



# First Nations healing in the hospital

*On the quest to implement indigenous healing in a clinical setting*



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Thesis submitted for the degree:  
Master of Philosophy in Indigenous Studies  
Faculty of Humanities, Social Sciences and Education,  
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## Summary

This thesis focuses on the interaction of so-called indigenous and Euro-American healing traditions in one of the most formal institutional settings: the hospital. The setting for this study is the Canadian Prairie provinces of Saskatchewan and Alberta, and the main indigenous population are Plains First Nations.

In the study I wish to discover if indigenous healing practices are able to adapt to a setting that is so central to the definition of settler states. I do so within a broader perspective that sets healing within a study of the decolonization process. The main argument is that part of the road to healing lies through the official institutions of the Canadian medical system and that it involves decolonization process for both the indigenous and the dominant society. The thesis asks why are hospitals settings being chosen today as the places to establish indigenous healing services and practices? To answer this question the thesis employs qualitative interview data and a reading of the literature.

One of the key answers is that the hospital context permits the community of biomedical practitioners and the indigenous healers to interact. On the one hand, this interaction is seen as an important step for the revalorization and formal recognition of indigenous knowledge, and as determinant for the preservation and survival of it. On the other hand the field research shows that aboriginal patients feel extremely vulnerable when hospitalized and that the integration of indigenous healing within hospitals would improve the quality health care.

Despite these strong answers, the project remains explorative. The conclusions show that there is no simple answer for how these two traditions can come together. One of the main reasons is that this process of implementation is at the very beginning. It shows as well that not all healers think that this is a good idea, and are worried about the expropriation and integrity of the knowledge. Some questions remain inconclusive and further research will be necessary in order to give further answers.

## Acknowledgements

I owe my gratitude to many people who have contributed to this thesis in different ways. Some times through personal encounters, others through beautiful writings.

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Cristal Laplante: Thanks for your energy and comitment. Thanks for share with me the claims and needs of your people. Good luck!

Wanda Whitford: Thanks for share with me part of your personal history, and help me to understand the role of the cultural helpers. Thanks for organizing our meeting.

Dr. Konkin: Thanks for your time and for what you shared with me.

Earle Waugh: Thanks for your entusiasm with my project and for your incondicionable help introducing me to other informants and giving me invaluable information. Thank you so much

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## CHAPTER 1

### *Statement of the thesis and research questions*

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Most studies of indigenous peoples involve great contrasts. Indigenous societies are often defined as strong before the arrival of settlers (Jennes 1990; Lux 2001; Adelson 2002; Galabuzi 2004; Waldram 2004; Carriere 2009). The arrival of settlers often signals a time when ancient traditions are destroyed or assimilated. These sharp contrasts, however, do not recognize the ability of people to heal themselves or to learn from new situations. This thesis brings into analysis the difficulties and the progress of Canadian Plains indigenous peoples to persist as “real people<sup>1</sup>” within the present circumstances. Although there could be many areas of study that would highlight on these issues, this thesis focuses on the study of the interaction of so-called indigenous and Euro-American healing traditions in one of the most formal institutional settings: the hospital. In the study I wish to discover if indigenous healing practices are able to adapt to a setting that is central to the definition of settler states.

The setting for this study is the Prairie provinces of Saskatchewan and Alberta, which have violent histories as well as periods of reconciliation, between indigenous Cree and settlers from Northern Europe. A standard theme in all periods has been policies of assimilation that prohibited traditional cultural practices thus emphasizing the difference between indigenous and western cultures (Kremer 2009). These differences have become not only qualitative differences but also differences in status and power. The dominant society has devaluated indigenous people’s knowledge, style of life, and spirituality. As the second chapter shows, perhaps because of this history, the two medical traditions, despite their common goal on healing and curing, are still defined as two different types. However in other parts of the world these two traditions are integrated in the practice of medicine and in medical curricula (Manaseki 1993:2). Plains Cree had and *have* their own approach to health and illness, and their own type of ‘medicine,’ which is defined in differently than within the settler societies. By contrast, the formal, state-funded medical profession defines itself with the bio-medical approach. These concepts are outlined in more detail in chapter II. However, as this study shows, the paradigms are quite different than either of these models. For example, the spiritual and holistic dimensions of healing

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<sup>1</sup> This term is explained in section 2.1.3.

are at the core of Cree medicine. On the other hand, biomedicine professes an “extreme insistence on materialism” (Kleinman 1995:29), defining itself through the use of scientific research as the only effective knowledge for understanding diseases (Leslie 1980: 191).

The argument of this thesis is that there is space to accommodate these two paradigms of healing. This idea is not new (Maar and Shawande 2010), but as the literature review in section 1.3 indicates, there has been little work done on the specific meetings of these two traditions within the walls of a hospital. Furthermore, as the interviews in this thesis show, none of the interviewees, whether they describe themselves as a traditional healer, a medical doctor, or a medical administrator, are entirely sure what programs or strategies would work to reinforce each paradigm. Although the findings of this thesis are open-ended, I nevertheless identify several strong visions that emerged from the fieldwork. One strong view is that biomedicine itself has found itself in a crisis as it tries to relate to patients of different cultural backgrounds. Therefore many feel that western medicinal personnel need to learn indigenous medical practices. Another commonly held view was that traditional medicine can complement aspects of biomedicine thereby improving the quality of health care. For example some illnesses that take place in the body are successfully treated with Cree medicine, thereby avoiding the side effects of chemical treatments. On the other hand traditional rituals and in general the holistic approach of indigenous medicines, help to heal the soul and emotional side of the patient, as is shown in the treatment of patients from mental health<sup>2</sup> or palliative wards.

However and despite the above proposed benefits that indigenous healing could bring to bio-medicine, the context of a hospital seems to develop tremendous challenges for the combination of the two paradigms of healing. Therefore, *why are hospitals settings chosen today as the places to establish indigenous healing services and practices?* To find answers to this question a qualitative approach has been used for this study. The following part of this chapter explains the reasons for the selection of this methodological approach, the main research methods used and a description of the field site.

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<sup>2</sup> See annex 2

## **1.1 Methodology**

### **1.1.1 Qualitative approach.**

One of the main goals of this study is to understand the complexity of the official implementation of indigenous healing through the view of its participants. It is relevant to offer comprehensive and meaningful explanations about these issues through some of the cases and some of the people involved. I am aware of the diversity of indigenous peoples and their traditional ways in Canada. The scope and type of aboriginal services at the hospitals throughout the country can also vary across different aboriginal communities. However a representative study would depend on a different methodological approach. For example a quantitative methodology could use general questionnaires. These will produce data from the replies of a large number of people to questions that are only superficial (Young, Ingram and Swart 2003:3). It would not be appropriate for this research. Instead, this thesis analyses the information obtained in close relation with the participants of my fieldwork. This technique has brought interesting challenges from a research point of view and has played in general a very important role for the study.

### **1.1.2 Significance and the challenges of the use of open-ended interviews**

The reading of literature suggested very important themes that I wanted to focus on in more detail with my informants, for example: the meanings of Cree healing, holism, the challenges of making public a traditionally private knowledge, the need or (lack thereof) for aboriginal healing within a hospital. I selected my informants based on these themes. I was able to obtain eight interviews; six of them were with aboriginal persons. The two others took place at the University of Saskatchewan and Edmonton, and both interviews were with academic staff.

Before I started the interviews I considered the type of interviews I would use. On the one hand I was interested in having access to my informant's own views without guiding their answers through a path that might distract them from what they considered the most relevant aspects of the questions (Noaks and Wincup 2004) In this sense the use of in-depth interviews seemed the most appropriated method for the data collection. On the other hand, the flexibility of these interviews meant they might not focus on the information I was interested in. However the following aspect helped me to decide to use open-ended interviews. There are some basic protocols (N.A.H.O. 2011) to follow when you talk with Cree First Nation Elders and healers. Despite some differences between

communities, it is common to offer a gift of tobacco and to allow a person to speak uninterrupted. In general recording is not accepted. The use of open-ended interviews would help me to follow these protocols and enable my informants to communicate in a more open way. In the beginning of the interview only two or three questions were negotiated with my informants.

As the fieldwork proceeded and after having obtained the first interviews, I was confident I chose the best method for my research. My informants gave me valuable information about my research topic that I analyse in the following chapters. They also seemed to feel comfortable as well with these types of interviews. However the information that they shared with me came in a “format” I was not expecting. The manner in which my informants answered my questions was different than that of a normal conversation. Hammersley and Atkinson (1983:107) commented on this when they noted that: “Accounts are not simply representations of the world; they are part of the world they describe”. It shows for example that my informants have a rich way of connecting issues in a holistic way. Their answers were never direct but full of information about other aspects that I did not ask about. I interpreted this to stem from the logic of relatedness and a holistic way of understanding the world. It was challenge but became an important source of information in and of itself and a good practice to develop my career as researcher.

For example in one of the interviews in Saskatoon, in the “Indian and Metis Friendship centre”, I was asking my informant to explain what the centre was, and why they used some traditional ceremonies. I have to say I was expecting a description of the centre, with explanation about the different departments and what the main function of it was. However I received a long introduction about the skin colour of my informant, about how his family was not only Cree but also Ojibwa. He explained how their people were disconnected of their communities for different reasons, and that many of them did not know who they are. He also explained the importance for his family that he is not in trouble, not in prison, drugs... and how the teachings of Elders and the practice of healing ceremonies played an important role. After more than half an hour talking about these issues, he said that the centre helped people to know who they are and to help them to be

proud of it and feel strong and responsible about their own life<sup>3</sup>. He claimed that it was the start of the journey toward health and well-being. He said:

“...our people are growing without direction... this centre tries to teach who they are, where they come from, and where they are going..., I am here to tell people that they are Brown, that to be Brown is ok,...” (Vernon Linklater, personal interview 2011)

Here, my informant introduced the centre within the historical context of his community, relating its functions to a broader scope of meaningful events and problems, but never really described the mechanical way that the Centre worked bureaucratically. This is one example of what I mean by a holistic approach, which offers new insights but somewhat sabotages pre-prepared questions.

Similarly, I worked with the interview data in a special way by grouping together insights from several informants into specific themes. For example, as I will analyse in later chapters, identity was emphasized as key in approaching well-being and understanding the role that traditional healing plays in people’s health. This argument will reappear in many other interviews and will play an important role in my thesis.

The way information is shared has the effect of forcing the interviewer to revise his or her expectations. The holistic way of approaching my questions made me look at the issue I was interested in, not only from my point of view, but with the same logic as my interviewees. This was important and helped me to gain understanding within a broader context. If I had interrupted my informants to better organize their answers, I would have only received a reflection of my own biases rather than what they considered was important to be told.

This and the following challenges I experienced during my interviews led me to disagree with Tim Rapley (2004 in Silverman 2006:112). I especially disagree with the following points: In his book he claims that in qualitative interviews “no special skills are required.” He writes that the skills used on this type of open-ended discussion “are used by all of us all the time in everyday conversation”. Although I did not talk too much during the interviews, I was an active participant during the whole process. On the one hand I was continually working to understand my informant’s main arguments. On the

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<sup>3</sup> My informant works with the Family Violence programme at the Friendship Centre.

other hand I was trying to interpret why the information was framed for me in a certain way.

I also encountered difficulties with the type of language that my informants used. For example many used specific Cree terms or used English terms that held a non-standard meaning. For example, terms such as ‘Elders,’ or ‘grandfathers’, are English words which do not correspond to the Standard English meaning. The term ‘grandfather’ is used with a different meaning depending on the context. During the interviews it was generally used as the Spirits who act as a wise guide through the journey of life and in some cases provide the sacred knowledge of healing. The same is true of the key term ‘Elder’. In Standard English this term refers exclusively to age, but in the usage of Plains Cree and other Canadian aboriginal people it refers to a ‘wise person’ who is usually elderly. Not every old person is an Elder, nor every Elder has to be old in order to be an Elder. However Elders are normally over 50 years old, since it is understood that a person needs a long journey before to reach enough experience and therefore wisdom to share (Cf. Stielbacher 1996). I caught these differences in meaning since I had encountered it in the literature I read before the interview. However, *contra* Rapley, a person with no special preparation would not have caught this layer of meaning.

### **1.2.3 “So, who are you”? My role as a researcher.**

Beyond definitions, a more difficult problem was the role that I played as a researcher. According to Fontana and Frey (2000:654 in Silverman 2006:110) in order to have an in-depth approach to the culture of the informants, the researcher needs to develop a rapport with the interviewee. How should I present myself? In many cases most of my informants asked not about my academic background but “my deep” intentions for the research. I told them about my background in anthropology and in nursing. Despite my nursing background, it was my anthropological background that made my informants cautious. One of my informants made clear that he was aware of how anthropologists have sometimes misused the knowledge and trust of his people. He did not give more information about that but it created a tension. He continued to ask about my intentions for this research. In general I explained the study I was doing, and introduced myself as a student doing research and who would like to learn and understand better their (the informant’s) point of view. However for this informant this explanation did not seem to work. My informant patiently waited for me to finish and asked: “...so, who are you? What are you doing here?” I shared with him about my previous experience working with

immigrants in different countries and how much I learnt from these encounters. I explained to him that I knew that there are many different ways of understanding life and that in my view, I said, knowing them made my life much richer. I told him that I decided to study anthropology because it is a science that studies how other people see the world, and I wanted to learn the skills to tell and write about it. My informant seemed very glad to hear this, and reacted with empathy, encouraging me to keep doing it and starting to talk openly about the questions I had presented to him.

I will conclude this section on methodology by emphasizing that the fieldwork was not only valuable in order to get information through oral sources that I was not able to obtain from written documents. As previously explained, the use of open-ended interviews and the challenges inherent in the research have helped me to grow in my career as a researcher. It also gave me a closer understanding of the people I met and the context where indigenous healing is to be implemented. In this sense, the fieldwork has provided a much more solid basis for the development of the thesis.

## **1.2 The fieldwork locations and the participants of the study.**

The fieldwork was planned and carried out in several off-reserve urban contexts – contexts that are more relevant to the study of the interaction with the indigenous community and clinical institutions. The places I visited and people I met were in Saskatoon and Edmonton. Most of the indigenous people who have participated in this research are Plain Cree First Nations, but they also told me that despite the general identification as Cree; most of them have a multicultural background where Ojibwa, Saulteaux and Dene are considered kin. Most of my informants gave me their permission to use their names in the thesis. Two avoided answering the question, and I present their comments anonymously. This is the reason why in some cases I give an open presentation of the informant, and in other cases I just refer to his/her position or just their connection to the project.

The city of Saskatoon was chosen because of its large aboriginal population (See Figure 1.2.1). The city is cited by statistics Canada as having one of the largest urban aboriginal populations in Canada of around 9% with a very high population growth (Statistics Canada 2009; Signer & Costa 2005: Fig 3.). The aboriginal population is both



of the status or non-status type<sup>4</sup>. Because of this demographic profile, I expected the city to be an ideal place to investigate the challenges with clinical aboriginal services.

