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Two Pathways to Health:
Exploring Potential Relationships Between Traditional Mi'kmaw Medicine
and Western Biomedicine

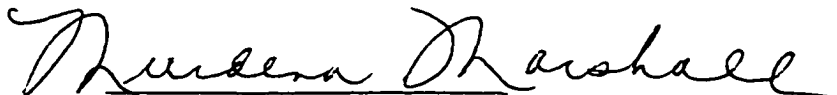
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A thesis submitted in partial fulfillment of the requirements for a Master of Arts degree
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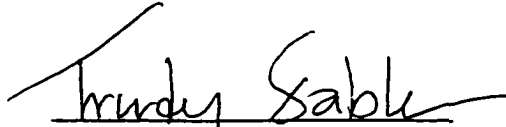
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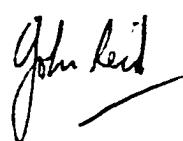
Thesis Committee Signatures


Colin Howell


Murdena Marshall


Harold McGee


Trudy Sable

 (Co-ordinator)



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Abstract

“Two Pathways to Health” explores potential relations between Mi’kmaw traditional medicine and Western biomedicine. Both medical systems are presented as cultural expressions. This thesis is built on the idea that health and health care are fluid concepts; they change across time and across cultures. It is unrealistic, therefore, to expect one health care system to work for everyone, all the time. There is more than one pathway to health.

Although the cultural frameworks guiding Western biomedicine and Mi’kmaw traditional medicine are often different, elements of both healing systems have been combined in the past. This thesis asks where relations between biomedicine and traditional medicine may lead in the future.

This thesis brings together a wide variety of research and analysis to form an insightful dissertation on medicine and culture. Oral interviews, primary sources and medical theory are woven together. The result is a valuable addition to Atlantic Canadian scholarship.

Acknowledgments

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Introduction

Introduction

This thesis is about health. It is about medicine, and it is about health care. It is built on the foundation that health and health care are culturally constructed.

Perceptions of illness and healing reflect a given culture's cosmological, spiritual and ethical assumptions about reality. Medicine, therefore, cannot be separated from the culture in which it operates.

To explore this idea, I have looked at two separate methods of health care: traditional Mi'kmaw¹ health care and orthodox biomedicine. I have tried to show that while both biomedicine and traditional Mi'kmaw health care hold the betterment of the patient's health as the ultimate goal, the cultural frameworks guiding the two medical systems are often different.

The inevitable question arising from this discussion is: If medicine and culture are so intimately related, can one health care system be truly effective for everyone? I believe it cannot; there is more than one way to heal. Biomedicine is one method of healing. Mi'kmaw traditional medicine is another. Both are valid medical systems. And depending on the context, one system may be more effective than the other at a given time.

The final goal of this thesis is to explore potential collaboration between traditional Mi'kmaw medicine and Western biomedicine. Today individuals involved in both traditional and orthodox health care have begun to discuss the possibility of

¹ **Mi'kmaq** may be roughly translated as "The Family." **Mi'kmaw** plays two grammatical roles. It is the singular of **Mi'kmaq** and it is an adjective in circumstances where it precedes a noun (Mi'kmaw Resource Guide, 1997).

different healing systems acknowledging each other, learning from each other and even working together. I hope this thesis adds to the conversation.

Chapter one is essentially a literature review. It is included to provide the reader with an overview of Atlantic Canadian medical historiography, and to situate Mi'kmaw medicine within that historiography. In this chapter I show that although Canadian medical historiography now examines broader relationships between medicine and society, the focus remains largely on orthodox health care. Alternative health care options in history are passed over, and traditional aboriginal health care is virtually ignored.

Within Mi'kmaw communities, the history and use of medicines have traditionally been passed on by word of mouth. This is congruent with an oral tradition, and it has also served as a form of protection when aboriginal medical practices were suppressed and forced underground by churches, provincial and federal governments. In chapter one I briefly discuss Mi'kmaw oral histories in the context of Atlantic Canadian historiography.

Chapter two introduces the concept that health, sickness and healing are culturally constructed. Linguistic and historical examples are used to show that perceptions of health and health care change across cultures and time. This chapter then examines orthodox biomedicine as an expression of Western culture. Orthodox medicine is often perceived to be somehow above culture. It claims to be objective, rational and scientific. It can transcend cultures because it is not built on one. In

chapter two I show that this is not the case. Biomedicine is saturated by values characteristic of a Western industrial-capitalist society.

I begin chapter two by discussing the philosophic and cultural foundations of orthodox medicine. I explore the roots of the mind-body dualisms pervading biomedicine. I then demonstrate biomedicine to be allopathic, mechanistic, reductionist and morally subjective.

Chapter three introduces Mi'kmaq traditional health care from an historical perspective. In this chapter I focus on the effects of European contact on traditional Mi'kmaq health care. Specifically, I discuss how the introduction of foreign diseases, lifestyle changes and massive depopulation affected traditional health care practices.

Chapter four discusses the cultural framework of traditional Mi'kmaq health care from a contemporary perspective. This chapter is built on personal interviews with individuals involved in, or knowledgeable about, traditional health care. While there are many similarities between what separate individuals have said, it is important to recognize that everyone's opinions are their own. This chapter is included to show that behind a different and functional system of health care, often lie different concepts of medicine and healing.

The final chapter in this thesis explores the possibilities of cooperation and collaboration between biomedicine and traditional Mi'kmaq health care. This chapter discusses the positive and negative aspects of collaboration. I outline potential barriers to collaboration, and I discuss options that may make an association

between the two medical systems possible. Ultimately, however, the specifics of any new relationships between biomedicine and traditional Mi'kmaw health care will be worked out by those involved in their practice.

**Chapter One: Situating Mi'kmaw Traditional Medicine in
Atlantic Canadian Historiography**

Introduction

In 1975 a doctor named Spencer Johnson published *The Value of Believing in Yourself: The Story of Louis Pasteur*. It is a children's book, but the theme of the narration captures the essence of early medical historiography in Canada and North America.

"I have invented a Vaccine," Dr. Pasteur tells the parents of a boy sick with rabies. "In my Vaccine are Magical Soldiers with bright eyes that can see in the dark. When they see the invisible enemy inside of Joey, my Magical Soldiers, who are very strong, will kill that enemy." The little boy is understandably distraught. But Dr. Pasteur asks him to be brave, and Pasteur's Magical Soldiers go to work. The "Terrible Germs" are the enemy, and the boy's body is a battlefield. After the war is over, Joey jumps out of bed and dances around in a circle with his parents and Dr. Louis Pasteur, "who felt as much like dancing as the rest of them."

Until recently, medical historiography in Canada deviated little from Johnson's tale. It was the story of great men, progress and the ultimate triumph of science. The patient, as one notable example, is passive in the narration. He is asked to be brave and to trust his doctor.

Things have changed, and medical historians now look at how medicine and health relate to questions of class, power, gender and social development. This chapter will explore these developments in the medical historiography of Atlantic Canada. Additional discussion will concentrate on the place of Mi'kmaw medicine and health care in Atlantic Canadian historiography. Although Canadian medical

historiography now examines broader relationships between medicine and society, the focus remains almost solely on orthodox health care. Alternative health care options in history are passed over, and aboriginal health care is virtually absent from the historical record.

Situating Mi'kmaw Medicine in the Historiography

The Value of Believing in Yourself was not written without strong precedent. Indeed, one of the most popular medical histories ever written reads like a war epic. Published in 1926, *The Microbe Hunters* describes the exploits of a group of nineteenth-century scientists, including Louis Pasteur and Robert Kock, hunting down disease-causing microbes and saving humanity with the help of a secret weapon: “the magic bullet” or the antibiotic. *The Microbe Hunters* has sold millions of copies, and historian Andrew Nikiforuk says new doctors still read it like a boot camp manual.¹

Early medical history in Canada stems from the same tradition. For the most part, it was written by amateur historians, often doctors themselves. They wrote the story of individual practitioners and traced the growth of the medical profession through changes in treatment, the establishment of medical institutions and the acceptance of physicians as professionals.² It was a history of progress.

¹ Andrew Nikiforuk, *The fourth horseman: a short history of epidemics, plagues, famines and other scourges* (New York: M. Evans and Company, 1991), p. 2.

² Wendy Mitchinson, “Canadian Medical History: Diagnosis and Prognosis,” *Acadiensis*, Autumn 1982, p. 125.

Until the 1960s, this was the case with most of the historical writing in Canada, which concentrated on political, economic and national themes. The emergence of social history challenged this perspective. However, the portrayal of medical history in Canada as a story of progress had strong foundations. Most of the people writing medical history were doctors who had devoted their lives to the profession and had a vested interest in depicting it favourably.³ Historians, for their part, did not challenge this congratulatory version of history. Historians might have viewed medicine as a specialized field, best left to those trained in it.⁴ The specialized language of medicine might also have been an obstacle, along with an unfamiliarity with historical sources available.⁵ But the tendency to view the history of medicine as a triumph of science has deeper philosophical roots.

Early writers of medical history carried medicine's classical heritage with them. In this tradition a person's health was hinged on two factors: one, leading a rational life; and two, the role of the physician as a healer of the sick.⁶ This second approach had been dominant since the seventeenth century. It derives support from Rene Descartes's concept of the human body as a machine which might be understood and manipulated mechanically, as well as by the success of the physical sciences in

³ Mitchinson, "Canadian Medical History," p. 125.

⁴ Wendy Mitchinson and Janice Dickens McGinnis, eds., *Essays in the History of Canadian Medicine* (Toronto: McClelland and Stuart, 1988), p. 8.

⁵ Mitchinson and McGinnis, p. 8.

⁶ *Ibid.*

controlling inanimate matter.⁷ According to Wendy Mitchinson and Janice McGinnis, the philosophical framework of modern medicine spilled over into the historiography:

Such a heritage led to an “engineering approach” to the body. The body was depicted as being invaded from without; it was the physician’s responsibility to fight the invasion and the patient’s to allow the physician to do so. Not surprisingly, the medical historiography influenced by this tradition structured itself around the role of the individual practitioner. It also focused on the internal developments of medicine, emphasized the way in which medical discoveries were made, and, in general, stressed the scientific aspects of medicine. . . . The historiography approved the direction medicine had taken.⁸

Any story of progress must begin with humble origins, and early medical histories in Canada stay true to this tradition. A favourite point of departure for these histories is the story of how Jacques Cartier’s crew, who were dying of scurvy during the winter of 1535-36, was saved by members of the local aboriginal population who made tea from what was likely hemlock or white pine. From this point, the story of medicine in Canada is depicted as a continuous march to the present. Titles such as *From Medicine Man to Medical Man* and *From Shaman to Modern Medicine: a Century of Healing Arts in British Columbia*, published in 1934 and 1972 respectively, epitomize a common theme.⁹

⁷ *Ibid.*

⁸ *Ibid.*

⁹ It should be noted that *From Shaman to Modern Medicine* gives credit to early aboriginal practitioners.

A notable example celebrating the heroic tradition of Canadian medicine is Donald Jack's *Rogues, Rebels, And Geniuses: The Story of Canadian Medicine*. Jack sets the tone for his study in the first sentence: "This is the story of Canada's contribution to the glory of the independent spirit, and to the progress of medicine, as told through the lives of its passionate, crude, roistering, neurotic, brilliant doctors."¹⁰ Jack focuses on the lives of individual practitioners. Not surprisingly, he writes about famous physicians such as Norman Bethune and Frederick Banting. However, the strength of the book is in Jack's effort to shine light on lesser-known practitioners such as Gustave Gingras, who worked with paraplegics after the Second World War. In the final analysis, however, Jack's study is really a love song. He introduces the reader to individuals who made a difference in Canadian health care. But for an exploration of broader themes connecting medicine to society, the reader has to look elsewhere.

The first significant volume examining these relationships in Canada is *Medicine in Canadian Society: Historical Perspectives*, published in 1981 and edited by S. E. D. Shortt. This collection scratches the surface of a number of themes which are expanded upon in subsequent works.

Medical professionalization emerges as an important topic in Shortt's collection. Early historians depicted professionalization as a process of public acceptance built on foundations of growing scientific expertise. Two articles in *Medicine in Canadian Society* call this perspective into question. Charles Roland's

¹⁰ Mitchinson, "Canadian Medical History: Diagnosis and Prognosis," p. 127.

“The Early Years of Antiseptic Surgery in Canada” describes the resistance of the Canadian medical establishment to Joseph Lister’s theory of antiseptics.¹¹ Thomas Brown’s “Dr. Ernest Jones, Psycho-analysis and the Canadian medical profession, 1908-1913” explores similar resistance on the part of the Canadian medical profession to Freudian psychoanalysis.¹² Both articles steer the reader away from an image of the medical profession as a unified body during times of change. They also suggest that in the process of professionalization and securing public acceptance, scientific reasoning might have influenced physicians less than ego, self-interest and inertia.¹³

Medicine in Canadian Society is also one of the first volumes to confront gender’s relation to medical history. Veronica Strong-Boag’s article, “Canada’s Women Doctors: Feminism Constrained,” demonstrates how social perceptions of idealized womanhood, in which women were both elevated and seen as being “uniquely susceptible to a multitude of emotional and nervous disorders,” frustrated their entry into the medical profession. In his article titled “Birth Control and Abortion in Canada, 1870-1920,” Angus McLaren explores the hostility of the medical profession toward birth control. The reason given was that it interfered with

¹¹ Charles Roland, “The Early Years of Antiseptic Surgery in Canada,” in *Medicine in Canadian Society: historical perspectives*, ed. S.E.D. Shortt (Montreal: McGill-Queen’s University Press, 1981), p. 237.

¹² Thomas Brown, “Dr. Ernest Jones, Psycho-analysis and the Canadian Medical Profession, 1908-1913” in *Medicine in Canadian Society: historical perspectives*, ed. S.E.D. Shortt (Montreal: McGill-Queen’s University Press, 1981), pp. 334-353.

¹³ Mitchinson, “Canadian Medical History: Diagnosis and Prognosis,” p. 131.

the natural process of conception. McLaren's article illustrates the medical profession expanding its authority into areas of traditionally controlled by females, such as birth and birth control.

Shortt's book is significant because it is path breaking. Although all but one of the essays printed in the book had been published previously, *Medicine in Canadian Society* brings together a collection of scholarship in one volume, forcing the recognition and enhancing the accessibility of new perspectives on Canadian medical history. Shortt, however, is fully aware of his compilation's shortcomings. In the book's introduction, he calls for further study into the relationship between organized medicine and politics, as well as into the patient's perspective, especially concerning hospitals. Shortt also notes the lack of scholarship in the field of aboriginal and unorthodox medicine.¹⁴

The professionalization of medicine is an area in Canadian medical historiography requiring further discussion. As stated, traditionally it has been depicted as the result of gradual public acceptance and the inevitable triumph of science. From this perspective, resistance to the growing authority of doctors is seen as a barrier to progress and to the greater public good. Donald Jack, for example, laments the slowness with which nineteenth-century Canadians accepted Listerism and cowpox vaccinations. He asks the reader to sympathize with the "ponderous pace" of these Canadians in responding to new ideas.¹⁵ In truth, however, while

¹⁴ S.E.D. Shortt, ed., *Medicine in Canadian Society: historical perspectives* (Montreal: McGill-Queen's University Press, 1981), pp. 7-12.

