THE OPPOSITIONAL CULTURES OF RURALITY AND URBANITY IN OKLAHOMA HEALTH CARE

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ABSTRACT

This paper studies rurality and urbanity (in the state of Oklahoma, and elsewhere) as bona fide cultural realities, and explores the consequences of rural/urban cultural differences and conflict for health care in rural settings. The methodology of exploring multiple viewpoints (borrowed from anthropology, as the emic/etic distinction), and the statuses and power associated with these perspectives, is fruitful in elucidating many long-standing issues in rural health care: access, isolation, boundaries, units of measurement, sense of place, stigma, identity, etc. From twenty-three years as a clinically applied psychodynamically-oriented medical anthropologist in rural and urban Oklahoma settings, the author provides numerous vignettes to illustrate the methodological and theoretical points made. The paper concludes that a powerful barrier to improved rural health care is the reciprocal stereotyping between rural and urban cultures, a binary opposition, that prevents accurate assessment of needs and realities.

INTRODUCTION: RURAL MEDICINE AND IDEOLOGIES OF PLACE

This paper inquires into the rural and urban contexts of health care in the state of Oklahoma. It is a study in qualitative anthropology/sociology. It contextualizes recurrent problems in health care delivery within the framework of rural and urban perceptions and relations. A number of vignettes illustrate the often oppositional relationship between these two cultural worlds that are ostensibly situated with "the same" state and national culture. I shall argue that group boundary, culture, identity, and sense of place influence health care decision-making in Oklahoma and elsewhere.

Ultimately, this viewpoint leads to a redefinition of place, and specifically of rurality. I shall argue that not only, culturally speaking, are things not what they seem, but they are not even entirely where we usually think they are. I shall explore the health care implications of the fact that these two ostensibly distinct cultural domains are deeply entwined with one another.

The material in this paper derives from my role since 1978 as a clinically applied medical anthropologist in the Department of Family and Preventive Medicine at the University of Oklahoma Health Sciences Center. I have spent most Fridays as be-

havioral science director/coordinator of the family medicine residency training program located in the Enid Family Medicine Clinic, in Enid, Oklahoma, a rural primary care training site in northwest Oklahoma. From 1979-1985, I worked in a similar capacity at the Shawnee Family Medicine Clinic, also an affiliate of the Department of Family Medicine at the University of Oklahoma Health Sciences Center, Oklahoma City.

RURAL HEALTH CARE AND ITS CONTEXTS

It is widely assumed that, when the term "culture" is used, it denotes certain *kind* of groups or units: e.g., ethnic, nationality, religious, and racial (that is, an American sociological category that is held to be biological). Thus, when a topic such as cultural aspects of rural health, or of rural medicine, in Oklahoma is brought up, we are accustomed to think, for instance, about Blacks *in* Oklahoma, Hispanics or Latinos *in* Oklahoma, Native Americans (or tribal groupings such as Choctaw and Cheyenne-Arapaho) *in* Oklahoma, Southern Baptists *in* Oklahoma, Vietnamese *in* Oklahoma, Mennonites *in* Oklahoma, Jews *in* Oklahoma, Germans *in* Oklahoma, and so on. The tendency is to view the culture as residing in the ethnic, nationality, or religious group, and for Oklahoma to be largely, or merely, a geo-

political entity in which the culture is geographically located.

Put differently, we tend to assume that, say, ethnicity is a matter of personal identity, while Oklahoma (or another state, or city, or region) is merely a matter of place. The same holds for other states and regions in the U.S. Yet, at its broadest, culture is a matter of boundaries, and with them, the sense of identity that distinguishes between "we" or "us" and "they" or "them" (Barth 1998; Stein and Hill 1977). The sense of group is primary; the label for the kind of group (ethnic, national, religious, occupational, professional, gender, racial, state-province-canton, etc.) is secondary (Stein 1992). The making of a distinction between groups – that "We are ABC" and "You are XYZ" – is itself a cultural claim. In a number of works I have argued that "Oklahomaness" (that is, the sense of being "Oklahoman," whatever other identity[-ies] one claims or with which one is identified by others; see Stein 1987a,c) is itself a distinctive cultural system (Hill and Stein 1988; Stein and Hill 1989; Stein and Hill 1993; Stein and Thompson 1991). In this paper, I develop this perspective of cultural localism further, to explore "rural" and "urban" as distinctive cultural systems that, among other things, have an effect upon health care.

It will be my argument that the cultural duality of "rural"/"urban" itself governs much health-related perception and behavior among practitioners, patients, and communities alike. Further, these two additional cultural categories crosscut conventional ethnic, national, racial, religious, and state understandings. In this paper, then, I shall devote attention to rurality, and urban-ness as themselves cultural ways of organizing life, and to their influence upon rural medicine in Oklahoma.

Stated colloquially, rural-ness, and urban-ness (in Oklahoma and elsewhere), are matters of who one is, not only a matter of where one is located. "Where-ness" becomes a defining part of "who-ness." Place becomes incorporated into the sense of place. This sense of place may, or may not, be articulated in language. It may be asserted ("emic", e.g., Oklahomans' and

Texans' emphasis on their differences from each other) or inferred from behavior ("etic", e.g., cultural continuities throughout the Great Plains). This paper has implications for the broader culture areas (Kroeber 1951; Devereux 1969) that intersect within the state: viz. "Little Dixie [The Old South]," the North American Great Plains or the Midwest, and the Southwest.

Before proceeding, I wish to attempt to systematize a number of terms I have thus far introduced. Such concepts as group, culture, identity, place, and sense of place all constitute facets or aspects of a unitary, ongoing, dynamic social process, one that occurs simultaneously at conscious and unconscious levels, and one that is undergoing constant "construction" and re-working. Recent critiques of the notion of a unified, consistent "self" (Schweder 1991) and of fixed ethnic or and other social characteristics and units (Kondo 1990; Lamphere 1987) emphasize the processual nature of all social structures. I use these concepts more evocatively and descriptively than definitively. They all express the linkage of "I" and "me" (singular, individual), with "we" and "us" (plural, group) with boundary formation and border regulation, and with the often binary opposition between "us" and "them" (Volkan 1988).

Put formulstically: "group" may be seen as the social, intersubjective process of boundary creation and maintenance; "culture" may be seen as the specific content of the group process, and hence of the boundary (the notion of "a" culture fuses form and substance); "identity" may be seen as the conscious and unconscious sense of belongingness and continuity with the group; and "sense of place" may be seen as an extension or projection of "whoness" or "whatness" into "whereness." This approach draws heavily from the pioneering work of Erikson (1968) on identity, and Barth (1998/1969) on social boundaries. Its relevance to the study of health care in rural and urban settings will be shown to lie in the fact that (1) "urban" and "rural" are in fact facets of one another, even when those links are con-

sciously disavowed; and therefore (2) "urban" and "rural" are inseparable, even when they are ideologically split into two distinct geographic realms.

METHODOLOGY AND THEORY: OVERVIEW

My methodology is that of an applied anthropologist whose data derive from long-term fieldwork in urban and rural Oklahoma health care settings (Stein 1999b). I "collect" what I know from day-to-day activity as clinical teacher, supervisor, group facilitator, faculty member, listener and observer, and participant/presenter at national Family Medicine conferences. In this paper, my two roles are those of (1) observer, participant observer, and cultural interpreter, and, occasionally (2) key informant (one who aspires to be self-observant). My data here consist largely of vignettes -- stories -- which can be read as cultural exemplars (Nuckolls 1997) that is, as instances of widespread, recurrent, patterns. Most of the data I "collect" – indeed, most of what I have learned about rural and urban medicine – comes less from questions I ask as from being present at "moments" when I discover that these cultural distinctions are precisely the point (often implicit) being made.

For instance, a frequent, rebuke-filled, comment made often at lectures on rural health care that I present to medical students and resident physicians in urban medical training centers, is: "If these people want to have good health care, why do they insist on living out in the country? It's their own fault if they can't get state-of-the-art medicine when they choose to live where it isn't accessible."