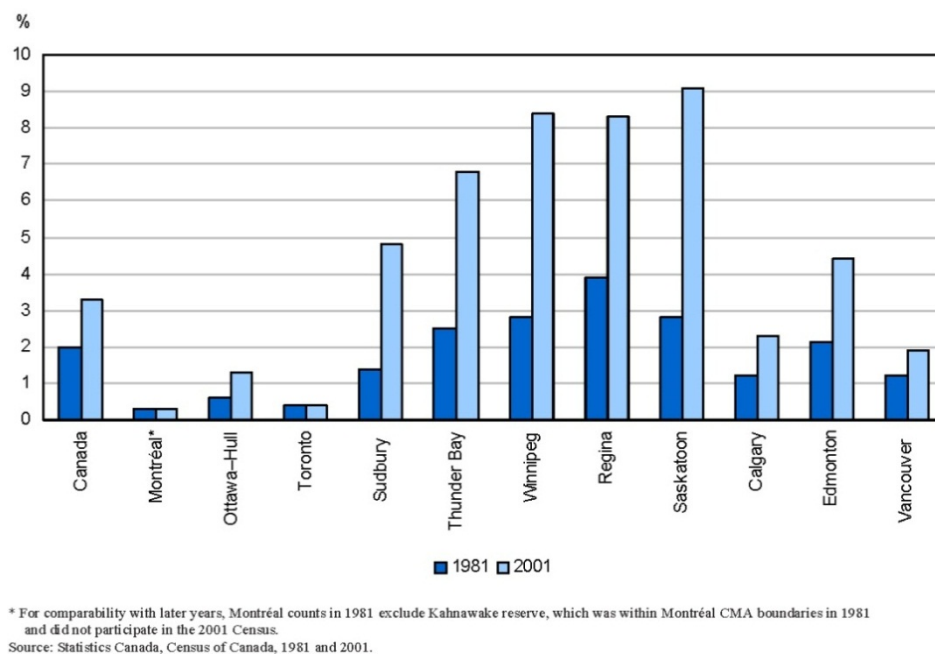


Figure 1.2.1 The aboriginal population of selected Canadian metropolitan areas (Signa & Costa 2005: 30)

I had five interviews in the city. The first, in the Department of Native Studies at the University of Saskatoon was designed to get an overview of the healing situation, here my informant remains anonymous. The other interviews, all with First Nations interviewees, were open-ended interviews carried out in different locations like workplaces or cafes. Of these interviews three were particularly important. One took place in the Saskatoon Indian and Métis friendship centre where, as above, we discussed the importance of identity for health and well-being. This interview grew into one of the

<sup>4</sup> In Canada, people of indigenous descent are classified in several legal categories. Descendants of the 'first nations' who signed treaties with the colonial or the Federal government after confederation are known as 'status Indians' and are 'protected' by special legal provisions in a Federal law known as the Indian Act. One of these provisions is free access to health care. Descendants of First Nations who did not sign a treaty, or who may have a mixed background are known as 'non-status Indians'. They enjoy protection of their rights in the constitution but their access to health care is often controversial. It is unique to Canada that Metis (descendants of mixed marriages) are recognised as an indigenous group (but non-status). The politically accepted term to refer to indigenous people in Canada is First Nations. The terms status and non-status Indian is a legal term. For more detail on this complex legal picture, which is beyond this thesis see Sawchuk (1985).

main themes of this thesis and its conclusions. Another interview took place in a cafe with a curriculum adviser at the Faculty of Medicine in Saskatoon. She shared with me how important cultural sensitivity is for aboriginal users within hospitals. Her concept of cultural sensitivity structures the discussion in chapter 3. I also had interviews with representatives of the Saskatoon Centre Urban Métis Federation (CUMFI) and the Kinistin Saulteaux Nation. There, my informants shared with me the main outcomes of a survey carried out with First Nations clients in the Saskatoon region. This study focused on elements of the hospitalization of indigenous people that were identified for improvement, and many of these ideas are analysed in chapter 3.

I also made four telephone calls to officers in the Saskatoon Health region administration office to get information about the aboriginal programs that are established. There, however, I did not get any clear answers. Later, through the other informants, I found out that the aboriginal services at hospitals were staffed mainly by volunteers. This situation is changing with plans to create a new program to establish 'cultural helpers'. These are to be individuals of indigenous descent who create links between aboriginal users and medical staff. The fact that these programs are not yet up and running gives many of the conclusions in this thesis a tentative character. More concrete are the universal statements that something must be done to improve the situation (Saskatoon Health region, C.U.M.F.I, and Kinistin Saulteaux nation 2010).

The second city I visited was Edmonton. My main reason for going there was to meet a very important traditional healer who was working at the University of Alberta and at the University hospital by the name of Clifford Cardinal. He is a traditional Cree healer who is well-known and respected within his community and in general within indigenous network. He is also an assistant professor at the faculty of medicine and dentistry at the University of Alberta. Earle Waugh has been a very important help as well. He helped me to organize the meetings and also gave very valuable information. Earle Waugh is the Director of the Centre for Cross Cultural Healing at the University of Alberta, and one of the initiators of position for Clifford Cardinal. There I would also meet Wanda Whitford who is administrator at the Indigenous Health Initiatives Program who provided information about the role of cultural helpers within the hospitals. I also interviewed Dr. Konkin, the associate Dean in the Division of Community Engagement. She shared with me what in her opinion are the main challenges of aboriginal healing implementation and the main argument why this implementation should happen. Everyone shared with me

their worries about the loss of traditional knowledge and the problems with implementing traditional healing in a clinical setting. Clifford Cardinal became one of the main participants of this study and section 4.5 is devoted to his biography (Cardinal 2006, 2008, 2011 and a personal manuscript “traditional healing protocols”). He also helped me obtain other written information and to contact further specialists informants. We have kept contact until today.

### **1.3 Previous research**

Before I left the field it was difficult to get a good idea on how indigenous healing is integrated within hospitals. The reason for this could be that the practice and integration of indigenous traditional healing, and aboriginal services in clinical care settings is very new (Maar and Shawande 2010: 19). There has been some recent work related to the issue although with a different focus. There are for instance some studies that analyse the importance of cultural sensitivity within at the hospitals (Graham 2010, Brascoupe 2009, Martin Hill 2009, Stewart 2008, Waldram 2008 and 2004). Other studies focus on how traditional healing practices take place within other clinical contexts such as mental health centres (Struthers, 2000, 2003). Other researchers have evaluated the effectiveness of traditional medicine (Waldram 2000) and the official establishment of aboriginal traditional healing projects at a community level (Waldram 2008; Csordas 2000).

Among these works, only Maar and Shawande (2010) focuses on the interaction of both traditions in a clinical setting. Their research took place in a mental health clinic. In their study they claim that traditional healing and western mental health care can be integrated successfully and their findings indicate that this combination gave good results in that mental health centre. According to this study, inter-professional education, the establishment of healing protocols and issues of physical access to services were the main three main factors that supported this coexistence.

Due to the scarcity of academic information about the issue that I wanted to study, I tried to get information through other sources. I found out that some communities are very active and are taking initiatives in organizing meetings that gather together Elders, healers and hospital and academic staff. Examples of these are the Traditional Healing Forum in the Dehcho region of the Northwest Territories (Awasis 2007; Lamothe 2009), or the Plains Cree Healing meeting known as ‘The Gathering’ (CPTMK 2010) During these events, problems and solutions are discussed. My review of these reports became

very useful in order to understand the point of view of the indigenous communities and traditional healers in the clinical settings. During the fieldwork I was granted access to a very recent research project related to the topic and carried out within the communities (SHR et al 2010). It was an invaluable source in order to have a broader view about the general situation of aboriginal healing and services.

## 1.4 Thesis outline

Before going forward with the outline of this thesis, it is necessary to revisit the research question of this project: *Why should aboriginal traditional healing be implemented within the hospital settings?*

The second chapter gives an overview of Plains traditional healing and contrasts the bio-medical model with that of Plains healing traditions. The chapter places its accent on the differences that create conflict with the aboriginal patients and negatively affect their health outcomes. On the one hand Plains indigenous healing is understood as a certain lifestyle that guides people toward well-being. In this sense healing is intimately related to the identity of the people and to the balance and relations between the community members, the land and the spiritual world. On the other hand, aboriginal healers stress a specific gift that some people hold that allows them to heal.

The third chapter analyses the main barriers for the acquisition of cultural competency at the hospital and give example of some solutions. Therefore, this chapter is on the one hand a presentation of the general problems that aboriginal patients suffer in relation to hospitalization and the stress created for the hospital staff. On the other hand it is an important starting point for the following chapter, which aims to answer: Why has Plains aboriginal healing been introduced and formal recognized in this conflictive context, and despite its differences with bio-medicine, will it create a positive difference?

The fourth chapter identifies three main arguments that provide causes, and some of the reasons against the combination of these two traditions. The first argument, or the political argument, is related to the wish of indigenous people from decolonization and the need of take their medical knowledge and healing traditions from the underground where it was pushed during colonization and assimilation process. The second argument claims that the introduction of aboriginal healing within hospital settings will improve the quality of health care, for both aboriginal and non-aboriginal users. The third argument

claims that a path is needed for the preservation, transmission and use of indigenous healing knowledge within the present circumstances along with the integration of this knowledge within medical urban settings. This argument looks at both the hospital and the university. The last argument is under debate and faces important concerns that need to be evaluated. Due to the challenging nature of this argument, the last part of this chapter provides an overview of some of the main worries, and gives the example of a Cree healer –Clifford Cardinal. The example illustrates the arguments of those who defend the implementation and open documentation of the knowledge, and describes the mechanisms used in order to protect and solve the main worries.

## **CHAPTER 2. Plains First Nations healing vs. the bio-medical paradigm.**

Although suffering is experienced in different ways around the world, it is common to all human societies. In the same way, medicine is a practice of care that is fundamental in all places, even if it is organized differently everywhere. All societies have persons who develop healing roles. However as this chapter shows, there are enormous differences in the ways that different cultural groups explain health and illness (Waugh, 2011), and a significant distance between the roles played by an expert trained in biomedicine and a medicine man with an expertise in non-Western traditional healing. Canada is a multicultural country; the diversity of the health care users is vast as are the different healing models. Although the official Canadian health care system is based on the bio-medical model, it coexists with others healing systems such as alternative medicine and aboriginal medicine. The main difference between indigenous medicines and alternative medicines is that complementary alternative medicines are not part of the country's own tradition, the formal health system, or their indigenous models of healing (WHO 2005). In contrast, the official definition of indigenous traditional medicine (Ibid) emphasizes that this knowledge forms part of the tradition of a people's country. The World Health Organization defines traditional medicine as "the sum total of the knowledge, skills, and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in prevention, diagnosis, improvement or treatment of physical and mental diseases" (WHO 2000:1 ). However this implies that what is considered traditional medicine in one country would be considered alternative if exported to another country or culture (Hætta 2011:27). For example, Chinese traditional medicine is considered traditional in its own country. However it becomes alternative in Western countries (Ibid).

The traditional healing approach of Canada's indigenous population has a long and distinguished medical tradition that remains viable (Waugh 2011: xii). There are important differences in cultural beliefs between the bio-medical model and the First Nation healing approach. Within a hospital context these cultural differences play a very important role. Waugh (2011) relates different cultural approaches to the ways symptoms are perceived, how resources are used and organized within a hospital, and even how individual patients are treated. Patients with a First Nation cultural background often have different views of illness, understand the healing process from different angles and have

different expectations from the health care providers. In general the medical staff working at a hospital does not have an indigenous background. In a multicultural country like Canada this issue becomes a real challenge within a hospital setting. It is difficult to understand the special needs that clients from a different cultural background might have. The limited knowledge about indigenous beliefs and the bureaucratic and busy environment of a hospital make it difficult for the staff to offer personalized attention and service. This context increases problems of distrust and misunderstandings and is a source of distress for the medical staff in the delivery of health services.

In this chapter I give a general overview of the Plains First Nations' worldview related to healing and introduce some of the main differences with the bio-medical system explaining how these created problems of mutual misunderstandings.

## **2.1 The healing traditions of Plains First Nations.**

In a Western context the term “healing” might lead to confusion or misinterpretations. It usually denotes some type of medical knowledge and therapies. For an aboriginal community, healing is not only understood as holding medical skills used to help cure people from diseases. It has a wider meaning and function. It should not be understood from this paper that aboriginal healing is only a type of medical tradition in a Western sense. For Cree First Nations all these aspects: identity, community relationships, spirituality and the natural world are deeply connected to healing. One of the main goals of this chapter is to present a clear explanation of how they are related.

### **2.1.1 Plains healing as a sacred knowledge**

“The last thing that defines a nation- a tribe- is the gift of healing”  
(Cardinal personal interview)

It took a long time before I began to understand what Clifford Cardinal meant with this statement. After several months of writing my thesis, and some telephone conversations with him, I started to understand. This sentence forms the basis of Cree healing. It means that a nation's most important goal is to provide the knowledge and the traditions that guide the people toward well-being. This knowledge is understood by Cree people as a gift because it is given by the Spirits to a human being so that people can learn how to keep balance with the four parts of one person (mind, emotions, body and spirit) and with everything around them (the community, the natural and spiritual world).

The equilibrium between these aspects provides healing. This is a holistic way to approach one's balance and healing. The spiritual world is the connection between all these aspects of one's life. Using Western words, we can say that it is a philosophy. Using indigenous words healing is sacred knowledge. It is sacred because the sources of knowledge come from the spiritual world. The spiritual world is often seen as the basis for Cree medicine and healing (FNCPN 2005:2).

Besides the spiritual world as the most important source of healing, an individual also needs the community in order to achieve and to preserve balance. As the following section shows, healing is not seen in an individualistic way, but rather a communitarian way. Healing understood in a holistic way is possible keeping and reaching balance with others in the community. Healing is in this sense a style of life.

### **2.1.2 Plains healing takes place within the community**

Healing has a very strong communitarian component and is not individually based or experienced. Bastien (2009) expresses this argument very clearly in her book. This paragraph is but one example:

“...learning the ways of knowing originates with the family, because they provide the source of knowledge during early childhood and adolescence. Knowing is relational and depends upon relationships that are learned in childhood”. (Bastien 2009:77)

As I stated above, healing is the spirit and the philosophy that guides the community and individuals within the community toward well-being, but healing is also the community practices or style of life that makes it possible to be well. The “practice of healing” takes place in very different ways. There are norms and values that a community seeks to guide the individuals and the whole group to be well, or to be in balance. My informants gave me examples of how traditionally this was maintained in everyday situations, like in the caring of children, in the transmission of knowledge, or in support of each other. Each individual represents different roles during life, in the care of the whole community and at the end in its well-being. Therefore every individual is necessary for the community's well-being.

The Elders for example represent wisdom. The Elders in the communities “practice” healing through teachings, humility, the transmission of knowledge, and by



keeping the spirits that guide the community's well-being alive. A mother, for example, practices healing by being strong and teaching her daughters to be happy and proud of being women, Indian women. Healing has its sources in the spirituality of the community and is manifested and cared through the daily life of the community. Therefore, healing is not only the art and gift of medicine nor in a broad sense is it only in the hands of medicine people.

In order to understand the function that the community has in relation to healing it is very important to understand how much damage was done to communities by some boarding schools. These among other assimilationist institutions broke the relations between community members with the dramatic result of much suffering and distress for the aboriginal population (Bastien 2009). If the goal of assimilation was to transform the "Indians" in "civilized white people" the result was the disintegration of a style of life that used to care for the individuals spiritual, mental, emotional and physical well-being. This argument is presented and analysed in more detail in the fourth chapter of this thesis.

### **2.1.3 Aboriginal healing and identity**

"Being *siksikaitstapi* [Blackfoot] means you have to take care of your mental, your spiritual, your emotional, and your physical. All these things" (Bastien 2009:85)

The identity of Plains First Nations is related to the responsibility of healing. This responsibility is none other than keeping balance between the others in the community, the natural and the spiritual world. This identity is common to the group, and we can say that the community used to share the awareness or this responsibility. Therefore, healing is deeply embedded in the identity of the group and represents whom a group is.

This responsibility, and therefore, the knowledge and the traditions that make the balance possible is according to Bastien (2009) what define her people's identity and what provides well-being. A people who take care of this sacred responsibility that provides healing is seen by Plain First Nations as the "real people" (Bastien 2009).

#### The real people

From a traditional Plains indigenous way of thinking, the main path towards healing is getting to know oneself (Adelson 2002; Bastien 2009). Learning about oneself in the end leads to the sense of responsibility and balance understood in the holistic way

described above. According to Bastien (2009) this is the way that people become real people.

