerns for Aboriginal women include: cervical cancer, well women care, mammography, and health care services for young children and families. Unfortunately, the government of British Columbia has overlooked the full range of health issues for Aboriginal women. It has identified HIV/AIDS, substance abuse, tobacco reduction, mental health, and diabetes as the government's priority areas for Aboriginal health (Government of British Columbia Ministry of Health Services., 2002b; 2002c). Further, in setting out its guidelines for the development of Aboriginal health plans, the government specifically asks health authorities to link these plans with HIV/AIDS, alcohol misuse, and violence. While the government makes use of the language of citizenship in recognizing the role of Aboriginal people in health planning and decision making, it frames Aboriginal health issues within discourses of adverse "lifestyle choices." Invited as citizens to advise government, the Aboriginal governors themselves (the majority of whom are women) cannot escape the construction of themselves in ensuing policy as irresponsible, discredited medical subjects whose health is imperiled by lifestyle choices.

**The lifestyles discourse implicitly shifts "problems" back onto the Aboriginal medical subject and away from processes and people of power.**

Encouraged by provincial policy, health authorities adopt the priorities set by the provincial government. This is reflected in spending patterns: the resources spent on Aboriginal tobacco reduction, for example, are almost 10 times the amount spent on Aboriginal women's health. Education and training get less than two-thirds of the resources spent on tobacco reduction (Government of British Columbia Ministry of Health Services, 2002b). The lifestyles discourse implicitly shifts "problems" back onto the Aboriginal medical subject and away from the social, political, historical, and economic structures in which the health conditions occur, and away from processes and people of power. It ignores the health issues raised by the Aboriginal governors.

While there is no doubt that the health issues identified by government have also been identified by Aboriginal women themselves as priorities, the manner with which health issues are associated with health status, rather than, as one example, the determinants of health, accentuates the policy's assumptions about the Aboriginal person as a discredited medical subject. The policy does not take into consideration the extent to which poverty shapes women's health status and health behaviours, nor does it address research on the links between women's life circumstances (e.g., education, lone parent status), tobacco use, and poverty (Greaves & Barr, 2000). The health determinants approach would offer a broader, more informed

perspective on what has come to be seen simplistically as "lifestyle choices."

The mission statement of the Aboriginal Health Division of the B.C. Ministry of Health Services describes how one area of ministry responsibility lies in "supporting Aboriginal people in assuming greater responsibility for the design, delivery, management and allocation of resources for health services delivered in their communities" (Government of British Columbia Ministry of Health Services, 2002d). The language of "supporting" Aboriginal peoples to take "greater" responsibility implies that Aboriginal peoples are currently too limited in their responsibilities. This is especially ironic in light of the policy outcomes of the Aboriginal governors' recommendations and the treaty referendum that sought public affirmation of the government's efforts to constrain First Nations' authority and to increase provincial authority over their local governments. In these contexts, policy discourse emerges as a kind of Orwellian "doublespeak." On the one hand, we have the paternalism of assisting people to assume ill-defined responsibilities (the governors were expected to take part in the consultations without clear indication of possible outcomes); on the other hand, we have governmental stall tactics that prevent treaty negotiations that would enable responsible self-determination.

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Despite the British Columbia government's call for consultation, its guidelines for developing Aboriginal health plans are directed, hierarchical, and without comment on the majority of the governors' 50 recommendations calling for greater equity between Aboriginal and non-Aboriginal decision makers. In short, the provincial government persists in "doing to" rather than "doing with" in its Aboriginal health policy.

In achieving membership in decision-making entities (the regional health boards), Aboriginal governors were expected to concur with stereotypes of Aboriginal patterns of ill health and disease. Aboriginal governors appear to have been called to health boards and Regional Health Authorities not to represent Aboriginal citizens of good health, but to provide representation in relation to specific ill health or moral needs perceived to be urgent in Aboriginal communities.

Non-Aboriginal governors, however, were under no clearly stated obligation to concur with or even respond to recommendations put forth by Aboriginal governors. Non-Aboriginal and Aboriginal governors were not called upon to address the same issues nor were they seen to be representing the same citizens. Stated bluntly, selection of "white" governors on the health board is dissociated from the discredited medical subjects while the selection of

Aboriginal governors is associated with discredited medical subjects as defined by racial and ethnic identity. At the government ministerial level, the practice of labeling Aboriginal governors and labeling them as such therefore reveals itself as a gesture of "Othering."[5]

## E. The Paradox for Native Liaison Workers

**Just as the views of the Aboriginal governors can be erased in the process of formulating policy, so can the voices of community women be silenced in the community.**