¹⁵ Mitchinson, "Canadian Medical History: Diagnosis and Prognosis," p. 128.

Listerism saved many, there were larger forces at work in the drive to professionalize than simply enhancing the public good, and scepticism toward physicians was often justified.

We should start by putting the rise of professionals, or expert authority, in the historical context of capitalist North America. Until the mid-nineteenth century, the 'professional' did not exist in the modern sense of the word. Certainly it was rarely possible to make a living out of selling advice and specialized services, rather than tangible goods.¹⁶ With industrialization came rising levels of population density and per-capita income, which then made it possible for substantial numbers of people to sell their expert authority.¹⁷ As work became increasingly fragmented, individuals were able to claim specific expertise.

Professionals, or experts, constituted a new group of people within the social order. When viewed through theoretical lenses, liberal scholars tend to identify experts as people who have acquired power and prestige because they possess valuable knowledge and skills. Marxists, on the other hand, identify experts as those who have acquired valuable knowledge and skills because they are favourably situated, socially and economically, in society-wide systems of power.¹⁸ Historical

¹⁶ Thomas Haskell, ed., *The Authority of Experts: Studies in History and Theory* (Bloomington: Indiana University Press, 1984), p. xii.

¹⁷ Haskell, *The Authority of Experts*, p. xii.

¹⁸ Haskell, *The Authority of Experts*, p. xx.

and contemporary debates are not confined within these perspectives; however, they are useful departure points when discussing the professionalization of medicine.

Stemming from a liberal tradition are those who interpret professions and the professionalization process as a challenge to the old capitalist class structure, which was based on control of capital. William Rothstein and Thomas Haskell believe professionalization replaced “false and pretentious claims to authority” with a plausibility based on investigation and scientific expertise.¹⁹ Harold Perkins suggests that this “human capital” may extend further down the social structure than traditional economic capital, thereby transforming society from within, instead of from the top down.²⁰

This perspective is countered by Daniel Bell. Bell argues that in a “post-industrial” age, human capital, or expertise, will result in the same power struggles as traditional forms of capital. “Just as strife between capitalists and workers was the hallmark of industrial society, Bell predicts that tension between experts and laymen will be the characteristic form of conflict in the post-industrial era.”²¹

Medical professionalization in Atlantic Canada saw physicians change from a position of limited public acceptance in the first half of the nineteenth century, to one of expanded authority and acceptance in the later half.²² This topic is most

¹⁹ Colin Howell, “Medical Professionalization and the Social Transformation of the Maritimes, 1850-1950,” *Journal of Canadian Studies*, Spring 1992, p. 5.

²⁰ *Ibid.*, p. 6.

²¹ Haskell, *The Authority of Experts*, p. xii-xiii.

thoroughly covered by Colin Howell. Broadly speaking, Howell is influenced by a Marxist perspective. He sees medical professionalization as part of a larger process of class formation and the buttressing of bourgeois social and cultural hegemony. Howell believes medical professionalization has played a key role in rehabilitating and redefining capitalism over the past century. Professionalization, Howell argues, has not supplanted class relationships within modern society. It has simply redefined the form those relationships take.²³

Medical professionalization in the Maritimes was a complex and layered process, involving issues of ethnicity, class and gender. In Halifax, Scottish ethnicity played an instrumental role. In his article, "Scottish Influences in Nineteenth Century Nova Scotian Medicine: A Study of Professional, Class and Ethnic Identity," Howell demonstrates that nineteenth-century Nova Scotian doctors initially emphasized their Scottish ethnicity and the "gentlemanly" nature of their profession. They did so in order to forge links with the city's Scottish elite and to secure public acceptance. As Nova Scotia industrialized, Scottish ethnicity and belonging to a profession of "gentlemen" carried less weight with the public, who saw the influences of science

²² Colin D. Howell, "Scottish Influences in Nineteenth Century Nova Scotian Medicine: A Study of Professional, Class and Ethnic Identity," Unpublished, 1997, p. 1.

²³ See, for example: Colin D. Howell, "Medical Professionalization and the Social Transformation of the Maritimes, 1850-1950" *Journal of Canadian Studies*, Spring, 1992, pp. 5-20; Colin D. Howell, "Scottish Influences in Nineteenth Century Nova Scotian Medicine: A Study of Professional, Class and Ethnic Identity," Unpublished, 1997; and Colin D. Howell, "Back to the Bedside: Recent Work on the History of Medicine in Canada," *Acadiensis*, Spring, 1988, pp. 185-194.

reflected in the industrialization of their society. Medical doctors were then more likely to emphasize their expertise and the “scientific” authority of their profession.

Public deference to “scientific expertise” opened the door for medical doctors to expand their authority. In “Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes,” Howell describes how concentrating authority in the hands of “experts” permeated the reform of politics, municipal government, education, conservation, criminal justice and public health.²⁴ The end result was that medical doctors were able to extend their authority to matters ranging from immigration to criminal sentencing. Howell argues that the expanded authority of physicians, combined with closer ties between medicine and the state, played a key role in reforming capitalism. “In the long run,” Howell states, “professionalization facilitated the transformation of capitalism from its personal form to its modern paternalistic form, where ‘experts’ provide professional services to every segment of society.”²⁵

Professionalization, however, was not a smooth process for medical doctors. Orthodox practitioners faced challenges to their authority from alternative practitioners and waning public confidence. The 1860s and 1870s, in particular, were times of therapeutic confusion. The public did not trust traditional practices of bleeding, blistering and purging. Alternative practitioners abounded, advertising in

²⁴ Colin D. Howell, “Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes,” *Acadiensis*, Autumn 1981, p. 3.

²⁵ *Ibid*, p. 4.

local newspapers and threatening the authority of orthodox physicians. For their part, medical doctors were unable to establish a workable system of therapeutics that separated them from their competition. Instead, according to Howell, they “sought refuge in institution-building, creating medical societies, hospitals, and medical schools which ... symbolized professional respectability and provided a setting in which new therapeutic consensus might be fashioned.”²⁶ Institutionalizing evidence of authority was only one strategy during this time. Orthodox practitioners also made efforts to discredit their competitors, while at the same time absorbing their competitor’s techniques under the umbrella of science.²⁷

Toward the end of the of the nineteenth century, the medical profession rose above its competitors in the eyes of the public and secured authority in the medical marketplace. The ultimate factor was arguably the success of laboratory research in demonstrating the virtue of scientific expertise. However, this final step would not have been possible without the work medical doctors undertook to secure their profession’s authority when threatened.

Establishing medical institutions and associations, emphasizing credentials, and expanding authority into ostensibly non-medical realms, all played a roll in stabilizing and securing orthodox medicine’s authority in difficult times. Recent challenges to the medical profession in the form of fading public acceptance and the

²⁶ Colin D. Howell, “Orthodox Medicine and the Health Reform Movement in the Maritimes, 1850-1885,” *Acadiensis*, Spring 1989, p. 58.

²⁷ *Ibid.*, p. 71.

growth in popularity of alternative medicine indicate this secured authority may be temporary, and that the orthodox profession may once again be forced to adopt survival strategies.

A few cautionary notes must be sounded when discussing the process of medical professionalization in the Maritimes. It is tempting to view professionalization as one interest group's attempt to control the medical marketplace. From that perspective, the development of licensing regulations, elevated credentials, the organization of medical associations and efforts to expand authority are simply self-serving strategies of market control.²⁸ However, as Howell argues, such a reductionist perspective fails to consider the role medical professionalization played in the larger process of capitalist rehabilitation.

Reducing medical professionalization to an attempt at market control is also flawed in that it implies monolithic social control by the medical profession. It is not possible to link the results of professionalization with the motives of physicians. That professionalization resulted in increased hegemony and the elimination of price competition does not indicate a premeditated conspiracy. Such a perspective ignores division within the medical profession,²⁹ the faith of the profession in science and the profession's shared assumptions with those it treated.³⁰

²⁸ Howell, "Scottish Influence in Nineteenth Century Nova Scotian Medicine," pp. 1-2.

²⁹ See, for example Kenneth Pryke, "Poor Relief and Health Care in Halifax, 1827-1849," in *Essays in the History of Canadian Medicine*, eds. Wendy Mitchinson and Janice McGinnis (Toronto: McClelland and Stuart, 1988), 39-61.

It is also important to recognize that doctors would never have been able to obtain the monopoly they did without the agency of patients. In *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, Wendy Mitchinson stresses the voice women had in their own medical treatment:

But in their own time they were anything but silent. As consumers of medicine they were instrumental in the regular doctors' gaining the kind of monopoly they did. Women raised money for the building of hospitals and their expansion and sat on committees that oversaw the day-to-day running of them. They were the ones who encouraged the building of female wards. They took their children to doctors and they went to doctors themselves. They were often the ones who insisted on the use of forceps and anaesthesia.³¹

Similar sentiments are echoed by Paul Starr. In *The Social Transformation of American Medicine*, Starr criticizes advocates of the monopolization thesis for exaggerating the extent to which the profession conspired to monopolize knowledge and skill. Instead he stresses the "decline of confidence in the ability of laymen to deal with their physical and personal problems."³² Howell suggests Starr underestimates the role doctors played in creating this crisis of confidence.³³

³⁰ Colin D. Howell, "Back to the Bedside: Recent Work on the History of Medicine in Canada," *Acadiensis*, Spring 1988, p. 188.

³¹ Wendy Mitchinson, *The Nature of Their Bodies: Woman and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991), p. 362.

³² Howell, "Back to the Bedside: Recent Work on the History of Medicine in Canada," p. 189.

³³ *Ibid.*

Nevertheless, Starr's arguments stress the awareness and agency of the patient, and they caution the reader against simplifying the past.

Moving away from the debate over medical professionalization, a number of other themes have recently emerged in Canadian medical historiography. In 1981 Shortt noted the need for more scholarship examining the relationship between the medical profession and the state. Three significant volumes have since been published dealing with this subject. The first is Ronald Hamowy's *Canadian Medicine: A Study in Restricted Entry*³⁴. Hamowy argues that the primary goal of professionalization and licensing was the elimination of price competition with other medical services. We should note, however, that *Canadian Medicine* was published by the Fraser Institute, which has as its self-stated objective: "the redirection of public attention to the role of competitive markets in providing for the well-being of Canadians." Hamowy makes a forceful case, but his study is undermined by selective research and analysis resulting from the policy-motivated nature of the book.

David Naylor's *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* examines relations between the medical profession and the state through the development of a compulsory health insurance program in Canada. Naylor finds consistent support within the medical profession for the provision of services on a fee for service basis. He states the ideology of medical professionalism assumed the interests of doctors and the broader public were

³⁴ Hamowy, Ronald. *Canadian Medicine: A Study in Restricted Entry*. Vancouver: Fraser Institute, 1984.

equivalent, particularly regarding clinical and surgical autonomy, and he questions whether this was the case. Naylor concludes that the medical profession's commitment to autonomy was motivated by professional self-interest more than a desire for beneficial public policy.³⁵

Naylor has also edited *Canadian Health Care and the State: A Century of Evolution*. This collection provides historical background to current debates about the connection between medicine and the public sector. Of note is a paper by Colin Howell entitled "Medical Science and Social Criticism: Alexander Peter Reid and the Ideological Origins of the Welfare State in Canada." Howell argues that Reid's belief that a new social order could be achieved through expert management lent credibility to "greater state involvement in matters involving the nation's mental moral, and physical well-being."³⁶ The end result, according to Howell, was not a reformed utopia, but a new form of expert management characteristic of welfare-state capitalism in the twentieth century.³⁷

Also noteworthy in Naylor's collection are essays by Jay Cassel, and by Robin Badgley and Samuel Wolfe. Cassel's paper discusses government policy on sexually

³⁵ Howell, "Back to the Bedside: Recent Work on the History of Medicine in Canada," p. 190.

³⁶ Colin Howell, "Medical Science and Social Criticism: Alexander Peter Reid and the Ideological Origins of the Welfare State in Canada," in *Canadian Health Care and the State: a century of evolution*, ed. David C. Taylor (Montreal: McGill-Queen's University Press, 1986), p. 17.

³⁷ *Ibid.*, pp. 32-33.

transmitted diseases in the twentieth century.³⁸ Cassel shows that the “magic bullet” approach has continuously dominated government policy on STDs. The vast majority of money has always been directed toward medical measures, as opposed to research, public education programs, contact training and individual-patient counseling services.³⁹ A similar trend is revealed in Badgley and Wolfe’s paper, “Equity and Health Care.” Badgley and Wolfe show that despite overwhelming evidence indicating links between poverty and ill health, even within a system which supposedly guarantees equal access to medical services, policy makers have preferred to treat diseases of poverty rather than poverty itself.⁴⁰

This orientation reflects a larger philosophy toward health care in Canada. We live in a society that prefers to confront the symptoms of unhealthy social conditions, rather than deal with the social conditions that lead to sickness in the first place. We would rather deal with the effects of a problem as opposed to the reasons for it. We prefer to spend money on heart-lung machines instead of child nutrition. We find it easier to treat the symptom than the cause.⁴¹

³⁸ Cassel discusses venereal disease in Canada in more detail in a 1987 publication entitled *The Secret Plague: Venereal Disease in Canada 1838-1939* (Toronto: University of Toronto Press, 1987).

³⁹ Naylor, *Canadian Health Care and the State*, p. 10.

⁴⁰ *Ibid*, p. 11.

⁴¹ This topic is developed in more detail in chapter two.

Gender and sexuality are emerging as frequently-studied topics in Canadian medical historiography. However, in earlier studies gender issues were rarely mentioned. Donald Jack, for example, virtually ignores female practitioners in his study of the “rogues, rebels and geniuses” in Canadian medical history. Instead, he uses women as a yard stick to measure medical progress, noting that today “through drugs and hygiene, contraceptives and endocrinology, surgery and sexual enlightenment, diet and genetics, vitamins and exercise . . . medicine can help to keep a woman looking and feeling young and fit well past middle age.”⁴² What Jack ignores, as Mitchinson rightly points out, is that valium is prescribed inordinately to women, that there has been an increase in the frequency of cesarean sections and that the medical profession still opposes licensing midwives.⁴³

Perhaps the best recently published book dealing with gender in Canadian medical history is *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* by Wendy Mitchinson. The influence social perceptions of womanhood had on medicine, as well as the expansion of medical authority into women’s lives, are common themes in this study. Mitchinson shows how the medical profession gave biological rationale and the weight of “scientific fact” to publicly established perceptions of women. The female body was seen by doctors to be deviant compared to the male norm. From this perspective, it was not a big step to link these physical deviations to sickness. For example, a woman suffering from “mania” was admitted

⁴² Mitchinson, “Canadian Medical History: Diagnosis and Prognosis,” p. 128.