Thus, the process of getting to know who one is, in itself is healing, and the identity is inseparable from well-being. In fact, often the term that defines an indigenous nation is related and means “to be well”. The Iroquois term *onkwehon* in the U.S.A is how they present themselves, and means “the real people” (Akwasasne 2005: 85-89). For the Blackfoot in the south of Alberta, the term *niitsitapi*, that translates as “real people” refers to “all Indians” (Bastien 2009: 212). The term *siksikaitsipoyi*, used for those who have Blackfoot as language, means “Blackfoot-speaking real people” (Ibid). This term, “Real People” denotes that they are healthy spiritually, emotionally, mentally and physically, but also that they are the guardians of the equilibrium between Spirits, natural world and human’s world. In this sense, traditional knowledge, healing and identity come together.

#### Dynamic identities.

Through conversations with some of my informants I could see that they are aware of how their “Identity”, deeply related to their traditions, is seen as a dynamic concept that gets modified and redefined throughout time depending on the circumstances. The ways of approaching healing are also dynamic and have experienced changes and adaptations even before the arrival of the Europeans. However, for indigenous people in Canada, due to the colonization and assimilation process, the adaptation of their knowledge and traditions in order to keep the community strong and well has become very difficult. Some of the most important barriers these people encounter is in a clinical context which are presented in full in chapter 3.

#### **2.1.4 Health, well-being, and illness**

For First Nations in Canada the notions of “health” and well-being are very similar and health is understood to involve more than the body (Adelson 1998:14-15). Naomi Adelson (1998) emphasizes the importance of examining health beyond illness in the studies of First Nations. In fact for the Cree the English word “health” does not have translation into the Cree language. According to Adelson (1998:14), the Cree word *miyupimaatisiun* translates to English as “quality of life”. This term according to Adelson is the closest word to the English term “well-being and health”. For this thesis I use health and well-being interchangeably. Since the focus of this study looks at the

hospital context, some cases of physical health appear in this thesis. However the examples used through the thesis show the interconnection between physical health and culture.

In relation to the holistic approach that First Nations people have to health, the idea of illness corresponds to the broad scope of aspects that concern their well-being. According to Cree tradition all these elements are interrelated. Therefore, for Plains peoples, illness might manifest itself in different aspects of an individual, in the body, mind, emotions or spirit. However, the causes of diseases are in many cases outside the place where illness appears, even outside the body. For example, when one of my informants, Clifford Cardinal, looks at mental health problems he believes that mental health is often affected by one's soul. The spiritual method of approaching illness runs contrary to the scientific approach taught in bio-medical training. However, according to Cardinal's holistic worldview, the reason for this is that "the spirit impacts personal balance and the mind impacts the health of the body" (Cardinal, personal interview 2011). In general, according to the Cree tradition, illness appears as an expression of the body seeking harmony or balance (Lux 2001:71).

#### **2.1.5 Indigenous healing- indigenous medicine**

The terms healing and medicine are used interchangeably by my informants. As I explained in the beginning of this chapter, in some cases they referred to healing as a philosophy and style of life, as a broad way of approaching the people's well-being. In other cases, though, they talk about healing as a more specific type of medical knowledge, the art and the gift of healing or doctoring. In this sense healing knowledge is in the hands of a few persons. These people are generally called healers. The medical skills that they have are related to the gift of helping people to become well and it (healing) involves a spiritual gift but also a learning process based on traditional medical skills. With this clarification, I am using the term healing indistinctly throughout my thesis. Although in some cases the term indigenous medicine will be used.

#### **2.1.6 Healing knowledge- learnt knowledge**

Despite that healing is understood as a gift it also requires a learning process. On the one hand healing related to medical knowledge is seen mainly as a supernatural gift that the Great Spirit gives to a chosen person (Lux 2001:73). On the other hand this specific art of healing or doctoring has to be learnt as well. This process of learning takes one's entire

life and is achieved through different ways, such as dreams, storytelling, ceremonies, traditions, ideologies, medicines, dances, arts and crafts, or a combination of all these (FNCPN 2005).

The fact that healing is both given *and* acquired is an important point that is often overlooked. The Plains First Nations worldview believes that one learns doctoring. Healing however happens because of the spirits of the herbs, and the spiritual gift given to the healer. Cree people believe that the gift of healing is given already in the womb before the healer is born. Teachings begin at an early age for those chosen for the learning of natwapokahn [the all-purpose medicine] (Cardinal, personal interview). For example, today, some people learn how to do healing ceremonies and become popular; however, the spirit and the moral bases for the power of a healer in order to heal cannot be learnt. Without the spiritual gift they are not considered healers from their own people. Therefore the “keepers of traditional healing knowledge have more than knowledge. They are well-known within the communities and exemplify an unusual capacity for humility.

### **2.1.7 Medicine man-woman**

The persons chosen with the gift of healing have received different names depending on the nations, communities, and the historical moment. However healer or medicine man/woman, are the most common names used today within the plains First Nations. Following the Cree world-view, the role that a healer plays is related to the holistic way to approach health and healing, and to the spiritual basis of medicine. According to Dene and Cree Elders at the second traditional healing forum (Carriere and Lamothe 2009), the names that earlier were given to a healer represented very well the spiritual role of a medicine man. The healer used to be called: medicine man/woman, spiritual leader, or dreamer. For Plain First Nations, the main traditional meaning of all these terms is “*person who uplifts the people*” (Male Elders, in Carriere and Lamothe 2009: 6). Therefore, a Cree healer can be seen as the person with the gift and knowledge to help to build an individual physical, mental, emotional and spiritual strength, and restore the balance within the different aspects of life (WalDRAM 2000: 607-8). In this sense the healer, despite the specific knowledge about medicine, plays a very important role in some communities in the general well-being of the people. From a Cree approach, a healer’s role is diverse. They can mediate between ‘supernatural’ powers such as curses

and humans and can be an expert in the uses of natural substances such as herbs or animal parts in order to cure the body and to repel curses.

Russell Willier is a Cree medicine man in British Columbia who shared his knowledge with three anthropologists (David Young, Grant Ingram, and Lise Swartz) of the University of British Columbia. These conversations were published in a book called *The Cry of the Eagle*, which is a representation of what this Cree medicine man shared to these outsiders (anthropologist) about the way he understands the world and how he attempts to transform his vision into action as a path for healing (Young, et al 1989: 3). As a medicine man, he would take responsibility to heal physical distress (or illness) even if the causes of them would be beyond the body. In some cases, he would locate the causes of evil curses. In order to treat them, he would normally use a combination of plants, prayer, and ceremonies. He would also be able to treat persons who have social and economic problems as an effect of bad medicine. For lifting the curse he will use plants and/or spiritual ceremonies depending on the case. One of the more extreme examples of the non-bodily aspect of his medicine was his role in controlling storms in order to protect the community's hay fields. He used a ceremony to split the storm sending the rain to either side of the split but keeping the location where he was sitting dry (Young, et al. 1989:18-21). This example of weather control is also seen by him as 'healing' although it goes well beyond healing a bodily disease.

Delores Cardinal is the wife of my informant, Clifford Cardinal, mentioned above. In a chapter of the book *At the Interface of Culture and Medicine* (Waugh, 2011:261-271) she explains the role that a healer's wife has. Delores offers a wide description of the different people they treat. This description is a rich example of the wide field and roles that Cree healing holds, in many cases beyond the body. The holistic dimension of Cree medicine is represented in the diversity of patients that they have and in the way she understands the causes of illness. The patients differ in their needs. They might suffer from physical illness, mental disorders, social problems and spiritual decline. She explains that they "see" illness from different origins: "germs, environment, life style and spiritual (Ibid: 261)" For example they treat people with asthma, cancer, brain dysfunctions, patients who use drugs, alcoholic, and who are suicidal. She emphasizes how difficult it is to treat the latter ones. Some of the people who they consider as patients are individual with socioeconomic problems- "some of them are totally welfare dependent which destroys their sense of personal worth..." (Ibid: 267). Delores identifies

the impacts of colonization on her people's style of life and sources of healing. She emphasized that the devaluation and prohibition of their traditional ways eroded her people's self-esteem. She blames the spiritual decline of her people on this history, which, according to her, underlies the illnesses of the patients they see.

As is seen Cree medicine involves a wide range of knowledge and abilities from the healer side that are not always related to quantifiable and objective events. This basic foundation interacts with the main basis for the effectiveness and accreditation of medicine that the biomedical model claims. Bio-medicine recognizes as valid only the research based in positivist and quantifiable data. The next part of this chapter explains these and other differences between the two paradigms of healing and show with examples how they create a conflict of communication and service delivery.

## **2.2 Bio-medicine and First Nations view of the world.**

This section introduces some of the main assumptions of bio-medicine and explains why there is often a conflict when the two interact despite the fact that both traditions aim to help people. The main contrast between the two types of medicine is related to the following differences:

- The practitioners of bio-medicine (except public health) focus on the individual not in the community
- Bio-medicine is based in positivist research not in sacred or spiritual thinking
- Bio-medicine focuses on the recovery or restoration of biophysical aspects of the person and does not consider the identity of the individual. Its goal is to treat illness not the whole wellness of the person.

These three differences in approach have often become exaggerated as entirely different paradigms due to the fact that each is associated with individuals of different cultural backgrounds. This cultural difference overlapping differences in practice produces conflicts. Aboriginal patients often describe these misunderstanding as a lack of respect for their culture that end up affecting the quality of care and the rejection of indigenous healing traditions. It is generally assumed that the biomedical model is universal due to the fact that it focuses on the body and not the person. Theoretically, the same protocols can be applied equally to any human body with the same effectiveness. For example, biomedically designed antibiotics kill bacteria irrespective of the cultural group of the

host. However, as this section shows, some cultural traditions interact and do not react neutrally to treatments and medical services.

### **2.2.1 The universal accreditation of bio-medicine vs. the historical discrimination of Plains healing knowledge.**

Bio-medicine was formalized by the middle of the 19<sup>th</sup> Century, and during the past century, Euro-American healing traditions have built itself around it – somewhat eclipsing earlier traditions which were more similar to those used by First Nations people today. Roy Porter (1997) uses the terms bio-medicine as synonymous of Western and scientific medicine. This author even makes claims that this type of medicine should be called humankind's medicine. In the introduction to his book he explains that bio-medicine has proved its efficacy in the results of diagnosis and treatments. This, according to Porter is the main reason why most people around the world accept this type of medicine. Others argue that the triumph of bio-medicine rests on its quantitative knowledge and positivist approach (Mechanic 1976). Other patriots of bio-medicine, such as Chantler (2002) and Bunker (2001), argue that quantitative biomedical research has brought some of the greatest benefits to mankind, such as the prolongation of life expectancy and the decrease of child mortality. Since the end of the Second World War the developments in bio-medicine have been spectacular including the eradication of small pox, the discovery of penicillin, the introduction of oral rehydration solution for children, vaccines, and the modern anaesthesia. In his book, LeFanu (1999) describes these developments as one of the most impressive achievements in human history.

There is an European-Western assumption that Western medicine is universally as valuable in itself (Lock and Nguyen 2010: 146). Despite the increasing acknowledgement in Canada that culture and ethnicity are “critical factors” in medical care (Waugh, 2011), biomedical practitioners assume that their skills can be applied to Canada's indigenous population without any cultural adaptation and still should help them to get rid of diseases and improve their health and well-being. Therefore many hospital staff members think that bio-medicine does not need other medical traditions, and least of all indigenous medicine.

Amanda Cronje and Ruth Fullan (2003), have a more critique perspective of scientific medicine, what they called “evidence-based” medicine. Their main critique is that the methods of this model, based on quantifiable evidence, conflicts with the practice

to improve the health of patients. According to them the quantifiable bases of bio-medicine does not match with “non-quantifiable” experiences, values and preferences of the patients (Cronje et al 2003: 353).

The universal accreditation of the bio-medical model is creating problems in multicultural countries like Canada, where the system is struggling to cope with multicultural patients. In relation to the conflict that hospital staff often experience with aboriginal patients, the problems are further exacerbated due to historical factors that set the basis for mutual distrust.

### **2.2.2 Spiritualism vs. materialism.**

One of the most important differences is the way that each tradition explains the sources of illness. Put in a simplistic way there is a conflict between the spiritual or material basis of medicine. On the one hand, the First Nations traditional healing system approach the sick person in a holistic way, related to a wider cosmos of spirits, ancestors, environment and society (Porter 1997: 7). On the other hand, modern medicine does not pay attention to such supernatural and socio-cultural aspects in order to be effective. In order to be effective, bio-medicine does only need to have a materialistic approach. It means that Western medicine explains sickness principally in terms of the body itself. Therefore, their immediate attention is devoted to the physical body and the dichotomy of health vs. illness (Kleinman 1995:30) This concentration on the body determines the type of protocols established within a hospital. For instance, diagnosis is the most important medical task. This can be done just exploring the body with different types of tests, without necessarily speaking to the person. To find the specific term to label the illness is determinant and guide all the following medical procedures and treatments.

On the other hand Cree healers approach diagnosis and treatments in a different way that does include sacred elements as a start point. When Clifford Cardinal talks about the properties of roots and plants on the treatment of some infections he explain it in the following way:

“The natural active ingredients consistent in plant life are used to arrest disease or to disorder the bacteria or virus, it therefore as in its contexts; ‘an active sacred agent’. With this in mind the sanctity of the selected plant(s) are therefore granted their full purpose and sanctity just by the fact they are used to heal people. Healers know that the secret



lies in; not the . To explain with clifford examplekilling of the virus or bacteria but indeveloping a relationship whereby the virus can be negotiated to leave the host lest it be made to feel responsible the harms it brings about in its pathway, this is way healers talk to plants” (Cardinal 2006:17)

### **2.2.3 Specialization vs. holism**

This concentration on the body guides medical research toward a very specialized field. Medical research believes that “everything that needs to be known could essentially be discovered by probing more deeply and ever more minutely into the flesh, its systems, tissues, cells, its DNA” (Porter 1997: 6). This high specialization is related for some authors as reductionist or partial blind (Mechanic 1976: 10). According to Mechanic, it means that the more specialized doctors get, the further they go from understanding other socio-cultural aspects involving the patient’s health. This approach deeply differs from the Plains approach to health described before. It is also related to the fact that indigenous healing looks at how spiritual, historical, emotional, and social aspects are involved in what they call the imbalance (referring illness) that the body manifests. This disequilibrium is just a manifestation of some cause often outside the body. Therefore for Cree people the holistic approach is very important.

### **2.2.4 Individual health vs. communitarian well-being**

As just stated above, in the bio-medical point of view, illnesses manifest themselves within the body. Although medical staff are aware that social behaviour can interact with the health of an individual (such as drugs abuse or alcoholism), bio-medicine simply diagnoses the alteration that occurs within the body and provides cures with the right treatment (Chantler 2002). Doctors and other health workers may be sympathetic to the personal situation of patients and families and are interested in those aspects as ‘factors’ influencing health. However, the role the family or community plays is not seen as an immediate factor for treating a person and recovering.

However simple cultural awareness on the part of individual medical professionals is not always enough. Sometimes the design of systems or even the architecture of the hospital itself works against indigenous healing. For example, a common problem between hospital staff and indigenous patients is related to role of one’s kin in the healing process. The protocols of the health care system recognize only the

“immediate family” as the group to which they are obliged to provide information and to offer support. The definition of the “immediate family” overlaps with Euro-American concepts of the nuclear family and not that of other cultures. For Plains First Nations, the family often is understood in a broader sense connecting kinship to spiritual affinity (CAPPE 2008: 8). In order to strengthen a patient’s sense of well-being the extended family will often gather around their sick or injured family member for support. This support is considered very important for the spiritual counselling of both family members and the patient. The “crowding” created by this support ritual is a source of tension between the patient, the family and the hospital staff since most medical institutions are not designed to cater to groups (S.H.R. et al 2010). To address this, in some hospitals a special room has been designated to allow people to gather without violating hospital rules. In the Royal Alexandra Hospital in Edmonton the opening of one of these rooms was a very important solution to improving the level of care for aboriginal patients. Today it is used for several purposes such as for ceremonies or for grieving when a patient passes away. In this type of conflict the awareness or best intentions from the hospital staff could not have fixed the problem of gathering big families.