I shall argue that, in addition to their scientific, biological dimension, rural and urban medicines are also a species of cultural medicine or ethnomedicine (see Gaines 1992; Purtilo and Sorrell 1986; Snider and Stein 1987; Stein 1987b.d; 1990a; 1991, 1992, 1995b, 1996; Stein and Pontious 1985). Situated within American and Oklahoman culture, rural and urban medicine are rife with stereotyping, "ethno"centrism, and bigotry toward one another (Miller 1979; Stein 1990b). The universal tribal claim that "Our way is the only right way, the human

way, and the way they do things is crazy if not evil" governs these professional cultures as much as it does ethnic ones.

One of the most fruitful contributions of anthropology to social research has been the distinction, originally borrowed from linguistics, between "emic" and "etic" perspectives or viewpoints (see Agar 1996; Sanjek 1990; Spradley and McCurdy 1988). Initially, "emic" referred to the "native" or "insider" point of view, while "etic" referred to the "observer" or "outsider" (even "universal" or "scientific") perspective. The distinction between viewpoints has been fruitful in conflict-identification and in problem-solving. As intra-group diversity and conflict came to be recognized, the distinction has come to be used to understand cognition, meaning, feeling, and power *within* groups as much as between them. Often, "etic" comes to represent official viewpoints, while "emic" comes to represent unofficial ones.

For instance, official compilation of healthcare data in and about Oklahoma often is based on the county as a fundamental unit, the hospital and its service or "catchment" area, and United States Census categories such as the Standard Metropolitan Statistical Area (SMSA). Actual patterns of access and utilization often differ widely from the official model (cf. Bachrach 1983). I shall return frequently to this distinction between cultural viewpoints, to the role of power in constructing and enforcing the distinction, and to their consequences for rural medicine.

One may also learn about Oklahoma rurality by proceeding in the "opposite" or reverse direction: that is, outward, to more encompassing systems that link the grain- and cattle-farming ethos of Oklahoma to Great Plains patterns that transcend state boundaries. These systems are characterized by such prominent structural features as "crossroads" towns and the *Einzelhofsiedlung* ("open country neighborhood") that originated in England, Ireland, and much of western Europe (Arensberg 1955: 1153-1156). The spatial patterning of settlement and cultivation is that of individual, dispersed farms.

The geographic expanse of Euro-American rural culture is attested to by the virtual identity between the findings of Long and Weinert (1987) for ranchers, wheat farmers, and loggers in Montana, and my own findings (Stein 1982, 1987c, 1995b, 1999a) among wheat farming and cattle raising families in central and northwest Oklahoma. Dominant or core values – all of which affect health care attitudes, timing, and "compliance" with medical authority – include: independence (personal, family), self-reliance, the desire to do for oneself (to "take care of our own"), the distinction between old timer and newcomer or outsider (status measured by length of residence and family links, rather than the medical school of one's training), isolation and distance (willingness to drive large distances, but infrequently, thereby making "routine" medical follow-up difficult), health defined as the ability to work and perform social role(s) rather than by the absence of symptoms, resistance to control by outsiders, closeness to and sense of control by nature and God, lack of personal anonymity, role generalism, and stigma toward mental health conditions and practitioners.

This identity of values and worldview – despite other large cultural and political differences -- commends a model advanced by Kroeber (1951) and Devereux (1951/1969) wherein individual tribal and ethnic boundaries become subsumed within a larger "culture area" possessing a distinctive "culture areal ethos." I have argued similarly (Stein 1978) for Slavic eastern, central, southern, and western Europe. The scope of North American Euro-American rural family culture stretches from north Texas to the Dakotas and Montana, and eastward on the central plains through Iowa.

What, then, is rural? It is foremost a word to which are attributed many, often conflicting, meanings (Bachrach 1983; Stein 1987a, b). People create and are entrapped in these emotion-laden meanings. Rural and rurality are often used as residual demographic categories, denoting those living outside Standard Metropolitan Statistical Areas (Bachrach 1983).

These same terms are also often used to denote agricultural, in contrast with industrial or high technology, ways of life and economic base. They are further used to refer to sparsely populated areas remote from densely settled urban centers. They are also associated with a worldview of close personal ties, of often-overlapping social roles. When they are not associated with a place distant (by some measure) from the city, they are associated with worldviews and values of groups of recent immigrants from foreign lands, "urban villagers" (Gans 1962) of one type or another, clustered geographically or in closely articulated social networks within cities. Within this diversity of meanings, a common thread is (1) a dichotomy that radically distinguishes between some "us" and some "them," and which in turn (2) neglects crucial lived social reality in both.

To summarize, then: I shall denote rurality to be less specifically a place as it is a sense of place and a way of thinking about a relationship between an "us" and a "them" (self and other). People who live far from "the city" might be considered living "in the boonies," while non-university physicians who practice within the urban community might also be regarded by their urban-academic counterparts as "boonie doctors." This paper will examine the nature of this polar state of mind and its consequences for health care in rural Oklahoma and beyond.

CENTER AND HINTERLAND AS CULTURAL DICHOTOMY

Within rural medicine, and between rural and urban medicines (in Oklahoma, on the Great Plains, and throughout the United States), there has long been conflict between the view that (1) rural medicine is real, genuine, biomedicine, one contextually tailored to the context of patients and doctors' lives, one that is simply different from that practiced in cities by virtue of geographic remoteness and factors intrinsic to rural life; and the view that (2) rural medicine is deficit medicine, sub-standard, medical practice. Urban physicians often label their rural counterparts as "LMD's," "Local Medical Doctors," "Boonie Doctors" (physicians who

elect to practice hinterland medicine and who lack much scientific knowledge and advancement), who practice far from the city because "they couldn't make it here in the city."

In Oklahoma as elsewhere in the U.S., rural and urban physicians often reciprocally stereotype one other: e.g., "The Center" and "The Mecca" versus "The Boonies" and "The Sticks." A common joke is that "It isn't the end of the world, but you can see it from here/there (name of town)." It should be noted that one member of the ideological pair does not exist apart from the pair itself; each requires the other for self-definition. In both cases, projection is part of the regulation of perception and knowledge of the other: put colloquially, what you see is where you look from, and what you project onto your counterpart or adversary.

In many respects, the relationship between rural and urban medicine recapitulates the broader sociological distinction between urban center and rural hinterland, the city as the source of control and the countryside as the source of resources (Kraenzel 1966; Miller 1979), the city as exploiter and the country as exploited. While "center" and "hinterland" are emotionally-charged cognitive distinctions between "here" and "there," they are often further governed by power relations of subordination and the struggle against subordination. Often, in health-related decision-making, urban, academic center-based views "count" and govern, while rural, community-based views tend to be discounted.

In a study of the psychology of place, Fullilove (1996) considers the rural adaptation to urban stigma, to the

> ...feeling that one's place is viewed with disdain by others. Julia Eilenberg, a psychiatrist working in a rural area of New York State, has studied the ways in which degradation of one's place is an alienating experience (1995). She has observed that rural America, no longer the center of national life, has settled into a state of invisibility that is lifted only by tragedy or disaster. A big tornado, for ex-

ample, suddenly brings the camera to the threatened town or county, only to have it leave again when the storm is over. Because people identify with the localities in which they live, the loss of visibility has led to a profound collapse of self-pride. The psyche is injured, she postulates, as a result of the involution of one's place.

The disparagement is as subtle as it is pervasive. It is revealed by off-hand comments such as "We in Oklahoma City and Tulsa have *stress*; you in rural Oklahoma don't;" or, "*You out there* don't understand; in the city, *here, we* have these problems...." Implicit urban idealization and romanticization of rural life, together with rural peoples' reluctance to complain to outsiders, fuels the stereotyped distinction between anxiety-ridden city and idyllic country (Stein 1987b; De Vos 1974). The moral universe is split along the lines of "good" and "evil," a fairly stable historical distinction. For example, rural violence (Stein 1994, 1995a) has, until the recent interest in "militant" and "survivalist" groups, passed mostly unnoticed in urban-based studies, because its presence conflicts with romanticization of the quality of rural life.

The emotional valency or affective "charge," however, can quickly switch. Sometimes, the idealized "country" is contrasted with the problem-ridden city, such that chronic problems in the country are both not seen and well hidden. Other times, the technology-wealthy city is set as polar opposite to the technology-deficient countryside. Rural peoples' expectations and values of local control, self-reliance, and autonomy occur alongside, and in the face of, increased outside control (ranging from international markets, to government regulations, to banking chains, finally to the weather. nature, and God).