Just as the views of the Aboriginal governors can be erased in the process of formulating policy, so can the voices of community women be silenced in the community. Women who participated in our study said they wanted to have Native liaison worker positions expanded, but at the time of our research, only the regional hospital had this service. Women wanted a similar service in the local hospital situated just outside of their reserve community, ostensibly to assist Aboriginal patients in a number of ways: as interpreters, as advocates, and as a bridge between the nearby Aboriginal communities and the power structures of the health system. The women argued that Native liaison workers, through their personal experience and cultural knowledge, would not only enhance individual patients' health care encounters but would also bring a new understanding of First Nations community life, traditional medical knowledge, and the socio-cultural needs of First Nations patients to the attention of the health care professionals. The women also recommended that Native liaison workers be able to influence the decision making by local and regional health administrators and the heath authority board. Placed within this broad range of responsibilities for patients and policy, the liaison workers could act as patient advocates, particularly for the most marginal patients, while having a voice in policy implementation. However, like the governors' recommendations, the vision for the Native liaison worker was transformed in the development of policy. When the Northern Health Authority (NHA) initiated a Native liaison worker policy, the result once again implicitly linked health policy to medical subjects who were constrained by their perceived socio-cultural "deficiencies." There was no expansion of positions; rather, the one existing liaison worker's job has been defined more clearly in terms of assisting individuals with personal needs rather than in terms of addressing structural power and racial relations. She is now placed in a mediating role, divided between advocating for patients and assisting the hospital with patient intervention. Moreover, in an effort to develop effective working relationships and communication, and acting as the sole mediator between patient and practitioner, the liaison worker is often compelled to adopt the dominant discourse of health care: a discourse that is meaningful to power brokers who exercise direct and indirect

authority over the patients she represents. She therefore risks being co-opted into language that contains embedded, discrediting messages about Aboriginal people—about adverse lifestyles rather than social awareness of the patient's circumstances.

# IV The Everyday Construction of the Discredited Medical Subject

While discourses of citizenship empower Aboriginal women and entreat them to participate in health policy reform, health policy destabilizes the very possibility of an empowered citizen. By calling for expediency and efficiency—values chosen from the culture of the health care system, and serving the needs of the system and professionals—policy standards and expectations inevitably frame moral judgments of the medical subject. These policy discourses are central to the construction of the discredited medical subject.

Whether it is in everyday encounters as patients, as mothers, as members of their communities and culture, or as participants in practices of self-government, Aboriginal women find themselves caught in numerous double binds set up by health policy. Whether principled or expedient, the policies described here are regulatory and often, if inadvertently, punitive. They frequently lead to undue scrutiny and surveillance, moral judgment, and racialization of Aboriginal women.[6] What follows are descriptions of the various subject positions that women are cast in by health policy.

## A. The Penalized Subject

When an Aboriginal woman enters a rural medical clinic in north central British Columbia, she will likely see a sign advising her that she risks having to pay a financial penalty if she misses or is late for appointments. The standard twenty-dollar penalty signals the expediency of health care in a fee-for-service practice. (Because the health care system pays doctors according to each service they render, the clinic charges this penalty to compensate the clinic for the "lost" fee resulting from a patient missing or being late for a doctor's appointment.) Financial penalties signal the clinic's desire for an orderly procession of clients managed within a strict time frame. However, as we noted in our previous report, because most women residing in First Nations communities do not own a car or have personal telephone services, arranging transportation from reserve to clinic is not easy. "The impoverished conditions in which many reserve women live preclude them from having the structures and conveniences in place that would allow them to arrive for appointments on time or to phone ahead and cancel" (Browne, Fiske & Thomas, 2000, p. 20).

Penalties affirm time management as a valued social practice: the rapid, steady movement of patients is preferred. As a disciplinary measure, however, such policies can acutely affect the women's relationships to

health care professionals and their self-presentation. To arrive late, or worse, not at all, can be interpreted as disrespectful behaviour or as an inability to organize one's affairs. Protest against the financial penalty may be read as a refusal to take responsibility for one's health care or as an ungrounded complaint about the clinic's need to run efficiently.

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The client is expected to place herself second to this need. When the clinic's staff voice grievance and resentment about "those patients" who expect "us" to rearrange "our" schedules to accommodate "them," the social distance that women feel in relation to clinical staff and professionals widens (Browne, Fiske & Thomas, 2000). Within this social distance and tension the medical subject is increasingly unknown and Other. A lack of credibility is more readily attributed to those we know poorly than those we know well.

