

'Where's the *dal*'?: Food and Nutrition Experiences of Ethnic Minority Seniors in Long-Term Care

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Executive Summary

With few exceptions, seniors' residences and long-term care facilities in British Columbia cater to the dietary needs of Anglo-American seniors. In this review, we are particularly interested in the extent to which the dietary preferences and nutritional needs of seniors of minority ethnic backgrounds who are institutionalized in LTCFs organized by the dominant Anglo-/Franco-Canadian majority are met. A multidisciplinary literature review reveals a dearth of studies on the topic. The goal of this paper is threefold: (1) to examine the dietary options *currently* available to ethnic minority seniors in LTCFs and how they and their families cope with any shortcomings of the health system in meeting their needs; (2) to examine the literature on the meanings assigned to food, particularly as these pertain to immigrants and the elderly; and (3) to make suggestions as to the *future* directions that dietitians, nutritionists and health administrators might take in order to address identified shortcomings. Special attention is paid to Canada's South Asian population.

I. Ethnic Minority Seniors in Long-Term Care – Current Realities

The potential for relocation to a long-term care facility to produce negative institutional effects, such as feelings of isolation and accelerated mental and/or physical deterioration, is well-documented. These losses are considerably magnified when the newly relocated senior is of a minority ethnic background. In a study of neglect and abuse associated with undernutrition in LTCFs in North America, 'lack of attention to cultural food preferences' is one of several factors found to contribute to the malnutrition of seniors. The food preferences of those over 65 are known to be especially strong and various studies have underscored the importance of ethnic food to seniors of minority backgrounds. A view of food as an element of "culture," raises the question as to what food and eating habits *mean* to peoples of various ethnic backgrounds; the loss of family and the loss of community also play a role in the dietary patterns of ethnic seniors in care.

A. Loss of Family

Families are most often the mainstay of long-term care for the elderly among them. Family members enable seniors to avoid institutionalization and, once the elder is institutionalized, continue to assist with personal care, offer social and emotional support, and serve as advocates and brokers of services. This type of aid is especially critical for ethnic seniors whose dietary needs often conflict with the means and objectives of the institution. The families of ethnic seniors are thus expected to take on a considerable burden in order to keep their elders comfortable, often providing all of their meals on a daily basis. Despite the ideal of filial responsibility to care for elders in the home, the ability to do so is limited to those families with greater financial resources and/or a larger uncommitted labour force. In Canada, increased longevity, the greater need and inclination for younger women-traditionally the primary caregivers of the elderly-to work outside the home, and decreasing adherence to 'old country' values among second (+)-generation immigrants means that more and more ethnic seniors are being institutionalized against their will. For many ethnic seniors, institutionalization entails considerable shame and loss of face; they have been dishonoured by the family. Even when ethnic seniors accept the need to move to a LTCF, there are few alternatives which

cater to their linguistic, culinary, religious and cultural needs. Instead, most remain in the family home where they may receive inadequate care.

B. Loss of Community

Unlike the majority of seniors in LTCFs, ethnic minority seniors are limited in their ability to re-establish a sense of community with fellow residents. Most confront the triple barriers of old age, increasing loss of a second language with age and adherence to a minority culture. Oftentimes, they do not share a common political history, religious traditions or community values with those around them. In one B.C. LTCF, nursing staff communicated the least with the immigrant elderly group and most especially with the men among them. Moreover, interpreter services in the majority of health care institutions are ineffective and health care staff receive little or no training aimed at helping them to understand ethnic variations in the perception of illness and health. The limitations around access of health care services to the ethnic elderly due to lack of communication thus deprives the ethnic elderly of the fundamental right to dignity and personal autonomy. Behaviours deemed disrespectful of ethnic seniors may be rooted in deep-seated racist attitudes of majority-population caregivers toward minority clients and/or in the numerous misinterpretations of behaviour and intent that can occur between individuals of different cultural backgrounds..

II. The meanings and messages of food: some theoretical approaches

A review of the theoretical literature on food and culture provides some insights into the what food *means* to people. The following points both clarify the extent to which the dietary needs of ethnic seniors are under-served and indicate areas worthy of consideration in formulating solutions:

- ?? It is important to examine not only the nutritive value of foods consumed but the historical, social, economic, political and cultural context within which this takes place.
 - ?? Cultural universals are only useful if translated into culturally specific formulations
 - ?? It is sometimes valuable to question why certain foods and not others are considered 'good to eat.'
 - ?? Food and eating are symbolic and communicative
 - ?? Rules about eating and the ability to impose those rules on others are manifestations of class, ethnic and gender distinctions.
 - ?? Food communicates individual and group identities
 - ?? Food may be used by a majority or dominant group to differentiate one group of people from another.

III. Holistic medical traditions and the meaning of food

In North America, the context within which ethnic seniors in need of long-term care typically find themselves is strongly mediated by a biomedical ethic characterized by the notion that the mind and the body are to be treated as separate entities. By contrast, non-

Western indigenous healing traditions are more holistic, taking into account familial, social, dietary, spiritual, mental and physical dimensions. Chinese and Indian health traditions similarly advocate that the maintenance of harmony with the socio-spiritual environment is central to the promotion of health and prevention of illness. Both systems recognize the importance of balancing various qualities such as hot and cold, light and heavy, etc., with health dependent upon their equilibrium in the body. Food is especially influential in maintaining or restoring this balance. Korean, Chinese and Indian (Ayurvedic) medicine similarly place considerable emphasis on the body's ability to digest food. Imbalances of various elements effects the digestion which in turn underlies many diseases. For the Punjabi elderly, food further establishes their relationships with their families and with supernatural forces and effects considerably their physical, mental and spiritual well-being. Dietitians ignore these messages at their peril.

IV. Conclusions and implications for dietitians

Dietitians need to be aware of what food means to the ethnic elderly. While these issues warrant further investigation, the following points of practice emerge from this review:

- ?? Currently, family members of the institutionalized ethnic elderly are unduly burdened with the provision of their meals. Nonetheless, this involvement may help to atone for feelings of guilt in not living up to culturally mediated sense of filial responsibility to care for the elderly. Efforts should therefore be made to relieve this burden while ensuring their meaningful involvement in the care of the patient in other less demanding ways.
- ?? Where sufficient numbers of any given minority exist, the construction of an ethno-specific facility in which the linguistic, culinary, religious and cultural needs of a specific group can be accommodated may be warranted.
- ?? Where this is not the case, facilities organized by the dominant culture should be mindful of the importance of eating food in the company of others with whom one can converse and recognize oneself as a member of a community. The act of eating together and sharing food is one of the most important ways of establishing one's place in the world; eating alone is symbolic of complete isolation and is assiduously avoided. Without eating companions, many seniors may prefer not to eat at all.
- ?? Food is symbolic and communicative. *What* is and is not eaten, *when* it is eaten, *with whom* it is eaten, *how* it is served all inform the individual's identity, first to him- or herself, then to the ethnic group of which he or she is a member, and finally, to the immigrant's host society. The dietary preferences of ethnic seniors thus provide valuable opportunities to observe the meaning-making processes of these individuals.

Introduction

With few exceptions, seniors' residences and long-term care facilities in British Columbia (and no doubt, the rest of Canada) cater to the dietary needs of Anglo-American seniors. While this may seem unusual in a society which has gone to the trouble of enshrining the value of multiculturalism in its constitution (Jones and Jones 1986),² this position is reflected time and again in numerous government-sanctioned documents. Dietetic Department Guidelines In Smaller Health Care Facilities, the 1988 report of the working group on the Department of Dietetics, is typical of many such directives offering nutrition guidelines for institutions. On "selective menus" it has this to say: "A selective menu offers choices at each meal. A full selective menu is not recommended for facilities with 75 beds or less. It will increase operating costs" (Canada 1988:79). There is no further mention of accommodating religious or cultural dietary restrictions or prescriptions. As far as these establishments are concerned, it is fiscal responsibility rather than patient satisfaction or quality of care which constitute the bottom line. Having conducted a study examining the dietary *wishes* of elderly patients in long-term care facilities in Sweden, Sallerberg (1989:279) concludes that the system organized to provide patients with *nutritionally balanced* meals was not prepared to incorporate such 'extraneous' information:

The changes within this information system seem a kind of self-generating process; they consist of the specifications and controls of the (nutritional) goals of the new guidelines and their measurement and so on. And these factors seem to exist and develop in a social world of their own.

Personal care residences may offer some electives, although residents are typically dissuaded from making "undue" demands as these comments made by residents of a private facility in Vancouver attest:

Woman: We get a weekly menu, and each day there's something a little different in it. If it's something you can't eat, you can phone down and they'll help you out the best they can with what you want.

Man: You're asked not to do that unless there's something that doesn't, that disagrees with you, you know (Food for Life 2001)

While there are choices at lunch-time these do not extend beyond the North American culinary palette (e.g. Spinach and Mushroom Quiche *or* Grilled Tuna Salad Sandwich). The Anglo-Canadian residents interviewed were, for the most part, happy with food that was provided. It is evident, however, that non-Anglo Canadians are simply expected to

conform to the dietary regime of the institution. Ethnic minority seniors would probably be inclined to look elsewhere.