⁴³ *Ibid.*, p. 128.

to a Toronto asylum in 1864; the cause cited by doctors was lactation.⁴⁴ Social deviation was also linked to disease. Women who deviated from prescribed social roles -- by riding a bike, for example -- were seen as responsible for their own illness.⁴⁵

Mitchinson's book is not a story of victimization. She attempts to demonstrate the agency women had in controlling their own lives and their own health. However, Mitchinson acknowledges that she is limited by what is available in the historical record. When looking at medical history, women are visible when they bring themselves to doctors. What we don't see are those who treated themselves or went to alternative practitioners. The historical record ignores that women as mothers, family members, nurses and midwives were consumers and practitioners of medicine as well.⁴⁶ There is a deeper history of women's health care below the surface.

The hidden history of women's health care alludes to what is still the biggest shortcoming in Canadian medical historiography: It remains the story of the winners. Almost every study of medical history in Canada revolves around orthodox practitioners. The focus may shift elsewhere -- to the patient, to women, to the state -- but physicians remain central to any discussion. This leaves a fundamental question unanswered. What is the story of those who operated outside of mainstream health care? Where do midwives and herbalists fit into Canadian medical historiography?

⁴⁴ Mitchinson, *The Nature of Their Bodies*, from the inside cover.

⁴⁵ *Ibid.*, p. 9.

⁴⁶ *Ibid.*, p. 10.

What of acupuncturists, faith healers and practitioners of home medicine?⁴⁷ And, specific to this discussion, what is the historiography of aboriginal medicine in Atlantic Canada?

There is not much in the current medical historiography to answer this question. However, the literature is expanding. John K. Crellin's 1994 publication, *Home Medicine: The Newfoundland Experience*, deals with the history of home medicine in Newfoundland. Crellin also co-edited *Alternative Health Care in Canada: nineteenth and twentieth-century perspectives*, which was published in 1997. Both books break new ground in Canadian medical historiography.

Historical discussions of aboriginal medicine typically begin and end with the story of a local aboriginal population saving Jacques Cartier's crew from scurvy. Occasionally, a more detailed discussion is included as part of an introductory chapter to a history on Canadian medicine. Brenton Stewart's *Medicine in New Brunswick*, published in 1974, is typical of this. In a 400 page volume, he devotes seven poorly-researched pages to "Indian Medicine and Surgery." Other works are more insightful. Eric Stone's *The Romance of Medicine in Canada* demonstrates that the health care systems of aboriginal peoples were sufficient to deal with indigenous ailments and sicknesses. This would change with the arrival of European diseases. Virgil Vogel's *American Indian Medicine*, published in 1970, is one of the more

⁴⁷ John K. Crellin, *Home Medicine: The Newfoundland Experience* (Montreal and Kingston: McGill-Queen's University Press, 1994). is the only scholarly publication I am aware of which deals with the history of home medicine in an Atlantic Canadian context. It is a unique and insightful addition to Canadian medical historiography.

comprehensive historical works published on aboriginal health care. Vogel focuses on a wide range of medicines and healing practices, as opposed to cultural components of health care. He stresses aboriginal contributions to contemporary Western medicine.

Most written information on the history of Mi'kmaw health care specifically is derived from *The Jesuit Relations* and the writings of Pierre Biard, Nicolas Denys, the Sieur de Dierville, Marc Lescarbot and Chrestien LeClerq. These authors were generally more interested in converting the Mi'kmaq than in understanding their healing practices. Their writing reveals a complex and functional system of health care among the Mi'kmaq; however, little effort is made to understand its details. In the past century, a number of authors have discussed Mi'kmaw medicine from an anthropological slant. Publications include Stansbury Hagar's "Micmac Magic and Medicine" (*Journal of American Folklore*, 1896) and Wilson Wallis's "Medicines Used by the Micmac Indians" (*American Anthropologist* 1922).

More recently, Laurie Lacey has catalogued and discussed medicinal herbs and plants in his book, *Micmac Indian Medicine: A Traditional Way of Health*, published in 1977. Frank Chandler, a pharmacy professor at Dalhousie University, has also researched and catalogued Mi'kmaw medicines. In 1991, Peter Twohig completed a master's thesis on the relationship between the Mi'kmaq, the medical profession and the state.⁴⁸ "Health and the Health Care Delivery System: The Micmac in Nova

⁴⁸ Peter Twohig, "Health and the Health Care Delivery System: The Micmac of Nova Scotia," MA thesis (Saint Mary's University: 1991).

Scotia” is an insightful and thorough work; however, the focus remains on health care provided by the state and by orthodox practitioners. Mi’kmaq who sought and provided alternative forms of health care are not discussed in detail. Finally, Trudy Sable’s 1996 master’s thesis, “Another Look in the Mirror: Research into the Foundations for Developing an Alternative Science Curriculum for Mi’kmaw Children,” discusses Mi’kmaw dance as a form of healing.

Within Mi’kmaw communities, the history and uses of medicines have traditionally been passed on by word of mouth. This is congruent with an oral tradition. It has also served as a form of protection. In the history of Atlantic Canada, traditional aboriginal health care has been suppressed and forced underground. Mi’kmaw medicine, like any health care system, is intimately tied to the culture and world view of the society in which it operates. Consequently, cultural assimilation policies employed by the Canadian government, such as the Indian Act, residential schools and centralization, directly and indirectly targeted Mi’kmaw traditional health care practices.⁴⁹

The medical profession in Atlantic Canada has also worked hard to discredit and suppress aboriginal practitioners and preserve their own hegemony. Two examples are revealing.

The first concerns Peter Paul Toney Babey, a Mi’kmaw man, describing himself as a “Physician, Chemist and Alchemist” who “from his youth has turned his

⁴⁹ Brian Titley’s *A Narrow Vision: Duncan Campbell Scott and the Administration of Indian Affairs in Canada* (Vancouver: University of British Columbia Press, 1986) provides a good exploration of many of these policies and their effects.

attention to the nature of plants, herbs and the various roots of the Country possessing medicinal qualities.” Babey compared his medicines favourably to those of orthodox practitioners, which he described as “minerals and noxious Medicines calculated to destroy life.”⁵⁰ In 1852 Babey petitioned the provincial government for compensation such as was given to orthodox doctors working on reserves. His request was greeted with derision:

Hon. Provincial Secretary would move that the Indian be standing physician to the house. (Laughter.)

Mr. Marshal: That might do very well, provided we know what party he belongs to.

Hon. Provincial Secretary: As he comes under the auspices of the learned member from Kings, our side will have to be careful. (Laughter.)⁵¹

It is worth noting that this dismissive laughter hid the reality of the state of medical orthodoxy, which lacked therapeutic direction, and was shaken by internal division and waning public confidence.

A further example illustrating the hostile reaction of the orthodox profession to traditional aboriginal health care is evident in the case of Frederick William Morris. Morris had been a vice president of the Halifax Medical Society and was the resident physician at the Halifax Visiting Dispensary. In 1861 Morris began publicly

⁵⁰ Twohig, p. 83. Twohig notes Babey preferred to call his knowledge of medicines “scientific pursuits,” describing his skills in the language of the emerging medical elite.

⁵¹ *Ibid.*, p. 84.

advocating the use of a Mi'kmaq medicine for treating smallpox. In the 29 April 1861 edition of the *Novascotian* he writes:

I can with confidence assure the public, from the astonishing influences of the remedy I have already seen, that I do not have the least misgivings as to its efficacy. I do not believe it will ever fail to cure, if given at any period of the disease up to the third or fourth day of the eruption, or as long as there is any power of reaction in the system.⁵²

Morris was subsequently kicked out of the Halifax Medical Society. He was allowed to retain his position at the Visiting Dispensary, and to continue private practice, only after promising not to prescribe the Mi'kmaq remedy in the future.⁵³

For the orthodox profession, simply punishing Morris was not enough. It was more important that they protect their authority in the eyes of the public. On 6 May 1861 the Nova Scotia Medical Society passed the following resolutions, with Morris alone dissenting:

Resolved ... that Dr. Morris has not had any reliable data upon which to found any opinion in favour of its value as a remedial agent.

Resolved that a copy of the foregoing resolution be published in two or more of the morning papers.⁵⁴

⁵² *Ibid.*

⁵³ Howell, "Orthodox Medicine and the Health Reform Movement in the Maritimes, 1850-1885," p. 55. and Twohig, p. 95.

⁵⁴ Twohig, p. 95.

In addition, the Halifax Visiting Dispensary required Morris to sign a letter promising that he would refrain from the use of “such remedies and such publications” while an office of the institution. This letter was also published.⁵⁵

Repercussions did not stop with Morris. John Thomas Lane was a Mi'kmaw man who provided Morris with his smallpox medicine. Lane frequently published testimonials in the *Novascotian* attesting to the value of his remedy. The last such testimonial was published on 6 May 1861, the day after Morris was discredited by the Nova Scotia Medical Society. It is not clear if Lane was under any pressure; however, by 3 June 1861 Lane was publicly recanting his treatment. Lane and Morris were then brought to an inquest concerning the death of a Mi'kmaw child from smallpox.

The inquiry focused on the efficacy of Lane's smallpox medicine. The jury stressed that smallpox, not human intervention, was responsible for the child's death. However, after the decision was made, the Coroner Edward Jennings addressed the jury: “[The] decision will clearly show to the public that had the deceased been under the care and treatment of a medical man, there exists every probability that life would have been saved.”⁵⁶ Even in tragedy, orthodox medicine sought ways to expand its own authority and to discredit that of its competition.

Despite this history of external suppression, a recorded story of aboriginal medicine is emerging from within Mi'kmaw communities. In a 1997 publication

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*

entitled *Our Story Tellers (Atugwewinu)* Sunset Rose Morris discusses possible origins of traditional Mi'kmaw medicines. Morris relates the history of Mi'kmaw medicines through stories. A different approach is currently underway through the Traditional Use Study.

The goal of the Traditional Use Study is to map out areas of Nova Scotia that have been used by Mi'kmaq within living memory.⁵⁷ The geographic locations of activities and events ranging from collecting medicines to settlement will be mapped out and documented. The study is based on oral history. It will involve interviews and mapping sessions with hundreds of individuals upon completion. The Traditional Use Study is designed to demonstrate use and occupation of lands covering all of Nova Scotia as part of a comprehensive land claim. It is also recorded history. The Traditional Use Study demonstrates the geographic history of medicines for hundreds of individuals and communities. Perhaps more importantly, it shows a physical connection between people, land and health.

The Traditional Use Study, as well as oral histories, are departures from what has traditionally been considered valid historiography in Western society. However, writing history has always been a privilege reserved for members of dominant societies. Furthermore, recorded history is culture-specific. It does not account for cultures and communities whose histories are built on oral traditions. These factors

⁵⁷ "Living memory" is described by the Traditional Use Study as "any event or activity pertaining to land use that is remembered by any Mi'kmaq person. Living memory also includes activities of individuals who have passed away."

have limited the place of Mi'kmaw medicine in the written historiography of Atlantic Canada.

In the future, historians who attempt to incorporate aboriginal medicine in medical historiography will have to broaden their approach. It is not sufficient to rely on the written historical record. Such an approach provides for narrow and limited research. Alternative historical records, such as oral histories and mapping surveys, provide insight into aboriginal medical history. They should be included as a valid component of the historiography.

Conclusion

Medicine and health care are late arrivals to field of Canadian social history, and it is too easy to be overly critical. In roughly 20 years, the historiography has come a long way. Hero worship has been replaced with a more refined analysis of relations between health care and society. Nevertheless, fundamental problems remain.

The most significant flaw is this: the current historiography revolves around the orthodox medical profession. Studies may discuss medicine's role in redefining capitalism or constructing gender. The focus may switch to the patient, the hospital, the state. But in any study, "medicine" is understood to mean the health care provided by medical doctors. The implication is that there has never been other forms of health care. This has never been the case in reality; it should not be depicted as such in the historiography.

In Atlantic Canada, the Mi'kmaq have had a functional system of medicine and health care for thousands of years. However, the existence and worth of Mi'kmaq medicine is rarely acknowledged in Canadian medical historiography. Within Mi'kmaq communities, medical knowledge and history have traditionally been passed on orally. These oral histories, combined with recorded histories now emerging from Mi'kmaq communities, will likely force a change in the future writing of medical history in Atlantic Canada. This change must occur if the historiography is to consider medical history in its entirety.

Chapter Two: Biomedicine as Cultural Expression

Introduction

What is health, anyway? What does it mean to be healthy, sick or healed? This thesis is built on the foundation that these concepts change through time and across cultures. Health and health care are culturally constructed. And ideas about illness, health and healing reflect a given culture's spiritual and ethical perceptions of the world. Health and health care are fluid concepts. They are bound only by the cultures in which they exist.

The word *health* is derived from the same Indo-European root as *heal*, *whole* and *holy*. To be healthy is to be whole. And to heal is, literally, to make whole.¹ Similarly, the Mi'kmaw infinitive verb, *wlo 'til*, which roughly translates as "to be well" implies notions of mental peace as well as physical health.² *Tajikeymk*, meaning to be healthy, is more specific to physical wellness.³

In Western society today, definitions of health have become more narrow and refined than its linguistic root would imply. Good health is often perceived as the absence of disease. This perception, however, is far from universal.

For the Whapmagoostui Cree of Northern Quebec there is no word that translates directly into English as "healthy." Naomi Adelson suggests the closest term is *miyupimaatisiiu*, which she translates as "being alive well."⁴ Adelson says

¹ Wendell Berry, "Health is Membership," *The Utne Reader* September-October, 1995, pp. 60-63.

² Bernie Francis, personal communication, 1998.

³ Bernie Francis, personal communication, 1998.

miyupimaatisiiu transcends western notions of physical health. It reflects social and political realities affecting both the individual and her community. 'Being alive well' is synonymous to living as a Cree. Similarly, the Ojibwa term for good living, *pimadaziwin*, may be translated as to honour life.⁵

Perceptions of what constitutes health change across cultures. Equally significant is that perceptions of illness are fluid as well. What is considered an affliction in one culture may be considered a gift in another. Larry P. Aitken, a Minnesota Chippewa of the Leech Lake band, writes:

In our medicine society, in the old days, a schizophrenic person was thought to be gifted: they had two spirits. We could control those spirits only by medicinal properties of this earth. Schizophrenic people were regarded as gifted and they were not institutionalized, they were not placed in jail; their gift was their two spirits.⁶

It is also important to recognize that perceptions of health change through time, even within one culture. Susan Sontag, in her book *Illness as Metaphor*, describes the way in which the physical effects of tuberculosis acquired romantic

⁴ Naomi Adelson, "'Being Alive Well': Indigenous Belief as Opposition among the Whapmagoostui Cree," PhD dissertation (McGill University, 1992), from the paper's abstract. Broken down into into component parts, *miyu*, means good or well, and *pimaatisiiu* means living or alive. In combination, *miyupimaatisiiu* becomes "living well." Adelson writes: "I intentionally use the more awkward translation of *miyupimaatisiiu*, 'being alive well,' so that the term stands out in English as having a distinct connotation.