### **2.3 Conclusion**

My informants used to tell me “healing keeps a strong individual, a strong community, a strong nation”. According to them healing is the most important responsibility of a nation (Cardinal, personal interview).. Coming back to the hospital context, it is important to understand this broad definition of healing in order to understand the aboriginal patients. In some hospitals where indigenous patients report distrust, low self-esteem, and disrespect for their “identities”, the patients suffer negative impacts. Thus some scholars see acquiring cultural competency (King 2009) as a positive and necessary aspect for their recovery and in general for a quality health care service.

This chapter illustrated the importance of cultural diversity as a critique of the European-Western assumption that Western medicine is universally valuable in itself (Lock and Nguyen 2010:146). The following chapter shows cultural, historical and structural factors that create barriers in the delivery of health care. When one makes a list of all the problems the health service faces in a multicultural country like Canada, such as linguistic diversity, the distrust of the aboriginal community, and the absence of tailored services, it seems that bio-medicine may not be as universal as Lock et al. (2010) claim.



### **CHAPTER 3. Cultural competence –a path for indigenous healing.**

The diversity of health care users in a multicultural country like Canada creates difficult challenges. The present Canadian health care system seems to struggle in order to give culturally appropriate attention to the diversity of clients it seeks to serve. As I pointed out in the previous chapter, one of the reasons is that the application of the Western medical model does not match a multicultural clinical setting. The biomedical model bases itself on quantifiable evidence, which may conflict with the specific values, experiences and preferences of different users (Cronje et al. 2003: 353). However there are many other factors involved in the provision of quality of care and a culturally “safe” healing environment (Walker et al. 2009). This chapter analyses the importance of clinical cultural competence in the provision of appropriated health care for the aboriginal population. In order to carry on this analysis I discuss some of the cross-cultural risk factors that act as barriers for quality care. The chapter also presents some of the programs and aboriginal services that some hospitals have developed in order to improve their cultural competence and therefore aboriginal patients’ health care.

#### **3.1. Cultural safety- Cultural competency**

“Cultural safety is used as an analytical tool to understand the everyday social interaction between caregiver and client” (Anderson 2003, in Walker et al. 2009: 59) . Cultural safety aims to minimize the risks involved in this interaction, trying to avoid placing the weight of adaptation on the patient (Paasche-Orlow 2004: 348). For example, access to quality health care can be a risk for those patients who do not speak English. However, there are many other considerations with aboriginal users in Canada that involve a high degree of adaptation and that deeply threaten their clinical experience. According to Birch et al. (2009), quality of care involves more than just medical proficiency. According to her, the main way to provide cultural safety, and therefore quality health care to patients, is to acquire cultural competency. Paasche-Orlow (2004) identifies two main reasons for cultural competency. On the one hand, culture affects health, and on the other hand, there is an ethical commitment to protect the patient’s autonomy. It is seen as a principle of justice. Cultural competency goes beyond cultural awareness and cultural sensitivity. These concepts acknowledge the importance of culture and the respect for cultural differences. However, cultural competence is an active term that involves the ability to minimize the negative consequences of differences (Paasche-Orlow 2004: 348). Cultural competence has been defined as “a set of congruent behaviours, attitudes, and

policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situation” (Cross et al. 1989 in Waugh 2011: 189). The goal is not to become a master in a particular culture, but to develop tools to cross cultural barriers and help improve insight and the working relationship with each patient (Paasche-Orlow 2004: 348). On the one hand, it requires that the staff at the hospital to acquire knowledge and respect the individuals needs of each patient. On the other hand, cultural competence demands changes in the systematic design of a hospital and of a health system in general. “A culturally competent health care system should be capable of delivering the best quality care to every patient despite race, ethnicity, culture, or language proficiency” (Betancourt et al. 2005: 499).

Ensuring that culturally appropriate options exist at all times within a hospital is a complicated and expensive process. However, this chapter identifies some important steps toward different accommodations that are currently happening in Canada. For example, in the clinical setting, the non-smoking policy conflicts with the practices of some of First Nations ceremonies, which involve cleansing the soul with smoke. To provide ceremonies in the Royal Alexandra Hospital in Edmonton, the hospital administration met with the Fire Marshall for the City of Edmonton to find a solution for the “smoke” conflict. As a result, a new policy was developed for the burning of substances for ceremonial proposes. Today, any aboriginal person has the right to have a ceremony that involves smoke in any health facility of this health region. The participation of aboriginal individuals in the design of health care centres and health care models seems to be a key for this process, but the collaboration of non-aboriginal people plays a very important role as well.

### **3.2. Barriers for aboriginal quality care**

The barriers identified as a risk for a cultural safe health experience are not distributed equally across Canada; neither are they experienced to the same degree within aboriginal individuals and communities. One of the main reasons is that provinces and territories have different priorities on their agendas in relation to the development of cultural competence and aboriginal health programs.<sup>5</sup> For example, the province of Alberta has

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<sup>5</sup> In Canada, health care is a provincial responsibility and therefore each province has a different health care system. Health care provision for status Indians is delivered by a special federal department called

many more aboriginal programs than the province of Saskatchewan. Another source of diversity is that each aboriginal group might have different needs and expectations of the health service. Patricia Kaufert (1990) claims that “no standardized approach to acquiring ‘cultural competence’ is appropriate”. She argues that the context related to the specific cultural group must be carefully studied, since it also impacts the needs and expectations of each group. It is especially relevant in Canada, due to the broad diversity of indigenous lifestyles and traditions. Besides the inner diversity of indigenous cultures, there are differences among nations depending on locations and the extent to which they are immersed in the lifestyle and values of mainstream society. For example, some people in reserves living a traditional lifestyle might find the adaptation to the values and culture of the hospital particularly traumatic. Other aboriginal people are totally adapted to the mainstream society and culture and possess little affinity for their indigenous traditional ancestry (Elford & Cardinal, n.d.)

### **3.2.1 Structural barriers**

Many aboriginal patients in the North live in remote communities. The logistics of transporting patients from the northern communities to the local hospitals is often traumatic for patients and families (Walker et al. 2009: 12). In many cases, the transport must occur by air. For example many expectant mothers are still evacuated thousands of miles from their families and homes to give birth in southern hospitals. This separation from families and homes has been linked, according to the National Aboriginal health organization (NAHO 2004), to a “decrease in birth weights, an increase in birthing complications, an increased likelihood of post-partum depression, and an unnecessary strain on family relations”. Patients and families need support mechanisms, not only in order to get to the health care setting, but also to deal with the “foreign” context, their own health issues, and in many cases in a foreign language.

### **3.2.1 Power and history**

Some of the problems mentioned above related to structural barriers, are reinforced by the history and experiences of colonization and assimilation. As I introduced in the first chapter, policies of assimilation have the power to exaggerate the differences between cultural groups. History has placed the settler community and the indigenous peoples on different status levels. This still has consequences today and makes the health care

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the Medical Services Branch. Since one finds status Indians within provinces, one often finds competing health systems within the same place. See Young (1984).

experience of many indigenous people distinctive and conflictive with other cultural groups of immigrants. On the one hand, the mainstream community and the official health care system still represent the dominant side of Canadian society. On the other hand indigenous culture and traditional ways of healing have been pushed underground and are often seen as superstitious and ignorant (Mechanic 1976: 11). The lower status of indigenous people's traditional ways and beliefs is still deeply embodied in the memories and conceptions of both the mainstream population and in many aboriginal individuals. This history reinforces feelings of fear and distrust and reinforces the traumatic experience that mere structural barriers involve.

A recent community study carried out in Saskatoon Health Region in 2010, gathered together the main complaints that aboriginal users experienced with the health care services (SHR et al. 2010). The project was called "Strengthening the Circle" and was run by the Central Urban Métis Federation, Kinistin Saulteaux First Nation, and the Saskatoon Health Region. I obtained an interview with one of the project staff members, Crystal Laplante. She shared with me the fact that the Elders continue to suffer the same fear and shame in hospitals today that they first experienced during boarding school.

The residential schools used fear and shame to teach our people that our ways were bad. ... It is very very sad to see how [the Elders] keep their heads down [in a hospital environment]" (Crystal Laplante, Personal interview)

She explained that some of the Elders in her community experience fear when they go to the hospital. In this context they are afraid and ashamed of asking for any type of indigenous spiritual counselling, for traditional ceremonies, or for the use of medicinal herbs. She later reported that some of these feelings are so strong that "some people would rather die than come back to the hospital". See also (S.H.R. et al, 2010: 30).

Two things impressed me about this interview. The first was the visible anger and emotion that Crystal exhibited when talking about the shame felt by the elders. The second was the stark contrast with other interviews in which some other researchers denied the need for culturally appropriate treatments. In particular, one Metis woman working at the University of Saskatchewan reported that her research showed that most aboriginal patients were Christians and were happy to have the spiritual counselling of priests and nuns. She denied the need for any special type of cultural counselling.

To get beyond these cultural blind spots other researchers argue for appropriate training for hospital workers. In the words of Valerie Arnault-Pelletier, an aboriginal nursing advisor at the University of Saskatchewan, “Hospital staff should be aware of this history of colonization” (Arnault-Pelletier, personal interview). She emphasized how important it is that doctors and nurses understand who the aboriginal patients are and to know about boarding schools, colonization, and other historical and relevant issues. She hopes that the acquisition of this knowledge would lead doctors and nurses to treat aboriginal patients from an holistic point of view. She is working on a new nursing curriculum which, for the first time, will have a module on aboriginal culture and history.

The patients also plays an important role in the effective delivery of health care. They must be open to sharing information, to trusting medical advice, and to taking medication properly and returning to the physician if necessary. However, when aboriginal traditional medicines are thought to be inferior to the bio-medical model, patients tend to hide or be ashamed to make public their healing approaches and needs. Crystal told me how in many cases aboriginal patients keep taking their own traditional medicines but hide them from hospital staff. Some of the medicinal herbs interact with the medical treatments, having negative consequences for patients’ health.

“They think that they [indigenous patients] are doing something wrong...they are afraid that they [doctors and nurses] will scold them [for taking herbs]...they [patients] take the herbs and hide them. They think that other people [non-Indians] cannot understand how good these teas are, and that they critique them [indigenous people] for being ignorant Indians.” (Laplante, personal interview)

The historical basis for this distrust gets reinforced due to a lack of understanding of distinct First Nation traditions and values.

The historical basis of relationships between indigenous people and the colonizers, and the well-settled assumptions of inferiority-superiority asserted to aboriginal and mainstream communities, respectively, are difficult to heal. These distinguish the situation that indigenous people suffer from other minority groups like immigrants. However, the problems related to different cultural ways of seeing the world and the needs and values that derive from this can easily be fixed. Of course, training and aquisition of cultural competence by the hospital staff is very relevant, but the



implementation of aboriginal programs and other services that make the experience of aboriginal patients more satisfactory is key as well.

### **3.2.2 Cultural and linguistic barriers**

#### Linguistic diversity

Multiculturalism is a distinctive feature of Canadian society. According to the 2006 census, 18,9% of Canadians were born outside of Canada (Statistics Canada 2007a in Waugh 2011: xi), 42,8% of Canadians have a language other than English as their mother tongue. Therefore, although the health care professional training and research is in English, a large percentage of the patients are not comfortable with this language. In the case of many aboriginal people English is the second language. The research “Strengthening the Circle” reports that some participants had experiences of being misdiagnosed due to their limited English and the fact that not every ward had interpreters, mainly in emergency situations (S.H.R. et al, 2010: 19). However the problem of the language is deeply related to the cultural barriers that indigenous people face at the hospital. Both issues, language proficiency and cultural specificities, have to be analysed together. A simple example is in the case of those native patients who, although they speak English as a second language, have problems in finding an appropriate term that can be easily translated to communicate an essential idea deeply rooted in the indigenous group tradition (Walker et al. 2009: 16). The research identifies that translation services have alleviated the tension of cultural adaptation and are evaluated as an improvement on the quality of care (S.H.R. et al, 2010). However, the mere translation from one language to another doesn’t seem to be enough to build bridges of understanding between patients and health care providers. In Saskatoon, one of the reasons is that the interpreter service often relies on volunteers and is therefore unable to provide continuous assistance. Another important reason why a mere translation is not enough is linked to the relationship between culture and language. In general, the translator is an indigenous person, identified for patients as not only an interpreter but as one of them. For the hospital staff, he/she is often seen as a cultural representative of the aboriginal group. Depending on the situational context, the interpreter job demands go far beyond a mere translation (Kaufert et al. 1984). For example, in many cases, interpreters are asked to give information and explanations about the aboriginal patient’s culture to professionals in urban context, to explain biomedical concepts to aboriginal patients, and in many cases, to work as advocates representing the interests of the individual patient,

group or even community (Kaufert et al. 1984) The diversity of roles creates problems of quality, since the demands go beyond the volunteer interpreter's competence, and create loyalty conflict, since they are expected to represent the values of either patients or medical staff. The unaccredited professional credential also creates conflicts of power between medical professionals and interpreters. On the one hand, the medical university credential enjoys a legitimated professional status. On the other hand, the tasks that the interpreters carry out are seen in many case as "local" or "amateur" knowledge (Ibid).

### The need for cultural competence

Even when everybody speaks the same language, different perspectives, values, norms, and general worldviews create misunderstandings about some symptoms or diseases and the ability to implement successful actions (Walker et al. 2009). As we have seen there are many structural problems, such as transportation, isolation of some communities and gaps in health services. However, during a process started in 1994 and led by a charity which aimed at improving the care for aboriginal peoples in the province of Alberta (CASC 2012; Elford & Cardinal, n.d.), the problems related to indigenous traditional culture and ways of healing were identified as the main gap in services for aboriginal people. The research done by CAPPE, the Canadian Association for Pastoral Practice and Education<sup>6</sup>, showed that the main sources of misunderstanding stemmed from a failure to understand the role of the family in healing, a disrespect for the sacred components of indigenous traditions, and a disrespect for individual autonomy. This cultural competency gap create distress for the hospital staff. The report showed that much of the disrespect was prompted by labels such as "difficult native people" (Elford & Cardinal n.d.: 2).

In order to minimize conflicts, beliefs and traditions need to be explained to the hospital staff. For example, the belief that taking one's sacred articles to surgery will help is a common tradition that aboriginal patients might hold. This creates an initial conflict with medical protocols regarding what one is or isn't allowed to take to the procedure. However, the misunderstanding is made worse when the sacred article is hurriedly discarded in the garbage bin.

Studies carried out by Kaufert (1999) and Wilson et al. (2011), identify substantially different cultural beliefs in relation to health issues. Kaufert (1999) writes about the general belief of Cree Elders that "telling bad news" had the capacity to create

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<sup>6</sup> The CAPPE is now known as the Canadian Association for Pastoral Care (CASC 2012).

reality (Kaufert 1999:405). In a western medical context, it is generally understood that offering information to the users increase their sense of control and, in some cases, offers security. However, in the Canadian context, medical staff and aboriginal users often hold different values about the need for truth-telling and maintenance of autonomy. It creates a conflict in how to provide explanations of diagnoses and treatment options (Ibid). While for the medical doctors spirituality is an issue of ethical and moral concerns, for the indigenous patients, the spiritual dimension is often the basis of understanding the problem that the person is suffering and approaching it with the right treatment.

A general belief within First Nations is that death is part of the cycle of life. Many elders see death as an expected event that they cannot avoid and should embrace. According to Wilson (2011), patients and families tend to avoid decisions about aspects as life-support technologies. These preferences interact with the quick decisions that medical staff need to make in life threatening situations. The high value that western medicine gives to the doctor-expert judgments creates a contradiction to the ideals of patient participation that the medical community seems to hold as a priority. This position interacts as well with the strong value that most First Nation elders give to one's personal autonomy, and the inherent right of an individual to choose for oneself. Present in this example is lack of cultural competence and demonstration that western medicine does not accept spiritual aspects as necessary for the effective delivery of health care. As we see in the following chapter, long-standing a historical basis for distrust negatively reinforce these misunderstandings between users and providers.