This type of ethnocentrism in elder care is especially troubling in long-term care facilities (LTCFs) or hospital geriatric wards wherein seniors have little choice as to whether they are admitted or not, the decision hinging primarily on their physical condition. In this review, we are particularly interested in the extent to which the dietary preferences and nutritional needs of seniors of minority ethnic backgrounds who are institutionalized in LTCFs organized by the dominant Anglo-/Franco-Canadian majority are met. The experiences of ethnic seniors institutionalized in facilities organized and populated at least predominantly by members of their own cultural background are distinct (MacLean and Bonar 1983). A multidisciplinary literature review reveals a dearth of studies on the topic. Even in the writings on long-term care and ethnicity, the topics of food, nutrition and eating are either summarily addressed³ or overlooked altogether.⁴ Kwan *et al.* (1985) further point to the exclusion of ethnic elderly from nutrition studies based on their inability to speak English. Without their input, they argue, comprehensive nutrition management in institutions is not possible.

The goal of this paper is threefold: (1) to examine in some depth the dietary options *currently* available to ethnic minority seniors in LTCFs and hospital geriatric wards and how they and their families cope with any shortcomings of the health system in meeting their needs; (2) to examine the literature on the meanings assigned to food, particularly as these pertain to immigrants and the elderly; and (3) to make suggestions as to the *future* directions that dietitians, nutritionists and health administrators might take in order to address identified shortcomings. Examples are drawn from a range of different ethno-cultural groups, as appropriate. Special attention is paid, however, to Canada's South Asian (particularly Punjabi) population with whom the author has over ten years of research experience.

Some preemptive comments on the nature of ethnicity

There is no doubt, writes Sokolovsky (1985:6) "that varying ethnic lifestyles will alter the way old age is encountered, perceived and acted out." Until recently, however, the literature on "ethnic" seniors has been sparse, although the last ten years have given rise to a veritable fluorescence of reporting on the subject. In their enthusiasm to embrace the topic, however, not all writers on the ethnic elderly have been equally conscientious of the various meanings assigned to and hence the limitations of 'ethnicity' as a variable or descriptor.

Anderson *et al.*'s (1995) comparative study of diabetes management by Chinese- versus Anglo-Canadian women counsels that caution is warranted. Although a larger proportion of women in the Chinese-Canadian sample meet the criteria for successful diet management (*i.e.* by following time schedules), the authors note that what appears to be a positive and statistically significant correlation between ethnicity and diet management may, in fact, have more to do with the nature of the sample and the context of their material existence. First, a significantly higher proportion of the Chinese-Canadian sample was aged fifty and over. This, combined with the lack of fluency in English within this sample? a factor negatively associated with workforce participation? may have afforded more Chinese-Canadian women greater flexibility in managing their time than younger women working outside the home. Anderson *et al.* thus conclude that "ethnicity is not a static concept, and people with common descent are not a 'homogeneous group' with common experiences. Two women from the same ethnic group may have different experiences, depending on their fluency in English and their life circumstances" (1995:193).

Accordingly, the notion of ethnicity, should be conceived not as an identity based on common descent so much as it is a factor which influences all manner of social relations. This is especially pertinent insofar as access to health and social services is concerned. As J-J. Lee (1986), MacLean *et al.* (1987) and NAPCA (1995) illustrate, institutional prejudice renders many services inaccessible or unreliable for ethnic seniors in North America. Elderly Chinese in Montreal were provided with few services or materials about those services in their native language, nor were they able to secure a firm commitment from the provincial government that services would continue from one year to the next (MacLean *et al.* 1987).⁵ Findings such as these point up the importance of viewing ethnicity not only in terms of its cultural and personal components but from a behavioral or organizational perspective which acknowledges the manner in which "the larger social context influences the kind of social organization exhibited by a particular ethnic group. In fact, ethnicity can be as much created by outsiders (through their stereotypes and resultant actions) as by members (through self-labeling)" (Cool 1986:265).

Ethnic Minority Seniors in Long-Term Care – Current Realities

Although relocation to a long-term care facility may be in the best interests of both the senior and his or her family members, the potential for such a move to produce negative institutional effects is well-documented. As MacLean and Bonar (1983:53) point out,

“the strangeness of the environment and the loss of familiar support systems at a time when the elderly person’s personal resources are low often influences his / her mental health.” These losses are considerably magnified when the newly relocated senior is of a minority ethnic background. MacLean and Bonar have identified three main difficulties specific to this group: (1) loss of family; (2) loss of culture; and (3) loss of community. Each of these losses contributes to the senior’s feelings of isolation and may well accelerate his or her mental and/or physical deterioration.

In their study of neglect and abuse associated with undernutrition in LTCFs in North America, Aziz and Campbell-Taylor (1999) found that ‘lack of attention to cultural food preferences’ is one of several factors contributing to the malnutrition of seniors. Citing a report on California nursing homes, these authors relate how one elderly “Chinese resident lost 31 pounds, or 30% of his body weight over a six-week period. His weight fell from 102 to 71 pounds at the time of his death” (1999:99). At its extreme, malnutrition can culminate in death. Other less dramatic but extremely grave consequences of malnutrition for seniors include higher morbidity of pulmonary infections and bedsores and increased dependency and a poor quality of life due to the “fatigue, confusion, hunger, thirst, pain and/or impaired mobility associated with malnutrition and its consequences” (1999:106).

Various studies have underscored the importance of ethnic food to seniors of Japanese, black, Puerto Rican and Chinese backgrounds in nursing homes in the United States (Yeo 1993). Irrespective of their ethnic background, argues Newman (a dietitian and Ph.D.), the

food preferences of those over 65 are especially strong. They are unusually significant during times of illness and loss. Astute care givers recognize that older people are cautious in their attitudes toward change; they know that familiar food and food patterns represent security by establishing links to the past, offering continuity and comfort (1985:15).

“[F]amiliar and favourite foods or drink,” suggest MacLean and Bonar (1983:54), are like songs, literature, newspapers and folklore--elements of “culture,” the loss of which ethnic seniors are likely to suffer in an institutionalized setting. Few would argue their point, although what does it really tell us? The reader is none the wiser as to what any of these cultural elements mean to the individual. *So what* if ethnic seniors cannot eat *dal* or *congee* or *kimchee*? Is anybody *really* satisfied with hospital or institutional food, after all? Maybe not, but the question as to what food and eating habits *mean* to peoples of various ethnic backgrounds certainly warrants closer scrutiny; this matter will be

addressed in the following section. First, though, let us consider each of the other types of loss that MacLean and Bonar have identified as pertinent to institutionalized seniors, that is, the loss of family and the loss of community, for it would appear that each plays its own role in the dietary patterns of ethnic seniors in care.

Loss of Family

Irrespective of the ethnic group involved, families are most often the mainstay of long-term care for the elderly among them (Barresi and Stull 1993, Wood and Wan 1993). Family members both enable seniors to avoid institutionalization⁶ and, in many cases, “continue to assist with personal care of institutionalized elders and to provide [them with] social and emotional support” (Wood and Wan 1993:40). The most extensive degree of care, both in terms of time and the tasks performed, is provided by a spouse (Montgomery 1999). Adult children, most often daughters or daughters-in-law, devote on average 10 to 20 hours per week to the care of elderly parents, which is usually divided between care management tasks and assistance with transportation and shopping. Additionally, they often “continue to serve as advocates and brokers of services” (Wood and Wan 1993:40).

In a case study presented by MacLean and Sakadakis (1989), the involvement of an estranged son in the terminal care of an elderly Lebanese man in a Montreal hospital ensured that the last days of his life were spent more comfortably. Two weeks before his death, “Mr. A.” suddenly rejected his rehabilitation program and refused to get out of bed or to eat. Recognizing that, at some level, Mr. A. had made a decision to die, social workers enlisted the help of his son (now grudgingly accepted by his father) who was able to speak to him in his native tongue. Equally important, he was able to describe some simple Lebanese dishes which could be prepared for his father. The social worker negotiated

with the dietary department to modify its procedures of providing vitamin supplements to patients who refused to eat since Mr. A. refused to take them. In this way, simple Lebanese dishes were prepared in order to give Mr. A. some pleasure from food and to encourage him to keep his strength up as long as possible (1989:214).

This level of advocacy on the part of social workers or other caregivers is, unfortunately, not always forthcoming. An ethnic senior participating in a Food for Life/Back to the Table⁷ information dissemination workshop (January 31st, 2001), related that during his stay in a Greater Vancouver hospital, he was visited on two occasions by two dietitians.

He told each of them that he would like his own type of food and provided descriptions but was informed by both that the system could not accommodate his request. Fortunately, his wife was able to bring food into him, but he expressed concerns for others like him without family members to provide this service.

The extent to which some family members go to keep elderly spouses, parents and so forth comfortable in LTCFs is considerable. Take, for example, the case of an Indo-Canadian man⁸ we will call Mr. Singh⁹ who related this story about his elderly father during a focus group conducted under the auspices of the Food for Life project (Food for Life 2001):

[M]y own father and mother are ninety years old. . . . My father had a stroke in October last year. Before that they used to live in Surrey. I live in Richmond, . . . independently. And they did the cooking all by themselves, shopping and cooking. . . . [O]nce he had a stroke . . . he had to go into the Surrey Memorial Hospital. And he ended up in geriatric unit there, assessment unit. And the food there, of course, was very very different from what he was used to eating at home. . . . So forget about the nutrition part of it. If you don't like the taste of the food, however nutritious it is, you, you just leave it aside. . . . So he would not [eat] the food at all. And he wasn't the only one, there were two other Indo-Canadians at that time in the geriatric unit. They won't eat it, either. . . . The food will come, in the tray, and it will go into the garbage. And so I and my sister, who lives in Surrey, we took it upon ourselves to provide to him two meals a day. He had a breakfast, sort of, he was used to cereal for breakfast, cereal with milk. So here we are, I am living in Richmond and [my sister in] Surrey: we virtually took turns in providing meals to him. And I could see the other [two] gentleman . . . also their families doing the same thing for them. . . . [H]e is in the continuing care now, in Surrey. And even now, he doesn't take the food provided in the continuing care. . . . December he moved, he moved to Surrey and now it's six months, and we still provide. I go now, food and delivery if it is my turn, to take food there, leave it in the fridge and mark it for what he should be eating with.