⁵ Andrew Nikiforuk, *The Fourth Horseman: a short history of epidemics, plagues, famines and other scourges* (New York: M. Evans and Company, 1991), p. 68.

⁶ Larry P. Aitken and Edwin Haller, *Two Cultures Meet: Pathways for American Indians to Medicine* (Duluth: University of Minnesota, 1990), p. 23.

associations in the 18th and 19th centuries. It became fashionable to look pale, sick and thin. Santog cites Marie Bahkirtsev as an example. “I cough continually!” Bashkirtsev wrote in 1887. “But for a wonder, far from making me look ugly, this gives me an air of languor that is very becoming.”⁷ The emaciated look of someone suffering from tuberculosis faded from fashion as the 19th century ended. While waif-like thinness remained popular for women, men began to associate obesity with power.⁸

If we can accept that perceptions of health and illness are intimately tied to culture, inevitably ideas about appropriate health care will change across cultures as well. Even when desired results are similar, the process by which different cultures attempt to achieve this goal may be radically different. And even within one community healing processes may change and evolve as does the culture that produces them. Wendy Mitchinson writes:

Different periods and cultures have their own favoured treatment but its perceived efficacy often lessens with time. Indeed, the power to heal is very much linked to the belief in the system being used rather than the rational underpinning for it. Thus, certain therapeutics gain ascendancy and are taken up amidst great claims for their merits, but with time they are superseded by a newer type and the older fades from memory.⁹

⁷ Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus and Giroux, 1977), pp. 26-31.

⁸ As an example, Canadian historian Michael Bliss says former Prime Minister R. B. Bennett intentionally over ate to acquire “dignity of the flesh.”

⁹ Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991), p. 4.

Mitchinson sees a society's cultural perceptions reflected in health care. And while Mitchinson's goal is to examine 19th century attitudes toward women based on their medical experience, her observations are not similarly confined. Just as Victorian Canada's perception of women influenced their medical treatment, so too are Western and Mi'kmaq cultural perceptions reflected in their respective medical practices. This chapter explores this idea as it applies to Western biomedicine.

Biomedicine as Cultural Expression

One of the most prevalent features of Western biomedicine is its claim to be objective, rational and scientific. It is neither defined nor constricted by religion or culture. As such, the implication is that biomedicine can be applied with equal success in any social or cultural environment; it can transcend cultures because it is not built on one. My goal is to show that this is not the case.

In this chapter, I will show that despite claims to rational objectivity, biomedicine is pervaded by a value system characteristic of a Western industrial-capitalist society. I will begin by discussing the philosophic and cultural foundations of modern medicine. Specifically, I will explore the roots of mind-body dualism in biomedicine. I will then demonstrate biomedicine to be allopathic, mechanistic, reductionist and morally subjective.

The goal of this chapter is not to hold Western medicine up for criticism, but to show that healing is a cultural process, even if it is attached to a world view that denies this.

Cultural Foundations of Biomedicine

An assumed separation of the mind and body is built into the philosophies guiding modern biomedicine. Much of this mind-body dualism may be traced to the Greek philosopher Plato. Plato divided all reality into mind and matter. The mind is higher and belongs to the celestial realm; matter is lower and cruder and belongs to the earthly realm.¹⁰ According to Plato, each person consists of an earthly body inhabited by a spirit whose true home is in the celestial realm. Human existence therefore consists of an internal struggle between the body, drawn naturally to the base, and the mind or soul, drawn naturally to the pure.¹¹ These ideas were later incorporated into Christian theology, which viewed the person as consisting of a physical body that is tempted by the material world, and a soul that seeks God.¹²

The separation of body and soul is part of a larger framework of dualisms pervading Western thought. Laurence J. Kirmayer traces a metaphysical tradition of separation and contrasts dating from pre-Socratic philosophers down through medieval alchemists. Reason is contrasted by passion, thought by emotion, male by female, free will by compulsion, matter by spirit, mortality by immortality and so

¹⁰ Emily A. Schultz and Robert H. Lavenda, *Anthropology: A Perspective on the Human Condition* (Toronto: Mayfield Publishing Company, 1995), p. 328.

¹¹ Schultz and Lavenda, p. 328.

¹² *Ibid.*, p. 328.

on.¹³ These dualisms have pervaded the Western metaphysical tradition for thousands of years. When discussing biomedicine, however, special attention must be given to the Enlightenment thinker Rene Descartes (1596-1650).

Descartes viewed the human organism as consisting of a physical body that was mechanical in nature and an animating spirit or soul inhabiting that body.¹⁴ The mind and the body were separated. The body was a soulless machine which the mind could not influence. Taken further, God was no longer necessary to understand how the body worked. Illness was a mechanical, not a spiritual, problem. And healing became a matter of engineering.

By viewing the body as mechanical in nature, Descartes linked the study of human beings to that of the natural, inanimate world. Enlightenment thinkers devoted themselves to disengaging nature from previous metaphysical and spiritual connections.¹⁵ This separation was reinforced by the discoveries of Galileo and Newton's laws of physics, which encouraged the investigation of the natural world as a mechanical device following certain logical laws of motion.¹⁶ Understanding the

¹³ Laurence Kirmayer, "Mind and Body as Metaphors: Hidden Values in Biomedicine," in *Biomedicine Examined*, eds. Margaret Lock and Deborah Gordon (Boston: Kluwer Academic Publishers, 1988), p. 76.

¹⁴ David Kinsley, *Health, Healing and Religion: A Cross-Cultural Perspective* (Upper Saddle River, New Jersey: Prentice-Hall, 1996), p. 171.

¹⁵ Deborah Gordon, "Tenacious Assumptions in Western Biomedicine," in *Biomedicine Examined*, eds. Margaret Lock and Deborah Gordon (Boston: Kluwer Academic Publishers, 1988), p. 24.

¹⁶ Trudy Sable, "Another Look in the Mirror: Research into the Foundations for Developing an Alternative Science Curriculum for Mi'kmaw Children," MA thesis (Saint Mary's University, 1996), p. 14.

world became a matter of understanding the physical laws governing reality. From this perspective, all things were predictable and all that which was not rational -- God, spirits, a soul -- could not influence the natural world.

In the last century, many concepts governing the perception of a mechanical, objective universe have begun to break down. Theories of relativity, quantum physics and chaos theory have all called into question the existence of an objective reality and the idea that the universe, and concomitantly the human body, function in a predictable and mechanical fashion.¹⁷ Nevertheless, a perception of the body as mechanical and independent of mind and spirit persists in Western culture, specifically in biomedicine. It is true that these ideas have inertia behind them; however, the split between mind and body has more complex roots.

Laurence Kirmayer argues that the separation of mind and body is deeply entrenched in the Western experience and is rooted in the moral order and the social construction of the person -- specifically, individualism and rational agency. Other scholars have looked further, to social organization and the individual's role in society. Emile Durkheim locates the mind-body duality in the inevitable tension between the collective and the individual. Just as the individual must be subordinated to society, the profane desires of the body must yield to the sacred quality of the mind.¹⁸

¹⁷ *Ibid.*, pp. 15-16.

¹⁸ Kirmayer, p. 78.

Splitting reality into contrasting dualisms has also led to the split between subjective awareness and objective observation. This dualism is particularly prevalent in biomedicine. It gives credit to a doctor's visual inspection and autopsy over a patient's subjective account of distress.¹⁹ From this perspective, the body may reveal its disease to the physician without the patient's subjective interpretation. In fact, M. Sullivan claims the real dualism in biomedicine is not between the mind and body, but between the physician as active knower and the patient as passive known.²⁰ Kirmayer argues this duality is reflected in the distinction between disease and illness. Disease stands for a physician's interpretation of a biological disorder, while illness represents a patient's experience of distress.²¹

A final dualism in Western thought to be discussed here is the separation of nature from human consciousness.²² From this perspective, nature is distinct from the individual. It is "neutral, indifferent to human purpose and to human relationships."²³ Emotions, therefore, are not necessary for understanding nature, as nature is neither emotional nor psychological.

What is missing from this perspective is a sense of human interaction with nature. Separating the individual from nature allows that people may observe nature,

¹⁹ *Ibid.*, p. 59.

²⁰ *Ibid.*

²¹ *Ibid.*

²² Gordon, p. 25.

²³ *Ibid.*

but not communicate with it. We may watch nature, listen to nature, absorb nature, but there is little sense of interaction with nature, especially on the level of social relations. What this philosophy means in biomedicine is a construction of a similar boundary between the 'natural world' of the body and the consciousness of the mind. It is conceded that emotions may cause illness, but this sickness is judged as psychosomatic. It is not real.²⁴

Stepping back from the specific origins of dualisms in Western thought, a number of themes are important to recognize. First and foremost, it must be understood that the cultural dimension of biomedicine, specifically mind-body dualism, is not something imposed by doctors on patients. It arises from cultural concepts of personhood in Western society. Given this conceptualization, some form of mind-body dualism in biomedicine is inescapable. As Laurence Kirmayer writes, "Medical theory offers a subtly articulated expression of the person's alienation from the body in Western society, but this alienation is found, as well, in every sphere of economic and political life."²⁵

Furthermore, a Western world view that stresses separation and isolation denies the interconnectedness and interdependence of reality. It sees the human organism, nature and the universe as a series of discrete parts instead of as one interdependent whole. In biomedicine, this results in a reductionist view of health and healing. Sickness occurs when something goes wrong with the body's mechanics.

²⁴ *Ibid.*

²⁵ Kirmayer, p. 81.

Factors external to the body -- the mind, emotions, the spirit, family, the environment -- are not seen as factor in sickness, and are consequently rarely accorded a role in the healing process.

What follows is an attempt to explore certain aspects of biomedicine that are most connected to Western society. In doing so I am guilty of making generalizations concerning the medical profession. I am fully aware that biomedicine is as diverse as are those who practise it. Indeed biomedicine is full of tensions and nuances, and there are those within the medical profession who are revolutionizing its practice. For example, on 11 January 1998, CBC radio aired a documentary on prayer and healing. A number of medical doctors interviewed on the show felt that the connection between prayer and healing -- regardless of the beliefs held by themselves or their patients -- was so strong they felt obligated to incorporate prayer as part of their medical treatment.

However, my goal is to look at the larger picture and show how, despite claims to be objective and rational, the cultural foundations of biomedicine reflect and express the philosophic and metaphysical traditions of Western society. Specifically, biomedicine will be discussed as being allopathic, mechanistic, reductionist and morally subjective.

Biomedicine as Allopathic

Allopathy literally refers to the treatment of illness by producing effects different than the symptoms produced by the disease. *Allopathic medicine* is often used to describe conventional biomedicine, as opposed to *homeopathic medicine* which, broadly speaking, treats disease by attempting to induce effects similar to the disease being treated.²⁶ What is most important, however, is that allopathy implies a struggle against disease by means of intervention to change the symptoms of an illness.²⁷

Allopathic medicine draws support from the idea that disease is separate from the individual; it is not linked to an individual's personal expression or life experience. This concept, often referred to as the ontological view of illness, sees sickness as a foreign invader in a person's body. For example, we speak of someone who "has a disease." The ontological view of illness dominates allopathic medicine.

In practical terms, the ontological view of illness justifies an aggressive, interventionist approach against disease. The patient is a victim of a foreign aggressor, and the doctor directs the counter-attack. The tools the physician uses to defend the body are characteristic of an allopathic approach to disease; drugs, lasers, radiation and surgery seriously alter the inner workings and balance of the mind and body. The patient becomes a battlefield where the physician and the invading disease fight it out.

²⁶ Kinsley, p. 169.

²⁷ *Ibid.*, p. 170.

I do not use the military metaphor accidentally when describing allopathic medicine. The language of warfare has saturated biomedicine for over a century. It first came to wide use in the 1880s, with the identification of bacteria as agents of disease. In more recent years, the language surrounding cancer epitomizes military metaphors in medicine. Cancer cells do not multiply, they are “invasive” and “colonize” from the original tumor. Treatment has a military tinge as well. Patients are “bombarded” with chemotherapy in the hopes of “killing” the invading cancer cells. Susan Sontag, writing in the late 1970s, suggests that the military metaphor pervades public and political discourse surrounding cancer as well. Cancer is conceived as an enemy on which society wages war.²⁸ Reporters and politicians in the 1970s spoke of the “war against cancer” the way their counterparts a decade later would speak of a similar war against drugs.

At this point it is fair to ask if the military language surrounding biomedicine truly reflects an aggressive, interventionist approach to health care. Battle allusions are not limited to Western medical treatment. And military metaphors pervade much of Western popular discourse. A hockey player with a biting wrist shot is a “sniper,” experienced politicians are “battle-scarred” and even a nation’s shaken economy may “battle back” or “recover.” Perhaps the prevalence of military metaphors in biomedicine reflects the influence two world wars have had on popular discourse in Western culture.²⁹ It is interesting to note that in Leo Tolstoy’s short story, *The Death*

²⁸ Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus and Giroux, 1977), p. 66.

of *Ivan Ilych*, published in 1886, the main character refers to his sickness, not in military terms, but as something that “gnaws” at him. However, he does refer to his illness as something externally invasive, an *It*.

A recent study by Emily Martin sheds some light on this question. Martin carried out research in a department of immunology to explore how a group of scientists imagined the world inside the body, specifically the immune system. Martin found that most scientists describe the immune system in terms of the body at war. This establishes common ground between the scientists, the public and the media; however, some scientists Martin interviewed believed the military metaphor is appropriate because it is accurate. Guy Lerchen is quoted:

It’s a pretty harsh world, the immune system.... I mean, these lymphocytes see something they don’t like, and they arrive at the scene, and they inject nasty chemicals onto it. They attack it, leave it obliterated, have their mop-up crew come by and chew it all up. It’s pretty harsh.³⁰

Other scientists stressed that the military metaphor is only accurate, and superficially at that, when the immune system is engaged by disease. Most of the time, the immune system is in balance, and military imagery is a distortion.³¹

But the military metaphor is easy to communicate, and it gets the patient’s attention at the only time she is most likely to think about her immune system: when

²⁹ See, for example: Fussell, Paul. *The Great War and Modern Memory*. London: Oxford University Press, 1977.

³⁰ Emily Martin, *Flexible Bodies: Tracing Immunity ...* (Boston: Beacon Press, 1994), p. 96.