The clinic's entrenched schedules and valued efficiencies are intertwined with policies about fees-for-service and the economic viability of physicians' private medical practices. Aboriginal women find that, in order to obtain health care services, they require social equivalency with the clinic's workers, at least in terms of a shared middle-class knowledge of clinic schedules, financial consequences, and time lines. If a patient lacks fluency with medical discourses and the kinds of social behaviour that define insider status, her credibility is further undermined (Browne, Fiske & Thomas, 2000). Women's social behaviours and agendas must match the clinic's expediency agenda or else they are viewed as Other in terms of class, culture, and knowledge. In the quest for expediency, the fee-for-service policy permits doctors to limit their consultations to between 10 and 15 minutes, hardly time enough for discredited women to transform themselves into credible medical subjects. The policy thus becomes a driving force that organizes women's health care encounters.

## B. Subjects Under Surveillance

British Columbian health policy requires health professionals to report incidents in which children are suspected of being abused or neglected. Policies of zero tolerance that demand rapid action in such cases create high indexes of suspicion about abuse and neglect and incite fear in case workers who are anxious to avoid being disciplined for failure to protect children. In such a climate, even the most principled of policies can lead to actions that are self-serving for health professionals.

Child protection policies necessarily result in surveillance of the mother. Cultural stereotypes, cultural ignorance, and a disregard for historical,

social, and economic contexts result in discourses about "risk factors" for child abuse and "at-risk groups" of people who may abuse or be abused by others. These discourses, in turn, are reified and reconstituted as a lifestyle or behavioural "syndrome" (Fraser & Gordon, 1994) that stereotype Aboriginal women as neglectful or irresponsible, lascivious, or lacking will power, judgment, or moral fortitude (Browne & Smye, 2002). Expedient actions by health or social service providers, and negative stereotypes, thus lead to the construction of Aboriginal women as implausible subjects whose medical needs and parenting may be viewed with skepticism, suspicion, and disapproval. This is how one First Nations woman in our study described her experience as a mother of a sick child:

> A bad experience I had was with my daughter who was about a year old. I was a new mother and I knew she was sick and she had a really high fever. So, I brought her up to the [local] emergency and they told me, the doctor said, "You're just looking for a babysitter for the week-end" and dismissed us and that was eight o'clock at night. I phoned back again [later that evening] to see who was on call and it was the same doctor, and I thought, well, if he's going to be the one that I see then it's no point in me going back. And at the same time I had no vehicle and I couldn't very well go back up [to the local hospital from the reserve community] again, so I just stayed up all night and tried to keep her as cool as possible. And then I went there, like, I knew the on-call [doctor] would change at eight o'clock in the morning, so as soon as it was eight o'clock, I bundled her up and I walked up there and then the doctor just gave heck. He said he was going to report me to social services because my child was very sick. So I told him what happened the night before and I said if you don't believe me you can check. So, that wasn't very good and she had double pneumonia.

**Narratives of personal abuse can be and often are co-opted to substantiate views that violence is an attribute of Aboriginal cultures.**

When it is violence or abuse against themselves that Aboriginal women disclose in the hope of receiving medical, legal, or social support, social surveillance intended to protect children often overrides them, again with the rationale that women who cannot protect themselves from the abuse of a family or household member cannot protect others. When women make public disclosures to help educate the Canadian public about the enduring impact of colonialism (Aboriginal Nurses Association of Canada, 2002; Dion Stout, 1997), they risk reinforcing stereotypes of Aboriginal men and women (mothers and fathers, wives and husbands) as abusive. In other words, narratives of personal abuse can be and often are co-opted to substantiate views that violence is an attribute of Aboriginal cultures. This hides the colonial underpinnings of social violence and exposes victims to

new dangers (LaRocque, 1993; 1997). Thus, for many Aboriginal women, disclosure of abuse means facing fear of violence from their abuser, fear of having their child or children apprehended, and fear of violence against their culture through perpetual stereotyping.

**By hiding violence women lose opportunities to receive help, but by disclosing violence they open themselves to other risks.**

It should come as no surprise that women may become silent as a result. Here is how a woman who participated in the first phase of our study described the dilemma:

> It's the same thing with physical abuse. For a lot of women, it's hidden—I know from my own experience. There are women who hide their bodies because of bruises and scars, and they would need painkillers. The doctors don't know any of this. All they know is that this Native woman is in pain. They could try to get to the bottom of it and try to make things better. If you're the woman who was constantly being beaten, you're going to clam right up; you're going to be quiet and submissive. But there are these misrepresentations of this as part of their culture. That's a pile of crap.

Aboriginal women's silence is all too often read as an expression of shyness, shame, or submission—moralizing tags to identify so-called cultural difference. An individual's silence can become a double bind: by hiding violence women lose opportunities to receive help, but by disclosing violence they open themselves to other risks.