This man is fortunate enough to have children who are able to offset the incompatibility that exists between his needs and what the institutions in which he must now reside currently provide. Others are less fortunate, however. A former LTC worker recalls how, in the care facility in which she was employed,

Chinese seniors . . . would just lose tons of weight, because they didn't like the food a lot. So I think the changes, first of all, being placed in a home is traumatic, if it wasn't their choice, which it tends to not be. But things are changing. [One man] would just be happy when we'd serve Chinese pastries once a month, pretty much. But like, ice cream for dessert, he didn't like the cold stuff and Jell-O, just like, just a way to, not serving his needs (Food for Life 2001).

This service provider's reference to the fact that institutionalization is often not the choice of the senior him- or herself is key. Contrary to the focus of 'North American' culture on the value of independence and self-sufficiency (Koehn, Coughlen and Stephenson 1996), many ethnic seniors were raised with the expectation that the elderly are cared for within the family. But as Sokolovsky (1985:11) points out, numerous

studies now indicate “that the capacity of the ethnic family for dealing with the most difficult problems of its elderly members is limited. In the context of rapid demographic and economic changes over the last decade, rural ideals are rapidly giving way to urban realities.”¹⁰ The ability to provide adequate elder-care in the home is usually limited to those families with greater financial resources and/or a larger uncommitted labour force (Wieland 1991). In Canada, the increased need and inclination for younger women, especially daughters-in-law-traditionally the primary caregivers of the elderly-to find employment outside the home, coupled with decreasing adherence to ‘old country’ values among second- and third- (etc.) generation immigrants means that increasing numbers of ethnic seniors are being institutionalized against their will (Barresi and Stull 1993, Koehn 1999, MacLean and Bonar 1983, Yeo 1993).

Seniors from any cultural background may well feel a sense of isolation and rejection following institutionalization. In addition, many ethnic minority seniors further struggle with the incongruity of institutionalization and cultural ideals of filial piety which contributes to a sense of profound shame, a feeling that they have been dishonoured by their family and lost face in the community as a whole (MacLean and Bonar 1983). The manner in which honour and shame function as a mechanism of social control is conveyed by a Punjabi-Canadian participant in Koehn’s (1993:42) research:

[T]here are exceptions [to the adequate care of infirm elders]--abuse is not unknown. But most people operate on the principle that one has to be able to show one's face in the temple. Keeping face is critical in Punjabi culture--one should not shame oneself, for in so doing, the family's honour is at stake (Joginder).

It is certainly unusual to find representatives of the Punjabi culture, and many others besides, in LTCFs, but it is not unknown.¹¹ More importantly, these numbers can only be expected to increase. During a focus group conducted under the auspices of the Federal government’s Seniors Quality of Life project (1999),¹² twenty-five Punjabi seniors¹³ related that while most of them would probably not choose admission into an institution, some have no choice: they are helpless. This is a new awareness¹⁴ that arises from the community’s long migration history and the fact that seniors are now living longer. Some may need to go into extended care facilities, but these are all geared toward the mainstream (Anglo) Canadian population. The language, food, religious beliefs, and overall atmosphere in these facilities are not conducive to Punjabi seniors. Hence they do not even put their names on wait-lists for such facilities, even though they know that they

are not getting suitable care at home. Understandably, they do not relish the idea of simply waiting to die once they become frail.

When asked to identify possible solutions to address their concerns they suggested that LTCFs which cater to their linguistic, culinary, religious and cultural needs are essential. In particular, they placed a great deal of emphasis on the food that such facilities should provide. Secondly they commented that part of their problem relates to the long period of dependency on their sponsors (typically adult children) that immigration regulations currently demand. Without resources, seniors cannot seek out alternative modes of care; hence the dependency period should be reduced¹⁵ (Seniors' Quality of Life 1999).

Loss of Community

Unlike the majority of seniors in LTCFs, ethnic minority seniors are limited in their ability to re-establish a sense of community with fellow residents. Often they do not speak English or French. Equally important is the fact that, oftentimes, they do not share a common political history, religious traditions or community values with those around them (MacLean and Bonar 1983). Although quasi-communities of ethnic minority seniors of various backgrounds may develop, these are formed only on the basis of the members' distinction from the majority of residents rather than the similarities among them and hence do not provide the same degree of comfort and reassurance that can be derived from one's 'own people.'

When Koehn (1993) asked elderly Punjabi Sikh immigrants living in Greater Vancouver to relate something of their lives in India, perhaps the things they missed, all replied that indeed, they missed their families, the village, the dust. In one way or another they all conveyed how much they missed their freedom, fitting in, the neighbourhood spirit and their part in it—in other words, a sense of control over their own lives, a sense of meaning and identity. Institutionalization in and of itself poses a serious threat to the identity of seniors. Further deprived of the opportunity to interact with others of the same community, minority ethnic seniors in dominant culture LTCFs may find themselves bereft of any opportunity for meaning-making: their sense of isolation can be profound and declines in mental and physical health are not unusual. The following case study presented by MacLean and Bonar (1983:57) is instructive in its depiction of the relationship between the loss of community and dietary behaviour:

Mr. B was an 82 year old Chinese man who was born in China but who had lived in Montreal's Chinatown for 45 years. He did not have any nuclear family, but was well rooted in his ethnic culture, traditions and values. . . . Mr. B. spoke only Chinese. . . . Because of his deteriorating health, he required a chronic care placement . . . [and] was admitted to the hospital section of [an English-Canadian LTCF in Montreal].

The stress of relocating to this foreign environment was experienced as culture shock by Mr. B. He was not able to communicate with anyone at [the LTCF]. *He also refused to eat any food served to him and indicated that he only wanted to eat Chinese food.* Because of his refusal to eat and his inability to communicate, his physical and mental condition deteriorated rapidly within the first month of his admission.

Some progress was made in Mr. B.'s eating and communicating with the involvement of a volunteer from the Chinese Community Service Centre. Nonetheless, "Mr. B. continued to manifest signs of anxiety and depression related to being institutionalized in a foreign environment. He died within two months of his admission date" (1983:57). Although these authors point to *Mr. B's* "refusal to eat" and "inability to communicate" as problematic, we might otherwise convey the problem in terms of the *institution's* refusal to provide him with appropriate (*i.e.* Chinese) food and the *staff's* inability to communicate with Mr. B.!

Noting the triple barriers of old age, increasing loss of a second language with age and adherence to a minority culture, Jones and Jones (1986) set out to examine verbal interactions between nursing staff and the elderly residents of a LTCF in British Columbia. The targeted seniors were divided into three groups—immigrant, Canadian-born, and Anglo-born—and the results compared. Collectively, all three groups were found to have minimal verbal interaction directed at them, the primary form of which occurred in the form of commands. Nursing staff communicated the least with the immigrant elderly group and most especially with the men among them. Needless to say, this diminished communication does not bode well for ethnic elderly with specific dietary needs. As Saldov (1992) points out, the retention and use of their native language is, for the majority of the ethnic elderly, critical as a vehicle for the transmission of culture to successive generations, as a tool to compensate for short-term memory loss and as an important symbol of their survival, both at the personal level and as a members of an ethnic group. The limitations around access of health care services to the ethnic elderly due to lack of communication is, in Saldov's view, "a denial of the elderly person's fundamental right to dignity and personal autonomy" (1992:2). While nursing unit supervisors acknowledge that communication is essential to the health care needs of their elderly ethnic clients, Saldov and Chow (1994:117) found that interpreter services in the

majority of health care institutions were ineffective: where they existed they were “frequently informal, unprofessional, and ad hoc.” Typically, health care staff receive little or no training aimed at helping them to understand ethnic variations in the perception of illness and health.

Resistance to the accommodation of different linguistic, cultural and religious norms by human service providers is unfortunately all too common in both the United States¹⁶ and Canada. Minority-group clients in Toronto report that they have experienced numerous barriers to Canada’s health and social services. These obstacles include

lack of information about the services provided, the unavailability of service, the service provider’s lack of knowledge of the linguistic and cultural needs of different groups, and the inappropriateness of treatment modes and counseling. There was a widespread perception that the difference in racial and cultural backgrounds between clients and White, Anglo human service professionals frequently resulted in misconceptions and negative judgments being made by service providers (Doyle and Visano 1987 as cited in Henry *et al.* 2000:210).

Behaviours deemed disrespectful of ethnic seniors may be rooted in deep-seated racist attitudes of majority-population caregivers toward minority clients and/or in the numerous misinterpretations of behaviour and intent that can occur between individuals of different cultural backgrounds. Wood and Wan (1993:45) comment, for example, on the offense taken by older African Americans when service providers use their first names or employ excessive eye contact, both of which are seen as discourteous.

The meanings and messages of food: some theoretical approaches

In order to understand the relationship between culture and food, or to establish what it is that food means to people, we must first pause and take stock of the various angles from which the topic has been viewed, for there are several—each with their own merits and limitations.