³¹ *Ibid.*, pp. 100-103.

she is sick. Despite this attraction, Ron Wilder, a doctor interviewed by Martin, was able to suggest a number of metaphors that were less reductionist and perhaps more accurate. These included likening the immune system to a symphony, a corporation and even to a nurturing mother.³² Additional metaphors are offered by acupuncturist Patricia O'Hara, who likens a healthy body to uninterrupted rivers; and by research scientist Bruce Kleiner, who wonders if T cells could "whisper in the ears of neurons."³³

It seems clear that the military metaphor is more than a choice of convenience and accuracy. And perhaps the military metaphor is not particularly useful for patients either. Bernie Siegel, a pediatric and general surgeon, founded Exceptional Cancer Patients in 1978. The organization works with patients toward self-healing through the use of patients' dreams, drawings and images. Siegel suggests that visualizing attacking a disease works for about 20 per cent of patients. The other 80 per cent require a different approach to heal.³⁴

However, what is most important when discussing metaphors used in biomedicine is to recognize that, regardless of how appropriate certain metaphors may be in the healing process, their use clearly roots treatment in a cultural context.

³² *Ibid.*, p. 97.

³³ *Ibid.*, p. 112.

³⁴ Bernie Siegel, *Love, Medicine and Miracles: Lessons Learned About Self-Healing from a Surgeon's Experience with Exceptional Patients* (New York: Harper and Row Publishers, 1986), p. 116d.

Biomedicine as Mechanistic

Rene Descartes's vision of the human body as a machine has resulted in more than a division between mind and body. Thinking about the body as a machine has resulted in a tendency to view the body as a series of discrete parts and systems, as opposed to a complex whole. Taken to its extreme, this philosophy sees health care as an engineering problem, a process of repair.

As mentioned earlier, much of biomedical treatment involves methods that physically alter the body such as surgery and drugs. Physically manipulating the body reflects a belief that illness is tangible and may be treated as such. This approach may be applied to explain the popularity in Western society of healing that utilizes physical substances. In an article entitled, "The Charm of Medicines: Metaphors and Metonyms," Sjaak van der Geest and Susan Reynolds Whyte suggest that the "charm" of medicines, specifically Western pharmaceuticals, stems from their concreteness. Medicines are *things*. And in them healing is objectified.³⁵ A subsequent article co-authored by van der Geest makes a similar argument: "By applying a 'thing,' we transform the state of dysphoria into something concrete, into something to which the patients and others can address their efforts."³⁶

³⁵ Sjaak van der Geest and Susan Reynolds Whyte, "The Charm of Medicines: Metaphors and Metonyms," *Medical Anthropology Quarterly*, (vol. 3) 1989, p. 345..

³⁶ Sjaak van der Geest, Susan Reynolds Whyte and Anita Hardon, "The Anthropology of Pharmaceuticals: A Biographical Approach," *Annual Review of Anthropology*, 1996, p. 154.

The mechanical bias of biomedical culture is also evident when exploring the placebo effect in Western medicine. A placebo is an inert substance believed to have no pharmacological property -- a sugar pill, for example. The placebo effect is the term given to the resulting improvement in a patient. Placebos have been shown to lower blood sugar in diabetics, relieve arthritis and shrink tumors.³⁷ They are often cited as evidence of a person's ability to translate expectations of healing into reality.

What is interesting when exploring placebo effects, however, is that placebos are most successful when the treatment involves a mechanical, or physically tangible, element. Studies have suggested patients believe tablets are more effective than pills, capsules as more powerful than tablets and injections are more effective than capsules. In one study, 88 people suffering from arthritis were given placebos instead of aspirin or cortisone. The results were as would have been expected had the usual drugs been given. Some patients who reported no improvement were given placebo injections. Of these, 64 per cent reported positive change.³⁸ Similar results have occurred in experiments involving placebo surgery.³⁹

The very nature of how biomedical culture deals with the placebo effect is also revealing. A patient's faith and expectation of success are significant factors in biomedical procedures ranging from wart removal to heart surgery. However, there is a tendency to discredit healing that cannot be physically explained, or that cannot be

³⁷ Kinsley, p. 160.

³⁸ *Ibid.*

³⁹ *Ibid.*, p. 161.

directly attributed to a treatment's healing properties. The placebo effect is described as almost a side effect of biomedicine. Healing that arises from a patient's mind is often seen as less credible than healing that may be attributed to medical treatment.

Psychosomatic medicine, or mind-body medicine, provides a good concluding example of the pervasiveness of a mechanistic philosophy in biomedicine. Ostensibly this approach brings mind and body together in harmony. However, psychosomatic theory often reproduces the same dualisms prevalent in biomedicine. In the words of Laurence Kirmayer, "Psychosomatics expresses its holistic perspective in dualistic terms that ultimately invoke the same values of rational control and distance from passion and bodily-felt meaning that are part of the mechanistic world view of biomedicine."⁴⁰

When emotions are considered in the healing process, it is usually from a mechanical perspective as well. The mind is seen as an extension of the physical brain, and the assumption is that it may be understood and programmed like a computer. An obvious example of this mind set is the popularity of mind and mood-altering drugs in biomedicine. These treatments affect chemicals in the brain so that even mental illness becomes a matter of engineering, and mental problems are reduced to physical therapies.⁴¹

⁴⁰ Kirmayer, p. 58.

⁴¹ Kinsley, p. 172.

Biomedicine as Reductionist

Biomedicine is highly reductionist. It concentrates on the mechanics of illness in the individual person. Emotional and spiritual factors are rarely taken into account, and the wider physical and social environment is accepted as a given.⁴²

Like much of biomedicine, a tendency to view illness in isolation from larger external factors has roots in the Enlightenment and the Western scientific tradition. Enlightenment thinkers did not contrive of and study nature in its ordinary state. Knowledge, and the understanding of nature, was sought in artificial settings created so that nature might reveal itself.⁴³ Nature could best be understood through isolation and analysis, that is, breaking down the whole into its components. Deborah Gordon expands on this concept:

The Western philosophical and scientific traditions have long assumed that detachment provides the purest window to truth. It is by withdrawing from the noise and the crowds that we can truly understand what is happening.... *Knowing* then is distinct from *being* according to naturalism.... This encourages the frequent separation of knowledge and practice.⁴⁴

Gordon continues to suggest that the distancing of knowledge from everyday practice contributes to the distance between physicians and patients and cuts physicians off from their everyday knowledge and understanding.⁴⁵

⁴² *Ibid.*, p. 173.

⁴³ Gordon, p. 32.

⁴⁴ *Ibid.*, p. 32.

A reductionist approach to health care is reflected in our allocation of health resources. Massive amounts of money are spent on cardiac units and treating cancer, but comparatively little money goes into studying and preventing environmental causes that may contribute to heart disease and cancer in the first place.

Once again, it would be wrong to attribute this approach solely to biomedicine. The reductionist approach to biomedicine reflects a society that prefers to deal with the effects of a problem as opposed to the reasons for it. For example, there is an undeniable link between poverty and illness, even in a society that prides itself on equally accessible health care.⁴⁶ Yet most of us continue to support public policy that treats the diseases of poverty rather than poverty itself. We prefer to spend money on heart-lung machines instead of child nutrition. We find it easier to treat the symptom than the cause.

Biomedicine's reductionist approach is also evident in its separation of the healing process from society. Just as biomedicine separates disease from the patient, and the patient from her wider social environment, biomedicine goes to great lengths to separate the physician from the patient and the healing process from society. Susan Sontag refers to the kingdom of the well and the kingdom of the sick. Biomedicine works to construct a third kingdom -- an alternate reality where healing is supposed to take place.

⁴⁵ *Ibid.*, p. 32.

⁴⁶ Robert Sapolsky, "How the Other Half Heals," *Discover*, April 1998, pp. 46-52.

Biomedicine has developed a variety of ways of distancing itself from the patient as a social person during the healing process. Consider the context of a modern medical centre:

The architecture of the hospital provides a series of barriers that separate the sick body from the social person. The hospital gown effaces individuality, leaving the body half exposed and available for quick examination. This minor loss of dignity marks a major change in social status: from free agent to docile patient, from actor to acted-upon.... Even the drapes and baffles that surround the sterile surgical field serve more than a biological function -- they help reduce the sleeping person to a technical problem of organs and blood.⁴⁷

On a symbolic level, booking an appointment and preliminary interviews serve as a kind of induction ritual to the healing process. Waiting rooms and receptionists then serve as a kind of outer circle protecting the inner sanctum where the patient will meet the physician and healing will take place. By the time a patient actually meets her doctor, she has gone through a number of steps distancing herself from her social environment.

It should be noted that many of the barriers separating a modern medical centre from society also serve a role in the healing process. Controlled access to a healing environment raises a patient's expectations that he will get better. The same principle applies to the decor of a doctor's office and a physician wearing a white coat. These symbols and rituals establish professionalism and begin the healing

⁴⁷ Kirmayer, pp. 60-61.

process in the patient's mind. Furthermore, rituals and formalities that detach a patient from her social person may make it easier for the patient to accept intrusion as it is not perceived to occur on a personal level. The hospital gown, for example, exchanges a minor loss of dignity for what would be a more major one if patients were required to undress on demand.

The importance of a healing environment to biomedicine is most clearly demonstrated when the accepted healing context is altered or taken away. Andrea Sankar recently completed a study on medical care in the home in an effort to explore the environmental context of the physician-patient relationship. Sankar's study involved medical students working in a Home Care Program with elderly, chronically ill patients. She found that the environment in which the physician-patient relationship takes place has a strong influence on power relationships, what kinds of information are visible and invisible, and how physicians and patients know and experience each other.⁴⁸ When doctors and patients met in the patient's home, physicians were forced to confront the social aspects of health that they could overlook in a hospital.

When asked to compare how they felt caring for patients in the home with the clinic, a number of students emphasized the loss of control they encountered in the home. One student, a future radiologist, is quoted: "In the home the patients are more

⁴⁸ Andrea Sankar, "Patients, Physicians and Context: Medical Care in the Home," in *Biomedicine Examined*, eds. Margaret Lock and Deborah Gordon (Boston: Kluwer Academic Publishers, 1988), p. 155.

in control than I am. In the hospital I could do to them what I wanted. The patient is sort of a captive in the hospital. Here I had to adjust to what they really did.”⁴⁹

Some students in the Home Care Program became unwilling or unable to assert their professional role and focused only on problems identified by the patient. They were reluctant to interfere and intrude unless they were asked to do so by the patient.⁵⁰ However, the result for the majority of physicians was a greater understanding of the patient and the patient’s total life. Some students altered their treatment plans to include the patient’s needs and expectations. Others developed greater emotional intimacy with their patients and used treatment that might not have been strictly medical in nature. The following example is revealing.

In this case, Bob, the doctor had been involved in the program for three weeks and had focused purely on medical problems. In the third week this exchange took place:

Bob: Give me a call if you need me.
Patient: I’m calling you now.
Bob: There’s not a whole lot I can do.

By the fourth week Bob had broadened his approach to treatment. The following exchange took place:

Bob: If anything comes up, call me.
Patient: What good can you do?
Bob: We can talk.

⁴⁹ Sankar, p. 171.

⁵⁰ *Ibid.*, p. 172.

Patient: That would be moral support.

Bob: Sometimes moral support helps a lot.

During the next three visits more than half the exchanges involved non-medical exchanges, while the actual number of medical exchanges remained the same. The proportion of non-medical exchanges increased during the rest of Bob's internship, and the patient's anxiety dropped noticeably.⁵¹

Even within the context of a hospital, doctor's office or medical centre, additional strategies may be used to distance medical treatment from social reality. One such strategy is language. Biomedical language has often been described as impersonal, abstract and artificially created.⁵² When this language is used to describe disease, the function is to suggest distance between the person and the illness. In 1976 Eric Cassel published an analysis of 2,000 recorded conversations between doctors and patients. Both doctors and patients were inclined to refer to illness as something detached from the person. Illness became depersonalized, referred to as an "it."⁵³

More recently Anne Burson-Tolpin discusses the language of biomedicine as a kind of defense mechanism for doctors. Burson-Tolpin examines the practice among doctors of using medical discourse to discuss non-medical issues. Burson-Tolpin

⁵¹ *Ibid.*, p. 157.

⁵² Anne Burson-Tolpin, "Fracturing the Language of Biomedicine: The Speech Play of U.S. Physicians" *Medical Anthropology Quarterly*, (Vol. 8) 1994, p. 288.

⁵³ van der Geest and Whyte, "The Charm of Medicines," p. 355.

coins the term “biomedical speech play” to describe the discourse doctors use to express emotional and social concerns in an almost coded, professional language. ‘Biomedical speech play’ may be used to criticize patients and fellow physicians, cope with difficult emotions, or to increase group camaraderie. The result is an alternative biomedical voice that is distinct from both regular social interaction and the scientific world of biomedicine.⁵⁴

Emotional expression is at odds with the rational and objective nature of biomedicine. Biomedical speech play allows physicians to discuss emotional, non-rational issues within the realm of a professional dialect.

How biomedicine treats the process of death provides a good example of biomedicine’s reductionist approach to health care. In most cultures death is understood within a larger framework of meaning. Biomedicine, because it pretends not to be culture-specific, does not locate death within a larger social or spiritual context. Biomedicine’s principle task is to preserve life and fight off death. Life and death are seen as diametrically opposed, and the idea that a patient may in fact become healthy through dying makes little sense. A physician, therefore, has little role to play in the dying process.

It may be argued that medicine has no place playing a spiritual role in the process of dying. However, biomedicine’s tendency to view dying as a strictly physical process -- the antithesis to living -- can have a detrimental effect on a

⁵⁴ Burson-Tolpin, p. 283.

patient's total health while dying. This concept is expanded upon in a recent study by Jessica H. Muller and Barbara A. Koenig.

Muller and Koenig explore how and when physicians-in-training define terminally ill patients as "dying." The authors suggest that physicians-in-training construct a clinical reality in which patients still have "a chance." This perspective justifies extensive medical intervention and delays the question of a patient's potential death.⁵⁵ Patients are not identified as dying until death is truly unavoidable.

On the surface, this orientation toward hope may seem to be in the best interest of the patient; however, the repercussions are more complex. When patients are defined as seriously ill, rather than dying, physicians are justified in continuing with aggressive interventions beyond the point of therapeutic benefit. Medical intervention may therefore prolong a difficult and painful process of dying. Furthermore, delaying the acceptance that a patient is dying may also delay a switch from therapy stressing intervention to non-aggressive palliative care which stresses pain control and emotional support. Consequently, assistance in the dying process occurs later in a patient's trajectory toward death, if it occurs at all.⁵⁶

Muller and Koenig also point out that when someone is defined as dying only when there are no more medical treatments to make, patients are no longer perceived as a medical concern once dying is seen as inevitable. Physicians may then withdraw

⁵⁵ Jessica H. Muller and Barbara Koenig, "On the Boundary of Life and Death: The Definition of Dying by Medical Residents," *Biomedicine Examined*, eds. Margaret Lock and Deborah Gordon (Boston: Kluwer Academic Publishers, 1988), pp. 351-352.