METHODOLOGY AND MEASUREMENT: WHAT YOU SEE IS WHERE YOU ARE LOOKING FROM: A VIGNETTE (#1)

Like all scientific methodologies, social science methodologies can simultaneously help us to "see" (to use the visual sense

and metaphor) and prevent us from seeing (Devereux 1967). A method presupposes the kind of data that we will find. In and of itself, this is not bad, but becomes limiting when we fail to recognize that every method presupposes a vantage point. That is, what you see is where you are looking from. To be aware of this as one is seeing permits us to see from other viewpoints. To be unaware of this – at worst, to be vested in a single viewpoint as reality itself – is to be self-blinded to other ways of seeing, and to be unable to discern data sets from those other perspectives.

For example, standard and standardized ways of gathering health-related statistics consist, among others, of US Census, CDC (Centers for Disease Control), SMSA, and the seventy-seven counties in Oklahoma. Issues of health care access and facility utilization are studied in terms of various official units. Within Oklahoma, such an approach can conceal as well as reveal. If one thinks demographically in county units exclusively, one will miss crucial cultural patterns that fall outside these ways of seeing. Rural Oklahomans often drive across the county line to towns in adjacent, or more remote, counties, for their health care. Those who live in counties near state borders might, in fact, cross state lines for their health care.

I know of several instances where, after physicians who have practiced for many years in one Oklahoma community move one or two hundred miles away to a new practice, many of their patients will "follow them" and drive the distance so that they can keep the same physician. Further, because of the stigma associated with "mental" illness, family members may travel several counties away from their home county for psychiatric, psychological, or family therapy. The official ("etic") measures are not wrong as much as they are limited in what they are able to conclude about lived patterns of health care access and utilization ("emic").

A vignette will make this point even more concretely. It illustrates how an unconsciously urban viewpoint can consciously distort rural lived reality by selecting certain data and overlooking crucial other data. In the middle 1990's, an eminent medical epidemiological researcher took me aside and offered me some advice on my work. He was familiar with my studies of Oklahoma culture, rural and urban facets of Oklahoma culture, from the early 1980's through the present. My notes here are approximate, but capture the spirit of his admonition.

Your research and publications about rural farming and its relation to health care may have been true for when you first came to Oklahoma (1978), but they just don't apply now. There's practically nothing left of rural culture in Oklahoma. It's a myth that we're a rural state [I have always tried to stay out of the ideological, either/or, argument, as to whether Oklahoma is rural or urban. HFS] You know full well that there's been migration to the cities, and rural depopulation, for a half-century. If you look at the 1990 US Census, even in the region of Enid [a city in northwest Oklahoma] that you talk about so much, practically no households earn a primary income from farming. Look at the data. Most people have urban jobs. I don't see how you can keep talking and teaching about rural Oklahoma and health care. It's become so minimal quantitatively.

My colleague was, I believe, speaking from an "etic" viewpoint, that is, from the (or at least a) official scientific standard of population trends, the US Census. I do not quarrel with his account of historical patterns. I question his conclusions based on his (and many others') limited data. Put colloquially, what one "counts" (enumerates) depends on the kind of data that "count" (that matter, that one takes into account, data that one notices and includes). Status becomes a part of science. Neither my colleague nor the US Census were close enough to the lived lives of many Oklahomans -- and, beyond that, many inhabitants of the North American Great Plains – to be able to conclude that there is a vital difference between "farm-

ing to live" (income) and "living to farm" (value).

Many individuals, and married couples, I know throughout Oklahoma earn wage-incomes in manufacturing, government, health care, banking, insurance, and other jobs in order to earn a livelihood and in turn in order to keep the farm in operation. Thus, the farm does not sustain them economically; they sustain the farm in order to "farm" (verb). Further, as grain and cattle farming have become increasingly technologized, industry has been located throughout ostensibly rural areas as well as concentrated in urban ones. My colleague is thus technically, statistically, correct, but his conclusions are misplaced. An "emic," or internal, viewpoint would be essential to notice the very kinds of data I have described – and then to "collect" it. I emphasize that I have not set out to prove that Oklahoma is "rural." Rather, I have discovered that much rurality flourishes and languishes, and that a part of the latter is because we fail (are motivated to fail) to look, to ask, and to listen. Our methodological assumptions and categories interfere with the very data we need to make rurality less "hidden" a variable.

CULTURE AND TECHNOLOGY TRANSFER: A VIGNETTE (#2) ON FIBEROPTIC TELECOMMUNICATION AND RURAL MEDICINE

Since the early 1990's the collaboration between urban academic health sciences centers and telecommunications companies has promised to bridge the chasm between rural and urban access to medical care. What could be viewed as errors in cross-cultural communication complicated and compromised the very media and technology that were designed to bridge cultural regions and hence to improve communication. In Oklahoma and elsewhere in the United States, fiberoptic telecommunication networks were depicted from the urban centers and government as the solution to the problem of high cost, high technology, concentration in cities. Distributive clinical justice would be achieved by statewide outreach from the city (-ies). Small, rural hospitals would now become -- almost magically – equipped to perform tests and procedures, and have their inter-

pretations, diagnoses, and clinical recommendations made as if much of the urban subspecialists and high technology were located in rural areas. Technology would conquer geography. Rural isolation would be a thing of the past.

The problem is that this "promise" is in fact a viewpoint ("etic") rather than the whole of social reality. It is a viewpoint from and with power, so that its adherents can attempt to impose point-of-view as if it were the only legitimate view. The neglect of these disturbing "facts" has led to unexpected, and costly, results. Greater initial attention to rural/urban factors in perception, power, and communication would have prevented at least some of the consequences.

Biomedical colleagues in rural Oklahoma, and in rural hospitals elsewhere, have repeatedly told me that millions of dollars of high technology lies idle in little hospitals. Why? They explain that when their urban counterparts installed it, they failed to ask the people who would be using it what they needed and wanted, that is, how *they*, the rural practitioners, would be using it. Health sciences centers and urban hospitals made assumptions about what rural clinicians should have and should want. By contrast, rural Oklahomans value doing things personally, one-to-one, to meet people face to face, then conduct business (cf. Hall 1959). Urban health and telecommunications planners just wanted to "get down to business."

There was a poor fit in communication style from the outset. One rural physician said to me, "Rural doctors have not been invited to design how the telemedicine equipment would be used. It's as if all the expertise and intelligence is in the city. It's a one-way street. And the money flows one way." In a paper on "U.S. Health Care Reform: Origins, Development, and Impact," medical anthropologist Carole E. Hill (1994) argued similarly with respect to health care policy-making. Health policy planners tended to view rural areas as extensions of urban areas. Health care solutions were designed in an urban-to-rural direction, centralizing services, and offering health care as a commodity rather

than as part of a relationship. Worldwide, not only nationally, telemedicine demonstration projects were being offered as a large part of the solution to "access to care." Yet that access was a highly controlled access (politically, economically, social status), one that maximized urban viewpoints and largely ignored rural ones.

Hill described one study, from Buckingham County, Virginia. A new, modern multi-specialty clinic had been built, yet it was poorly utilized. Middle class and aspiring middle class patients refused to travel to what they perceived as the "welfare" clinic. Perception of space, or cultural geography, and not distance alone, is an important, often neglected consideration in planning the location of new medical facilities. Rural peoples throughout the American (United States) South, Midwest, and West often travel large distances (say, 100-150 miles) for family visiting, shopping, and the like. The question of "Where?" is inseparable from the question of "How far?"

In summary, many rural clinicians' objection is not to telecommunication networks per se, but to the sense of disrespect, of discounting, that is imbedded in the planning and implementation of the projects. Rural Oklahomans often remind me that they are hardly the backward, simple, country folk they are often portrayed to be. Grain and cattle farming require much high technological and scientific skill. And no sooner do the farm implement companies develop tractors, balers, and combines that are safer than farmers figure out how to take them apart and "jerry rig" them themselves! Rural physicians and their colleagues have increasingly linked themselves to computer networks of national medical databases and personal networks. Such linkage helps to reduce the sense of isolation and to help rural practitioners keep up with current medical advances. What they reject is the image of medical technology as self-standing, an independent variable, when it also symbolizes rural-urban relationships. "Technology transfer," they remind me, is never merely about technology, but about networks of relationships,

meanings, and power – topics which often may not be discussed at the conference table.