Food in the context of social structure, social roles, and social history

The earliest studies of food and eating typically approached the topic from a functional perspective which assumes that social or cultural groups can be viewed as systems which operate somewhat like machines, the various components of which influence the operation of each other and the whole. As early as the 1930s, for example, Audrey Richards (as cited in Mennell *et al.* 1992) sought to relate the *production, preparation* and *consumption* of food among southern African cultural groups to the larger concerns of life-cycle, interpersonal relationships and the structure of social groups (see also

Arnott 1975). A more contemporary manifestation of the functionalists' concern with "food as a path to understanding culture and history" (Counihan 1998:1) is reflected in a collection of articles presented in an edited volume entitled *Food and Gender: Identity and Power* (Counihan and Kaplan 1998). These authors examine power of two kinds:

First, there is the power that society allocates or denies to men and women through their access to and control of one essential resource: food. . . . The second meaning of power we examine is personal power: whether men's and women's relationship to food and its meaning contributes to a valued sense of self. . . . We are concerned with how their relationship to food may facilitate gender complementarity and mutual respect or produce gender hierarchy.

Social distinctions based on class, ethnicity and gender are communicated through food in a number of ways. As Counihan (1998) observes, "maleness and femaleness in all cultures are associated with specific foods and rules controlling their consumption" (1998:7). On the one hand, men and women claim different roles in regard to food, while on the other, identification with specific foods can define masculinity or femininity (the protestation that "real men *do* eat quiche" comes to mind).

The adaptive 'fitness' of foodways

Archaeological and evolutionary examinations of the food practices of ancient and contemporary cultures take a similar tack, each questioning the evolutionary "fitness" of the particular foodways¹⁷ pursued by a particular group.¹⁸ Ritenbaugh's (1978) evolutionary approach to human foodways, for example, establishes that the majority of biological and foodway adaptations protect the nutritional status of populations:

It has become clear in reviewing a wide range of foodways that one of the most significant indicators of the probability of a particular behavior being adaptive is its time depth. Practices that are central to the culture and that have been in existence over hundreds of generations are far more likely to be nutritionally beneficial, or at worst neutral, than are practices that have been introduced as recently as this century (1978:119).

There are, nonetheless, cultural food practices which prove deleterious to certain segments of the population at particular periods of their lives. Ritenbaugh points, for example, to the historical and political association of certain foods with status. Just as Indians consider polished rice to be a higher status food, so do Americans rate and price prime beef most highly. In both of these cases, the preference is contrary to nutritional recommendations: the development of beriberi associated with exclusive consumption of vitamin-poor polished rice is in itself a status symbol in some parts of the Far East; and it is precisely the high fat content of prime beef that appeals to many Americans,

irrespective of its association with various forms of cancer or heart disease. One question that such practices raise is whether they offer other health benefits that outweigh their more obvious nutritional shortcomings, or if these beliefs are simply so embedded in the larger socio-cultural fabric of people's lives that they are resistant to change, despite their negative health implications. Accordingly, it behooves the researcher interested in nutrition to examine not only the nutritive value of foods consumed but the historical, social, economic, political and cultural context within which this takes place.

Structural oppositions: the 'raw' and the 'cooked'

Charting a rather distinct course, Claude Levi-Strauss (1969) aims instead to use cultural distinctions between different types of food to prove his point that all cultural differences can be reduced to a few basic cultural universals. Thus from the bipolar distinction between culture and nature, he derives the "universal opposition" between the 'raw' and the 'cooked.' Khare (1976) points out, however, that the parallel terms for the notions of *raw* and *cooked* in the Hindu cultural taxonomy are imprecise. The terms *kacca* and *pakka* can indeed differentiate between raw and cooked food, just as they distinguish ripe and unripe fruit, but the major distinction here is the food's 'readiness for eating.' In the complex system of Hindu food classification "the application of common differentiation between the 'raw and the 'cooked' does not yield a significant result . . . , unless translated in terms of the central principles of cultural meanings and priority" (Khare 1976:14).

One criterion of vital importance in the Hindu situation, for example, is the matter of who has handled certain types of food. Translated instead as 'perfect' and 'imperfect,' *pakka* and *kacca* foods among the Gujaratis of Tabor's (1981:451) sample were variously susceptible to pollution: "The 'imperfect' foods? everyday foods? are either boiled or fried and may not be received from a lower caste. 'Perfect' foods, made from sugar or milk, and cooked in *ghee* (clarified butter), have a greater resistance to ritual impurity and pollution, and might therefore be accepted from a lower caste" Accordingly, Levi-Strauss' ideas have been soundly critiqued as "an overly intellectual re-working of popular stereotypes" (Mennell *et al.* 1992:9).

The 'rationality' of food aversions and preferences

In their efforts to address the structuralists' disregard for history as well as Levi Strauss' reductionistic penchant for binary dualisms, other theorists have argued that the biological and cultural, ideological and material are engaged in a much more dynamic

interaction than such formulations allow. In particular, they seek to discover how and why certain foods and not others are considered ‘good to eat.’

One such approach is the cultural materialist view, represented most vocally by Marvin Harris (1985), according to whom the food aversions and preferences of all cultures are equally “rational.” In most instances, argues Harris, rational motives have become shrouded in ideological justifications. Take, for example, India’s “sacred cow.” Here, Harris is referring to the phenomenon of the free-roaming cow which, to this day, prevails throughout India’s villages, towns and cities. The cow’s liberation rests on the belief of the Hindu populace in its sacred status. While Harris does not deny the cow’s symbolic import, he rationalizes the ban on cow slaughter by pointing to the animal’s utilitarian value as a draft animal, as a supplier of milk and, perhaps most importantly, as a producer of dung which is used as cooking fuel, among other things. Yet Harris’ argument differs not only from the traditional Hindu view, contends Simoons (1980), but also from innumerable reports by economists and animal husbandry specialists with first-hand experience in India. Having carefully studied the socio-legal arguments for and against cow slaughter, Simoons concludes that it is “fruitless to view everything as being under the influence of the techno-environmental imperative” (1980:132). Important, too, are religious factors, as well as the various political agendas of law-makers.

The communicative value of food as symbol

By contrast, Mary Douglas (1982) and numerous others who have followed her lead seek to understand, instead, the *communicative* value inherent in the symbolically weighted domain of food and eating. Douglas focuses on the “social uses to which food is put” and hence anticipates “correlations between the structure of the food and that of the social relations between people who habitually ate the food together” (1982:83, 84). With reference to southern Chinese foodways, Anderson and Anderson (1977:366, 367) have this to say:

[F]ood is the great social facilitator. It is needed every day; it is highly divisible and quantifiable; it is usually prepared and consumed socially, and almost all eating is a social event. Thus sharing food is a great social bond, and the foods shared communicate the forms and intentions of social interactions. In fact, second only to its nutritional value is its communication value. . . . Meals, from snacks with friends to formal banquets, are the most important concrete expressions of social bonds, actually creating and maintaining them.

For the Chinese, write Anderson and Anderson, food not only affirms their relationships with other human beings but with the supernatural: “Food sacrifice is obligatory in all

major rituals and serves as a key way of communicating to the gods” (1977:367). On this point, the authors make an interesting distinction between the Chinese food sacrifice, which is viewed as a type of meal shared with gods rather than living humans, and the Indian view which regards even the humblest meal as sacred and hence akin to a divine sacrifice. In effect, the Chinese approach places greater emphasis on the social bonds that food effects rather than its sacred nature *per se*. By the same token, explains Spillman (1985a), the Jewish observer of the rules of Kashruth, among which are the kosher dietary laws, derives a sense of connection not only with his or her heritage, but with ancestors, children, community and God. It is not unusual for the observance of these laws and the bonds they signify and facilitate to excel in importance as the individual ages.

To return to Douglas’s assumptions concerning the communicative value of food, we are assured that within any given culture there is some degree of patterning, particularly within what she terms the ‘family food system’: “variations take place within a known matrix. Within that framework, there may be minor changes, but everything conspires to imply that at least the frame is steady” (1982:89). Most British diners, for example, expect sweet liquids and fruits to conclude a meal, not begin it, as might be the case in Hungary where cold pink cherry soup is served as a first course. Equally strange for the British gourmand is the idea of eating the same food for all three courses. Hence variation and sequence must be taken into account.

Douglas points, as well, to the tension between food systems that exist within families and those prevalent in the broader cultural context: “Information is continually pressed upon the family by the media, advertising and friends” (1982:87). Rules about eating and the ability to impose those rules on others, argues Counihan (1998), are manifestations of class, ethnic and gender distinctions. For example, the distribution of thinness across various demographic clusters is testimony to its association with “power, wealth, competence and success” in the United States (1998:8): Greater wealth and whiteness go along with thinness; poor Puerto Rican, Black and Native American women have lower status and greater obesity rates than well-off Euro-American women” (1998:8).

Food and the negotiation of identity

Ultimately, then, the question of what is food and what is not and which methods of preparation are deemed acceptable points toward the value of food as a communicator of both individual and group *identities* (Ritenbaugh 1978). Harbottle (1997:176) explains,

Food beliefs are culturally reproduced (and transformed) from one generation to the next and throughout the life course food is inextricably linked with kinship and with community membership. . . . The categorisation of a substance as edible implies that it is accepted into a particular group of people; commensality based upon the sharing of permitted foods draws people into that community. The ways in which different groups variably categorise foods as edible serve as important markers of difference.