### **3.3. Cultural helper. The Royal Alexandra Hospital**

The frustration of some health care providers in dealing with indigenous peoples and the often traumatic experiences of these patients in the clinical setting have, during the last decades, increased interest in building bridges of understanding. The case of the Royal Alexandra Hospital in Edmonton is one excellent example of how is possible to find mechanisms that help to make possible the delivery of appropriate health care to every patient despite the specific cultural background. In 1994, some meetings were held between hospital administrative staff, the director for pastoral care and counselling, and aboriginal people. The main goal was to create a respectful relationship that helped identify how to best provide care for aboriginal patients and relatives, and how to cooperate. Neil Elford, director of pastoral care services at this hospital, met with a group of native people leading a health care advisory organization and later, over several

months, met with a Traditional Elder. Through these meetings they found that one of the most important barriers for the development of bridges between aboriginal patients and the hospital system was that the assumptions and values of the main society were “incarcerated” in the health care system. As I wrote in this chapter, those assumptions held as superior stood in the way of creating trust and respect. The meetings always kept a spiritual foundation. Prayers and traditional ceremonies were carried out with the goal of getting light from the Creator and Grand Father Spirits, in order to find the best solutions. Following more meetings and discussions with Traditional Elders and Neil Elford they got to understand that the Royal Alexandra Hospital needed to employ somebody who represents aboriginal people and helps to make a difference within the hospitals.

### 3.3.1 The naming of the Cultural Helper position

It was not clear which type of role, or which name should this position have. Due to the wide magnitude of social problems that the aboriginal patients might have, Neil Elford thought to create a special position for an aboriginal social worker. This idea was rejected. The main reason that the Elders ruled against the social worker was that this title provoked negative reactions within aboriginal people. This type of position often brings painful memories of the boarding schools, or was associated with the role that social workers used to play in child welfare, and many families lost their children due to the social policies. Another important need identified within patients is the spiritual counselling. However the Elders somehow rejected the idea of creating a position related to Christian churches. The reason is this has its roots in the history of assimilation and colonization and the role that the Church played during the residential schools, and the assimilation process. On the one hand, they were afraid the new position might end up being another way to assimilate native people. On the other hand, the hospital looks to some of these patients just like another institution managed by white people, and this thought brings sad memories and feelings of humiliation and racism.

The position should be deeply connected to the traditions of the aboriginal patients, and be identified as a help rather than a threat. It became very important that sacred boundaries would be respected within a hospital setting. The Elders thought the person who holds this position should protect and help the practice of aboriginal healing and spiritual ceremonies, and build a general awareness of the importance of holism for the health of the indigenous users. Besides these basics, the position created should be

able to support not only one group of aboriginal people but the many diverse beliefs and traditions within them.

The community Elders started to think that the best person to fit this job was the *oskapewis* or “traditional helper”. The role of *oskapewis* in Cree communities involves “honouring the Creator, learning through service and experience about ceremonies, giving humble and respectful service for others, offering support for people of the community in times of difficulty and preparing ceremonies for Traditional Elders” (CAPPE 2008: 5). In relation to the position at the hospital, the Elders thought that the name of this new position should be “Helper”, as this person helps those who suffer within the hospital. The *oskapewis* should be the right person since this person is able to understand the sacred aspects of some traditions and practices, and to prepare ceremonies under the right protocols and within the right spirit. Besides these cultural abilities, this person should be good at building bridges between native patients and hospital staff. The role played by the *oskapewis* within Cree communities is supported in the spiritual value to humility, service and trust in the Creator. Cree Elders define the spiritual basis of this role with a say: *oskapewis* is “about serving the Creator, serving the people and least of all ourselves” (CAPPE 2008: 1). These strong values to be humble and to focus on the needs of the people were identified as necessary and basic in order to carry on the responsibilities, challenges and right spirit that the new holder of this position could need. They would help the Helper to be patient and keep going through difficulties.

One of the first challenges identified for Neil Elford, was whether other hospital staff will accept the position. As an official position, staff would need to respect the position and integrate the Helper as part of their team and as an accredited role they could come to trust. Due to this concern, he insisted on the importance of defining the “Helper’s” role very clearly. What kind of helper would this be? To this question the Elders defined that the help had to be focused on the most important source of suffering that aboriginal people experience at the hospital, the lack of cultural understanding. Therefore this will be a “Cultural helper,” “ for this person would help aboriginal people live their cultural identity while in the hospital and help the hospital learn about respectful ways of supporting aboriginal people” (CAPPE 2008)

Robert Cardinal, a Cree man who had been serving as a *oskapewis* for many years was selected as the first cultural helper at the Royal Alexandra hospital in Edmonton. His

experience was tough in many senses. It took for him almost two years to form part of the hospital team. It was especially difficult to define the specific roles that this position will fulfill. According to Cardinal, the support of the traditional Elders and the keen goal of not offending anyone made possible for him to keep working in building bridges between the “two” cultures, the health care and the aboriginal people (Elford & Cardinal n.d.: 7-8).

### **3.3.2 Aboriginal Cultural Helper Education program**

Today, the position of cultural helper is well-established in the main hospitals of the province of Alberta. Through this position, the cultural helper serves hospital staff to better understand their patients, and any aboriginal people who need help. This includes First Nations, Métis and Inuit. An official cultural helper education program has also been established in order to avoid the risk of this role ending up as a temporary experiment and to provide the understanding and skills needed to develop this position. The cultural helper education program now obtains most of its funding from the central budget of the Royal Alexandra Hospital. At the moment, Edmonton is the only place in Canada where this program exists.

The main objectives of this program are related to the primary tasks and roles that the position requires. The report about the aboriginal cultural helper education program, submitted from the spiritual and pastoral care services of the Royal Alexandra Hospital, describe main 11 objectives:

- to provide spiritual care to aboriginal patients and their families;
- to respect both cultural and hospital worlds and bring them together;
- to respect and learn the aboriginal beliefs and practices of various communities and the ceremonies they would use while hospitalized;
- to relate to professionals in other disciplines through bridge-building;
- to develop good, helping relationships with people who suffer and heal;
- to assess people’s needs;
- to learn basic relationship and psychological theory in order to understand people and be able to bridge with other disciplines;
- to support spiritual care providers from the community in their care of aboriginal people;
- to learn administrative and time management skills;

- to explore social, political, and health issues relation to Aboriginal care;
- to gather learning using educational, reflective and evaluative processes.

(CAPPE 2008: 16-17)

### **3.3.3 The main roles of an Aboriginal Cultural Helper**

The cultural competency of the Cultural Helper is illustrated through several roles, although these may differ in different places. The Helper might look after the sacred articles that patients may choose to take to surgery. He or she might offer explanations to the hospital staff about the meanings of sacred bundles and the importance of respecting a patient's choices. A cultural helper works as a link between patients' families and medical people. In some cases, the patient may choose to contact a traditional healer. The cultural helper should be able to contact him or her following the right protocols and working as a bridge between this person and the hospital environment. The cultural helper attends staff meetings. These meetings are identified as excellent opportunities to build bridges with the medical staff. In some cases the helper might be asked to interpret. Another important task is to provide and support ceremonies when required. Within the hospital, some of the most common ceremonies are the sweet grass ceremony, welcome baby ceremony, prayers, sacred songs, or just to offer cultural and spiritual counselling to patients and families in difficult times. A common role for the cultural helper is to arrange preparations when a patient passes away. He arranges either traditional ceremonies or for prayers with the Chaplain. In some cases families request both services.

The learning method is a combination of practices, personal supervision and theory. This supervision is carried out by traditional Elders within the community. The spirit of this supervision is to find solutions to the problems that might appear, to find mechanisms that help the cultural helper manage stress, and to address each specific situation. The practical training takes place within the hospital setting in company of other Cultural helpers. The program also has a theoretical side. One important part of the curriculum is aimed at gaining a better understanding of the health care system, of medical terminology and hospital protocols. Due to the diversity of aboriginal users, it is also important to address traditions and values. The acquisition of some psychological tools in order to manage anger and aggressive behaviour are addressed as well within the program.

### 3.4 Conclusion

Despite the general growing awareness of the importance of cultural competence for an appropriate health care service, the implementation of mechanisms that improve aboriginal service is very diverse along Canada. The main programs point to the implementation of interpreters, cultural helpers and cultural navigators; establishment of specific space within the hospital where to have ceremonies and gatherings; and the implementation of aboriginal traditional healing. The implementation of traditional healing seems to play a very important role now. The vision for this implementation differs between groups. Some defend a parallel health care system and services, others preferred an integration model that makes room for both paradigms to work together within the hospitals.

The implementation and therefore recognition of aboriginal healing involves deep advances for indigenous people. On the one hand, it minimizes the strong assumption that bio-medicine holds of being universally valuable and superior to holistic care. On the other hand, the implementation will mean the official recognition of the right of aboriginal users to have access to a holistic health care under the official support of the government and provincial institutions. However, due to the barriers that this chapter has presented and the internal division of opinions between aboriginal groups about how the implementation should happen, the process is not absent of challenges and debate. The general reasons for implementation and the main aspect of the debate are discussed in the next chapter.



## **CHAPTER 4. Why Indigenous healing at the hospital?**

This chapter analyses the arguments for and against implementing traditional aboriginal healing in a modern, urban medical environment. Through the journey of my research and fieldwork I have identified the following three reasons why some indigenous people and members of the medical institutions aim to implement healing knowledge and practice within a modern, urban medical environment.

- The need to decolonize the hospital.
- To improve the quality of health care and the health outcome of aboriginal and non-aboriginal patients at the hospitals.
- The protection and preservation of indigenous healing knowledge through the documentation of this knowledge.

The first argument is a political argument put forth by an elite group of aboriginal community Elders (Bastien 2009) (Carriere et al. 2009) and some members of the academic research community (Adelson 2002; Galabuzi 2004; Waldram 2008). The second argument comes from the aboriginal users at the hospitals and for hospital staff who recognize the need to address the difficulties related to indigenous health status and health care service (S.H.R. 2010) The last argument is made by healers themselves, who have the vision that if indigenous knowledge is to survive it must find path of healing within the present circumstances, through official documentation and practice (Cardinal 2008; Young et al. 2003). This last argument is controversial, and I will devote special attention to it in the last section.

In order to contextualize these three arguments the chapter uses the province of Alberta as a case. This case describes how beyond the concerns, the implementation of aboriginal healing within Western clinical settings is a positive aim. The example shows also some of the solutions applied in order to solve the worries of integrity and appropriation.

### **4.1 The need to decolonize the hospital**

Nowadays indigenous healing is much about healing the consequences of colonial history and Europeans ideologies (Kremer 2009)

As we saw in the chapter two, aboriginal healing is based on a worldview that understands life and human beings in relation and in balance with everything around them. The intrusion of the colonizer in indigenous life, and the imposition of changes deeply affected this balance and equilibrium. The colonizer created policies and imposed an ideology that made the previous lifestyle impossible (Bastien 2009: 26-34). Bastien emphasizes that colonization destroyed this equilibrium through the destabilization of the “alliances” between the community, and the natural spiritual worlds. According to her this has meant a direct attack on the ability of communities, families and individuals to provide “self-caring”.

Canadian governmental policies constituted a coordinated plan to disrupt and destroy the essential foundations of *niitsitapiipaitapiiyssin* [well-being] and the resultant actions fit this definition of genocide. They were an attempt to destroy a holistic way of relation to the world by disrupting the process of maintaining the alliances central to the Niitsitapi [real people] way of life and identity through ceremony, language and traditional instruction. Colonization can be described as a process that disconnects tribal people from their kinship alliances (Bastien 2009: 27).

She defines the consequences of these policies as genocide. Genocide for her is understood not as an immediate destruction but a continuous process that destroys the most important foundations of the group’s well-being (Bastien 2009: 26-34).

Today many communities and families are separated. Many of the young generation “are lost,” unaware of their origins. They cannot find a significant source of knowledge that make sense for them and guides them through healing and a strong life. During my fieldwork, more often than I expected, I met people who emphasized that many First Nations people do not know who they are. They use the expression “to be lost” when they referred to this aspect.

The ability of finding the path of healing and well-being within the present circumstances is difficult. However, there is a growing indigenous awareness of the need for aboriginal peoples to be participants and not only patients. This healing process is understood by some scholars as a process of decolonization (Kremer 2009). According to Kremer, in this process of decolonization the society that has participated in the racist and supremacist process of colonization and assimilation, the settler community, needs to

decolonize itself (Kremer 2009: 184). It means that in order to make possible healing for the indigenous people the mainstream society, organizations and ideologies have to break with the supremacist ideology that sustains discrimination and superiority (Akwesasne Notes 2005). Because of these broad goals, the healing movement often looks like a political movement:

The healing movement among aboriginal people in Canada is perhaps the most profound example of social reformation since Confederation. The potential impact of the movement –for all Canadians and especially Aboriginal people- is profound. The efforts for restore Aboriginal societies after centuries of damaging government policies continue to revitalize individuals and communities that, in turn, contribute to a healthy and vibrant future (Waldram 2008: 7)

King (et al. 2009: 83) express the same argument through the following words: “True healing cannot occur until mainstream society also heals- together”.

One of the concrete ways to achieve this is to implement aboriginal healing practices within clinical settings, both at the hospitals and at the medical faculties. This is seen as the first step in the transformation of the Western bio-medical system into a culturally safe and competent health care model. The challenges that both indigenous and mainstream communities face are to establish exchanges between both cultures in an egalitarian way. Due to the dominating status that bio-medicine has held until now in our Western context, the implementation of aboriginal healing in an institution dominated by the bio-medical paradigm is described as a “hard road to walk” (Cardinal 2008).

The hope of the decolonization movement within health is that formal medical protocols might change and be more open to new visions and practices. The hope is that the official health care system will become one of the sites for the reproduction of indigenous knowledge (Awasis 2007). Needless to say, this vision is controversial since some worry about the misappropriation, commodification and misuse of indigenous ideas. This argument is discussed in more detail in section 4.4.

#### 4.2 To improve the quality of health care.

Another justification of the indigenous health movement is that the implementation of aboriginal healing in the hospital will improve the quality of health care in general. This is argued from two different although related perspectives. On the one hand, there is the

argument that hospitals as places have to be made more tolerant of alternate treatments that are proven effective for indigenous clients. On the other hand, there is the argument that healing strengthens everyone's identity and the community. Although these two approaches of healing are two sides of the same coin, they are hard to separate in practice. Separating them analytically is useful to present the argument that the implementation of indigenous healing within a hospital setting will improve the quality of health care.

#### **4.2.1 Culturally safe hospitals. A path for healing.**

The broadest perspective of healing is founded in the argument of the creation of new alternative spaces for understanding health and illness. In general this argument gives voice to the demands of patients and hospital staff. Aboriginal clients at the hospital actively demand what some scholars (Birch et al. 2009; Paasche-Orlow 2004; Anderson 2003 in Walker et al. 2010: 59) call a "cultural safe environment" and access to indigenous medicines as complementary health care (S.H.R 2010). According to Kaufert (1999) one-third of the Cree and Ojibwa First Nations patients entering Winnipeg tertiary hospitals hold traditional beliefs about illness and follow traditional healing practices. Although this belief system is predominant among older patients the number of requests from patients of different ages to participate on traditional healing rituals is increasing (Kaufert 1999: 419). The ways that aboriginal medical traditions and practices take place within clinical settings is diverse. During my fieldwork in Saskatoon, my informants documented the broad use of medicinal herbs, the use of sacred items, and in some cases the patient or the family contact an aboriginal healer for treatment within the hospital. However this usually happens in a hidden way with dramatic consequences for both the self-esteem of people and their recovery.