The individual's dilemma can be replicated at a wider level when whole communities become enmeshed in well-meaning policies that carry unintended consequences. For example, in spite of a lack of community-specific data regarding alcohol consumption patterns of Aboriginal women (Poole, 2003, p. 4), there is a popular view that all Aboriginal communities in northern B.C. "suffer" from extraordinary high rates of Fetal Alcohol Syndrome and Fetal Alcohol Effects (FAS/E). This perception is exacerbated by reliance on so-called social diagnoses; that is, in the absence of medical diagnostics, social workers, teachers, counselors, and others "diagnose" FAS/E in children and adults who exhibit a range of symptoms and functional challenges. Since access to intervention programs for people with special needs is based on diagnosis, not on generalized disabilities or measured levels of function, social agencies encourage women to have their children labeled accordingly (Tait, 2000a; 2000b). Communities wishing to help children and adults who have special needs therefore find it prudent to accept the aid offered by provincial ministries, which, in these communities, is likely to be in the form of FAS/E classes and training programs. As a result, the numbers of perceived FAS/E cases are elevated

and communities are caught in programming criteria set by others.

When an Aboriginal woman seeks FAS/E services for her child, she implicitly labels herself as an unfit mother, and if her child is diagnosed as being FAS/E, she is likely to be placed under greater social scrutiny by helping professionals. Even as she seeks to act in the "best interest of the child," the woman's reputation as a credible and responsible individual is threatened. When professionals associate entire communities with high rates of FAS/E, the women living there are stigmatized. A place of residence becomes a warning tag for professional and para-professional surveillance.

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When a policy invites a community to compete for short-term project money (i.e., "soft" money) and thereby assert itself as being in "control" of its own programming, the community can find itself in another double bind. By taking responsibility for its future generations through seeking funds targeted for FAS/E prevention or treatment, the community risks being stereotyped as the site of impaired conduct. Communities recognize the value of expediency and principled policy, but when they act on it they do so in circumstances not of their own making.

## C. The Entitled Subject

The current political context of British Columbia brings the stigma of politics grounded in entitlement into sharp focus. The treaty referendum of 2002 shifted discourses of treaty negotiations grounded in Aboriginal rights and entitlement to a discourse of unwarranted claims against the state and the personal wealth of British Columbian citizens. Notions of freeloading subjects unfairly benefiting due to "race" continue to be expressed matter-of-factly in media and public conversation (Le Moal, 2000a, 2000b). Barbara Yaffe, a *Vancouver Sun* columnist, gave us a good example of this attitude, when in 2002 she claimed:

> "It's called a culture of entitlement and a whole lot of Canada's aboriginals have it real bad. Even the label First Nations speaks of entitlement, as though all others are second in line. Those who suffer from this energy-sapping affliction almost always grow lethargic and passive …. People around them come to resent them, a situation that fosters an unhealthy society... Pandering to Native Indians is virtually an industry in this country" (Yaffe, 2002, p. A14).

Policy and negative attitudes intersect when health benefits are ostensibly more generous for First Nations subjects than the public at large. The non-insured health benefits accorded First Nations—dental care, prescription drugs, vision care, and prostheses, for example—are often resented by

members of the dominant population and reconstructed not as entitlement, but as an undeserved "racial" benefit. In this context, references to "unfair" health care benefits reconstitute the medical subject as the racial subject, reinforcing the intersection of policy, suspicion, and negative attitudes like that espoused by Yaffe. As a result, even the most principled policy recognizing the federal fiduciary obligations to First Nations people can contribute to their marginalization.

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Consider the situation we described earlier of an Aboriginal woman protesting the penalty fee at a health service. Women in our study were aware of resentment towards them as undeserving medical subjects. Having presumably received "something for nothing," women who protest the fee find themselves treated as dependent subjects with diminished rights. As Romanow explains, Aboriginal-specific health policies have become "an irritant to neighbouring non-Aboriginal communities" who "view the differences in access to federal and provincial programs as a breach of equity" (Romanow, 2002, p. 217). From this perspective, the Aboriginal medical subject is construed as taking advantage of race-based privileges, not as acting on her rights as an Aboriginal citizen. Casting her as "dependent," "lethargic," or "passive" implies that she lacks credibility, both as a medical subject and as a citizen.

Whether discredited by allusions to adverse lifestyle choices, cultural differences, entitlements, or by a combination of all three, Aboriginal women find themselves displaced as citizens within health care policies that resonate with popular perceptions and nationalist politics. At this juncture, the promise of citizenship falters. When the medical subject is redefined as a racial subject and her role as a citizen is misrepresented as a freeloading subject of the state, her voice in policy making is displaced and her credibility and commitment to the country as a whole are called into question.