⁵⁶ *Ibid.*, p. 370.

from treatment, leaving other personnel, usually nurses, to take over the palliative care until a patient's death. "Dying" thrusts a patient to the periphery of biomedicine and symbolizes her passage beyond the physician's professional domain.⁵⁷

It should be noted, however, that as disjointed as biomedicine's treatment of the dying process is, it is one of the few places where death is openly confronted. Western society does little to prepare its members for the dying process. Death and dying are treated as taboo subjects.⁵⁸ This tradition of secrecy denies most people the opportunity to learn about the dying process, and to place dying within a larger context of meaning. In Western society there are many accepted rituals following death, such as wakes, funerals and viewings. But few social norms exist concerning interaction with dying individuals or their families. Unfortunately, this often results in dying individuals feeling cut off from the rest of the world.

The experience of chronically ill patients, at least as depicted by Muller and Koenig, reflects the compartmentalization of biomedicine and indeed all of Western society. Chronically ill patients are treated by separate professionals on their trajectory toward death. But most of Western society functions in a similar fashion. Medical treatment is given by doctors; care is given by nurses; we go to counselors or psychologists for therapy; and our spiritual needs are attended to by priests and other

⁵⁷ *Ibid.*, p. 371.

⁵⁸ Benita C. Martocchio, *Living While Dying* (London: Prentice-Hall Publishing and Communications, 1982), p. 116.

religious advisors. We live in a fragmented world. How can we expect our health care system to be holistic in a society that isn't?

Biomedicine as Morally Subjective

Despite claims to be objective and morally neutral, biomedicine continues to play an active role in defining and constructing the moral order. Medicalizing morality is not new, and it is always easier to identify this practice when it occurs in the past. Historically, medicine has given the air of legitimacy to social programs ranging from immigration to criminal justice. It has justified keeping women out of the workplace, and it has defined homosexuals as pathologically sick. Many of these examples have been well documented in the historical literature.⁵⁹ What I propose here is to show in two examples how pervasive this connection still is.

In 1957, Maurice Laufer coined the term *hyperkinetic impulse disorder* to describe the apparent inability of some male children to sit still and pay attention, especially in educational situations. Laufer claimed the disorder was the result of “minimal brain injury,” although he was unable to show any organic basis for this belief. A recently synthesized drug, methylphenidate (Ritalin), was prescribed to treat

⁵⁹ Wendy Mitchinson's *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* demonstrates how 19th century Canadian attitudes toward womanhood were shaped and reinforced by the medical establishment. The repercussions are still felt today. In a variety of articles, Colin Howell discusses how orthodox medicine expanded its authority into social and political spheres, specifically in Atlantic Canada. Susan Sontag is noteworthy for exploring links between sickness and sin in Western society. I discuss these issues in more detail in chapter one.

this disorder, and its calming effects were aggressively advertised. Whether hyperkinesis is a “real disease” is a debatable question, but one that is beyond the scope of this essay. What is important to recognize is that a fairly common behavior, which previously would have been dealt with by the family and school, was now labeled a medically treatable illness, and medical intervention could therefore be justified. Most people would object to drugging young boys to impose social control. Few people would object to treating an illness.⁶⁰

The second example is much more subtle. In an article entitled, “The Egg and the Sperm: How Science has Constructed a Romance Based on Stereotypical Male-Female Roles,” Emily Martin explores how the reproductive process is depicted in popular and scientific accounts. Martin concludes that reproductive biology relies on gender stereotypes which imply female biological processes are less worthy than those of males and also that women are less worthy than men.⁶¹

Once again it is the use of language that is most revealing. Martin begins with depictions in scientific and medical texts of how sperm and egg are formed. A female *sheds* a single gamete each month, whereas a male *produces* hundreds of millions of sperm each day. The sperm and the egg are also given very masculine and feminine characteristics respectively. The egg is large and passive. It does not *move* or *journey* along the fallopian tubes, but *drifts* or *is swept*. The sperm, in contrast, are aggressive,

⁶⁰ Kinsley, pp. 180-181.

⁶¹ Emily Martin, “The Egg and the Sperm: How Science has Constructed a Romance Based on Stereotypical Male-Female Roles.” *Journal of Women in Culture and Society*, 16 (3) 1991, pp. 485-486.

strong and streamlined. Sperm have a *mission*. They carry out a *perilous journey* into the *warm darkness* where they will find their *prize*. Here, they *deliver* their genes and *activate* the developmental program of the egg. They *burrow* through the egg's wall and *penetrate* it.⁶² These are only a few examples suggesting a passive, fragile egg that depends upon a heroic sperm for rescue.

What is interesting is how easily the reproductive process might be depicted to suggest just the opposite. Recent research suggests a more mutually interactive relationship between the egg and sperm.⁶³ The language depicting the fertilization process is changing; however, it is still infused with cultural stereotypes of males and females. For example, images granting the egg a more active role in fertilization also portray the egg as aggressive and dangerous, recalling gender stereotypes of the *femme fatale* who traps and victimizes men.⁶⁴ Imagery and language surrounding the fertilization process may shift, but it remains trapped within a larger framework of gender stereotypes.

But must it be this way? In other words, are the gender stereotypes reflected here inevitable, or can biomedicine be detached from the culture in which it operates? My belief is that it cannot. Biomedicine is so intimately shaped by Western philosophic and metaphysical traditions that it cannot help but remain tied to Western

⁶² Martin, "The Egg and the Sperm," p. 489.

⁶³ Martin, "The Egg and the Sperm," p. 495.

⁶⁴ *Ibid.*, p. 498.

world view. The imagery used to describe fertilization will continue to change. These changes will likely reflect shifts in gender imagery occurring in larger society.

The models and metaphors scientists use to describe their data have important implications. This example has been used to show that cultural stereotypes and moral definitions pervade biomedicine even at the level of cells. Biomedicine reflects these stereotypes, and it also contributes to them. At the very least, the imagery used in scientific texts to describe fertilization protects some of society's most regressive gender stereotypes: the femme fatale and the damsel in distress. The fact that these stereotypes are being recorded at the molecular level demonstrates just how intertwined Western morality and culture is with biomedicine.

Conclusion

In this chapter I have tried to show that biomedicine both reflects and reinforces many cultural perspectives in Western society. Biomedicine is not objective, and it is not removed from the culture in which it operates. Indeed it is saturated with Western values and cultural assumptions.

Many of the philosophies guiding biomedicine may be linked to Rene Descartes. Descartes envisioned a separation of the human organism into a physical body that is mechanical in nature and an animating soul inhabiting that body. Illness was therefore perceived as a mechanical, not a spiritual, problem. The dualism between mind and body, as articulated by Descartes, is reinforced by similar dualisms and separations pervading Western world view. The Western metaphysical tradition

separates the individual from society, subjective awareness from objective observation, reason from emotion, and nature from human consciousness.

The end result is a world view that stresses separation and isolation, denying the interconnectedness and interdependence of reality. The human organism, nature and the universe is seen as a series of discrete parts instead of as an interdependent whole. What this means for biomedicine is a reductionist view of health and healing. Sickness occurs when something goes wrong with the body's mechanics. Factors external to the body, such as the mind, emotions, spirit, family and the environment are rarely accorded a role in the healing process.

On a practical level, this translates into a number of tangible features in biomedicine. *Allopathic medicine* stems from the idea that disease is separate from the individual who is sick. This philosophy justifies an aggressive, interventionist approach toward treatment: If the patient is the victim of a foreign aggressor, the physician will direct a counter-attack to defend the body.

A mechanical conceptualization of the human body often results in a similar mechanical bias in the healing process. Biomedicine tends to emphasize healing and therapy as a physical matter, a process of repair. Sickness is legitimized if it is physically tangible, and much of biomedical treatment involves methods that physically alter the body.

Concentrating on the mechanics of illness in the individual patient is a feature of a larger reductionist approach to biomedicine in Western culture. Biomedicine tends to consider illness in isolation of larger social and environmental factors. A

reductionist approach to health care is evident in the allocation of health resources, the context of a modern medical centre and the language used in a medical environment. The end result is the separation of medical treatment from social reality.

Finally, the close relationship between biomedicine and the society in which it operates is demonstrated by considering its role in defining and constructing the moral order. In this essay I discuss in detail only two examples reflecting this connection. In reality the association is much more pervasive.

The overriding goal of this chapter is to show the interconnectedness of Western society and biomedicine. Biomedicine is both a product and a producer of Western culture. The two are interconnected and must be considered in relation to each other. We all play a role in shaping the medical treatment we receive.

**Chapter Three: The Effects of European Contact on Mi'kmaw
Traditional Health Care**

Introduction

The first European immigrants arriving in North America encountered aboriginal societies with low population levels. They believed they were settling unoccupied land, an assumption that justified further European settlement in the New World. What was rarely acknowledged was the possibility that aboriginal communities had suffered a dramatic decline in health and population following initial contact with Europeans.

This chapter will explore the effects of European contact on the Mi'kmaq. Pre-contact Mi'kmaq health and population levels will be discussed, and the effects of contact on Mi'kmaq population and health will follow. Finally, how contact affected Mi'kmaq medicine and healing will be discussed in detail. The focus will be on how Mi'kmaq traditional health care responded to declining health and depopulation.

Mi'kmaq Population and Health Before Contact

Mi'kmaq population levels prior to European contact is part of a larger debate concerning pre-contact aboriginal populations. Three decades ago Henry Dobyns estimated that aboriginal societies suffered a mortality rate of 95 per cent following contact with Europeans. Emphasizing the destruction of early epidemics, Dobyns arrived at a figure of at least 9.8 million aboriginal people living north of Mexico prior to the arrival of Europeans. He put the figure for the entire New World between

90 and 112 million.¹ Some historians consider Dobyns's figures to be inflated, and his estimates are certainly not uniformly accurate. However, they have forced a reevaluation of previously recognized population levels. North American estimates of 0.9 to 1.1 million, given early this century by James Mooney and A.L. Kroeber respectively, are no longer acceptable.²

Early estimates of the aboriginal Mi'kmaq population are now also considered low. And like those for all of the Western Hemisphere, they continue to be debated. The earliest estimate is given by the Jesuit priest, Pierre Biard, who set down a figure of 3,500 Mi'kmaq in 1616. This estimate set the standard for later demographers and historians. Mooney estimated 3,500 Mi'kmaq were alive in 1600 based on Biard's quote. In 1932, Diamond Jenness put the original Mi'kmaq population at around 4,000, a figure repeated by John Swanton in 1952.³ The problem with these estimates, which all essentially stem from Biard's, is that by 1616 the Mi'kmaq had been interacting with Europeans for well over 100 years.

Europeans began extensive fishing and whaling in Northeastern North America at the turn of the sixteenth century, with the first expeditions beginning as early as the 1480s.⁴ By the late 1570s, the English merchant Anthony Parkhurst

¹ *Ibid.*, p. 79.

² Bruce Trigger, *Natives and Newcomers: Canada's "Heroic Age" Reconsidered* (Kingston: McGill-Queen's University Press, 1985), pp. 232-233.

³ Virginia Miller, "Aboriginal Micmac Population: A Review of the Evidence," *Ethnohistory*, Spring 1976, p. 117.

⁴ Calvin Martin, *Keepers of the Game: Indian-Animal Relationships and the Fur Trade* (Berkeley: University of California Press, 1978), p. 40.

estimated that England, France, Spain and Portugal together sent some 400 vessels and 12,000 men to the region each year.⁵ Both the Mi'kmaq and Europeans quickly fell into trade with each other. The full extent of these interactions remain unclear. Archaeological evidence is lacking, and due to rising sea levels, may never be collected.⁶ However, the sheer number of Europeans in the region suggests the impact would have been large.

The only written evidence concerning Mi'kmaw populations during this time period comes from seventeenth-century reports. Writing in 1611, Biard comments that the region is sparsely populated. He continues to write: "Membertou assures us that in his youth, he has seen *chimonutz*, that is to say, Savages, as thickly planted there as the hairs on his head. It is maintained that they have thus diminished since the French have begun to frequent their country."⁷ Membertou was a prominent chief of the Mi'kmaq. At the time of Biard's writing Membertou was over 100 years old, which would put his "youth" in the early 1500s. Biard offers further evidence of population decline in 1616. He writes: "... they assert that, before this association and intercourse, all their countries were very populous, and they tell how one by one the different coasts, according as they have begun to traffic with us, have been more

⁵ Ralph Pastore, "The Sixteenth Century: Aboriginal People and European Contact," in *The Atlantic Region to Confederation*, ed. Buckner and Reid (Toronto: University of Toronto Press, 1994), p. 22.

⁶ *Ibid.*, p. 23.

⁷ Miller, "Aboriginal Micmac Population," p. 118.

reduced.”⁸ And Pierre Cherlevoix claims when Port Royal was settled in 1605, deserted settlement areas existed in the area, which were said to have been heavily populated before French fishermen began frequenting the coast.⁹

Declining Mi'kmaw populations are also mentioned by Nicolas Denys, Chrestien LeClercq and Anthony Maillard. It should be noted, however, that Denys's contact with the Mi'kmaq began in 1635, with interaction of LeClercq and Maillard occurring later.

Seventeenth-century European reports suggest the Mi'kmaq enjoyed high levels of health prior to contact. “They still lived long lives,” Nicolas Denys writes. “I have seen Indians of a hundred and twenty to a hundred and forty years of age who still went to hunt Moose; the oldest, who neared a hundred and sixty years, according to their account, no longer went.”¹⁰ In a separate passage Denys writes: “They were not subject to disease, and knew nothing of fevers.... They were not subject to the gout, gravel, fevers, or rheumatism.”¹¹

Writing in the last quarter of the seventeenth century, the Recollect Priest Chrestien LeClercq attributes the following statement to a New Brunswick Mi'kmaw:

... before the arrival of the French in these parts, did not the Gaspesians live much longer than now? And if we have not any longer among us any

⁸ *Ibid.*

⁹ *Ibid.*

¹⁰ Nicolas Denys, *The Description and Natural History of the Coasts of North America (Acadia)*, trans. William F. Ganong (Toronto: The Champlain Society, 1908), pp. 399-400.

¹¹ *Ibid.*, p. 415.

of those old men of a hundred and thirty and forty years, it is only because we are gradually adopting your manner of living, for experience is making it very plain that those of us live longest who, despising your bread, your wine, and your brandy, are content with their natural food of beaver, of moose, of waterfowl, and fish, in accord with the custom of our ancestors and of all the Gaspesian nation.¹²

Marc Lescarbot also reports Mi'kmaq reaching "a great age."¹³

Europeans at the time, in contrast, were lucky to reach thirty.¹⁴ Diseases such as smallpox, measles, the plague, leprosy, influenza and yellow fever, which were foreign to North America, laid waste in Europe. Pock-marked Europeans arriving on the shores of the New World must have wondered at the differences in health. Why were aboriginal North Americans so healthy? Five centuries later, academics are still looking for answers.