In a social institution like a hospital, some hospital administrators, and indigenous groups expect that the implementation of aboriginal healing would facilitate not only complementary medical tools for the treatment of illness but the space of positive identities within the indigenous population. They hoped that this would reinforce the self-esteem and trust of these users within the hospital and therefore their recovery. King (et al. 2009) emphasizes that facilitating positive identities is the basis for the healing of people who suffer social discrimination, and he explains how important it is to endorse cultural expressions within society's institutions as a path for healing.

As we saw in chapter 3 different barriers force native peoples to hide their needs or to suffer frustration. Some of the examples that I have given involved the notion of an extended family, the use of sacred items, or the parallel use of healing plants. The acquisition of a culturally safe environment means the destruction of racist, cultural and structural barriers already analysed in the previous chapter.

#### **4.2.2 How can indigenous medical knowledge improve the quality of care?**

Advocates of traditional healing argue that it can treat some diseases better than bio-medicine, and moreover can offer a new insight to the health situation of the aboriginal patients. Some medical staff and administrators are aware of the need to address the incidence of high morbidity and mortality rates among the aboriginal peoples and have therefore started to introduce traditional healers within their team (See section 4.5). One of my informants, the associated Dean in the Division of Community Engagement in Edmonton, described this need in the following way: “We need as many tools as we can get in order to heal. We have to recognize we do not have the monopoly of knowledge” (personal interview).

Indigenous healers claim their medical knowledge successfully treats diseases manifested in the body, despite the fact that this knowledge does not have the same scientific foundation as bio-medical knowledge. Many indigenous healers do not look for rational explanations. However others have chosen to document those practices in a formal way and in a language that makes sense for the biomedical community as well (Cardinal 2006; Annex 1). They want to prove the effectiveness of the practices using the same academic and scientific words as bio-medicine. In this way they hope that the dialogue between the two types of medicine could be more effective.

Aboriginal healers make clear that aboriginal medicine is not magic. It does not have solutions for all illnesses, especially if the patient asks for help too late. However they claim they have lot to teach and share to bio-medical practitioners and can treat some diseases better than doctors do. They admit they will be happy to work with them since bio-medicine has features related to testing and some medicines that aboriginal medicines cannot deal with. They should work together in order to offer a better service to the patients and families of any kind of cultural background. Aboriginal healers claim that the mainstream population will also benefit from this implementation, since they could have access to the indigenous treatment, and improve or heal from some illnesses. In fact, more often no aboriginal users are demanding help from aboriginal healers in the

places where they work. In general most of the demands are related to mental health issues (Cardinal 2006).

### **4.3 The argument for the preservation and protection of Indigenous medical knowledge.**

Today we have been confused by other values and beliefs that are very different from our own. We have lost many parts of the original instructions given to us by *sonkwaiatison* (our Creator). How will we ever find our way back, so that we can move forward? [...] Part of our way of life has to do with our traditions, our rules, how we deal with medicines and our traditional approach to health. We have ignored many of these rules and these natural laws. We have also encountered unfortunate consequences. We are beginning to understand that if we take the best of our knowledge about traditional medicine and use it, and be restored to health. (Kanentakeron 2006: 7)

This passage speaks of “lost identity” and the need for coming back to the “sacred” sources of healing, which the author understands to be in his people’s traditions and knowledge. I raise two important aspects of this text. The first is the need to go back, but in order to move forward, the second is the need to get back the knowledge and “use it”. Some of the defenders of the implementation of indigenous healing within urban medical context are exactly defending these points. They are aware of the immense value of their sacred knowledge. They are aware that with the loss of this knowledge, their people as “real people” and their hopes for healing disappear. However, they are trying to find a way to use this knowledge and to preserve it within the present circumstances. These present circumstances tell us of a great loss of this knowledge (Carding 2006), and that many Elders and healers die without passing on this knowledge. These circumstances also refer to problems in the transmission, even when the knowledge is there. That is the case of some of the young generation who seem confused about their people’s medical knowledge. Many indigenous people think that the need to share is great (Carriere et al. 2009). First, they argue that sharing must take place within the community. Second, they argue we need to document the knowledge in writing and creating protocols for its protection and preservation (Carriere et al. 2009). Finally, the institutionalisation of the knowledge in hospitals and universities is seen as an important step to challenge the discriminated status of this knowledge.

To achieve these ends, national meetings occur in Canada almost every year and gather many healers, At these gatherings the preservation of knowledge and the ways of protecting it are discussed (Carriere et al 2009; CPTMK 2010). Despite the fact that everybody involved in these gatherings are trying to find solutions, not all of them defend the use of their sacred knowledge within a foreign institution. As the next section will show, these worries are a constant background in the debates on these issues.

#### **4.4 Worries about integrity and appropriation.**

##### **4.4.1 Expert public knowledge vs. sacred knowledge**

In our Western societies, most of the knowledge that we have is transmitted publicly, through schools, universities and churches. All of these institutions are organized in a way that trains certain individuals to become experts in a type of knowledge in order to teach and transmit it. Most of these teachings are gathered in books, and the pupils must study and show they learnt the information. In order to value the knowledge achieved, standards on knowledge acquisition are agreed upon publicly. There are no secrets.

In earlier history on the Canadian prairies there was the Mediwin Society. This society provided supervision and protection of Cree traditional healing practices and principles within other tribal matters. The members of this society were Cree Healers, acknowledged as holy people. There were four members elected in secret either by divine order or by birth-right. These healers met every four years in a separate place indicated by a dream. Through these meetings they evaluate how healing was practiced giving special attention to the integrity of the knowledge keepers, to the protocols that a healing recipe must follow and to the documentation of the healing recipes in birch bark templates (Cardinal 2006: 12-16)

The integrity of the knowledge keepers included the humility of the healer and the recognition of the spiritual side of plants and healing power. Additionally nobody could choose to be a healer and beyond the knowledge about plants and healing practices they could achieve, there was a spiritual gift of making healing possible. If the integrity of a healer was under question, it was pointed out to the community and his/her own medical recipes were retired and he/she lost the right to use them.

It was very important as well that protocols were followed. These protocols included, among others, the correct and respectful way for picking plants and the correct

way of preparing and mixing them. For example it was (and still today) is proper to offer a gift to the land before picking any herbs. It reminds the person that they do not own the herbs nor do they have the ability of making herbs work. Rather they share the spirit of the herbs.

Another aspect related to protocols is the way of organizing the treatments. It is normal that healers have a set time for healing a person's disease from the beginning of the treatment. The way of organizing this treatment depends on the patient, and the right time and process for treatment depends on the healer intuition and experience. The intuition is seen as part of the gift and spiritual involvement (Cardinal 2006: 36-45).

This style of protecting Cree healing knowledge and practice continued right up to the 1930's. The suppressive assimilation policies of the state then pushed this practice underground giving the management of sacred knowledge a 'secret' edge.

Because of this history, many traditional healers reject the idea of making this knowledge public. There is an active debate within the Cree community that addresses these worries. The main worries are reflected in some of the following questions: If healing is a gift and not only a learnt process, if healing involves humility and deep connection with the land and the spiritual world, how could teaching the indigenous medical knowledge at the university "create" real healers? How could these persons get the gift, the humility, the spiritual bases of healing? In a formal institution such as a hospital, would the job of a Cree healer would be paid? Who would hire indigenous healers? Should these and the Elders write curriculum vitae in order to get a job? What expert committee would then decide the integrity and qualification of the healers?

#### **4.4.2 Some of the main worries in relation to the implementation could be the next:**

##### Worries of exploitation and appropriation

It is common to find in indigenous gatherings and forums the fear that indigenous knowledge would be lost. Despite the awareness of the need that the knowledge should be recorded before the Elders pass on, many are worried about sharing this knowledge and that it could become misappropriated and exploited. (Carriere et al. 2009: 14) They feel that the integration of their traditional healing within a bio-medical/Western context would lead to the appropriation of traditional healing practices. Those who have these worries see the Western institution as superior. They fear that the society that has oppressed Aboriginal peoples for centuries will manipulate or exploited their sacred



knowledge. In the second traditional healing forum in Fort Simpson, Dene Elders emphasized that the knowledge of their medicine is the only tradition left. Although they are aware of the need to keep it alive and to share with others, they are afraid to give it away, to make it public, since it could affect its integrity.

#### Worries about integrity.

Most of the indigenous people involved in this issue are worried about the integrity of their traditional healing if it is made public. They are worried about people claiming they are indian healers when it is not true. It would affect both the efficacy of treatments and the reputation of indigenous healing. They are worried that the right and sacred protocols will not be followed. One of my informants explained this to me through one example. He explained that some people might learn how to develop a ceremony, or how to use the right combination of plants, but it does not mean they have their gift of healing. Anybody could learn the protocols but the integrity and the humility that characterize a healer cannot be learned.

Another worry related to integrity is the monetary compensation that healers will receive working at hospitals. Traditionally people who were treated with success rewarded the healer with ceremonial gifting such as tobacco. However now-a-days money is normally used as a reward. Some healers argue that the present circumstances must incorporate money (Carriere et al. 2009). The main argument is that healers have costs associated with healing practices. The picking of medicine (plants) for example means traveling further and further each time (since the forest is often contaminated or destroyed). They have to pay for gas and accommodation. Today the welfare of the community is different. Before, the members of the community sustained each other. Today it has changed. Thus if the healer works full time, some question: how can the healer sustain their family, pay for the utilities, the rent, and so on.

Despite this antagonistic environment, some of my informants think that the crisis is so large that it cannot be underground anymore – The crisis refers to two main aspects: one is related to what indigenous traditional medicine has to offer in health improvement for both indigenous and non-indigenous society. The other is related to the need to preserve indigenous knowledge. At the present most knowledge that the Mediwin society used to have is lost. The ceremonial knowledge is too diluted and dispersed around Canada. Despite the effort of many indigenous healers to gather the knowledge that is left, it is a difficult task. Clifford Cardinal claims a great need to provide a consensus in

the total amount of recipes by known healers of each tribe, and documenting this seems to him necessary for its preservation. He and other healers want to record all this knowledge before the keepers of healing knowledge pass away.

All of these worries have led to different solutions for the preservation and protection of traditional knowledge. The following case aims to show through an example some of the main arguments for the formal implementation of aboriginal traditional healing within medical institutions, and which solutions speak to the worries presented above.

#### **4.5 The Case of Alberta. Why a traditional healer at the University?**

As a traditional Cree healer on the medical school faculty at the University of Alberta, I argue that conventional medicine has much to learn from traditional healing practices and that these practices should be shared. If traditional knowledge and wisdom are to remain intact and alive, our people must open their doors to dialogue about practices that historically have not been documented. (Cardinal 2008)

The Faculty of Medicine at the University of Alberta was known to be one of the most conservative in Canada with clear interests only in bio-medical and scientific solutions.<sup>7</sup> Even immigrant doctors were mistrusted. This changed due to the shift of one of the senior administrators. About seven years ago (2005) the new provost Carl Arnheim became interested in the concept of ‘patient-centred care’ and the fact that demographically aboriginal people in Canada were rapidly becoming the largest client group in the health system. He was worried that nobody understood the needs of this population. 35% of their clients in Alberta are aboriginal, as are 50% in Saskatchewan. The epidemiology of the population showed a crisis: diabetes, high birth rate to unwed mothers, respiratory disease, AIDS, and ‘post-colonial stuff’ [residential schools, land claims]. When he suggested hiring a traditional healer on staff the Dean was also supportive. There might have been an element of competition involved since the University of Calgary had a Blackfoot doctor on staff who trained aboriginal students.

Carl knew of Clifford Cardinal earlier. He is a traditional Cree healer, well-known and respected within his community and in general within the indigenous network.

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<sup>7</sup> All of the institutional details of this story are from a personal interview with Prof. Earle Waugh.

Clifford also held an MA from the School of Public Health. The two men also worked together well. Carl ran into Clifford when he made trips out to Saddle Lake, to St. Paul, and Good Fish Lake to meet aboriginal activists. In Alberta, these places are famous as places where there are assemblies. Clifford took almost a year before accepting the offer. During this time he visit different Elders and prayed for the right answer. He told me that there were three main reasons why he ended up agreeing. He could practice his knowledge, he could teach the knowledge and he could feed his family with the position. According to the Cree tradition, indigenous knowledge has to be used and has to be taught in order to be living knowledge. Despite these basic considerations, something else pushed Clifford to agree: the preservation and transmission of this knowledge, through its practice within an antagonist environment. He defended his position with the following arguments: He wanted doctors and other hospital staff to witness the efficacy of traditional healing (personal interview 2011). He also wanted to break the barrier of rejection and discrimination that this type of medicine has suffered. After years of experience he looked back on his decision and evaluated it as positive and correct.

Due to the increasing referral of patients from the hospital doctors to Clifford office, he has had to develop a support system (Cardinal 2011). This consists in creating a referral system of the existing healers within Edmonton. The growing number of patients means Clifford could not possibly to attend to all of them. Besides that, his integrity pushes encourages him to deliver patients to other healers. Each healer is an expert in different areas of healing. Therefore he refers patients to those who he believes can treat the patient best. Beyond this, it is expected that through this referral system patients attend accredited and well-known healers. In this way people are protected from using false healers. He found a solution to worries of integrity.

In regards to the goal of showing that traditional indigenous healing is efficient, Cardinal (2006) has documented cases where the traditional healing treatment has been successful. With this I mean here that the illness as physically or mentally manifested has been eradicated, and the person and relative hs identified themselves as healthy again. In the annex at the end of the thesis are attached copies of these case studies, all related to mental health problems, such as schizophrenia and bi-polar disorders. As the cases show, the protocols of treatments, the process and the involvement of supernatural events differ from the bio-medical model. However the goal of curing and restoring health is something shared by the two types of medicine that needs to be emphasized as well.

Another problem identified by Cardinal, and in general for the aboriginal community, is the need to educate hospital staff, so they can better understand the indigenous patients and culture. Within an urban medical context, Cardinal (2008) identified a great need of education and information about traditional healing by doctors, both indigenous and non-indigenous. His main goal is to train “not only doctors but healers”. With this, Cardinal hopes that doctors can see people in more holistic way. He was asked to develop a course on traditional medicine, and he was to have a contract of teaching, community outreach, and research. He ended up teaching two courses: one course on traditional medicine and a second on plant therapy. He also receives up to 1200 visitors a year who he counsels. For his plant course he takes students to the mountains and teaches them to find plants and to treat them properly. The main goals of his courses at the university are summarised in the following points:

1. “Bringing about awareness that the medical training at the University of Alberta can be enriched by the learning and observance of the traditional healing practices.
2. Providing for the Undergraduate Medical Student an opportunity to access the secular knowledge by way of participation in dialogue and in discussion with Healers/Patients on Aboriginal Peoples health status today
3. To learn essential virtues and to acquire traditional healing teachings on the part of the student is tantamount to the taking of the Hippocratic Oath on one’s completion of medical training, it is the start of a life of health and healing of the self and of the people around our circle of life.
4. It is also designed to provide for an understanding of the manner by which Healers have been trained in the past and what this training encompassed.” (DFM 2010)

#### **4.6 Conclusion**

Cardinal evaluates these years of interaction between the two medicines as positive, especially noting the admiration provoked in some young doctors about indigenous medicines. The medical recognition of indigenous healing brings up his normally discriminated status. This seems important for its survival within the present

circumstance, within a dominant society who knows little about indigenous knowledge and practices.

This case shows a path of interaction and integration; however, this integration does not happen in the same way as other bio-medical practices. With this I mean that despite integration within the hospital, it does not officially form part of the system. It is something attached to the hospital rather than an indivisible part of the medical model at the hospital. As the conclusion of this thesis notes, other methods of formalising aboriginal healing in Canada have been explored and put in practices. Although I do not go into the analysis of them, I bring an open reflection and a general overview of the current practices.

Despite the problems involved with the argument of preservation of indigenous knowledge, we cannot look at the whole issue of traditional healing's formal implementation without taking in to account the arguments of decolonization and the improvement of the medical health care presented in this chapter. These arguments create a unanimous forum and are persuasive enough to justify the integration of indigenous healing within the hospital. Best practices for the integration of indigenous healing in the hospitals have yet to be established but the exploration for new health care model has begun.