## D. The Self-Governing Subject

There is a complex process of delegated health care administration by which First Nations communities assume control over some or all of the health care programs originally managed by the federal government. These health transfer policies arise from the federal government's and the Supreme Court's recognition of Aboriginal rights to self-governance and from the federal government's stated desire to demonstrate greater respect for First Nation leaders whose authority is founded in traditional social and cultural practices and/or in the terms of the *Indian Act*. Health Canada describes the policy as reflecting decades of efforts by First Nation and Inuit peoples

to regain control over community health care. Through health transfer, First Nations can develop culturally and socially appropriate health programs that address specific local needs. Unfortunately, health transfer can also marginalize First Nations women and entrap them in the contradictory subject positions or double binds that we've become familiar with in this study.

A health clinic in operation as a consequence of Health Transfer policy would, as envisioned by one participant in our study, be able "to have more programs that are geared toward the people, instead of government programs. You know how the government tries to fit the program into what you want, and sometimes it doesn't work." Health transfer aims to facilitate the construction of people/patients as credible and as having influence over local health policy. Yet policy development can transform Aboriginal women's language and visions into practices that are still defined, not by the women, but by federal health policy makers, even when the women have advocated for very specific actions.

**Health transfer policies can reinforce inequality between Aboriginal and non-Aboriginal authorities.**

The word *transfer* itself denotes equality, a giving over of something on an equal basis, but, in reality, this is a health care delegation policy whereby policy and fiscal powers are retained in a federal bureaucracy while increased responsibilities to meet policy goals of that bureaucracy are assumed at local levels. As Warry (1998) says of conflict resolution processes, health transfer policies can reinforce inequality between Aboriginal and non-Aboriginal authorities. Through its centralized control over the language of policy, and its power to set the terms of accountability that community agencies and front-line workers must meet, the state bureaucracy influences local conceptions of personal competency and individual morality. As public discourses come to stress accountability and affordability, they simultaneously cast suspicion that these standards are not being met—suspicions that come to rest on communities and individuals. Ironically, when it comes to real accountability, the Assembly of First Nations has this to say about what standards are not being met: "As for an equitable investment and Aboriginal Rights in Canada, an equal share means that in 1999 [the federal government] spent $10,036 per First Nations or Inuit person as opposed to $14,567 per Canadian. In terms of First Nations health outcomes, it means you get what you invest" (Assembly of First Nations, 2002).

As Aboriginal women move between on-reserve and off-reserve health services, how they are perceived and how they present themselves continually shift, depending upon varying constructions of them as medical

subjects, as national citizens, and as citizens of self-governing First Nations. What confers credibility in the women's home community—traditional medicinal health knowledge, protocols of respect, and care giving, for example—does not confer credibility in health care practices beyond it. A young community leader in our study offered this insight:

> Trying to break that barrier in the white medical field is probably harder than it is in anything else, like politics, for example...you know, actively working to try to build some bridges between the white medical field and our own medical clinic here [in the reserve community]. Why don't they [the doctors in the town] ask us about what we used before they came? You know, let's take a look at this history. How long have they lived here and how long have they shared with us their medical expertise? But how were things before that? Let's look at that. You know, we had our own source of medicinal plants. We had our alternative methods of healing.

**Women who held or had held roles of influence in their community, or had been appointed to health boards and other regional or provincial advisory bodies, found that health practitioners showed them deference and respect.**

Conversely, when women in our study experienced a shift in status that was imbued with authority in the dominant community, health care providers treated them differently. Women who held or had held roles of influence in their community, or had been appointed to health boards and other regional or provincial advisory bodies, found that health practitioners showed them deference and respect. A woman holding public office described her discomfort with her shifting status like this: "They sure walk on eggshells around me now….Yeah. Some of them do. Even I feel uncomfortable. It's like they're uncomfortable and I don't know how to make them comfortable now." The women viewed this change as a sign that, in general, First Nations women do not receive the same quality of care as their leaders do. At the same time, they sensed that members of their own reserve communities distrusted their new power as representative others who might judge and discredit them in the same way the dominant community has.

However well meaning, health transfer policy does not release First Nations women from the burden they carry as racialized subjects. Once health transfer comes into play, an Aboriginal woman who has had long-standing health care relations with off-reserve community health nurses may now be told that she should seek health care at "her own" on-reserve clinic. Policy represents such a scenario as a jurisdictional issue intended to ensure efficacious use of taxpayers' money, even though being refused service because of jurisdictional boundaries may well be a gesture of exclusion. When members of the dominant society constitute Aboriginal entitlements as a drain on the system, this sense of exclusion is exacerbated.