RURAL AND URBAN, BACKWARDNESS AND CUTTING EDGE: A VIGNETTE (#3)

Just as the internalization of (projected) stigma can be devastating in inter-ethnic and inter-religious relations, it can be equally destructive in one's estimation of self-worth – and, by extension, the worth of place – in urban-rural relations. Around 1985, L. W. Patzkowsky, M.D., the medical director of the Enid Family Medicine Clinic, a rural Family Medicine residency training site, called me aside to visit. He was also my supervisor at this work-site. He said, with urgency and embarrassment:

> Howard, I'm just an old country doctor. I knew families because I practiced in the small town of Kiowa, Kansas, for 25 years, and I got to know them the old fashioned way. One a time. I got to know their stories. But with Bill Doherty and Mac Baird now in the Department, I feel way behind. (William Doherty, Ph.D., and Macaran Baird, M.D., had recently published [1983] *Family Therapy and Family Medicine: The Primary Care of Families*, a work that, even when in manuscript form, had been touted by the chair and others as *The Book*, "The Bible," a sacred text, one required by everyone in the department, and one that would "put the department on the map" and help give Family Medicine stature in medicine.) Would you set me down one of these days and teach me about 'family systems'? It's a whole new world, and I guess I don't know about families as I should. I don't know their language. All I know is that I got to know my patients by taking care of them for many years, by listening to them. I guess I just missed a lot....

As he spoke, my eyes began to water. I was shaking my head from side to side, incredulous at what I was hearing. I felt humiliation in his behalf. Here was a man whose medical chart notes on the personal and family history of clinic patients were

like little paragraphs out of a novel or short story. The people and their lives as well as their ailments leapt off the page. Once, I had begun long-term counseling of a patient of his based exclusively on a reading of her chart — he was too occupied at the moment to sit down and visit with me about her. I said to him that, certainly I would tell him the principles and language of family systems medicine that I knew, but that I couldn't accept a world that had made HIM of all people feel inferior and backwards, when in fact HE had so much to teach us, the younger and ostensibly more rigorously scientific of the generations.

What kind of disrespectful world of clinical education are we creating, I wondered, where many of those who had so much to offer were intimidated into feeling they had nothing to teach but, instead, had to learn all over again? Certainly I could acquaint him with family systems theories and clinical models, but in the very least, did the new and the old, the big city and the small town, both have not to learn from one another? Other, non-clinical, issues seemed to be at stake and to permeate the ostensibly linguistic and methodological differences: social status, narcissism, power, to name but three. Among the processes at work was, I believe, what Freud termed the "narcissism of minor differences" (1930), a narcissism that induces one group to believe that it "knows," that it possesses truth, and that another group knows little or nothing of merit, and that induces self-doubt and shame (and often compensatory pride) in the devalued group.

STATUS AND RURAL MEDICINE: VIGNETTE (#4)

A chronic conflict in cultural identity within the discipline Family Medicine over its thirty-year history has been between those who advocate "rural," and those who advocate "urban" medicine. Although I have long striven to bridge and integrate contexts, I have come to be seen by many Family Medicine academic colleagues as strictly a ruralist rather than as a contextualist -- since one is culturally permitted to be in only one camp, not both.

A linguistic cognate of the rural/urban conflict is that between two domains: (1) community-based medical training and practice sites (whether those sites are geographically remote or located within the city), and (2) urban, academic, health sciences health sciences center-based medical training and practice sites.

The following personal example illustrates the role of us/them, inside/outside, urban/rural, health sciences center/community, distinctions in identity negotiation.

In 1992, I received the Donald J. Blair Friend of Medicine Award from the Oklahoma State Medical Association. It is an annual award bestowed to a lay person (non-physician) who is seen as having contributed much to the health of the state of Oklahoma. I learned more than I bargained for about cultural identity, and its statuses, when my immediate academic supervisor in Oklahoma City, himself an eminent family physician teacher and researcher, tried to explain to me why there was virtually no mention of the award in my "home" department: "You just don't understand, Howard. You got a 'boonie award' from 'boonie doctors.' The award you received doesn't count at the health sciences center. If you were to receive an award that counted, it would have to be bestowed by the health sciences center."

On this occasion, as on others, he admonished me: "You keep asking for respect. Don't you understand, you don't deserve respect? Your work is marginal to the discipline and to the university."

In his lecture to me, he assimilated rural physicians into the stigmatized category of supposedly backward, uneducated, uncultured, hinterland people, folks of the "boondocks." He blurred "community" physicians – even practitioners in the cities -- with "rural" physicians, saying essentially that even urban-based physicians who are not in the academy are just as second class as physicians who practice in the remote "boondocks." "Boonie" and "boondocks" is more a place in the mind

than it is a location in geographic space. In the realm of social comparison and envy, virtually any place fan feel like the "boonies" relative to another place, or can be disparaged as the boondocks" by a place that is larger, and associated with higher status, than it.

From his word choice and admonitory tone of voice, he was not reporting about someone else's culture, but instead he was claiming its values as his own. To hear this was as culturally edifying as it was personally devastating. I felt as if my career and contribution had been reduced to rubble and feces. I wondered whether he could elevate his "urban," "academic" stature by identifying me with rural and community "boonies." What, I further wondered, was the current status of the early Family Medicine ideal as advocate for underserved groups? In his admonition, I felt not only that I had been relegated to the hinterland, but likewise the reformist philosophy of Family Medicine had been demoted if not banished. Clearly, from his position, there was little or no room for integration.

CLINICAL MEDICINE AS CULTURAL MEDICINE: FIVE VIGNETTES

The following five brief clinical vignettes illustrate how rurality-as-culture colors virtually any facet of clinical reality, and in turn how this fact merits consideration in any clinical case, rural or urban. Clinical (biomedical) examples will range from chest pain, to hospital discharge planning, the measurement of central venous pressure, performance and evaluation of "routine" laboratory tests, and the diagnosis and treatment of headache. Together, they will show how culture, identity, group, and sense of place play a central role in patient, family, and clinician values, decision-making, and health-related behavior.

VIGNETTE #5: RURALITY, SICK ROLE, AND GENDER

No "physical" symptom, however common, is without context. Consider the experience of chest pain. The "what" is part of the "who," which is in turn part of the "where" (context). A 51 year-old Euro-

pean American wheat farmer in northwest Oklahoma comes reluctantly to the hospital emergency room with chest pain. He comes at the insistence of his wife. There is an implicit treatment timetable to his delay in seeking medical treatment. Like many rural, European American men, when he experienced chest pain, he kept it quietly to himself, and waited for two days to tell anyone; he tried to "work it off" by mowing the lawn, driving the tractor, and other forms of work. After he told his wife about his chest pain, he finally agreed to go to the ER only because his wife insisted. She becomes his face-saving agent and pretext to seek medical care. His presenting complaint is that "My wife made me come in." In his own eyes and in others', he does not lost his sense of masculine pride (often called "macho").

There are cultural consequences for going "too early" to the doctor: e.g., shame from one's rural male peer group. Medical consequences often clash with cultural consequences. The choice often comes to losing face (pride) versus risking losing one's life. From the (often urban-trained) physician's viewpoint, medical consequences and restoration to health are the paramount cultural consequences, while for the rural wheat farmer patient, the fear of ostracism and the equation of health with the ability to work, are the paramount cultural consequences.

VIGNETTE # 6: RURALITY AND CLINICAL ROLE GENERALISM

This brief vignette is a lesson in rural and urban clinical epistemology and role assumptions. Rural and urban medicines are not and cannot be identical precisely because one cannot automatically transpose all contexts when one leaves one and enters another. I have learned a great deal about rural and urban Oklahoma culture less by asking questions than by being in, and observing, clinical situations where the distinction helps to make sense of the nature of the problem. For instance, in the early 1980's, a second year family physician resident who had completed his internship in Oklahoma City, approached me as he was preparing to discharge a hospitalized patient

back to her home in the community in Enid, Oklahoma, where he was receiving his residency training. He said urgently to me, "Tell me where I can get a medical social worker to do the discharge planning."