One popular theory for the lack of diseases in New World populations is traced to the arrival of aboriginal people across the frozen Bering Straight. This theory essentially holds that because the entry point was cold and harsh, diseased immigrants and their microbes died off. The land bridge acted as a kind of germ filter, leaving

¹² Chrestien LeClercq, *New Relations of Gaspesia: With the Customs and Religion of the Gaspesian Indians*, trans. William F. Ganong (Toronto: The Champlain Society, 1910), p. 106. It should be noted that this quote is taken from a long speech which may partially reflect LeClercq's own discontent with France.

¹³ Lescarbot, Marc. *The History of New France*, vols. 1-3, trans. W. L. Grant (Toronto: The Champlain Society, 1914), p. unknown.

¹⁴ Andrew Nikiforuk, *The fourth horseman: a short history of epidemics, plagues, famines and other scourges* (New York: M. Evans and Company, 1991), p. 69.

Old World diseases behind.¹⁵ The germ filter theory may have merits, and it is widely cited. However, the crux of the theory stems from an event that might have occurred thirty thousand years ago. It is a difficult argument to accept on its own.

Other possible reasons for the lack of diseases in the North America compared with Europe may be traced to different living patterns. Andrew Nikiforuk writes:

By the 1400s the Old World had domesticated goats, sheep, cattle, pigs, donkeys and horses. Europeans paid a price for all of this four-legged help and protein by sharing a lot of their microbes. Tuberculosis probably sprang from cows, chicken-pox from chickens, measles from dogs, influenza from hogs and ducks. Domesticated animals and humans probably share more than two hundred diseases in total.¹⁶

Mass agriculture and the domestication of livestock resulted in thousands of people living together with their garbage and sewage. Nutrition was terrible and mortality was high. The result of all this exposure to germs, however, was that Europeans built up immunity to the microbes they unleashed.

Across the ocean, the immune systems of aboriginal people remained vulnerable. Although many communities practiced agriculture, few animals were domesticated.¹⁷ Those that were contributed little if anything to the North American

¹⁵ Martin, *Keepers of the Game*, p. 48.

¹⁶ *Ibid.*, p. 69.

¹⁷ Nicolas Denys, Chrestien LeClerc and Marc Lescarbot all describe Mi'kmaq using dogs to assist in hunting moose.

disease pool. As a result, aboriginal immune systems had little defense against microbes arriving from Europe. The potential for destruction was large.

The specifics of Mi'kmaw population decline immediately following European contact remain unclear. There is evidence indicating high mortality rates. However, it is difficult to reconcile severe depopulation with continued cultural and political integrity. Despite the disease and death that came with European contact, the Mi'kmaq maintained much of their language, culture, politics and world view. This continuity indicates that Mi'kmaw depopulation might not have been as severe as historians such as Henry Dobyns would suggest.

If we move the debate beyond numbers, what remains clear is that the health of the Mi'kmaq had been radically changed for the worse. This chapter will now look beyond demography to the social effects of disease and depopulation. The focus will be on Mi'kmaw health care.

Early contact and Mi'kmaw health care

Unfortunately, most available information on early Mi'kmaw health care comes from the writings of priests and other Europeans. Most of these men were interested in converting the Mi'kmaq, not understanding their healing practices. Early reports are superficial and are often coloured by the Christian world view of their authors. Chrestien LeClercq writes:

In fact these Indians imagine that certain ones among them have communication with the Devil, from whom they hope to learn that which they wish to know, or to obtain that which they ask. They believe that in all their maladies there is, in the part afflicted, a Devil, or germ, which these barbarians, whom we call jugglers, have the power to make come out, and they believe that these jugglers can restore health to the sick through their breathing, their songs, and the horrible postures which they take in their wigwams.... It is true that I have never been able to discover any pact, explicit or implicit, between the jugglers and the Devil; but I cannot persuade myself on that account that the Devil is not predominant in their nonsense.¹⁸

LeClercq continues to describe a curing ceremony:

... he chants some song in praise of the Ouahiche,¹⁹ and he makes some postures and frightful contortions: he comes near to, and draws back from, the sick man: he blows several times upon the affected part: he plants and drives deep into the ground a stick, to which he attaches a cord, and through this he passes his head as if he would strangle himself. Here he

¹⁸ LeClercq, pp. 215-216.

¹⁹ LeClercq likely misheard this word, which he wrongly translates as "Devil."

makes his invocations until he has worked himself all into a sweat and lather, making believe that, because of all these shameful and violent contortions, the Devil has at length come out, and that he even holds him bound in order that he may grant health to the sick person. He then calls the Indians and makes them enter the wigwam; and he shows them the cord which, says he, holds the Devil enchained. he cuts from it a piece, and thus lets him escape, promising that the man will infallibly get well.²⁰

Nicolas Denys, a French trader, spent many years among the Mi'kmaq in the seventeenth century. His accounts of Mi'kmaq health care acknowledge the existence of a pharmacopoeia: "They had knowledge of herbs, of which they made use and straightway grew well."²¹ He also refers to sweat lodges as "their general remedy," noting that "our Frenchmen make themselves sweat like them ... and are never inconvenienced thereby."²² Denys describes a ceremony similar to that related by LeClercq:

... there were old men who claimed to speak to the *manitou*, that is to say, the Devil, who came to whisper to them. These fellows put many superstitions into the mind, of which I have mentioned several in the foregoing. They were men who had some cunning more than the others, and made them believe all they wished, and passed for their physicians.... For this purpose they set themselves a dancing, and speaking to their *manitou*. They danced with such fury that they emitted foam as big as fists on both sides of the mouth. During this performance they approached

²⁰ LeClercq, p. 218.

²¹ Denys, p. 415.

²² *Ibid.*, pp. 416-417.

the patient from time to time, and at the place where he had declared he felt the most pain, they placed the mouth upon it, and blew there with all their might for some time, and then commenced again to dance.... And often in fact the man got well through imagination.²³

Similar accounts of healing ceremonies and the role of those involved are also given by Biard, Marc Lescarbot, the Sieur de Diereville and Abbe Pierre Antoine Simon Maillard.²⁴

These early European descriptions of Mi'kmaw health care are valuable but one-dimensional. They record what French observers could see and what they thought they could understand. However, as James (Sakej) Youngblood Henderson writes, this was a limited perspective:

European visitors, traders and guests to Mi'kma'ki lived in cognitive solitude, separate from the Mi'kmaw worldview and language. They may have shared a space but never the same context. Although they could observe, speculate about and describe within their own context much of what the Mi'kmaq did, Mi'kmaw worldview or ecological context was usually incomprehensible to them.²⁵

²³ *Ibid.*, pp. 417-418.

²⁴ Notes by Ganong, in Denys, p. 417.

²⁵ James (Sakej) Youngblood Henderson, *The Mi'kmaw Concordat* (Halifax: Fernwood Publishing, 1997), p.23.

Aboriginal history cannot be adequately explained from a foreign world view.²⁶ But a number of important features in the healing process are still apparent, even in a colonial literature.

Perhaps the most important component of the healing process revealed in these description is the belief that sickness is not rooted in the physical body. The Mi'kmaq patients described by LeClerq and Denys are not sick because something has gone wrong with the mechanics of their bodies. They believe they are afflicted with "a Devil, or germ." To confront this affliction, the healers bring the spirit world into the healing process. Through dancing and ceremony, forces external to the patient are harnessed by the healer to play a role in the patient's healing.

It is also important to recognize that the healing ceremonies described by LeClerq and Denys involve more than just the patient and healer. They involve the entire community. The community witnesses the ceremony and the dance. And when the healer described by LeClerq releases the "devil" or force which had inflicted his patient, he brings everyone into the wigwam to watch. The community plays an active role in the patient's healing, and when the patient is freed from suffering the entire community benefits.

What is alluded to in these accounts is that Mi'kmaq health care was an interrelated process, involving the healer, the patient, the patient's mind, body and spirit, her family, community and the spirit world. Essentially, healing is tied into every facet of being alive and living with others. This is the context in which

²⁶ *Ibid.*, p. 23.

Mi'kmaw medicine and healing must be considered. Massive depopulation and disease on its own would not have been enough to overturn healing practices. For this to occur would necessitate tremendous social disintegration and the breaking of a spiritual edifice. The entire Mi'kmaw world view would have to collapse. This did not occur.

There is no doubt European diseases shook the framework of Mi'kmaw society. Depopulation frayed family and community ties. And the death of so many, especially elders, would have hit at the political and spiritual heart of a community.²⁷ However, disease and depopulation did not cause the Mi'kmaq to reject their traditional belief system. There is simply too much evidence indicating the Mi'kmaq were fully aware they were dying because of contact with the French.

One of the most telling pieces of evidence comes from Pierre Biard. Writing in the early 1600s, Biard says of the Mi'kmaq: "They are astonished and often complain that since the French mingle and carry on trade with them, they are dying fast, and the population is thinning."²⁸ Biard later notes that some Mi'kmaq felt that French traders had tried to poison them with adulterated food.²⁹

²⁷ Discussing epidemics among the Huron, Trigger notes that the very old and the very young often suffered the most. (*Natives and Newcomers*, p. 250)

²⁸ Ruth Holmes Whitehead, *The Old Man Told Us: Excerpts from Micmac History 1500-1950* (Halifax: Nimbus Publishing Limited, 1991), p. 39.

²⁹ Bruce Trigger, "Ontario Native People and the Epidemics of 1634-1640," in *Indians, Animals, and the Fur Trade: A Critique of Keepers of the Game*, ed. Shepard Krech III (Athens: The University of Georgia Press, 1981), p. 32.

European contact also brought Christian missionaries to Mi'kmaw communities. The early relationship between the Catholic Church and the Mi'kmaq is a complex and layered topic. Most historical scholarship on this topic is one-sided, with the majority of research coming from European sources. In 1997 James (Sakej) Youngblood Henderson published *The Mi'kmaw Concordat*. Henderson grounds his study in the Putu's teachings, or the oral traditions, of the Mi'kmaw Sant'e Mawio'mi,³⁰ the traditional council of elders. Henderson blends these teachings with historical, legal and religious scholarship to produce a work that is insightful and unique.

In an introduction to Henderson's book, Marie Battiste writes that at the beginning of the cycle of *Jenu* (the Ice Age), during a great famine, the spirit of the sun came to an elder in a dream. The elder was approached by a young man, who offered the elder three crosses. One of the crosses would serve the people in times of conflict; another would grant them safety on their voyages and new experiences; and the third cross would aid the people in making decisions for future generations. The elder awoke, and the symbols of his vision were explained to the village council and to allied families.³¹

Many generations later, faced with increasing French settlement in Mi'kma'ki,³² the Mi'kmaq began to question the future of their relations with the

³⁰ Sant'e Mawio'mi may be roughly translated as "holy gathering."

³¹ Marie Battiste, "Nikanikinu'tmaq," in: Henderson, p. 16.

³² "Mi'kma'ki," referring to Mi'kmaw territory, may be roughly translated as "land of friendship."

Europeans. Widespread sickness and death reminded the elders of a great war that Kluskap had prophesied. The Mi'kmaq were aware of massacres and enslavement that had taken place far to the south. Messamouet, a prominent Mi'kmaq chief and relative of Membertou, had been to France where he had been exposed to Catholicism and many of the religious and secular tensions in European society. Henderson writes that Messamouet offered the Mawio'mi a solution that combined his experiences in France with a vision that had come to him in a dream.³³

Messamouet's vision sought to avoid the warfare prophesied by Kluskap in a manner consistent with the vision of the three crosses. Messamouet informed the Mawio'mi that the keeper of the third cross of the ancient prophesy was the Holy See, viewed as the keeper of European spiritual forces. The Mawio'mi therefore decided to enter into a peaceful alliance with the Holy See, the keeper of the third cross:

Most of the Mi'kmaq families astutely saw that Messamouet's vision was the best option. Events along the southern coast of America had shown them that secular control by the European monarchs would eventually lead to violence. Perhaps as a Catholic republic in the Holy Roman Empire, under the protection of the spiritual leader of the European monarchs, the Mi'kmaq could maintain their independence, freedom and lifestyle.³⁴

Membertou and Messamouet began an alliance with the Holy See in 1610. The Mi'kmaq presented the Church with wampum belts, and about 140 Mi'kmaq were

³³ Henderson, p. 82.

³⁴ *Ibid.*, p. 84.

baptized. Henderson writes that by 1630 most Mi'kmaw families had joined this alliance as an independent Catholic republic.³⁵

The Mi'kmaw alliance with the Catholic Church was more than a political bond. Catholicism had a tremendous impact on Mi'kmaw world view. However, Catholicism did not replace Mi'kmaw spiritual traditions: "The conversion processes that led to Mi'kma'ki becoming a Catholic nation were seen by the Mi'kmaq as enfolded within their existing belief system.... The Mi'kmaq saw their conversion to the third cross as a continuation of an old dialogue involving new spiritual forces."³⁶ According to Henderson, the Mawio'mi synthesized their aboriginal beliefs with Catholic teachings. They questioned and challenged Catholic beliefs, refusing to accept the new teachings without reflection or without integrating them into their own world view.³⁷

Evidence of the combination of Catholicism and Mi'kmaw traditions may be found elsewhere as well. Marc Lescarbot describes the Mi'kmaq chief Membertou incorporating excerpts of Catholic Mass into his chants.³⁸ Alfred Bailey writes that Jesus was first identified with the sun, or the spirit that lived within it. Kluskap took on characteristics of Noah; at other times he was the rival or forerunner of Christ.³⁹ Christianity became integrated into Mi'kmaw world view. It did not replace it.

³⁵ *Ibid.*, p. 86.

³⁶ *Ibid.*, p. 90.

³⁷ *Ibid.*, pp. 91-92.

³⁸ Whitehead, *The Old Man Told Us*, p. 26.

³⁹ Martin, *Keepers of the Game*, p. 58.