Following Dumont's lead, Farb and Armelagos (1980) accept caste as the pervasive ideology governing all social interactions within the Indian cultural tradition. Their emphasis is on the correspondence between food categories and social categories: "[A] person acceptable for the table is also acceptable for the marriage bed" (1980:152). Here they are referring to the notion of purity as it pertains to commensality and intermarriage restrictions observed by members of different 'caste' rankings. In order to avoid 'pollution,' food should only ever be prepared by individuals of higher or equivalent caste ranking.

Appadurai's (1981) more detailed study of South Indian "gastro-politics" nonetheless exposes their analysis as overly simplistic, failing to account for a host of competing social and moral propositions according to which food is served and distributed. In both the household and the wedding feast, maintains Appadurai, the quantity and quality of food as well as the context in which it is served (e.g. order of serving, seating placement, etc.) rely on a set of principles which, besides caste, take into account the individual's age, sex, matrilineal/patrilineal affiliation, patrikin/matrikin status, kinship distance, and length of stay in the household ('burdensome kinsman' versus 'guest'). Food, concludes Appadurai (1981), serves to solidify group identities.

The negotiation of identity through the medium of food is nowhere more apparent than among immigrant communities. Adopting a view of ethnic identity as a *process* rather than a thing,¹⁹ Kalcik (1984:46) suggests that the study of foodways can help us to understand "the processes by which ethnic groups form, reform, and maintain themselves and how group and individual identity is communicated to in-group and out-group members by means of symbol and performance." In other words, we can communicate that we are part of a group, or not part of a group by what we eat. Hence immigrants to Canada may wish to communicate their new Canadian identities to other Canadians by consuming food familiar to the majority (e.g. burgers and fries) or they may draw greater comfort from fellow ex-patriots of their homeland and continue to eat traditional foods on a regular basis. Some manipulate their identities with care, selectively consuming either "Canadian" or traditional foods to their tactical advantage. Traditional foods are most

likely to be eaten on special occasions at which time even acculturated individuals choose to emphasize their traditional community membership. In this way, “food links people across space and time, so that it helps create a bond with past members of the group as well as between living ones. Festival and holiday foods are especially important in this way” (Kalcik 1984:59).

Gupta (1975) maintains, for example, that the food habits of a sample of Indians living in Pennsylvania, became increasingly Westernized, which is to say, non-vegetarian, over time. Although they gradually lost their inhibitions against eating beef, most of the forty-one Hindus in Gupta’s study chose other meats more frequently. Half of the participants, primarily men, had also taken to drinking alcohol on social occasions. Breakfast and lunch were most often Americanized, while dinner was typically more traditional, with the addition of some American food items. Those most likely to adopt Western food habits were younger (20-26), male (since their occupations took them away from the home and traditional fare), unmarried, with urban backgrounds, and had been living in the United States for at least five years. Caste membership in combination with the region of origin further set the baseline of taboos from which individuals chose to deviate, or not.

More recent studies of the effects of acculturation on diet among South Asian immigrants are somewhat inconclusive. On the one hand, the South Asians in Anand and Yusuf’s (1997) Canadian study are more inclined toward vegetarianism—a factor positively correlated with heart health—than Canadians of European heritage. Yet they also report a greater weekly consumption of high-fat dairy products, salt and fried foods—factors which may increase their risk for cardiovascular/coronary heart disease for which South Asians are known to be at increased risk. A more extensive British study of South Asian dietary practices underscores the importance of considering the heterogeneity of this population (Simmons and Williams 1997). Detailed analysis of each of five South Asian subgroups, determined by region and religion (Punjabi Sikhs and Hindus, Pakistani Moslems and Gujarati Hindus and Moslems), reveals distinct dietary patterns for each. All South Asians have nonetheless adopted some high-fat English foods—such as burgers, chips, cakes and cookies—at a similar rate, although their consumption of these foods is lower than that recorded for the ‘European’ control group. In addition, their consumption of Indian sweets and fried snacks remain high. According to Sevak, McKeigue and Marmot (1994:1072), however, “South Asian men in west London have lower total fat intakes, higher polyunsaturated fatty acid intakes, and higher intakes of complex carbohydrates” as compared to their European counterparts.

According to Newman and Ludman (1984), the food habits of elderly Chinese-Americans show remarkable resilience to change: “the main meal is very similar for Chinese in the P.R.C. and Chinese Americans, regardless of age, sex, or occupation. Almost 60 percent of the Chinese had special foods they considered appropriate for the elderly; more than half of these were animal or high-protein foods” (1984:3). A more recent study by Lew (1997) nonetheless indicates that at least some food habits are mediated by the influence of western medical advice, among other factors. Research among Chinese seniors in both Los Angeles and Taipei, Taiwan, indicates that health concerns prevail over the traditional valuation of eggs as nutritious and symbolically potent to the extent that 58% and 44% of the L.A. and Taipei participants, respectively, limit their egg intake.

Harbottle (1997) suggests that what is at issue among immigrants such as the ‘British Iranians’ of her study is the “perception of taste” such that shifts in ethnic identity are reflected through tastes in food:

Even amongst those who had spent many years in Britain, some continued to perceive the flavour of meals in Iran to be superior to those dishes prepared here [i.e. Iranian food prepared with ingredients purchased in Britain]. In other cases, informants noted a change in their perceptions of taste, such that one woman found that she no longer liked the flavour of food prepared by her mother, but preferred her own culinary efforts, based on British ingredients. . . . Significantly, this woman also admitted that she could no longer consider returning to Iran to live and now thinks of England as her permanent home (Harbottle 1997:180).

Pasquali (1985:36) reports similar findings with reference to elderly Cuban-Americans for whom eating traditional food offers “comfort and security by serving as a means of identifying who they are, reminding them where they have come from and differentiating them from Americans.”

Identity is defined not only by oneself, however, but by others with whom an individual must interact (Cool 1986). Accordingly, immigrants may be set apart by their distinct food practices. Kalcik (1984) provides such an example whereby the settlement of a sizable number of Vietnamese refugees in a small Kentucky city prompted residents to initiate a rumour that people’s dogs and cats were disappearing. This blatant allusion to the notion that the Vietnamese’s food habits were responsible for the alleged disappearances is a common and clearly racist stereotype used to imply that the newcomers are strange and unwelcome intruders.

Food, politics and power

Narayan's (1997) discussion of 'curry powder' similarly illustrates the power of food in differentiating one group of people from another. Invented for the consumption of Victorian Britons, curry powder serves as a metaphorical device for the exoticization of the Indian subcontinent. According to Narayan, the evocation of an imaginary India replete with spices, silk and muslin was necessary "to provoke an imperial interest in incorporating this Jewel into the British Crown" (1997:165). Conversely, British expatriots living in India sought to justify the colonial imperative by establishing clearly the social and cultural differences between themselves and India's "ignorant natives, indolent and incompetent rulers, . . . and the hard-to-convert heathens" (1997:165). The almost exclusive consumption of British food and the virtual absence of Indian household decorations in their homes were powerful symbols of their distinct status.

Where the assertion of group identity is most troubling is in instances where there is an imbalance of power. The promotion and distribution of infant formula in Third World countries by multinational corporations based in the West is but one such example (Ritenbaugh 1978). The imposition of Western food groups on immigrant populations could well be another. Perkin and McCann (1984) suggest, for example, that the U.S. government's nutrition recommendations that Americans daily select foods from the 'Basic Four' food groups²⁰ is primarily a politically motivated message which reflects "an orientation toward the marketing of agricultural products" (1984:239). The advice, moreover, ignores the multicultural composition of the American populace and is culturally biased in its disregard for the differing dietary needs of these various groups (see also Newman 1985). To cite but one example, adherence to the recommendation that all Americans consume dairy products on a daily basis, could in fact make a great many lactose-intolerant Americans (especially those of African, Chinese or Mexican descent) quite sick. Having noted that the U.S. government does not include suggestions as to how guidelines for food intake might be incorporated into the range of sub-cultural foodways that characterize its population, Perkin and McCann (1984:253) question whether this is merely an oversight or, worse, "a conscious or unconscious effort toward lessening ethnic identities by the promotion of one diet for the American people." Cultural insensitivity, discrimination and racism may thus influence the food and nutrition experiences of ethnic seniors in dominant society LTCFs at many levels.

Summation of theoretical insights

So what does all of this tell us and how is it useful in light of the problem posed in this paper? Our task, after all, is to determine what happens with respect to the dietary requirements of ethnic seniors in dominant society LTCFs and what can be done to address identified shortcomings. Let us review the main points:

✍✍ It is important to examine not only the nutritive value of foods consumed but the historical, social, economic, political and cultural context within which this takes place.

- ?? The production, preparation and consumption of food is inter-related with concerns of the life-cycle, interpersonal relationships and the structure of social groups
- ?? Access to and control of food influences the societal power of men relative to women and the identification with specific foods can define masculinity or femininity
- ?? Food practices with considerable cultural and historical depth are most likely to be nutritionally beneficial to a population. In any population, however, there may be food practices which prove deleterious to certain segments of the population at particular periods of their lives; such foods are often related to status.

✍✍ Cultural universals are only useful if translated into culturally specific formulations

- ?? E.g. In Hindu India, the oppositions of 'raw and 'cooked' can only be understood as 'perfect' and 'imperfect.' This distinction refers to the degree to which foods are susceptible to ritual 'pollution.'

✍✍ It is sometimes valuable to question why certain foods and not others are considered 'good to eat.'