I said to him: "Here, like in a lot of rural medicine, you ARE the medical social worker. A rural doc has to be much more of a generalist than in cities. You need to get to know the town well enough either to do the planning yourself, or to develop some of those skills in nursing or other staff. Let's talk about what medical and social needs you've identified and what we can put together with the types of people who are here."

He was rudely awakened – and displeased – by the differences in cultural reality between urban and rural practice. He had expected to be able to move on quickly to the next clinic patients, and not have to get "bogged down" in performing for himself roles that he did not feel should be his.

VIGNETTE #7: RURALITY AND ALTERNATIVES TO HIGH TECHNOLOGY

The following vignette, like the previous one, illustrates the confusion of urban with rural realms, and the possibility of utilizing context-specific clinical strategies to achieve similar clinical ends. A patient with an acute myocardial infarction comes to the emergency room in a rural Oklahoma hospital. The physician wants to find out the central venous pressure (CVP), requests a Swan-Ganz pulmonary artery catheter, or an echocardiogram, neither of which are possible to order here. The solution, a hospital nurse tells him, is to check the neck veins for jugular venous distension (JVD). That is, if the neck veins bulge, high blood pressure may be inferred.

The larger cultural-clinical lesson here is that in rural medicine, many high cost, high technology tests and procedures are not immediately available. In many cases, rural clinicians have developed alternate, low-cost means of approximating the kinds of biomedical data they seek.

VIGNETTE #8: RURALITY, MEDICINE, TIME, WEATHER, AND DISTANCE

Many American (including Oklahoman) physicians prefer to treat their patients in hospitals rather than in outpatient (ambulatory care) settings, because inpatient facilities offer the promise of greater control over the patient's medical condition. Yet that wished-for control is often illusory and elusive – and not only in rural locales. The following vignette illustrates how generically rural and specifically Oklahoman factors can intervene to complicate the course of hospital-based medical care, especially when only urban values and expectations are taken into consideration.

A patient is hospitalized with severe breathing problems, uncontrolled by outpatient treatment. Part of the medical work-up is to rule out the presence of tuberculosis. The test is performed in a rural Oklahoma hospital. The lab, however, that can determine the presence or absence of TB is in Dallas. The test takes place during a severe ice storm that plays havoc with the southern Great Plains. It will take at best 3-4 days to receive the test results. Treatment alternatives are sought based on the interplay of distance, travel, weather, time, loss of control, expectations, and frustration.

This scenario is frequently played out in Oklahoma and in many neighboring states where ice storms and treacherous winds bring to a virtual halt all ground and even emergency medical air transportation. On occasion, the ice storms will interrupt telephone and other communication networks. Perhaps more dramatically than any other cultural situation, these circumstances make explicit the clash between the wish to control nature (including disease) – the presumption that even it can be "managed" -- and the recalcitrance of nature, a duality more extreme in urban than in rural culture.

VIGNETTE #9: RURALITY, MEDICINE AND THE STATUS INEQUALITY OF DISEASES

This final vignette illustrates how even the seemingly most commonplace features of American medicine are not immune to rural-urban contextual considerations.

Consider the common symptom or "complaint" of a "headache." The context of a patient's "presentation" of a symptom to a physician in the office or hospital partially determines which diseases will be considered (that is, enter the physician's "differential diagnosis" list).

For the common symptom of "headache." urban and highly academic center-oriented physicians will tend to think of complex, rare diseases, often called "zebras." The detective search for these internal medicine entities is both exciting and high status (Stein 1990). More ordinary causes are of far less interest than unusual ones. In rural Oklahoma, both equine (horse) and bovine (cow) encephalitis often "present" with the symptom of headache. Yet, because many urban-oriented physicians tend not to think of these common, low-status, diseases, the correct diagnosis might be missed, or take longer to make and therefore correctly treat.

This vignette reflects a larger contextual issue in clinical methodology. If I may borrow from George Orwell's novel, *Animal Farm*, "Some diseases are more equal than others." That is, diseases are not alike symbolically. The etic/emic, official/unofficial distinction, helps to account for the social status of diagnoses. In making biomedical measurements, rural and urban physicians implicitly ask themselves: How do we measure? What do we think we should measure? What do we regard as worth measuring? What "units" count? What makes us feel good, competent? These universal issues become played out on the cultural landscape of the conflict-ridden relationship between rural and urban medicine in Oklahoma, and elsewhere as well.

CONCLUSIONS AND IMPLICATIONS

This paper has explored issues in Oklahoma rural health care insofar as they are governed by out-of-awareness differences in rural-urban perspectives. Specifically, I have explored rural and urban ideologies of place and the identities they express and sustain. I have argued that the rural/urban distinction is a bona fide cultural distinction and opposition, one that is driven by often-reciprocal group stereotypes that safeguards the boundary between rural and urban identities.

Vignettes from my twenty-three years of clinically applied anthropology in Oklahoma have illustrated the operation and tenacity of this cultural oppositional system (Spicer 1971) within ostensibly "the same" state and national culture. I have argued specifically that psychologically and historically rooted stereotypes of the cultural "other" by urban-based academic health sciences centers and hospitals impede the delivery of culturally-sensitive health care to countless rural areas. Usually unstated assumptions about group, culture, identity, place, and sense of place are at least partly responsible for the intractability of problems that are more narrowly defined as issues in "*rural* health care delivery." Ideologies of place play decisive roles in rural health care decision-making on large and small scales alike.

The "lens" of ethnocentrism is one through which people commonly view and (mis-)understand "otherness." Its distortive potential increases with the anxiety that surrounds the subject matter. Rural-urban distinctions have long been emotionally charged and are heir to this human legacy, one that is usually associated with ethnicity, nationality, and religion.

In Oklahoma and elsewhere, proposed healthcare "solutions" in rurally underserved areas are constrained to the degree that they fail to recognize "rural" and "urban" to be inter-linked cultural systems. In Oklahoma and elsewhere, we – an inclusive "we" -- can genuinely address, and perhaps solve, problems of rural health care only if we are willing and able to perceive rurally lived life on "its" own terms – rather than as extensions of urban-based stereotypes steeped in ideologies of romanticism and condescension.

Attention to others' lived and experienced lives – rural, urban, and otherwise – can improve health care as we come to realize that much we had thought to be "pure" perception was heavily informed by prejudice – that was in turn distorted by projection. A rural-urban health care dialogue might well begin with the basic question: "What is it like to be you?" Rural

health planning will best be served by approaches that acknowledge rural and urban "places" to constitute bona fide cultural groups, each having a distinctive identity tied to a sense of place.

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Journey from Dark to Light and Then?
The Legacy of Oklahoma's Terry D. Lawsuit

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Abstract

In 1978, Oklahoma's child welfare and juvenile justice systems were sued by Legal Aid of Western Oklahoma, the National Youth Law Center and the American Civil Liberties Union concerning conditions in the state's child care institutions. The suit alleged abuse of children and youth through extreme restraint practices, isolation, and physical punishment. It further alleged that the institutions were not properly staff, were located in isolated rural areas that made it impossible to find qualified professional staff, and sometimes the institutions housed deprived and delinquent children together. Specifically, it was alleged that deprived children were sometimes transferred, without due process protections, from non-secure, open settings to secure institutions designed to house delinquent youth. During the nearly twenty years of litigation, the state's juvenile justice and child welfare systems underwent extensive changes and the lawsuit was finally settled. At the final hearing, the Honorable Ralph J. Thompson, Federal Judge in the case, commented that the state had made a "journey from dark into light." This historical essay explores what happened, what changes were made, how settlement was reached, and what has transpired since federal court involvement ended. It explores the legacy of this litigation and the prospects for using such an event as an effective and lasting change agent.

Oklahomans have long prided themselves on being a caring and compassionate people. Following the Oklahoma City bombing of April 19, 1995 or the disastrous tornado of May 3, 1999 citizens from all walks of life pitched in to help not just their friends and neighbors but also total strangers. This caring way of life is thought to be a part of Oklahoma's heritage and is extended to providing for deprived and delinquent children as well.