## E. The Racialized Medical Subject

**Racialization goes hand-in-hand with discourses of cultural differences in which attention is displaced from the citizen who may be engaged in policy reform, to a medical subject whose needs can be met through cultural "sensitivity."**

Racialization goes hand-in-hand with discourses of cultural differences in which attention is displaced from the citizen who may be engaged in policy reform, to a medical subject whose needs can be met through cultural "sensitivity." Such assumptions are "culturalist" in the sense that cultural differences, not structural inequities, are presumed to determine health status and lifestyle. From this perspective, cultural differences are also presumed to endure even when social, economic, and political changes such as treaty settlements or health transfer occur. At a very personal level, what a woman might eat or drink, how she might deal with stress or depression, where she might reside and with whom, or how she communicates with health care professionals can all be attributed to immutable cultural values rather than to socio-economic or geographic circumstances. Where such decisions are seen as having a negative impact on health, health professionals are told only that they need more knowledge of "cultural differences." That is, remedial action is individualized and focused only on health care encounters where minor changes in practice can be made, even when significant structural changes are called for.

The recommendation to expand Native liaison worker positions, made by women who participated in our study, shows the limits of the culturalist approach. The women originally envisioned the workers as advocates and as intermediaries between their community and the power structures outside, such as, for example, being able to participate in decision making for local and regional health administration and the health authority board. Placed within this broad range of responsibilities for patients and policy, the liaison workers could act as patient advocates, particularly for very vulnerable patients, and contribute to policy decisions. The workers we interviewed did attempt to advocate for the most marginalized patients, but they saw their job as focusing on cultural and language interpretation for elders and as fulfilling a social work role that primarily provided for patients whose needs extended into the realms of social, economic, and/or personal and family support. To a very large extent, this meant assisting patients with health care bureaucracy and medical technicalities. At the same time, the actions of their colleagues—nurses and doctors in the hospital—revealed practices consistent with culturalist assumptions that led them to tag both the liaison worker and the Aboriginal patients as Other. The more that the liaison worker carries cultural markers of identity and world view (for example, her attire, accent, appearance), the more likely her colleagues will view her as different and place her at a social distance from themselves. Although the word "liaison" implies a cultural bridge between differences,

this tagging of the liaison worker as Other leaves little if any room for the worker to negotiate structural changes and limits advocacy to actions focused on individuals as their needs arise. Notions of cultural sensitivity, rather than alleviating practices of Othering, tend to accentuate difference and create social distance between practitioners and patients without offering remedies for social or health status inequities (Browne, 2005, 2007).

**Notions of cultural sensitivity, rather than alleviating practices of Othering, tend to accentuate difference and create social distance between practitioners and patients without offering remedies for social or health status inequities.**

One way out of this apparent Catch-22 might be through "cultural safety," a concept originally developed by Maori nurses to address the health concerns of Maori people (Cooney, 1994; Papps & Ramsen, 1996; Ramsden, 1992, 1993, 2002; Reimer Kirkham et al., 2002). Incorporated as a required component of nursing education in New Zealand, cultural safety practices include an analysis of power imbalances, institutional discrimination, and the nature of colonial relationships as they apply to health care encounters at the structural, institutional, and interpersonal levels. The spirit of cultural safety is evident in the recommendation for expansion of the Native liaison worker positions and the recommendations of the Aboriginal Governors Working Group.

However, where the Native liaison worker is most closely tied to the cultural practices and social protocols of her home community, and most earnest in her defence of the marginal, her presence may undermine the principles of cultural safety by inadvertently contributing to stereotypes of patients as being so other as to be unapproachable. When health care workers assume the social distance between themselves and their clients to be too vast, they can turn to the Native liaison worker to mediate their discomfort rather than finding ways to traverse the perceived cultural divide (Browne, 2005).

Assumptions of Otherness lead to "proof" of Otherness as practitioners retreat further and further from direct communications and as patients respond to social distancing through withdrawal, respectful silences, and other strategies that unwittingly further exacerbate problems. For the demands of cultural safety to be fully met, practitioners need to be aware of and reflect upon their own subject positions in the context of the colonial, economic, and political processes that have undermined generations of Aboriginal peoples. Undertaking these principles of cultural safety could remedy the liaison workers' dilemma. Rather than being called upon to mediate practitioners' discomforts, the workers would be freed to act with these practitioners to address the underlying contexts that create barriers to communication. Without this self-reflection on the part of practitioners,

it is First Nations women themselves who are seen as responsible for practitioners' attitudes and distance.

The processes by which medical subjects are constructed are complex, interlinked, and often contradictory. Health policies are but one of many threads of discourse that position Aboriginal women as culturally and racially different. Whether well intended or expedient, policies act as a powerful force within the legacy of colonialism to reinforce the status quo, and in so doing set up paradoxes between the democratic values of citizen participation in governance and the pragmatics of health care delivery.