- ?? Ideological explanations can obscure more rational motives for food taboos and preferences, but religious factors and political agendas should nonetheless be taken into account

✍✍ Food and eating are symbolic and communicative

- ?? Food is put to social uses, hence there are correlations between the structure of food and that of the social relations between people who habitually eat together
- ?? Food affirms people's relationships both with other human beings and the supernatural. The symbolic affirmations of these relationships often excel in importance as the individual ages.

✍️✍️ Rules about eating and the ability to impose those rules on others are manifestations of class, ethnic and gender distinctions.

- ?? There is some degree of patterning (e.g. in the variation and sequencing of food items within a meal) within 'family food systems' although these exist in a state of tension with food patterns that are prevalent in the broader cultural context

✍️✍️ Food communicates individual and group identities

- ?? E.g. In Hindu India, both caste and competing social and moral propositions according to which food is served and distributed must be taken into account; together these considerations solidify group identity
- ?? The symbolic and performative qualities of food reflect the processes by which ethnic groups form, reform, and maintain themselves and the manner in which group and individual identity is communicated to in-group and out-group members. Shifts in ethnic identity are reflected through shifts in the perception of tastes in food.
- ?? The food habits and hence the ethnic identities of older immigrants are typically more resilient to change than those of younger group members: for older immigrants, eating traditional food can offer comfort and security.
- ?? Immigrants most likely to partake in non-traditional foods are unmarried men with urban backgrounds who work outside the home. Length of time in the receiving country is positively associated with the likelihood for change.
- ?? The heterogeneity of ethnic designations such as 'South Asian' must be taken into account when examining food practices in detail, since there is considerable regional and religious differentiation in identity and diet alike.

✍️✍️ Food may be used by a majority or dominant group to differentiate one group of people from another.

- ?? The almost exclusive consumption of British food was a powerful symbol of the distinct status of British ex-patriots in India.
- ?? Minority immigrants are sometimes set apart (and thus discriminated against) by their distinct food practices
- ?? Nutrition recommendations that Americans daily select foods from the 'Basic Four' food groups may be politically motivated (to benefit powerful elements of the majority); they are also culturally biased in their disregard for the differing dietary needs of various ethnic groups of which the population is comprised.

The findings in this section both clarify the extent to which the dietary needs of ethnic seniors are under-served and indicate areas worthy of consideration in formulating solutions.

Holistic medical traditions and the meaning of food

In North America, the context within which ethnic seniors in need of long-term care typically find themselves is strongly mediated by a biomedical ethic. Although many in the West ascribe the qualification that a behaviour or trait is 'cultural' to peoples from 'elsewhere,' we are all equally embedded in our own cultural perspectives. That Western ideals and biomedicine are often seen as acultural is testimony only to the domination of both in other parts of the world. Characterized by 'germ theory,'²¹ and 'Cartesian dualism'-the notion that the mind and the body are to be treated as separate entities-biomedicine is as embedded in Euro-American beliefs as is Ayurvedic medicine in Indian values (Lock 1991). Twentieth century biomedicine is further characterized by hierarchical, acontextual divisions (Lock 1987). By contrast, non-Western indigenous healing traditions rely, in large part, on analogical reasoning capable of embracing societal relations as well as the supernatural. Hughes (1990:136) similarly points out that most non-Western medical systems

are holistic in scope and basic premises. Not for them the seductive Cartesian division between body and mind. Rather, an affliction, a discomfiture of mind, an accident of nature is seen in a context of not only ailment-in-body but also of possible soul loss, spirit intrusion, taboo violation, malevolent acts of other persons or agents, or any number of other constructs that define the world of unseen power.

Health is thus broadly conceived, taking into account familial, social, dietary, spiritual, mental and physical dimensions. For the Chinese-American seniors of Chen's (1996) study, for example, the maintenance of harmony with the socio-spiritual environment was deemed central to the promotion of health and prevention of illness. A perceived imbalance of the concepts of Yin and Yang? "opposing but complementary forces that control the flow of *qi* [energy] and account for changes that are used to describe the nature and treatment of diseases" (Chan 1997)? is brought about by either an excess or a deficiency of a substance or activity (e.g. eating, bowel movements, sleep) (R. Lee 1986). While Yin (the shady side) represents cold in the body, Yang (the sunny side) corresponds to heat. It is only when the two are balanced that the body is considered healthy. An excess of either heat or cold can upset the balance, thus certain illnesses are classified as 'hot' (due to excess Yang in the body) and others 'cold' (resulting from a surplus of Yin). Although the Yin-Yang balance can be affected by multiple variables such as climate, age and emotional state, the cooling or heating properties of food and herbs appear to exert the greatest influence (Chan 1997, Koo 1984, McNamara 1996). Consumption of a particular type of food or herb ('heating' or 'cooling') could thereby upset or reestablish equilibrium in the body.

In parallel, the Korean-American seniors of Pang's (1991) study evaluate health status in terms of a person's desire to eat and ability to digest. Rather than greeting one another with the North-American catch phrase, 'How are you?' these elderly women were more likely to inquire as to whether a compatriot had eaten breakfast or if she had a good appetite these days. Food intake is explored as the possible reason for health complaints, whereas good food is deemed to be on a par with restorative or tonic medicine. The Chinese concept of 'vital energy' or *qi* is recognized among Koreans as *ki* which originates in the abdomen. "Food as a source of energy is digested there, mixed with air or force, and transmitted to different parts of the body" (Pang 1991:198). Accordingly, weak digestion is thought to underlie many diseases.

Turning to the oldest known traditional medical system of South Asia, we see, once again, considerable inclusivity in its definition: literally translated, Ayurveda means the 'science' or 'knowledge' (*veda*) of life (*ayus*), the latter broadly conceived as body, mind and consciousness or spirituality (Lad 1984, Larson 1987). Accordingly, the study of the Ayurvedic tradition in South Asia offers considerable potential for understanding the configuration and development of symbolic patterns of 'health' and 'disease.' Koehn's (1999) in-depth research with twenty elderly Punjabi woman in both India and British Columbia, Canada, found that, to varying degrees, the "obsessive attention given to food, season, habitat, lifestyle, and social interaction in Ayurvedic diagnoses and therapies" to which Larson (1987:255) refers, do indeed translate into daily practice for these women. This is nowhere more evident than in the realm of food, to which we will now turn.

South Asian seniors and food: a case study

Each of the twenty elderly Punjabi Hindu women interviewed by Koehn (1999) asserted that food is connected to health in multifarious ways. The following extract from one participant's account provides an especially cogent example:

I think food is a basic thing, whatever you eat, it affects your health. Because this is where you get the blood, and blood is the basic thing for the health. So, food is really very necessary. I mean, one has to have *balanced* food. And if somebody is taking balanced food, there are very few chances that he or she will get ill, unless it is hereditary (Sumati, as cited in Koehn 1999: 242).

Sumati's reference to balanced food indicates less of a concern with the 'Basic Four' food groups than it does with concepts such as the three 'humours': *vata*, *pitta* and *kapha*. Each of the three humours combine the qualities of hot, cold, wet and dry. In their ideal state of balance and harmony, *vata*, *pitta* and *kapha* are responsible for the smooth

functioning of the human body. Whenever that balance or harmony is disrupted, illness of some kind results. Among British residents of Indian origin, for example, the Punjabi term *bhye bhaddi* was used spontaneously by 25 of 65 interviewees to denote a condition which, they maintain, arises due to an excess of 'cold' in the body (Bhopal 1986).

Traceable to an imbalanced diet of certain 'cooling' foods, *bhye bhaddi* manifests as excessive mucous production and, if left unattended, abdominal distention, flatulence and indigestion or, taken to its extreme, joint pains and arthritis.

Also worthy of note in this population is the observance of an Ayurvedic principle known as *Viruddhaahaara* (Radhika and Balasubramanian 1990:74). This concept refers to a range of seventeen different typologies of combinations involving one or more food articles which, when ingested, aggravate the humours (*vata*, *pitta*, *kapha*) which then cannot be removed from the body, hence giving rise to disease. Koehn (1999) notes that several of the elderly Punjabi Hindu women that she interviewed identified incompatibilities between various foods: Combinations of fish or meat with milk, and yogourt with radish are both said to result in leucoderma ('skin depigmentation'); combining hot and cold substances such as coffee and ice cream or tea and *lassi* (a cooling yogourt and water drink) is thought to bring about colds, coughs, sore throats, stomach upsets, or the loosening of gums and teeth; and sour substances, such as yogourt or juice should not be taken with milk. These beliefs are nonetheless susceptible to acculturative pressures. One woman told Koehn that her grandchildren in the United States mock her observation of the prohibition against taking hot and cold substances together which has succeeded in modifying her behaviour. Another notes that, in Canada "there must be some effect, but here, we don't mind, we take tea, and *dahi* [yogourt] and everything hot and cold, so the perception [in] Canada [is] very different than in India. Here . . . nobody thinks of these things" (Anju as cited in Koehn 1999:258).