From the earliest days of statehood, Oklahomans endeavored to provide for children who had no place to go or who found themselves in trouble. Over the years the state provided homes and services for children in a series of large public institutions. But as time went by something went wrong. The facilities which were intended to serve as a refuge for unfortunate children became isolated, antiquated and troubled. It was as if Oklahoma had forgotten a segment of its population and, if Oklahomans thought about it at all, were satisfied that the state's deprived and delinquent children were being taken care of in safe havens. Unfortunately, this was not the case (Durrill 1978:

1 & 15).

By the late 1970's, Oklahoma's children's institutions were an operational part of the Department of Human Services (DHS) and had a capacity of 1211 beds (Buckner 1987:1). The DHS had been headed by Director Lloyd E. Rader since the early 1950's. Mr. Rader and his chief subordinates believed that large congregate care facilities were fit and proper places to raise children. With one exception, the institutions were located in small rural communities such as Taft, Helena, Boley and Pryor. The lone exception was a new facility located near Tulsa (Trzcinski 1996: 92).

Despite his considerable administrative skill, Mr. Rader allowed the institutions to become isolated from the national children's services community. As a result, local practices developed that, when exposed, caused great controversy and consternation (Pearson 1994: 3). Rumors of extensive use of security cells and isolation rooms, even in institutions for deprived children, began to surface. The practice of "hog tying" (the shackling of hands and feet together behind one's back)

was alleged to be commonplace (Taylor 1998: 1).

At about the same time. the nation began to be exposed to allegations of systemic abuses of children residing in institutional care. Kenneth Wooden in his landmark book *Weeping In The Playtime Of Others* cites Texas' 1973 *Morales v. Turman* case as being one of the nation's first wake-up calls to constitutional issues involving children (1976: 4-7). Wooden detailed on a national scale abuses in a juvenile justice system he described as "a formidable fortress, built with the powerful forces of status quo and vested self-interest and reinforced by traditional thinking and political realities (1976: 232)." While Wooden's book only mentions Oklahoma one time. he could have been writing specifically of the Sooner State. Barry Krisberg later noted that juvenile correctional facilities were, generally speaking, "almost impervious to change (1996: 47)."

TERRY D. 1. RADER

In January, 1978, lawyers from Legal Aid of Western Oklahoma, the National Center for Youth Law and the National Prison Project of the American Civil Liberties Union filed a lawsuit in Federal Court concerning unconstitutional conditions alleged to exist in Oklahoma's institutions. The case became known as *Terry D. vs. Rader* because Terry D. was the first name on a list of children who were seeking relief. The suit alleged that the state abused its youth through the use of extreme restraint practices, isolation, and physical punishment. The suit further alleged that the institutions were not properly staffed, were located in isolated rural areas that made it impossible to find qualified professional staff, and sometimes housed deprived and delinquent children together. Specifically, it was alleged that deprived children were sometimes transferred, without due process protections, from non-secure, open settings to secure institutions designed to house delinquent youth (Trzcinski 1990: 194).

In its twenty years of life, the lawsuit took all of its participants on a strange trip.

The first years of litigation were bitterly contested. Later. the lawsuit became less contentious and the two sides worked together with an attitude of cautious cooperation. The DHS went through six directors, seven juvenile justice administrators and five child welfare administrators. There was a similar number of lead attorneys for the state. The Plaintiffs' side was more stable with Stephen Novick leading their effort throughout the course of the suit. During the life of the lawsuit, the author of this article worked as a senior level staff person for both the DHS and the Office of Juvenile Affairs (OJA). In this capacity, the author served as the liaison to the Federal Court's Monitor for both the OJA and then the DHS. As such he was deeply involved in the eventual settlement of the case.

In 1984 a Consent Decree was signed by the parties. The Consent Decree established rules for the operation of the institutions including removal of deprived children from large congregate care. The Consent Decree also established parameters for the use of restraints and the use of isolation in the institutions. It required the state to seek accreditation of its juvenile justice programs from the American Correctional Association (ACA) and from the Council On Accreditation (COA) for its child welfare programs. Perhaps most significantly, the Consent Decree directed that the state develop a "balanced system" of community programs for custody youth, although it did not define what constituted a "balanced system" of community programs (1984: 8).

The Department worked diligently to implement its unofficial and non-court sanctioned understanding of the requirements of the Consent Decree. It closed its two large institutions which served deprived children and began developing a system of community placements. In addition, the Department closed three institutions which had served delinquent children. Secure operations were available at only two remaining sites that could house a total of 212 youth (Buckner 1987: 1).

The DHS actively pursued accreditation of its various programs. The Department's

child welfare system became the first state-wide program in the nation to achieve accreditation from the COA and the Department's programs for delinquents became accredited through the ACA. These significant achievements were not reached without resistance from some administrators and line staff. Some believed accreditation was a "paper process" that guaranteed little. Others wondered why the agency had to follow national standards. It was not uncommon to hear the comment, "Oklahomans know what is best for Oklahoma." Despite such resistance there was little room for hesitancy; both the Consent Decree and state statute required DHS programs to achieve and maintain accreditation (Trzcinski 1990: 196).

By 1992, the parties had agreed upon an implementation plan to delineate the actions necessary to end the suit. Judge Ralph Thompson appointed Paul DeMuro of Montclair, New Jersey, to serve as the Court's Monitor. DeMuro's task was twofold: to assure the parties remained in agreement and to monitor the implementation of the court approved plan.

Between 1992 and 1995 the DHS, with the support of the Governor and the Legislature, began active implementation of the plan. Perhaps the most significant part of the plan was the creation of the Oklahoma Children's Initiative (OCI), designed to assure compliance with that part of the Consent Decree which mandated "a system of balanced community services (1984: 8)." The OCI included independent living services, comprehensive home-based services, educational advocacy and other programs which had not previously existed in Oklahoma and were contracted to private service providers located throughout the state. The Legislature and Governor provided funding to assure that specific target levels of service could, over time, be met. This public and private sector collaboration was the largest partnership of its type in Oklahoma's history.

The implementation plan also required the Department adopt a philosophy of "strengths and needs based" assessments and case planning to assure that children,

youth and their families received individually designed services to assist them in meeting their goals. Previously, treatment plans, if they existed at all, had focused on simple assessments which typically stated only a broad goal (e.g., "The parents are required to stop drinking and abusing their children"). Under the philosophy of strengths and needs based assessments, treatment plans were to become much more detailed and specific in regard to how goals were set and how they were to be achieved. The new philosophy required the staff to increase the involvement of parents and children in developing and carrying out the plans (Beyer, DeMuro and Schwartz 1990: 59). Even with a massive training effort and top administrative support, the concept was not well received by the staff.

Two independent evaluations of the Department's progress in this area were conducted by the University of Oklahoma's School of Social Work. Despite intense training for line staff, the initial results were not encouraging. Generally, it appeared that staff were not adept at the new techniques and saw the increased family/client participation as having dubious value (Rosenthal, Baker and Atkinson 1993; Rosenthal and Greenwood 1996). This would be an area of concern for the Department and the Court Monitor until the final days of the suit (DeMuro 1997: 2).

In 1995, the changing political climate and the public's concern over a perceived rise in juvenile crime brought about the creation of a new state agency to take over the operation of Oklahoma's juvenile justice system. On July 1, 1995, the Office of Juvenile Affairs (OJA) took over the operation of the state's juvenile justice programs. All employees, programs and facilities in the state's juvenile corrections system were transferred from the DHS to the new agency. Child welfare programs remained with the DHS

With the two service systems now operated by separate agencies, DHS and OJA re-negotiated their respective court approved implementation plans, but the Consent Decree remained applicable to both.

Each agency had its own legal team and from that time forward. there was very little coordination between the two. Both agencies desired to bring an end to the litigation but took different paths toward achieving this goal.