## CHAPTER 5. Conclusion

This thesis has been about the “Real People”: about the contemporary journey of the First Nations peoples of the Canadian plains to attain well-being and a sense of identity. The full story is about this people working to heal the consequences of a devastating history of assimilation and colonization. My argument has been that part of that road of healing lies through the official institutions of the Canadian medical system. The thesis explains that this new path of decolonization is deeply integrated into a change of mentalities and the “decolonization” of the mainstream community as well. An important area where indigenous people and the dominant society must build new bridges is in the area of health care, especially within the hospital. This has been the topic that has been discussed most in this thesis.

The main question to answer has been: *Why indigenous healing should be integrated into western bio-medical settings?* Others settings have also been chosen for the practice of indigenous healing. Within prisons (Waldrum 2000, 2004), or independent health care centres run by First Nations, people are cured of their mental health problems, recover from addictions or domestic violence. My informants spoke of some of these places. Some are quite well stocked and even have access to databases which identify possible side effects from the mixture of traditional plant medicine with biomedical products. However it was not a goal of this thesis to provide a catalogue of all of the possible ways that traditional healing might be integrated into official settings, but only to answer the question just mentioned above.

One of the key answers has been the importance of having these two communities interact – the community of biomedical practitioners and the indigenous healers. As the hospital context shows, decolonization involves both groups in this process simultaneously. On the one hand the field research shows, aboriginal patients feel extremely vulnerable when hospitalized. They ask that hospital staff (often from a different cultural background), try to understand who they are. They want to be understood. They demand to be respected. They need to be listened to. These aspects are evaluated as important determinants of quality health care. In order to this happen the architecture and organization of the hospital must change, and the staff must be trained to be aware of cultural differences.

On the other hand, some Plains Elders, who place a great value on their traditional knowledge, argue that if indigenous healing protocols were introduced within a clinical setting the staff would begin to work with the Cree healers to cure the people. Clifford Cardinal thinks that if doctors witnessed how their traditional medicine works, they could not reject it. He thinks as well that if indigenous healing could take place in an open and formal way in public it would bring indigenous medicine closer to non- aboriginal patients as well. In this way it, creates opportunities for the mainstream community to experience how indigenous medicine works. Therefore he works hard to create the space for this to happen. This is happening already in Edmonton. Clifford Cardinal is getting increasing referrals from doctors, and more non- aboriginal patients demand their service.

Therefore, the integration of indigenous healing within hospitals is seen for its defenders not only as an improvement of quality health care, but as an important step for the revalorization and formal recognition of indigenous knowledge. This is seen as very determinant for the preservation and survival of it.

According to my informants, their knowledge and traditions are very important for their people's recovery. According to them, when they recover their sense of self, the path of healing starts (Bastien 2009). "It is not possible to know who we are and not to be proud, not to be strong, not to have peace" (personal interview).

Although this movement of indigenous people healing is in its very beginning, is creating already deep changes in terms of indigenous involvement and government policies. It is no longer strange that patients (under patient-centred care) might be given different food brought by relatives, or use sweet grass in the hospital. As the third chapter shows some hospitals now run a service of cultural helpers. A major change was brought by ethical codes. Hospitals can get into legal trouble if they do not respect the patient's need. The threat of legal action has made them more flexible. The increased number of immigrant doctors has helped. The immigrant doctors are more likely to 'turn a blind eye' to local cures and local foods.

However, this project has shown that there is no simple answer for how these two traditions can come together. Nobody really knows which best practices should be placed in a hospital. It has also shown that not all healers think that this is a good idea. Neither do we know the time that will take to change mentalities and to get the mainstream

society to “decolonize” themselves. I mean, to break with the historical past that has built so many stereotypes and barriers between the two societies, indigenous people and the new settlements. As I have started before in this thesis, this is explorative and some questions remain inconclusive. Thinking about the communities who are reaching out for some integration, some of the no answered questions present themselves as topics for further research:

- Accreditation. Despite the success of Clifford Cardinal in creating a referral system of accredited healers, there is not a general agreement on which protocols should be set in place in order to protect indigenous knowledge. Similarly hospitals do not have a way of validating the integrity or accreditation of those who claim to be healers. There has been some talk of creating an association of healers, but it has not happened yet. As stated in Chapter 4 it is not entirely clear *how* this could happen. If healing is a gift, what kind of association could sit and review the skills or CVs of healers? One wonders if these two communities are too far apart on this philosophical point.
- Emphasis. Many of the examples of traditional healings within medical settings speak to a peripheral integration of this knowledge. In fact in many institutions one would have to look hard to find these practices, as subtle as they are. This leads to the question of at what level at what intensity these practices should be integrated in order to make a real difference in the health of First Nations people.
- Revitalization. A related issue to that of above is would a greater profile traditional healing in hospitals have a further effect of revalorizing healing in aboriginal communities?

The revitalization of aspects related to healing, comes with strong determination and involves much more than not forgetting about old traditions. It involves the survival of Plains Canadian First Nations as a people. According to the legends, the Creator, or the Great Spirits, have created the Plains First Nations so they can take care of the land. When they do so, the balance of the world is restored. Some writings (Akwesasne 2005) tell about the sadness that many of these people feel when see the western history, mainly related to exploitation of the natural world. They think that the way that western



development follows will destroy life as is known today. They claim that their way to understand the world, their traditional knowledge, has a lot to teach to the rest of the people in order to get a more sustainable type of life: “to show people how to develop as persons, rather than how to achieve the best curriculum” (Cardinal 2006).

Who knows if through making room for indigenous people traditions and getting to know indigenous wisdom western societies would find some answers for the problems that experience today.

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## **Annex 1. Interviewees.**

**Vernon Linklater** : Saskatoon Indian and Métis friendship centre. Family Violence Programme.

**Val Arnault-Pelletier**: University of Saskatoon. College of Medicine. Aboriginal Coordinator and curriculum adviser.

**Cristal Laplante**: Saskatoon Centre Métis Federation (CUMFI) and the Kinistin Saulteaux Nation. Health department representative and staff member of the research “strengthening the circle” (SHR 2010)

**Clifford Cardinal**: Traditional Cree healer and assistant professor of the Faculty of Medicine & Dentistry, University of Alberta.

**Wanda Whitford**: Administrator Indigenous Health Initiatives Program, (CE) Faculty of Medicine & Dentistry, University of Alberta

**Dr. Konkin**: Associated Dean, Division of Community Engagement, University of Alberta.

**Earle Waugh**: Director of the Centre for Cross Cultural Healing at the University of Alberta.

Another informant remains anonymous



Blessings were bestowed upon the University of Alberta to conduct and educate students of the sacred and sensitive traditional medical practices of the Aboriginal People by **Medicine Beaver Bundle Keeper, Fred Eagletail** and renowned healers of the day and age; left to right are, Dean of Medicine Dr Tom Marrie, Fred Eagletail, (late) Howard Cardinal Saddle Cree Nation, MD. Daniel McKennit (then in his 2<sup>nd</sup> year), and Treaty 8 Sundance Chief George Calliou. It was conducted within the University Grounds September 7 2007.

## 16. The First Case Study

The medical student approached me after a presentation I had done on the approaches used in traditional healing and the possible interactive work with healing and modern medicine at KATZ 1080, she also shared with me that her sister was suffering from schizophrenia. Her request was to acquire the services of a traditional healer to “try” another alternate method. I have come across many stories during my academic career of people hearing and having been healed when all else have failed, and in the case with schizophrenia, there has been no evidence that cures or complete healings to have been found in conventional medicine in recent times with this particular mental illness. A lot has been written on the subject to warrant another approach in addressing the affliction with people affected with this debilitating mental disorder but other than the treatment or in medicating the person there is little that is offered the patient. This was a 13-year affair with the patient visits to the emergency clinic occurring at the rate of 2 or 4 times per week to enable the patient to have a semblance of a life. The possibility of a cure seldom leaves a family with cases of chronic

and terminal diseases and this was perhaps in the family's minds at the time, and at the least a viable option was now on hand rather after the nominal protocol of *giving of tobacco* was done on behalf of the sister. Much later the sister shared with me that this was just a emergent hope which the family had had in the 13 years since whatever happened to start the schizophrenia, the voices, and the suffering which affects over 280,000 people in Canada.

This article details the journey on what the family experienced in the 5 weeks from the onset of treatment to an absolute cure. It challenges modern medicine to provide a better treatment for the many sufferers of schizophrenia and the different ways mental illness impacts people's lives. Lastly it commends the patient own personal will and the mental health story in light of prior treatment(s) she received and as it is offered today in mental health care. In addition to this patient over 60 patients other than aboriginal people have been treated in similar fashion with different forms of mental illness in the past three years and have been treated successfully since the University made the appointment to have the services of a healer in the Faculty of Medicine's Family Medicine department.

From the time of completing the treatment which took five weeks the patient had had no relapse or episodes to present date. A concern to many is the protocol that it requires to access the service of a healer, this concern is the giving of tobacco, sadly today's tobacco consists of many chemicals which are lacking in traditional natural tobacco, many people are not aware that **Kinnickinick** the original tobacco of healers has non of these chemicals and is therefore safe for humans and in fact has curative properties as well. To say a little of nicotine we should also know a little of its properties as well.

Nicotine resembles one of the body's natural chemicals, the neurotransmitter *acetylcholine* (**ACH**), which carries messages across the synapses between nerve cells and by attaching to *receptor cells* in the motor nerves, it tells our muscles to either relax or contract. **ACH** receptors are found in the medulla, hypothalamus, thalamus, cerebellum and cerebral cortex regions of the brain. Like a skeleton key nicotine fits all the **ACH** "locks." Inside the body, nicotine acts as a stimulant. It accelerates the burning of glucose the raw material for cellular energy, setting off quick, low voltage brain waves to produce a hyperalert mental state. *Nicotine* also releases potent neurochemicals such as *epinephrine*, *norepinephrine*, *serotonin*, and *dopamine*.<sup>15</sup>

Nicotine sensitive ACH receptors in the hippocampus are responsible for healthy gating. High doses of nicotine are more likely to activate the receptors, but even this treatment in

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<sup>15</sup> Guterman, L. 2007. *The Medicinal Value of Nicotine*. (Really), The Chronicles of Higher Education 2007

which the peak last for no more than 15 minutes leads to desensitization and only transient improvement. In treating this patient processed tobacco was not used.

There is an urgency to explore the relationship of the traditional mentally-gearred medicine in possession of Aboriginal Healers as there is little that western medicine can offer in terms of treatment with positive outcomes. With the negativity that is related to tobacco and specifically nicotine it would be difficult to persuade medical researchers to open up to finding the positive outcomes I alluded to.

What effect would nicotine have when introduced with traditional smudge medicine specially designed for mental disorders and when used in conjunction with compounds traditionally used by healers in North America; Valerian Root, rat root extract, Castoreum, and granules of porcupine quills. And when used in sync with prayer, meditation and **traditional drum therapy**, also stimulates slow but highly charged brain waves, which are indicative of mental focus, intuition and tranquility. Within the central part of cerebellum which is divided into two parts [left brain and right brain] the amygdale serves as Will the effects of drumming override the effects of nicotine or did the drumming along with singing provide for the proper setting for healing? Ceremony will indeed affect the behaviour of naturally occurring internal chemicals as the patient is anticipating healing outcomes. *Human subjects who received nicotine intravenously cannot distinguish between the euphoriant effect of nicotine and that of morphine or amphetamine.*<sup>16</sup>

## **17. Method of treating Patient**

In treating the patient A (which started Oct 7, 2007) I quickly found out that she was intuitive she understood the meaning of the concept "Grandfathers" and was open-minded. This was indeed a good start for me. After an initial meeting in my office that October, her sister (██████) presented tobacco to me as it is the protocol, and we proceeded to lay out a treatment plan for her for the next 4 treatments that we agreed upon for her healing. As profound it is for me always to prepare patients timelines, there are people who do not have a clear understanding and history of my methods who are surprised that it does have a definite period for the treatment to occur; a stated amount of time. Do healers have a set time for the healing of specific diseases to occur? That is the case for traditional healers as generally those adept in the practices do know how long a treatment should take, but the fact there is no standard period of time for any healing to occur, or a set time for a certain disease to be treated allows for flexibility in scheduling. For some patients the healing will occur on a

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<sup>16</sup> Austin, James MD. 1998, *Zen and the Brain*, Cambridge Mass. MIT Press. P. 169

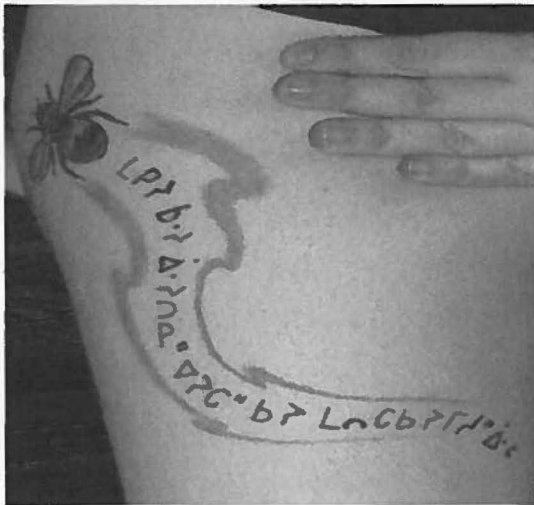
timeline providing that respect is shown, an example is, that it can take only one treatment for a palliative patient to heal, while others may take up to twenty treatments depending on the nature that brought them to the healer. We set up a series of ceremonial treatment for the patient in the following manner that day (Oct7/07) and kept the schedule right up to completion date.

## 18. Series of Treatment

1. the preparation for making an inhalant is made specific to age of the patient, weight, length in time with the illness, and my initial intuition of the patient this called for a series of compounds which were in my possession, a good sign and included: Valerian Root, Ratroot, grounded up dried Beaver Castor, and grounded porcupine hair (those of a male porcupine—and for treating a male patient I would use female porcupine hair). With these four ingredients in powder form, it becomes a potent inhalant which only trained healers have authority. In the past this mixture was a vital part of healing as it was also used for treating cancer, treatment of allergies, blood disorders but was used primarily for mental disorders.

This is done with the intent of coaxing the negative elements and negative spirit (energy) of the disease away, in this case schizophrenia. A heated stone the size of the patient's palm is heated and this is where the ground up medicine will be placed. After the stone is heated she is then covered up in a blanket and made to inhale the substance which is put onto the stone and patient is told to inhale through her nose until coughing and sneezing ensues. Then

the disease having made into a spirit by the power of both the medicine and healer, is manifested into something tangible, something that can indeed move on its own and carry the ailment away from the host, in her case a bee that crawled out of her nose, I wondered what she was thinking at this point as she did not question me nor did her sister who witnessed the bee coming out of her nostril.



**Figure 1:** to illustrate her healing that day the female patient had this tattoo made August 2010 on the outside of her thigh. The Cree Syllabics is from a line from the Poem "Ecstasy of Rita Joe" it reads, "When pride is claimed by oneself it is at the cost of ones inner pride." The permanent fixture of this tattoo exemplifies her believe she is healed; the bee a symbol of what her condition had manifested into was symbolic of 13 years of pain she endured.