# V Implications and Concluding Comments

If discourses of citizenship empower Aboriginal women and entreat them to participate in health policy reform, health policy destabilizes the construction of the empowered citizen. Government's appeals to Aboriginal peoples as citizens, followed by practices that discredit these same peoples emerges as a pattern in policy reform and implementation (Fiske, 2006).

By calling for expediency and efficiency—values chosen from the culture of health care and serving the needs of the health care system—policy creates standards and expectations that inevitably frame moral judgments of the medical subject. Unquestioned negative constructions of Aboriginal women in health and social policy undermine their well being, set them up in numerous double binds, marginalize women as culturally and racially "different" Others, silence them, and, as the first stage of our research indicated and other studies have shown, create barriers to health care (Dion Stout, Kipling & Stout, 2001; Fiske, 1995; Fiske, 2006; Sherley-Spiers, 1989; Tait, 2000b; Varcoe, Dick, Walther, 2004). Health policies are regulatory, frequently (if inadvertently) punitive, and often lead to undue scrutiny and surveillance, moral judgment, and racialization of Aboriginal women. By constituting the lives of the poor and marginalized as marked by reproductive risk factors and lifestyle choices—rhetoric that implies moral judgments —social and health policies construct substance-using women as necessarily "indigent, welfare-dependent, possibly homeless, marginalized, and more than likely Aboriginal" (Rutman et al., 2000, p. 85).

Health care policies directed to Aboriginal health needs, and more specifically to Aboriginal women's health needs, are informed by moralistic assumptions respecting lifestyle choices and at-risk client groups. The lifestyles discourse implicitly shifts "problems" back onto the Aboriginal medical subject and away from the social, political, historical, and economic structures in which the health conditions occur, and away from processes and people of power. While there can be no doubt that Aboriginal people themselves have identified mental health, HIV/AIDS, addictions, and chronic disease as urgent health concerns (Northern Health Authority, 2002; 2003), it is the singular representation of these health needs as Aboriginal needs by provincial and federal governments and regional health authorities that threatens to mark First Nations women as deviant, passive, and even as the victims of their own culture. This approach accentuates the policy's assumptions about the Aboriginal person as a discredited medical subject. Removed from their holistic health needs and without reference to colonial strategies that have marginalized,

impoverished, and de-legitimated Aboriginal women, these policies carry forward what Furniss refers to as our "burden of history" (1999).

Failure to confront this burden of colonialism's history lies in part with citizens' willingness to accept policy reform as government "doing the right things" or correcting wrongs without questioning either the ideology embedded in policy or the power structures inherent in policy formulation and implementation. Today, policy reform processes such as the Romanow Commission on the Future of Health Care fuse national identity and universal health care. The future of health care is depicted as resting on the shoulders of the citizens who respond to calls to participate. It is our view that conceptually linked ideas such as "citizens' dialogue," "getting involved," "partnered policy debates," and "deliberative dialogue" (language used to evoke public participation in the commission's consultations), cloak health policy reform with social legitimacy and portray it as apolitical.

**Although calls to dialogue with government about health care policy reform empower the Aboriginal citizen... either many of First Nations women's recommendations are ignored, or efforts by health service administrators to implement them do not reflect the women's visions.**

There is a co-existing discourse of Aboriginal health that is imbued, as it must be, with identity politics and constitutional entitlement asserted at the broadest level of governing principles as articulated by the First Nations and Inuit Health Branch, but which is sidelined in health policy reform. As a result, structural remedies are eschewed in favour of reconstituting differences in health status primarily as cultural difference. It is therefore fair to say that policy is a form of power that works upon an individual's sense of the Other. It is this positioning on the sidelines that creates anew First Nations women as powerless subjects.

Although calls to dialogue with government about health care policy reform empower the Aboriginal citizen, as we have seen, either many of First Nations women's recommendations are ignored, or efforts by health service administrators to implement them do not reflect the women's visions. Once policy is enacted, the First Nations woman as medical subject is subsumed under an implicitly moralistic construction of a discredited subject who stands outside of authentic citizenship.

As we argue in this report, the vision for the Native liaison worker was transformed in the development of policy. The Native liaison worker policy implicitly linked health policy to medical subjects who were constrained by their perceived socio-cultural "deficiencies." The one existing liaison worker's job has been defined more clearly in terms of assisting individuals with *personal* needs rather than in terms of addressing structural power and racial relations. Just as the views of the Aboriginal governors could be

erased in the process of formulating policy, so could the voices of community women be silenced in the transformation of their recommendations into policy.