OJA'S EFFORT TO END THE LAWSUIT

The new Director of the OJA announced that his first and primary task was to "end Federal Court involvement" in the state's juvenile corrections programs; a position he reiterated numerous times (Lackey 1997). The new agency took an aggressive stance that the suit would end by negotiation or litigation. The OJA devoted a great deal of effort to complying with the letter of its implementation plan and the administration did a commendable job of marshaling its resources to achieve compliance. A new study of OJA's "strengths and needs based" service planning revealed that the agency had met this goal. Additionally, the specific numeric levels of services delivered to youth and their families under the OCI increased and eventually reached the levels of service contemplated under the implementation plan (DeMuro 1996: 10).

When the OJA administration felt certain that all target levels and other terms of the implementation plan had been reached, the parties began negotiation of a dismissal order. The OJA administration took the position that the terms of the plan had been achieved; the plaintiffs pointed to several possible shortfalls and did not agree that compliance had been reached. In a "land for peace" agreement the two parties reached a compromise. In exchange for the plaintiffs not opposing the dismissal, OJA offered to agree to several conditions which would be a part of the final settlement order (DeMuro 1996: 9-10).

The settlement included agreements on limiting the use of isolation and mechanical restraints in the juvenile institutions and continued accreditation of all programs by the ACA. It was agreed that mechanical restraints could only be used "to transport a violently out of control child to a place of confinement. but only after less restric-

tive methods of control have failed. When restraints are employed in this situation, they shall be removed as soon as the child regains control or is confined, whichever comes first (OJA *Terry D. v. Rader* Dismissal Order 1996: 9-10)." Additionally, it was agreed that placement in a security room can not exceed three hours and the child must be released when he or she has gained control of themselves (OJA *Terry D. v. Rader* Dismissal Order 1996: 9-10).

It was agreed that non-compliance with these requirements would allow the plaintiffs to move for a reinstatement of the lawsuit (OJA *Terry D. v. Rader* Dismissal Order 1996: 4). In summary, OJA achieved a much heralded dismissal of the suit and the plaintiffs received assurances that perpetual safeguards would remain to prevent the reestablishment of previous onerous practices.

The OJA portion of the lawsuit was conditionally dismissed in April, 1996. The parties agreed, and the Court ordered, that OJA would submit to six months of monitoring to assure that compliance was maintained. Court Monitor DeMuro certified compliance at the end of October. 1996 and final conditional dismissal was granted by Judge Thompson. At the final hearing for the OJA case, Judge Ralph Thompson commented that Oklahoma "had made a journey from dark to light" in the manner in which it treated its troubled children (Thompson 1997: 1).

DHS' EFFORTS TO END THE LAWSUIT

The administrative staff of the Department of Human Services appeared stung by the early dismissal of OJA and increased its efforts to end the case. Working with the plaintiffs' attorney and the Court Monitor. the DHS identified several critical issues requiring resolution. These included determining the status of the Department's commitment to implement strengths and needs based assessments and case planning. assuring that numeric target levels of services were being met through the OCI, and displaying continued progress towards resolving issues surrounding the DHS operated emergency

shelters in Tulsa and Oklahoma City (DeMuro 1997: 7-8).

In an effort to resolve long-standing problems at the two DHS shelters (Bond and Moore 1982: 22-23), the Department agreed to establish a system of emergency foster care to assure that children under the age of six would not spend more than a few hours at the shelters. The Department also agreed it would not allow the population at either shelter to exceed its licensed capacity. Finally, the Department agreed to move all children in the shelters to alternate placements or home as quickly as possible. The DHS committed through its formal policies that under no circumstances would any child stay over sixty days in a DHS operated shelter. The policy included the designation of a representative of the DHS Director whose function would be to assure that no child remained in the shelters for over the agreed upon sixty days (DeMuro 1997: 6). Optimism was high that a problem in existence since the 1975 creation of the first DHS operated shelter would finally be corrected (Trzcinski 1997:1-2).

About the time that the OJA portion of the lawsuit was being dismissed, the DHS got another discouraging report about its strengths and needs based treatment planning (DeMuro 1996: 2-3). An internal report indicated the Department's staff had still not implemented the concept (Linam undated). As a result, the Department agreed to a massive training effort requiring participation by all child welfare line staff and supervisors. The parties agreed that following the training another study of the status of strengths and needs based assessment and planning would be conducted (DeMuro 1997: 7).

However, since the OCI numeric target service levels were being met, the agreements regarding shelter practices had been put in policy, accreditation had been achieved and other conditions of the implementation plan and Consent Decree had been met, the parties agreed to a dismissal of the suit prior to completion of the treatment plan study. Judge Thompson dismissed the lawsuit in January, 1998 (Taylor 1998: 1).

The treatment plan and assessment study was completed a few months later (Herrerias 1999). The training effort had been effective and the Court Monitor accepted the report that the Department had complied with the terms of the settlement agreement. The Terry D. lawsuit was over some twenty years after it was first filed (DeMuro 1998: 1-2).

Both state agencies had achieved their goals. The OJA in 1996 and the DHS in 1998. The most significant difference between the two Dismissal Orders was the existence of conditions which the OJA must continue to meet. No such "legacy conditions" existed for the DHS.

Following dismissal of any class action lawsuit, it is prudent to examine whether the changes brought about by the litigation have become an operational part of the agency's program culture. When the "scaffolding" of the Federal Court is removed, which court ordered programs will continue and which will not? Did the changes that came about through the efforts of so many persons survive; or, will the changes be dismantled and the agency move in a different direction?

THE DEPARTMENT OF HUMAN SERVICES: POST TERRY D.

The DHS has no legacy agreement with which it must comply. It now operates under the mandates of state and federal law, the rules and regulations which come with federal funding, its own policies and procedures, and the COA standards.

The current administrator for child welfare services stated in an interview with the author that the Department remains committed to the progress and changes which occurred as a result of the Terry D. lawsuit. In keeping with current social work thought, the administrator indicated that the agency is working to become less focused upon process matters and more on overall outcomes (Ballard 2000).

For example, during the lawsuit much effort was made to assure that case planning focused upon the strengths and needs of clients. While strengths and needs based training is still a part of the agency's new employee core training, the DHS is

now focusing its efforts on impediments that prevent the achievement of safety, well-being and permanence for children. The Department is working to determine what must take place to move children through the child welfare system in order to achieve family reunification, adoption, or in a few instances, placement in a long term setting or in independent living. Agency leaders state that rather than do another study of case planning, the agency is preparing to study its longest term cases to determine what needs to be done in order to achieve some sort of permanency for the child. The results of the study will influence the future planning of the agency (Ballard 2000).

The DHS has reorganized the Oklahoma Children's Initiative. It is now called the Oklahoma Children's Services (OCS). According to DHS officials, the services have been somewhat restructured to provide greater accountability for expenditures and results. While some of the basic components of OCI are still recognizable in the OCS, there is now increased monitoring of what actually happens to the families involved and the manner in which the money is spent separate from OCS, a "contingency fund" has been established which allows local staff to spend limited money to assist a family in overcoming problems which may hinder a child's return home. For example, up to $750 per family can be spent for things such as automobile repair, bedding, utility deposits and so forth (Ballard 2000).

The DHS reports they have sustained a $300.000 (4.3%) reduction in the amount of funding for the OCS during the Fiscal Year 1999-2000. The agency indicates that a recent round of general budget cuts were mandated by the Governor and Legislature and, since not all money earmarked for OCI/OCS had always been spent, the reduction was ordered.   Ironically, the agency reports that service utilization has increased and they are now experiencing shortfalls in this area. The DHS also reports there is now a waiting list for services for some clients (Ballard 2000).

Two years following the dismissal of the lawsuit, the DHS acknowledges it still

experiences problems managing the populations of the two shelters and acknowledges that length of stay continues to be an issue The agency reports that generally the shelters operate under their licensed capacities and children under the age of six do not typically spend more than a few hours at the shelters before going to emergency foster care (Ballard 2000). Speaking upon a guarantee of anonymity, several DHS shelter personnel commented to the author that teenagers, minority children and children with behavioral problems sometimes still experience unacceptable lengths of stay and small children sometimes stay longer than the DHS administration would care to admit . If true, the safeguards set in place at the end of the lawsuit have not been entirely successful in assuring that no child remains in shelter care over sixty days, and the Department is frequently in violation of its own policy concerning maximum length of stay.