2. The second phase of her healing consisted of meeting her spiritual self (regressive therapy), this is usually done with the assistance of a person with a good knowledge as to how to conduct a "Shaking Tent"<sup>17</sup>. This presented us with the formidable task of asking a person who would be willing to participate with the healing of non-Aboriginal people. The trip took us to the community of Calling Lake, the healer that day had refused to answer our phone calls and when they did his wife told us he was away on a moose hunt, knowing the ways of these people we decided to go anyway after 7:00pm, and also knowing he would be home by that time (10:30pm) and I would ask on behalf of the two sisters who did not know the protocol of asking help from a shaman. Upon asking him he immediately made a reason that he was not in position to do this ceremony at that time. Then I went on the rationale which he would understand, telling him that it was his duty to help those who sought help, that the Sacred Pipe knows no racial boundaries, and that we travelled 3 hours to get there and that he should have told us "no I don't want to help you." Within a couple of hours later at about 12:00 am we entered the spirit lodge and it was there that the patient finally confronted the voices she had been hearing for the last 13 years. After a long discussion, between the patient and the spirit behind the voice, and on the pain(s) inflicted by the whole family and by her many, many visits to the emergency room in St Albert over a decade a resolution and reconciliation was finally reached between the two. We the participants only sat there in the darkness in silence as the dialogue came to a completion after one hour. This was the second part of the healing process; the healing of the brain would now begin.

3. The third phase included *talk therapy* around the matter that the brain is in itself a separate entity supported by the balancing of the quadrants of the human state: the emotional state, physical state, social state and intellectual state, what we feed the brain (knowledge, nonsense, humour, peace, love, compassion, a sense of the future, and our own mortality) and lastly how we confront our demons who dwell within our minds. This took about 10 working days of 1.5 hours each as to not overload the patient; this could be called psycho-therapy, process healers learn from their teachers. My teacher for this was Peter Shirt (Goodfish Lake, Alberta) who had spend a lot of time on these subjects with me ensuring that I should know the basis of providing this type of help when called upon. When the patient with mental illness realizes that the world is seen differently by everyone and at different times can indeed be horrific images of the mind, and it either accepts or deletes the horror that the

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<sup>17</sup> A Shaking tent is usually conducted by a trained person knowledgeable in contacting the spirit world, people present can request to speak with someone from the spirit world or a spirit that has been bothering them, in this case the patient had requested if the voices she was hearing were real or not.

dream-world may inflict upon any innocent person's dream space. It is at this point I separate the real from the unreal with the patient as my tribal beliefs have always recognized the relationship between the lucid dream-world and the spiritual reality of mankind. Most people do not realize the importance of dreaming; the Senoi<sup>2</sup> tribal people from Malaysia practice the sharing of their dreams each morning which is attributed by their near absence of mental health conditions and much like the Cree people are involved in healing, believed in the co-existence of lucid dreams and the intellectual nuances of knowing the meaning of dreams, but this was disputed by academics (Domoff, 1997)<sup>3</sup>. The need to know ones dreams is important to ones mental health and in time as one attains a high degree of lucidity in the dream-world one can indeed reach levels of spiritually unheard of in the western world. For this patients needs, she attained her own levels of consciousness while in the spiritual world. In the context of the aboriginal people; the voices were the voices of her ancestors or dream/spirit helpers also called "Grandfathers" by modern traditional people and in her reality she reconciled with her grandfathers during this period, a powerful notion indeed.

4. This phase now included the family, and how she would balance her life alone. Of contention was the medication (Haloperidol, Zoloft and Lorazepam<sup>4</sup>) she had used for over 12 years as a Schizophrenic. There was fear from the mother if she stopped the medication right away she might suffer or have a seizure especially for Ativan as it has been proven to cause seizure<sup>5</sup> if stopped suddenly. This was dealt with by herself without consulting other people including me as she did indeed stopped everything she been taking to treat her disease. In the following months we spend time with the family getting to know the suffering they had endured in the past 13 years. Her mother shared with us that it was tiring to get up in the middle of the night to bring the patient to Sturgeon Hospital in St Albert (they live in Villeneuve) at least three times a week in the emergency when she had an episode to be sedated, most involving rage and inner violence only she can describe and only a mother who would know the different effects at each time. By December of 2007 the patient was well enough to travel to Belize for the first time in many years disease free, and after the joy of healing which was celebrated in a pre-Christmas event the patient went off to her journey in Central America to be finally freed from Schizophrenic. To establish the medical aspect of the treatment the compounds are described below.

## **19. Treatment Outcome**

When the Patient first came to see me she was perhaps between 250 – 300 lbs, with little care for her personal hygiene, but that is never my concern, people who are gravely ill should be the responsibility of the family that indeed her personal needs are taken care of. After one year when she had completed the treatment she had lost over 100lbs and was indeed very strikingly beautiful. The Voices had long disappeared after the four treatment modes described above in detail, in fact today she is practicing the game Roller Derby and is socially active around the Whyte Avenue region. She has had no relapse or episodes to date. She visits us on a regular basis and in fact her sister the medical student has taken on the choice to be a traditional healer and a medical physician at the same time a choice she made on her own. She is currently doing her medical residency at Grand Prairie as an MD no longer a medical student and this year will make the trek where Healers are made, the Holy Grail of the “*Mediwin Healer*” the *Holy Circle Sundance* at Rosebud South Dakota and will make the vow of piercing on her arms. Two small incisions on her arms to mark a live-long commitment to this archaic healing art, I have tried to talk to her of the gravity of the matter but to no avail. She is committed to this. As for the mother life is simply another world as she told me last Christmas, looking at her three daughters who had bravely undertaken to take care of and love their stricken sister in spite of the schizophrenia, “*if only others can be so lucky*” said the grandmother with tears in her eyes as she had seen what this did had done to the whole family. No one can ever estimate the hurt one family can experience with the affliction of a central being as a middle sister, nor the sentiments of a mother whose daughter is the one ill, or a family that did not give up on her. In fact the medical student’s purpose in entering medical school was to take care of her sister, the sole purpose of ever becoming a physician; and now with the problem gone she now has higher aspirations “to be a healer”.

## **20. The Compounds used in Treatment**

**1. Valerian Root** the stabilizing properties of *valerian* *\*officinalis*<sup>6</sup> provides for mood stabilizing effects and as an anti-convulsant. It has been found that it bounded to human adenosine A<sub>1</sub> Receptors, site that enables the cortex, hippocampus, cerebellum and spinal cord to benefit from the properties as stated. Studies have supported what Native Americans have believed the plant to be as an important medical component. The studies also identified its important role as a mood stabilizer and a powerful mind medicinal. For that purpose alone its use in treating people with schizophrenia, bi-polar disorders and hysteria<sup>6(1)</sup> is duly noted by its long history with the Woodland Cree and other indigenous groups in this region of Alberta. Valerian root called *apiscakôwaskôs* in Cree is an important and integral ingredient



in many of the recipes held by older woman who have kept the secret recipes intact, and of training apprentices who go into the Rocky Mountains to harvest the roots in late June.

**Figure 2.Hysteria (Wikipedia)**



**Ratroot** This plant *Acorus calamus* has been used among the Cree/Blackfoot Nations for numerous medicinal reasons; perhaps the overriding properties are those of the respiratory tract. Both the leaves and rhizome have been to be psychoactive, with the rhizome being more potent. Many healers have also used the plant as a partner to other(s) such as valerian officinalis whose properties appear to be heightened by the addition of ratroot in the making of an inhalant for mental health concerns. These include the treatment of schizophrenia, bipolar disorders, compulsive-obsessive disorders and depression.

**Porcupine Hair** *Hystricidea keratin*<sup>8</sup>

Little is known in modern science of the property this compound has, alone it has tremendous value among the Plains Indians of Canada, as ornament and as medicinal additive with other compounds. It is always used as an additive in the making of curative smudging much as one would see used as in Sweetgrass or Sage Incenses. It is specific to bettering the mental health of sick people but is never used in isolation. Woman while pregnant would be asked to do ornate porcupine quill work on jackets, mittens and other aboriginal designs of the day. It was thought to pass the curative nature of the quills to the child by the expectant mother.

**Beaver Castor** *Castor Canadensis*<sup>9</sup> was thought to have curative properties as early as 15<sup>th</sup> century as espoused by the German Medical physician Paracelcus<sup>10</sup> (1493-1541) although conventional medicine at the time frowned upon his method. He treated people with Castoreum on three conditions; headaches, fevers and hysteria. He stressed nature's healing powers as opposed to conventional medicine at the time. He believed that "like, cured, like."

All of nature existed as Pharmacopoeia and the alchemist-physician guided by observation and experience knew which of its parts related most closely to the various parts of the body.

After selecting the appropriate material, the doctor needed to separate its purities from the impure and possibly poisonous parts. The spiritual powers thus were then further ennobled and communicated as a medicine to a specific diseased part of the body (Goldhammer, Kurt. 1953)...Microcosm-macrocosm et al.<sup>11</sup>

It is not paradoxical to know that the Cree Indian people of western Canada also believe and work under this belief with the difference being that all true Recipes in medicine as used by traditional healers have not been put through trial and error but were divinely given from time immemorial to this day, and this being true of all compounds, are still embodied under the little known society; Metiyōwak or the Mediwin Medicine Teachers who are still used, recognized as the true holders of traditional medical knowledge as used today. In August 10, 1987 at the Sylvester Youngchief Sundance at Kehewin Alberta, Morris Lewis 88 years old spoke during the noon hour speech time “in this time, and of a time before the settlers came the Metiyaw were never affected or bothered by tribal conflicts as there were members from different tribes at any given time”, The Beaver castor has always been used by the indigenous people as an added compound to what is referred to as *Sacred Head Smudge*; and is used for headaches, fevers, aneurysms, and to find good balanced ways of thinking as well as treating the mental infirmities of mankind. *Castor Canadensis* was used as partner with the compounds mentioned in this article in treatment of this patient.

## **21. Conclusion of Case Study**

This healing ceremony was perhaps a much more documented case of traditional healing than any other healings that were performed by my family previously. That is not to mention the work we had completed with San Diego Health Centers where we “doctored” over 30 patients in a one month period. In that particular ceremony we completed the treatments on the 30 patients, of whom 24 are free of HIV/AIDS and some however had indeed tested negative (1996). People must remember there was no treatment at the time and also fear had impacted care-givers, simply because there was no other treatment available to patients. In that group were people of many ethnic backgrounds, with the help of a very prominent agency (NIH) our work was complete in August of 1997, later the next year the drug INDINAVIR© was introduced as a result and as a cocktail (calling for the need to use 3 protease inhibitors) for patients with the disease. In addition with our work I collaborated with a person (Craig Venter) who later developed a novel method of genotyping with the introduction of the PCR in mainstream research. This healing ritual however gave me the most gratifying form of giving something back to the world that believed in the work I

health centers and hospitals. This has been a primary concern for all hospitals as the safety of the patient is firstly a priority.

## **24. Types of mental illness known to the Aboriginal people**

### **1. Ê-pâwâmîhyakasoht / kônta e-yayisihna / e-pahpiyitah kêkiwâyi (*Schizophrenia*):**

means possessing supernatural insight and is quite common in the Aboriginal context and is a condition known as Êpawamiht (having spiritual insight) often where birthing was not accidental or the belief that people shared a common ancestor who was an unnatural figure in life, and often a hero in the community. They are often in dialogue and in conflict with the ancestor who already died. My task is to reconnect or sever this relationship with ceremony and traditional therapy and often I will see that it is too beneficial for the whole of the community to completely obliterate the condition. If not treated right away the spirit may leave or go elsewhere where it may be provided with a better home.

**2. Ên-pâyimâciyitwât (*Bi-polar*):** means living in perpetual anger, and an ability to show extreme kindness resulting from spells which are somehow acceptable to the Cree Beliefs, however at present time uncalled anger against another person is not acceptable but representative of an aggressive drive such as what is needed in many positions of political power. Erratic behaviours may be a result of irreconcilable deep-seeded thoughts of personal violence. Personal life's histories are examined in sharing circles (Pipe-ceremonies of old) as to; "why there is anger here" The whole community may suffer if someone has been unusually angry at anytime (an imbalance has affected the community) and is indeed not-beneficial. Usually reconciliation is reached by the smoking of the Sacred Pipe to address the dark cloud hanging over our heads. Recently I suggested this in a School Board Meeting and was met with mixed reactions such as he is not from this Reserve. Indeed Indian Affairs has impacted Cree Reserve life through the bureaucracy developed by the Indian Act (Indian Act, 1867, defines who is an Indian, certain rights and legal disabilities for all registered Indians) which was created at the time of John A McDonald. Many Aboriginal People think that the extent of their cultural base is within the confines of their own Reserved lands. There are 46 Reserves in the Province of Alberta, including approximately 60,000 "registered Indians."

### **3. Ya-hakosîyîtah (*Depression*):**

A person may think too much of one thing and may eventually get mentally ill as a result. Êpômêyiyêtah; A person with this disorder is thought to be linked with self-induced pity,

loneliness may stem from behaviours which are not acceptable to this time period. People with depression were thought to have a lowered sense of being and lowered self-esteem. *“Banishment faced those people who ignored advice and treatment, (the words of Velma Memnook, Merging Borders Conference UA. Nov 2007), therefore treatment was forced upon the person anyway.”* I would often see people brought into my parents home late at night for treatment for this disorder and in many cases the elders deemed it to be linked with Bad Love Medicine so we would exorcise the deity responsible for the bad medicine.

The treatments for these three types of mental illness are similar and are defined in the following slide. Very often the minute amounts of curative substances used by the healers will vary in agreement with how extreme the disorder is at the time.

**4. E-takokasoht** (*love medicine affects the mind by unnatural process of human desire to own another person's feelings*).

This is often today's understanding of losing a loved one, it literally means cementing one's love through bad medicine a common medicine used in the pre contact era but nevertheless still in existence today and provided for by medicine people through the protocol of one's purchase to ensure that a loved never leaves the person. There are in existence medicinal remedies to stop the medicine from really doing its impact on the targeted person. Upon knowing someone may be affected by 'love medicine' several indicators are obvious; unusual loneliness of the partner even when the partner is present, insomnia evident by the constant desire to be by his/her companion's presence, loving the partner more than his/her children, and hysteria upon the partner imminent departure and of leaving the partnership as is the usual final stage of the disease. Due to the nature of the medicine's impact the reality of separation is a part of the final resolution of the medicines efficacy and should not be underrated even in today's time in stating "we no longer believe in traditional medicine" in spite of the loss of medicinal knowledge in aboriginal communities today. this medicine has survived in spite of Christianity and Colonization. In all I have treated over 100 people affected by this medicine and mental health concern, and I do believe that many people out there today are still affected by the result of what we can call "*bad medicine.*"

It is usually treated by a mixture of four ingredients which separates the impacted person from the bad medicine and having returned it to the person who sought this out originally for personal use and its vile medicinal impacts he/she must beware of it coming back as reversing its impact is usually the only treatment for this. The giver of the medicine is usually impacted by the reversal of the symptoms and therefore has to live with the mental ill aspects of the initial desire to use love medicine so that the partner would surely never leave his/her

partner. It is considered the breaking of Creators Natural Laws; the unnatural love which has destroyed real and genuine compassion as shown by person's who readily give of their love.

5. **E-Yociyîhnêt** (Obsessive/Compulsive/Impulsive Behaviours)

6. **E-yakosiyivetah** (Wind Sickness)

When one thinks of their illness too much very often they will become impaired by the thinking alone. allopathic medicine calls then hypochondriacs.

7. **E-mocowayat** (Stupidity Behaviours)

8. **E-kepacayitiht** (Moronic Behaviour)

## **25. Treatment modality of each type of mental illness**

Sweatlodge Ceremonies are inclusive of spiritual cleansing, emotional healing and the purification of unhealthy brain cells which have had to evolve when that particular type of mental disorder took over the person's life and place. Most noted changes are the unusual amount of brain cells used by an ordinary person and the small percentage of the brain used in daily life. Our elders have stated it is in this component that the greatest achievements can be made in the treatment of the human person. We regret the mistakes we've made with our minds, we regret the past issues we've perpetuated through our own frailties as people, but however we have to live with those mistakes knowing they will impact us in the future. The Sweatlodge is indeed the place where mistakes can be fixed without sudden impact such as introducing mind altering medication to the person deemed mentally unstable.

26. **Appendix:** Forthcoming from Elders, Patients, Peers, Family.

27. **Bibliography:** forthcoming