Besides the three humours, Hindu Indians strive to attain balance as well in their consumption of the three *gunas* or 'strands': *sattva-rajastamas* (Marriott 1990). Sweets and other *sattvik* foods generate the "proper," which is to say, "moral" emotions of "peacefulness, truthfulness, compassion, kindness and sympathy to all creatures" (Lynch 1990:103), whereas *rajasik* foods are associated with passion, and the consumption of *tamasik* foods give rise to 'dark' emotions such as hate or depression. Table 1, below, summarizes those foods included by the elderly Punjabi women of Koehn's (1999) research in each category and the effects that they associate with each *guna* on the body, mind and spirit, respectively. Items indicated in bold type were most commonly mentioned for this category.

| <i>Guna</i> | Foods of this nature | Effects on mind/body/spirit |
|---------------|--|--|
| <i>Sattva</i> | "simple food"; vegetarian with little/no spice: fruit, vegetables (esp. raw, NOT turnip), milk , rice pudding, custard, <i>roti</i> , rice, butter, <i>ghee</i> (in moderation), almonds, <i>panir</i> (curd cheese), (possibly) yogourt, sweet foods (in moderation), <i>dal</i> (NOT <i>masar dal</i>) | easily digested, healthy, invigorating (activate blood circulation); enable the mind to be calm, to concentrate, to meditate; associated with generosity, goodwill for all, purity enable you to become closer to God, more spiritual, engender a pious nature (associated with Sita of the <i>Ramayana</i>) |
| <i>Rajas</i> | "rich" foods: some cooked vegetables, (possibly) yogourt, very sweet dishes, deep-fried foods , dishes with a lot of <i>ghee</i> , onions and garlic (in smaller amounts), spices and pickles, 'restaurant' food | associated with high energy, anger (hot temperament), pride (link with ego - <i>ahamkara</i>), prosperity, leadership, selfishness |
| <i>Tamas</i> | meat, fish, eggs, alcohol , 'hot,' 'sharp' foods, spices , etc., onions, garlic , turnips, leftovers, over-ripe fruits etc., sour foods (e.g. <i>amchur</i> , i.e., mango powder), bitter foods | hard to digest, especially for older people; associated with anger, cruelty, rudeness, lethargy, lust (sensuality), bad thoughts and deeds, 'downward-pulling' energy, hatred, lack of inclination to gain knowledge makes you "devilish" (associated with the demon Ravana of the <i>Ramayana</i>), of the body rather than spirit, associated with <i>tantriks</i> (practitioners of 'black magic') |

Table 1: The classification and effects of foods according to their *gunas*.

One of the most important distinctions drawn between *sattvik* and *tamasik* foods is their relative digestibility. Easy on the digestive tract, *sattvik* food is considered the best type of food for the elderly. Koehn found that the concept of digestion occupies a prominent place in the women's conceptualization of food as a preventive on the one hand and as a remedy on the other. From the perspective of Ayurveda, the proper maintenance of the

digestive fire (*Agni*) is essential to good health (Radhika and Balasubramanian 1990:16). Besides herbs and spices, certain foods are singled out as especially beneficial to digestion. Yogourt ('curd' or *dahi*) is identified by the majority of Koehn's (1999) interviewees as an important digestive aid. For most women, curd is a daily staple, taken especially with the mid-day meal.

Another category of food associated with good digestion is that denoted as 'light' (*halka*) or 'soft' (*naram*). According to one of Koehn's interviewees,

naram food is easily digested, like rice and *kitcheree*. We give these to sick people. Milk, *dahi*, and drinks are also *naram*. *Sakht* ['hard'] foods are hard to digest, like meat, cereals, especially kidney beans and black *urad dal*. You would not give these to sick people (Radha as cited in Koehn 1999:263).

Other pulses, such as chickpeas, and raw vegetables, are similarly classified as 'hard' foods that can be difficult to digest. The association of *naram* foods with the weak and sick is especially evident in references to *kitcheree*, the preparation of which Prita (as cited in Koehn 1999:263) describes as follows: "You make this with rice [and] *mung dal* with *illaichi* [cardamom] and lots of water. Cook it until it's really soft and easy to digest." Like Radha, Prita suggests that *kitcheree*, together with yogourt, can be given to those with a bad stomach. Rice is classified by most women as readily digestible unless, as Sumati observes, it is fried "with lots of *ghee*²² [clarified butter]" (*op cit.*:264). As a rule, however, Punjabi people usually prefer *roti* (unleavened whole wheat bread) to rice, pointing to its greater capacity to satisfy hunger and provide strength (Koehn 1999).

While light foods such as rice and *mung dal* "[assist] the mind's efforts to integrate body, mind and spirit because it pulls less blood down into the body during the digestive process" (Svoboda 1989:61), heavier, less digestible foods such as meat have the opposite effect, grounding the individual firmly in the body. Here then we see how the relative digestibility of food corresponds with the notions of *sattvik* and *tamasik*. In Tara's words,

Sattvik food is easily digested, so it's especially good for older people—people over fifty-five. They don't exercise any more. Why keep hankering after certain foods? It creates problems for yourself and in the family. It's not proper. *Tamasik* food is all these wonderful preparations, but they're not good for the health. They're not digestible, there are so many things in them (Tara as cited in Koehn 1999:128).

The consumption of *tamasik* substances is commonly associated with the "destruction of the [social or familial] environment" (Sita as cited in Koehn 1999:245). Here in Canada,

this is more of a problem, since most people tend to eat meat. Especially interesting in Tara's statement, for example, are the interrelationships that she discerns between the relative digestibility, simplicity and piety of the food, on the one hand, and the older person's position in the family, on the other. While the relationship between food and old age is phrased initially in terms of a lack of exercise on the part of the elderly, the 'inappropriate' desires of elderly family members for "wonderful preparations," which might be translated as 'special treatment' or 'attention,' seems to be more at issue here.

Besides its *tamasik* qualities, the meat of the cow in particular carries considerable symbolic weight among Hindus who typically observe strict taboos against its consumption. None of the women in Koehn's sample have ever eaten beef, nor are they likely to do so in the future. The most common analogy employed by the women is typified by Lakshmi's contention that "the cow is like your mother, she gives you milk, so how could you kill your mother? This is very harmful" (as cited in Koehn 1999:248). To this Tara adds,

she's addressed as 'cow mother,' *gai mata*. She's kept in a special place, a clean place. She gives milk, and at festivals, people put flowers on her. Now things are changing. Previously our mother wasn't to be spoken to rudely, whichever mother. Now it's not always like that. In our spiritual teachings, the mother held a high place, but now it's less (*ibid.*).

As indicated in Table 1, above, cow's milk is regarded as perhaps the most important among those substances regarded as *sattvik*. Accordingly, it is said to bring calm and peace to the body and mind, to enhance one's ability to pursue spiritual enlightenment. The vast majority of the women in Koehn's sample extolled the many virtues of milk and indicate that they typically drink at least one and up to three cups per day.²³ For strict vegetarians, milk is an important dietary staple. Milk is "energizing," the women agree, it is full of nutrients and in combination with an egg, claims Sumati, provides all of the elements necessary for a nutritionally balanced meal. According to Radha, milk is a good source of protein, calcium, fat, and minerals. Many other women draw attention to its beneficial calcium content. Typically, milk is taken warm rather than cold. While this preference may be customary, some women believe that lukewarm milk is more digestible. Reassured by her sister who has been living in Canada for some time, one participant began drinking cold milk, only to find that it was aggravating her knee pains. Although the association may be far-fetched to the western health practitioner, it is perfectly consistent with an Ayurvedic framework according to which arthritis "is related

to low *Agni* [digestive fire] and poor digestion” (Frawley 1989:223). Hence less digestible cold milk is more likely than warm milk to aggravate arthritis.

Another food thought to have diverse curative and preventive benefits is honey. Participants in Koehn’s (1999) research assert that honey is an essential component in remedies for cough, cold, weight loss, stomach ache, the flu, diabetes, teething, and pain in the joints. It is also thought to be good for purifying the blood and conditioning the eyes. Perhaps most contentious is the recommendation by many Ayurvedic practitioners of honey in the treatment of diabetes mellitus (e.g. Frawley 1989); more recent Ayurvedic research has nonetheless identified glucose and leolose as constituents of honey which would contraindicate its use for this condition (Radhika and Balasubramanian 1990). These conflicting positions are mirrored by the participants in Koehn’s (1999) research: although two women suggested that diabetics can use honey in place of sugar, several women in India and Canada who themselves suffer from diabetes emphasize instead the sugar constituents of honey and have eliminated it along with other sugars from their diet. One of these women is Tara, whose various ailments have forced her to control her diet considerably in recent years:

For the diabetes, I had to cut out sugar and carbohydrates. One gets used to it. Because of the heart trouble, I have to avoid concentrated fat, so I have a very simple diet, what we call '*dal-roti*' [literally, 'pulses-bread']. . . . When I first had the 'sugar' [diabetes], I ate only boiled food for some time and this helped to reduce it. Too much starch and concentrated oil, like *ghee*, is not good for anyone unless they're physically active. They stay in the system and this affects you (Tara as cited in Koehn 1999:128).

Although Tara appears to manage her diabetes fairly well, Simmons and Williams’ (1997) maintain that South Asian eating practices are not well-suited to the control of this commonly diagnosed ailment.²⁴ First, they argue, South Asian men and women often eat less frequently than three times daily, as per the dietary guidelines of the British Diabetes Association. Moreover, they are more likely to vary their meal times, often eating much later in the day than Europeans. These authors suggest, therefore, “that South Asians with newly diagnosed diabetes will have to make greater lifestyle changes than their European counterparts” (1997:13). The religious custom of fasting, commonly practiced among older Punjabi women in British Columbia (Koehn 1999), can likewise prove problematic for diabetic patients (Chandalia, Bhargav and Khataria 1987). Tara, among others, nonetheless applauds fasting for the opportunity it provides to train the mind and prevent you from "uselessly" putting food in your mouth whenever you feel depressed or worried (Koehn 1999).