Health care policies need to be read in a context of media and political discourses where erasure and silencing reinforce negative stereotypes. Discourses that reframe health policy in market metaphors of product, in terms of efficiency and fiscal accountability, also construct the Other as undeserving and relieve all citizens of concern for or dependence on one another. Disconnected from historical, political, and economic realities, media's and some governments' suggestion that Aboriginal health care and other entitlements are "unfair" to non-Aboriginal peoples further discredits First Nations people as medical subjects.

The Referendum on Treaty Principles provides one of the clearest examples of the reciprocal relations between commonly held perceptions of First Nations peoples and the political discourse of government. The discourse reflected back to the public creates both discontent and misunderstanding of the treaty process and suspicions and distrust of First Nations peoples and their political and legal aspirations. Negative constructions about Aboriginal women as medical subjects also seep into and discredit claims by Aboriginal peoples that they are capable of taking on the responsibilities of self-government. Disconnected from historical, political, and economic realities, media's and some governments' suggestions that Aboriginal health care and other entitlements are "unfair" to non-Aboriginal peoples, for example, discredit First Nations people as both medical subjects and citizens.

This study demonstrates the value of critically scrutinizing the assumption that health care policies can be effectively reformed independent of broader structural transformations. Critical discourse analysis allows us to challenge taken-for-granted political approaches and their consequences. Specifically, it allows us to reflect on the ways that seemingly disparate political agendas and practices resonate with one another through the use of common language and communication strategies to reproduce the status quo. When critical discourse analysis is applied to case studies, we can see the power dynamics in ideas of difference—we can see persistent contradictions between liberal democracy and the burden of colonial legacy that is steeped in racial assumptions and actions.

Health policies that recognize cultural difference are embedded in larger political discourses. The implications of minor policy changes, therefore, cannot be understood without considering both the power of discourses to shape social and political assumptions and actions, and the inability

of isolated policy "reforms" to alter structural impediments to Aboriginal women's well-being. Health policy reform is and will continue to be impotent in effecting true social change unless it is accompanied by a significant shift in socio-economic power structures, critical awareness of the powers of discourse, and consciousness of the colonial legacy that underpins notions of reform and consultation. Without these interlocking transformations of power relations, Aboriginal women, discredited as medical subjects, will find policy itself a barrier to well-being.

**Health policy reform is and will continue to be impotent in effecting true social change unless it is accompanied by a significant shift in socio-economic power structures, critical awareness of the powers of discourse, and consciousness of the colonial legacy that underpins notions of reform and consultation.**

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## Endnotes

1 Discourse theory often refers to "the subject" instead of "the person" or "the individual" to indicate that discourses can alter or shift conceptions of the individual.

2 Deborah Lupton (1994) defines discourse as a "coherent way of describing and categorizing the social world" through "patterns of words, figures of speech, concepts, values, and symbols" (p. 18). As Escobar (1997) explains, "it is through discourse that social reality comes into being…it is the articulation of knowledge and power, of the visible and the expressible" (p. 85). Discourse is found everywhere – in policy or political arenas, in government, in research literature, in the media and popular culture, in health care institutions, in the justice system. Paying attention to its ubiquitous messages, "discourse analysis is often used as a tool to identify and define social, economic, and historical power relations between dominant and subordinate groups" (Henry et al., 2000, p. 46).

3 Semantic reversals refer to playing with words to reverse intended meanings and objectives; mobilizing metaphors arouse sentiments and actions while masking underlying political intentions. Literary tropes involve the colorful use of language and figures of speech to convey emotion and unstated associations of meaning, while analogies are associations between objects otherwise not connected. Referential strategies involve situating and manipulating references and false associations between peoples, actions, and contexts to invoke emotions, shape moral judgments, and manipulate meaning and intent.

4 In 2002 we conducted a survey of health authorities and health boards asking for data on Aboriginal health administrators. While we were unable to construct a representative sample that would offer valid statistics from across Canada, our respondents overwhelmingly confirmed that the majority of Aboriginal peoples in these middle management and para-professional positions were women.

5 Othering refers to the projection of assumed cultural characteristics, differences, or identities onto members of particular groups. These projections are not based on real or actual identities; rather, they are founded on assigned, often stereotyped identities. As a social process, Othering is central to establishing and reinforcing unequal social relations – often based on sharp binaries between "us" and "them" (Narayan, 2000). By "defining the Other (usually as inferior) one implicitly defines oneself against that definition (usually as normal or superior)" (Ahmad, 1993, p. 18).

6 Racialization is a process of attributing social, economic, and cultural differences to race. Racialization may be conscious and deliberate (an act of racism that discriminates openly) or it may be unconscious and unintended. In either case, racialization takes its power from everyday actions and attitudes that marginalize individuals and collectives on the basis of presumed biological, physical, or genetic differences. Fundamentally, racialization refers to a process of "categorization, a representational process of defining an Other" (Miles, 1989, p. 75).

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