Within the DHS, there seems to be no consensus on how to remedy the problems of shelter care and, thus, no effective action to correct the problem. Oklahoma state law (Title 10: 7004-1.1) clearly prohibits placement of deprived children in an institution operated by the DHS; the DHS shelters are, however, designated as "emergency shelters." When children stay beyond the sixty day maximum set by DHS policy, the shelters functionally become "public institutions." One of the fundamental tenets of the Terry D. case was that deprived children who cannot go home have a right to live in "home-like" community-based settings(*Terry D. v. Rader* Consent Decree 1984: 7). Failure to effectively deal with this issue creates a risk similar to that faced by children placed in public institutions prior to the filing of the lawsuit in 1978. While staff and administrators in DHS often speak of doing "what is in the best interest of the child," (DeMuro 1996: 7-8) they have not yet remedied this serious problem.

The DHS remains committed to accreditation by the COA. There is recognition among staff that the new COA standards mandating a system of "Continuous Quality Improvement" will be difficult to meet.

However, both the child welfare division head and the Director of Human Services support accreditation and will continue to maintain it (Ballard 2000).

THE OFFICE OF JUVENILE AFFAIRS: POST TERRY D.

The Director of the Office of Juvenile Affairs did not respond to requests for an interview to discuss what has happened within the agency since the dismissal of the Terry D. lawsuit in 1996. The agency did provide a copy of its latest annual report in which the OJA's "Promise Approach" to juvenile justice is explained. In *Future Focus: The Promise Approach, 1999 OJA ANNUAL REPORT*, then OJA Director, Jerry Regier wrote, "In this approach we tell the youth that there are certain and swift consequences for delinquent and criminal behavior. We will not tolerate his anti-social actions. We will not tolerate his disrespect and self-centeredness. He is responsible for his behavior and must change, and we will help him to change while he is in our custody by holding him accountable and providing tools to change (2000: 4)."

There has been a significant increase in secure and "staff secure" beds for juvenile offenders, including an increase of capacity at the existing facilities in Sands Springs and Tecumseh. Prior to the creation of the OJA, the legislature authorized the creation of a new state operated medium security institution at Manitou, Oklahoma. The new institution became operational during 1996 and added approximately 80 secure beds to Oklahoma's system. The OJA also contracted for a privately operated medium secure training school, with a capacity of approximately 80, located at Union City, Oklahoma. This facility became operational in 1998.

The OJA has become a leading proponent of boot camps for juvenile offenders. During the final days of the lawsuit, negotiations began with VisionQuest for the operation of a boot camp in Faxon, Oklahoma. These negotiations and plans were not discussed with the plaintiffs and Court Monitor. The OJA has also contracted for a second boot camp operated by the Okla-

homa National Guard in Pryor, Oklahoma, on the site of the former Whittaker Children's Home which was closed during the Terry D. lawsuit. The Terry D. issue of locating facilities in rural areas of the state where qualified staff are difficult to hire and retain seems to have been ignored.

In 1999, the OJA dismantled its Oklahoma Children's Initiative, which was a significant part of the "new" programs mandated under the lawsuit. The OJA has redirected much of the OCI funding into its State Transition and Reintegration System (STARS). STARS is operated through a contract with the Oklahoma Military Department and is described as a program to provide "accountability, control and disciplinary services for OJA youth returning to their home communities from juvenile justice system placements (OJA 2000: 17)."

Perhaps of greatest concern and most difficult to ascertain is the quality of life and conditions of confinement in the OJA's secure institutions. The Dismissal Order required that certain conditions in the institutions be maintained including restrictions on the use of solitary confinement and mechanical restraints. Solitary confinement is defined as "the involuntary removal of a child from contact with other persons by confinement in a locked room, including the child's room, except during normal sleeping hours (OJA Dismissal Order 1996: 8-9)" The Dismissal Order further states, "No child shall remain in solitary confinement in excess of three (3) hours. As soon as the child is sufficiently under control so as to no longer pose a serious and immediate danger to himself or others, the child shall be released from solitary confinement. The use of consecutive periods of solitary confinement to evade the spirit and purpose of this section is prohibited (1996: 9)." The Dismissal Order also addresses the use of mechanical restraints by the OJA. The Dismissal Order states mechanical restraints can be used, "Within OJA institutions, to transport a violently out of control child to a place of confinement, but only after less restrictive methods of con-

trol have failed. When restraints are employed in this situation, they shall be removed as soon as the child regains control or is confined, whichever comes first (1996: 9-10)."

However, regarding the use of restraints, the agency's annual report states, "The Office of Juvenile Affairs has developed a Continuum for the Use of Force in Oklahoma's juvenile institutions...The use of mechanical restraints and temporary monitored placement in a crises management room may be used in response to moderate and high levels of risk (2000: 17)." If, as the OJA 1999 Annual Report seems to indicate, mechanical restraints are used for any other purpose other than transporting a youth from one point to another there is significant concern about compliance with the Terry D. Dismissal Order. Similarly, if the use of solitary confinement is beyond that contemplated in the Dismissal Order, the Plaintiffs could ask for re-instatement of the Terry D. lawsuit.

THE FINAL LEGACY OF TERRY D.

Judge Thompson spoke of Oklahoma making "a journey from dark to light." In the ensuing years following the dismissal of the Terry D. lawsuit there remain questions about the direction both of Oklahoma's agencies have taken. The critical issue for Terry D.'s legacy is how well did the agencies learn the lessons of the past as evidenced by their program efforts following the lawsuit's dismissal. What reforms have become systematized and what have disappeared?

For the Department of Human Services, there has clearly been an internalization of some of the fundamental issues of the case. The agency's leadership appears to accept and affirm the basic principles which led to a resolution of the case and continue to be guided by a dedication to the spirit of the settlement. Community services are provided and accreditation is maintained. However, the Department has not resolved the significant issues it faces concerning its shelter operations. The agency appears to continue to allow long lengths of stay at its shelters in violation of the agreements made at the end of the lawsuit and its own internal policies.

On the other hand, the Office of Juvenile Affairs has moved in an entirely different direction. The new direction is reliant upon the use of a growing number of residential programs and represents a turning away from the community programs that were created during the lawsuit. The agency's latest annual report raises questions about the use of isolation rooms and mechanical restraints in its institutions. Today, Oklahoma's juvenile justice system appears to be moving toward the system of the past by returning to a possible over-reliance upon costly secure and "staff secure" residential programs which are often located in rural and isolated areas of the state. Community services have been replaced by "accountability follow-up. (Regier 1999: 5)"

Can litigation be a meaningful change agent? In the short run, certainly. Despite being a painful and costly experience, a lawsuit can cause an otherwise dormant system to develop new resources and move forward. Such was clearly the case in Oklahoma. As one DHS administrator commented in 1990, "Mr. Rader loved his institutions. As painful as it was, it was the only way we would ever move forward (Gordon 1990)." Will the changes last? Certainly not all changes will last when the scaffolding of court oversight is removed. But if the significant changes are internalized into the system, some changes may stand the test of time. If the changes are not internalized or the management of the agency has a counter philosophy, the changes and improvements will likely disappear.

When settling a lawsuit that has brought about sweeping changes, the parties must consider the future and make an assessment of the probabilities of continuing the progress which has been made. This must include an assessment of the political climate of the jurisdiction and the people who will likely become decision makers in the foreseeable future. While no one can guarantee the future, every effort should be made to preserve the best of the progress which has been made.

Oklahoma's experience provides a case study of two different directions agencies can take following the dismissal of such an action. One agency is clearly working to move forward by preserving many of the gains made while under court supervision but still faces serious unresolved issues. The second agency seems to have turned its back on the lessons of the past and appears to be moving toward a return to the conditions which originally caused the lawsuit to be filed over twenty years ago; a phenomenon Barry Krisberg refers to as resembling the popular movie "Back To The Future (1996: 48)." Judge Thompson was correct when he commented that Oklahoma had made a "journey from dark to light;" however, the state's final destination remains unclear. Oklahoma appears to be unsettled in the direction it will take concerning helping its troubled children and youth. Lessons from *Terry D. v. Rader* may serve as a guide for the future or as a signpost to the past.

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