From this brief foray into the medical beliefs and practices of a sample of elderly Punjabi women we see that food is rich in signification. Besides the continuity with tradition that eating one's customary food provides, the consumption of certain foods by the Punjabi elderly establishes their relationships with their families and with supernatural forces and effects considerably their physical, mental and spiritual well-being. Dietitians ignore these messages at their peril.

Conclusions and implications for dietitians

Currently, LTCFs in British Columbia and elsewhere in North America do not appear to address the considerable losses of culture, family and community that ethnic seniors experience when failing health mandates their institutionalization. Each of these losses deleteriously affects the dietary patterns and hence the health of ethnic seniors and deserves consideration in the planning and implementation of nutritional strategies that will better meet their needs.

Demographic and acculturative pressures in North America translate into the ever-increasing likelihood that ethnic seniors requiring extensive care will be institutionalized. Ensnared within the family, those who immigrate to Canada as seniors have little opportunity or need to develop English or French language skills. Although their diets may change somewhat, seniors living with family members can usually continue to eat the traditional foods to which they are accustomed. Often it is they who prepare the family's meals. They may nonetheless experience the detrimental fallout of the acculturation of younger family members whose busy 'North American' lifestyles afford little pause or inclination to spend the time with and show due respect to their elders.

This becomes especially critical when the senior falls ill. He or she may be kept in the home, in accordance with the dictates of filial responsibility, and receive inadequate care because the family does not command sufficient resources. Alternatively, the family may conclude that they are not capable of providing sufficient care and, ridden with guilt in many instances, will admit the elder to an institution. In addition to feeling sick and vulnerable in a totally unfamiliar environment, ethnic seniors may perceive that they have been abandoned by the family and hence shamed in the community as a whole. Eating may be the last thing on their minds. Frequent visits by family members, particularly when they have taken the trouble to prepare a meal for the senior, may at least partially atone for this necessary measure. Family members may thus become involved to a considerable degree in the care of institutionalized elderly relatives, particularly with respect to meal provision. Efforts to relieve the family of this considerable burden

therefore need to ensure their meaningful involvement in the care of the patient in other less demanding ways.

The loss of community further speaks to the unfamiliarity of the linguistic and physical environment in which the institutionalized ethnic elderly find themselves. Every effort should be made to congregate institutionalized seniors of like ethnic backgrounds whenever possible, although sub-cultural differences and culturally mandated gender segregation should be taken into account. Where sufficient numbers of any given minority exist, the construction of an ethno-specific facility in which the linguistic, culinary, religious and cultural needs of a specific group can be accommodated may be warranted. Where this is not the case, facilities organized by the dominant culture should be mindful of the importance of eating food in the company of others with whom one can converse and recognize oneself as a member of a community. In many cultures, the act of eating together and sharing food is one of the most important ways of establishing one's place in the world; eating alone is symbolic of complete isolation and is assiduously avoided. Without eating companions, many seniors may prefer not to eat at all.

Loss of 'culture,' as we have seen throughout the literature on food and eating, is not akin to leaving one's Nana Mouskouri cassettes at home. Cultural practices and the meanings assigned to them are complex and multi-layered. Here the points raised in the section concerning the meanings and messages of food are especially pertinent. Food, it transpires, is symbolically laden and capable of communicating all manner of relationships and states of being. What is and is not eaten, when it is eaten (in the course of a day or over a lifetime), who it is eaten with, the manner in which it is served-each of these factors, and others besides, inform the individual's identity, first to him- or herself, then to the ethnic group of which he or she is a member (so long as in-group foods are consumed and other norms adhered to on a fairly regular basis), and finally, to the immigrant's host society. To view the dietary preferences of ethnic seniors as whimsical fancies (should I have chocolate or vanilla ice-cream today?) is clearly a mistake. Rather they should be viewed as a valuable opportunity to observe the meaning-making processes of these individuals, the gateway to understanding not only the foods that they like to eat, but a great deal more besides.

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Endnotes

- ¹ *Dal* is the generic term applied by Hindi and Punjabi speakers to all manner of pulses (e.g. chickpeas, kidney beans, black beans, lentils, etc) which, cooked with spices, liquid and sometimes onion and/or tomato is a staple of the traditional Punjabi (northwest Indian) diet.
- ² See the 1982 Charter of Rights and Freedoms.
- ³ See Yeo's cursory mention in Barresi and Stull's 1993 edited volume on the topic. An article by Steenberg, Ansak and Chin-Hansen in this volume also devotes a couple of paragraphs to the role of food in the treatment of illness among the Chinese residents of the On Lok managed LTCF in San Francisco; nonetheless, this topic is by no means central to the article.
- ⁴ E.g. Mui, Choi and Monk's 1998 publication.
- ⁵ This point is further explored and elaborated in the ensuing discussion of the loss of community and in relation to certain theoretical positions.
- ⁶ It is estimated that as much as "80-90% of all health care to older adults [in the United States] is provided from informal sources, chiefly family members" (Wood and Wan 1993:40).
- ⁷ Permission to use this data was granted by Beverly Grice (nutritionist, Vancouver/Richmond Health Board), the grant holder for the project.
- ⁸ This man and his parents identify themselves as Punjabi Sikhs, denoting first their regional / ethnic background and secondly, their religious identity.
- ⁹ All names assigned to research participants are pseudonyms; this measure was taken to protect their anonymity and hence the confidentiality of the information that they have shared.
- ¹⁰ The *ideal* of filial piety is not always consistent with reality even in the country of origin (see for example, Cohen 1995 or Koehn 1999, re: India).
- ¹¹ See discussion of under-utilization of health and social services in the following section.
- ¹² Permission to use this data has been obtained from Patrick McGowan (Centre for Health Promotion Research, UBC), the Vancouver project coordinator.
- ¹³ The group was comprised of approximately 60% men and 40% women.

¹⁴ These comments reflect and amplify concerns tentatively voiced by participants in Koehn's earlier (1993) research. At the time, only one elderly Punjabi man and one service provider out of a total of 62 participants were willing to identify a need for ethno-specific or more generally ethnic Seniors' Homes. The Service Provider suggested that such a facility "should employ workers from the different cultures which would be represented by four to five residents from each community. This would provide for some familiarity while still permitting the combination of different cultural groups" (Inderjit, cited in Koehn 1993: 135).

¹⁵ Citizens of Canada and permanent residents of more than three years may now sponsor parents of any age (Islam 1989). Nevertheless, sponsors are bound by immigration regulations to an Undertaking of Assistance, or a "promise . . . to the Canadian Government to look after the care and shelter of their relatives," for up to ten years (Immigration Canada 1992:2). The decision as to the exact duration of this period of assistance is left up to the discretion of the Immigration Officer. Failure to live up to this promise amounts to a legal infraction by the sponsor who may have to repay the cost of any help provided by the government, and any future applications for sponsorship will be denied. The impact of sponsorship regulations on immigrant seniors is examined in detail in Koehn (1993).

¹⁶ Mui, Choi and Monk's (1998) comparative study of White, African American and Hispanic seniors in the United States reveals that improvements in morbidity and mortality associated with healthier lifestyles seen among 'White' seniors do not hold for the latter two groups, *i.e.* ethnic minority seniors. Despite their comparatively poor health status, "ethnic minority elders tend to underutilize the services that could enhance their health status and quality of life" (1998:103; see also Barresi and Stull 1993). Of particular interest, "White frail elders were 73% more likely than African American or Hispanic frail elders to have applied for nursing home admission" (1998:202). These authors go on to argue that not only cultural attitudes but a failure to provide adequate and non-discriminatory services on the part of the state are also to blame.

It is important to bear in mind the distinct structure of the Canadian medical system, on the one hand, and the ethnic composition of the two countries on the other. Unlike the United States, Canada's minority ethnic population is not dominated by the two groups on which most U.S. studies focus their attention-Blacks and Hispanics. Over the last three decades, various Asian countries have collectively been the greatest source of immigrants to Canada, with Chinese and South Asian immigrants the most numerous among them (Henry *et al.* 2000: 87).

¹⁷ "Foodways" is used here to refer to "behaviors that affect what people eat" (Ritenbaugh 1978:111).

¹⁸ See many of the articles in Arnott's 1975 edited volume.

¹⁹ Kalcik (1984) is here referring to Barth's (1969) definition of ethnicity which moves us away from a definition based on "cultural content" toward the more flexible notion of boundaries, through which certain individuals may pass without challenging, necessarily, the integrity of the ethnic group. This position is consistent with that adopted in this paper.

²⁰ "(1) meat or meat alternatives; (2) fruits and vegetables; (3) breads and cereals; and (4) milk and dairy products" (Perkin and McCann 1984:238).

²¹ European medicine did not shift toward a "doctrine of specific etiology" (also known as 'germ theory'), equating a single biological causal agent with each "disease", until the middle of the last century (Lock 1987).

²² *Ghee* is a form of clarified butter used in Indian cooking. Ayurveda attributes innumerable medicinal properties to *ghee* which occupies an equally exalted position in Hindu ritual.

²³ One has only to drive around a Punjabi neighbourhood, such as those found in Surrey, B.C., on recycling collection day to witness the piles of empty four-litre plastic milk containers outside virtually every home.

²⁴ Migration and westernization are strongly implicated in the increased prevalence of adult onset diabetes among numerous populations worldwide (Cohen 1989, Ramaiya, Kodali and Alberti 1990), and South Asian immigrants are no exception. Even so, a genetic disposition to develop NIDDM is now well established among South Asians and appears to manifest when they migrate and achieve improved socioeconomic status.

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