Any conflict of cultures will result in adaptation and adoption. And this is certainly true concerning contact between the Mi'kmaq and Europeans. However, contact with Europeans did not cause the Mi'kmaq to give up their traditional beliefs. The Mi'kmaq accepted trade goods and even Jesuits into their communities without accepting everything the Europeans had to say. LeClercq records Mi'kmaw children cajoling him for trying to persuade their mother to abandon certain customs. He says the children told him, "Indians had their manner of living, as well as the French, and that we should follow our maxims without wishing to oblige them to abandon theirs."⁴⁰

A frequently cited statement by Chrestien LeClercq gives some insight into early French-Mi'kmaw interaction. LeClercq attributes the following passage to a Mi'kmaw speaker:

Thou sayest of us also that we are the most miserable and most unhappy of all men, living without religion, without manners, without honour, without social order, and, in a word, without any rules, like the beasts in our woods and our forests, lacking bread, wine, and a thousand other comforts which thou hast in superfluity in Europe. Well, my brother, if thou dost not yet know the real feelings which our Indians have towards thy country and towards all thy nation, it is proper that I inform thee at once. I beg thee now to believe that, all miserable as we seem in thine eyes, we consider ourselves nevertheless much happier than thou ... there is no Indian who does not consider himself infinitely more happy and more powerful than the French.⁴¹

⁴⁰ LeClercq, p. 228.

⁴¹ *Ibid.*, pp. 104, 106.

Similar sentiments are echoed by Pierre Biard, who describes the Mi'kmaq, "holding their heads so high that they greatly underrate us, regarding themselves as our superiors."⁴²

What emerges from the story of contact, then, is disease, depopulation and a culture that changed, evolved, reformed and adapted. In the final analysis, however, the Mi'kmaw world view was never rejected. What this means for the history of Mi'kmaw health care is that the cultural framework of medicine and healing remained whole as well.

This is not to say Mi'kmaw health care practices did not change as a result of contact with Europeans. High mortality rates will strain the cultural foundations of any health care system. And Catholicism had a strong influence on Mi'kmaw communities. In the end, Mi'kmaw health care changed and adapted as did the rest of Mi'kmaw society. Indeed, some traditional Mi'kmaw medicines make use of plants and animals originally not found in North America. European intrusion also resulted in many traditional healing practices going underground for a number of years. But these practices never disappeared.

The continued use of traditional medicines is confirmed in Mi'kmaw oral histories, and evidence of their use turns up in European written records as well. Patrick Campbell describes the interior of two Mi'kmaw wigwams he encountered on the banks of the Restigouche river in 1791:

⁴² Martin, *Keepers of the Game*, p. 55.

Besides these, I saw a root drying, which the Indians use as a cure for many complaints, and took a piece of it along with me. The name they give it, I think, is Calomet. It has a strong spicy taste, an aromatic scent, and heats the stomach almost as much as dram.⁴³

Chapter one of this thesis describes the dismissive attitude of the orthodox medical profession toward traditional Mi'kmaw medicine in the 1800s as it was practiced by Peter Paul Toney Babey and John Thomas Lane. Similar sentiments are recorded by Dr. Edward Jennings in 1847. Jennings describes an outbreak of typhus among Mi'kmaq living in the Dartmouth area: "A number of Natives were successively attacked and died having had no medicine administered save the decoction of some astringent barks, which certainly hastened the fatal termination."⁴⁴

Jennings's account also alludes to the lack of orthodox medical care provided in many Mi'kmaw communities.⁴⁵ Traditional medicines were often the only treatment available. As late as the 1920s, Mi'kmaw elder Margaret Johnson recalls the absence of a medical doctor for people living in Chapel Island.⁴⁶

These brief examples are included to show that the use of traditional medicines continued well after initial contact with Europeans. Even in recent history, with the

⁴³ Whitehead, p. 180.

⁴⁴ *Ibid.*, p. 231.

⁴⁵ For a more detailed description, see Peter Twohig's "Health and the Health Care Delivery System: The Micmac of Nova Scotia (Master's Thesis, Saint Mary's University, 1991).

⁴⁶ Margaret Johnson, personal communication to Trudy Sable, date unknown.

arrival of tens of thousands of Europeans, reserves, the Indian Act and residential schools, Mi'kmaw traditional healing practices persisted. They are continued today.

Conclusion

The arrival of Europeans in the New World may be described as a biological Armageddon, one of the greatest demographic disasters in the history of the world. The story of contact for the Mi'kmaq reflects this. Disease was prevalent, and mortality rates were high. This chapter has attempted to explore the effects this had on traditional Mi'kmaw health care.

For the Mi'kmaq, traditional medicine and healing are part of a larger belief system, involving a patient's mind, body and spirit, his family, community and the spirit world. This is the context in which traditional medicine must be considered. When discussing the effects of contact on traditional Mi'kmaw health care, it is necessary to look at how contact affected the Mi'kmaw belief system. This chapter suggests that, despite massive depopulation and the intrusion of a foreign culture, the foundations of Mi'kmaw world view remained whole. Although Mi'kmaw medicine and healing underwent adaptations following European contact, the cultural and spiritual framework guiding medicine did not change. Mi'kmaw health care before and after European contact stem from a common root.

Chapter Four: Mi'kmaw Traditional Medicine as Cultural Expression

Introduction

Basil Johnson begins his foreword to Rupert Ross's book *Dancing with a Ghost* with a story. He describes a meeting between a European missionary and the Six Nations in 1805. After hearing what the missionary had to say, Red Jacket, a Seneca orator, rejected the missionary's overture on behalf of his people with words that translate into English as: "Kitchi-Manitou has given us a different understanding."¹ Johnson concedes that Red Jacket formally represented only the Six Nations; however, he states Red Jacket spoke for all aboriginal peoples.

Johnson's straightforward point is that when Europeans arrived in North America, they did not contact less civilized versions of themselves. They encountered developed societies that embraced different cultural traditions and ways of life. Native and Western societies did not evolve from similar roots, and they did not follow similar paths to get to the present. Western and aboriginal societies developed in isolation from each other. And many aboriginal communities have their own cultural frameworks pertaining to law, education, child development, indeed every facet of living in a society with others. It is the goal of this chapter to explore these cultural frameworks as they relate to traditional medicine and health care. The focus will be on the Mi'kmaq inhabiting what is now known as Atlantic Canada.

¹ Basil H. Johnson's foreword in: Rupert Ross, *Dancing With a Ghost: Exploring Indian Reality*, (Markham: Octopus Publishing Group, 1992), p. vii.

Limitations

This chapter is not a complete piece of work. My research is drawn from secondary sources, conferences, site visits and interviews. Those I have spoken with, and who have shared information, have helped me place Mi'kmaw healing in a cultural context, and I am grateful for this knowledge. However, I am writing about a culture that is not my own. This chapter is therefore written from an outside perspective.

An additional point is that cultures are neither constant nor static. They change and evolve. They adopt and adapt. Given the diversity of people and communities, this chapter may misrepresent many aboriginal people. It is not meant to do so. The intent is to discuss a number of similar themes concerning traditional medicine, and to show that behind a different method of health care, often lie different concepts of medicine and healing. What follows is essentially what I have been told. I hope it is conveyed accurately in this paper.

This chapter is intentionally narrow in scope. The intent is to look at a limited number of cultural values and traditions that have a direct effect on the way health care is perceived. Holistic healing, the ethic of non-interference and a healer's² relation to his patient and community will be discussed as they relate to traditional health care.

It is also worth noting that this chapter relies heavily on oral histories and personal communication. I will not discuss the value of oral histories here in detail, but a short story is revealing. While in Malagawatch this October, Margaret Johnson, an elder from Eskasoni,

² A variety of terms are used in this essay to describe an individual involved in the some aspect of medicine and healing, none of which are sufficiently accurate. I have not been able to find an English word that is wholly acceptable. The Mi'kmaw term told to me by Murdena Marshall is *nuji npiteket*, which may be roughly translated as "a person who is capable of healing." The term is gender-neutral.

told me a detailed story about two boys spying on a woman giving birth. Thinking this might have been something Margaret had seen herself, I asked her where the event had taken place.

“Antigonish,” she said.

“How long ago,” I asked.

“Oh, maybe 400 years ago. This old lady told me about it. She was 75.”

Holistic Healing

The idea of holistic healing is best understood as a component of traditional Mi'kmaw world-view. It is neither within my abilities, nor within the scope of this essay, to discuss Mi'kmaw world-view in detail. However, there are a few things that are important to understand in the context of holistic healing. The Mi'kmaw traditional world view is one of interrelation and interdependence. Some insight may be found in the Mi'kmaw language.

Consider the following possible translations of “God” or “Creator,” given to Trudy Sable by the Mi'kmaw linguist Bernie Francis:

Kisu'lk: the one who created us; he, she, it who (or that which) created us.

Ankweyulkw: he, she or it who (or that which) looks after us.

Jikeyulkw: he, she, it who (or that which) watches after us or over us.

Tekweyulkw: he, she, it who (or that which) is with us.³

What is important to recognize is that the Creator is not defined in isolation. The Creator is viewed in relation to a process involving something or someone else, reflecting a

³ Trudy Sable, “Another Look in the Mirror: Research into the Foundations for Developing an Alternative Science Curriculum for Mi'kmaw Children,” MA thesis (Saint Mary's University, 1996), p. 79.

world view of interrelation and interdependence.⁴ The same concept holds true for the Mi'kmaw term for father. There is no independent Mi'kmaw word meaning "father." It must be attached to a possessive pronominal marker. *Nujj* means "my father," the "n" indicating possession. Similarly, the blessing *Ta'nteluisit wekwisit niskam*, translates to, "In the name of the father who has a son." In Mi'kmaw, a father cannot exist isolated from someone else. Even in reference to a father who had lost a child, one would say "*wunjanip*" meaning, "he or she had a child."⁵

A final example of language reflecting a relational world view involves the Mi'kmaw word *kamulamuk*, meaning heart. The following passage is taken from Sable's thesis:

In this word, the intuitive and intellectual, or the cognitive and emotive, are inseparable. The whole concept embodied in this word is better translated "heart/mind." When a Mi'kmaw speaks, it is from the notion of mind and heart being inseparable, not simply that the mind is a function of the brain. A Mi'kmaw speaker might say, "*Atelewey nina kamulamuk*" or "And then I said in my heart..." meaning heart/mind (Francis, personal communication, 1995).

A number of dualisms -- physical/ mental, intuitive/ intellectual, rational/ emotional, objective/ subjective -- inherent in western science, are missing. Implicit in the word for heart, is the notion of mind. You cannot have mind without heart. The question arises whether anything can be extracted and isolated

⁴ *Ibid.* Sable also cites Francis explaining the term *Niskam*, which was adapted by early missionaries to connote "God." The Jesuits were uncomfortable perceiving God as being both or either male and female. They consequently assigned *Niskamij*, meaning "grandfather," "step-father" and "father-in-law," to communicate the concept of "God." The *ij* was dropped by the missionaries, and the term evolved to connote a masculine God. Murdena Marshall notes *Niskamij* can also mean "the Sun."

⁵ *Ibid.*, p. 82.

from the relationship or constellation in which it occurs, e.g. can a father exist without a son?⁶

The interrelation of objects, spirits, and energies is a pattern which emerges in many components of traditional Mi'kmaw world view. Everything in the universe is connected, is part of the same web. Vaughn Doucette lives in Eskasoni and practices traditional Mi'kmaw spirituality. He spoke about these connections:

You're talking about things that are really, I don't know how to put it in English, intangibles. Okay, you have to open up your mind to the unseen world around us. And in the Mi'kmaw view of spirituality, everything is important, all the world is important. There's a continuing cycle happening. The only way that I can probably give you a visualization of that, it would be to imagine yourself as standing on the ground. Your feet are on the earth and your head is in the air.

Okay. From that point of view, your head is in the air, or spirit world, and your feet are on this world, the physical world, the three dimensional world. So from that point of view you're a part of a cycle. If you were to draw a circle around that figure of the person standing on the ground with his head in the air, the energy exchange that happens is in a circle....

So the ideal, the ideal exchange of energy, would be in a circle. What you are putting out is going back into the cycle and is coming back again. So what you put out is coming back on you. There's a saying that goes ... what goes around comes around. And that's probably an aboriginal saying, or an aboriginal understanding of energy, and energy exchange in the world and the universe that we know.

⁶ *Ibid.*, pp. 86-87.

Health and wellness must be considered in the context of this same interrelated universe.

Sickness is not limited to the physical body. It involves a patient's emotions, mind and spirit, his family, his community and the spirit world. Healing must address this reality.

Medicine and healing that is undertaken from a holistic healing perspective begins with the understanding that an individual's physical body is only one factor in that person's total wellness. Murdena Marshall is a Mi'kmaw scholar living in Eskasoni. She said "the human body is comprised of four components, one of them of course being the body, then the mind, then the emotions, then of course the spirit. Those four have to jive in order for one to have health."⁷

Joel Denny lives in Eskasoni and is knowledgeable about traditional Mi'kmaw culture and spirituality. Denny described the human body as a shell for the spirit. If the spirit is hurt, this will affect that person's total health. Someone's spirit could be harmed by factors affecting his mind, heart and body. The spirit can also be weakened by factors external to the body, including the loss of language and the environment. All these things are connected, and all are a part of being healthy.⁸ A patient's family and community also play a vital role in that person's health. For example, the disorientation of a child's family might contribute to that child's sickness. But by the same token that family's reconciliation might also aid the child's health.⁹

⁷ Murdena Marshall, personal communication, 1997.

⁸ Joel Denny, personal communication, 1997.

⁹ Murdena Marshall, personal communication, 1997.

If a person's health is to be considered from a holistic perspective, treatment, too, must operate within the same parameters. If a patient is suffering from spiritual or emotional pain, this must be addressed before the body can be healed. If the patient's relations with his family and community are strained or broken, these too must be mended. Treatment can take on a variety of forms. Often no medicines are given at all:

Murdena Marshall: You know, sometimes there is no medicines applied at all.... The person who comes to help you heal doesn't have in their medicine bundle different medicines. It's just they're working with your spirit, working with your mind. They're opening up your emotions in the hopes that the body will benefit from all of this.... So the other person comes in and tries to look at it from a holistic point of view and from a spiritual point of view. And works with you in trying to bring your spirit up to a level that is acceptable.

Petrou: So what will that person do?

Marshall: That person just talks, you know, and assures the person ... And sometimes the person that's helping with the healing doesn't even say anything. The patient himself does all the talking. So he gets in his language and he's able to express himself fully. And most of the time when I go into hospitals they tell me, "Well, go tell that to the doctor, just what I've told you." Because they're unable to express themselves. And just that sometimes is enough, knowing that their own feelings and their own messages are now going to be conveyed to the people who are taking care of them.¹⁰

¹⁰ Murdena Marshall, personal communication, 1997.

And healing may not even involve interaction with the person who is sick. Describing Margaret Johnson, a Mi'kmaw elder, Murdena Marshall said, "Granny is considered a healer, without even going to the woods and getting medicine. Just her presence in the room is enough, and she'll be able to lift the spirits and help you in the process of healing."¹¹

What is important to recognize in these examples is that reasons for a person's health involve his body, mind, emotions and spirit. They include his family, community, the spirit world and all the energies in the universe. All play a role in that individual's health, and consequently, all are part of the healing process. Good health means more than the absence of disease. And healing must look at the larger picture to understand a person's sickness. It is not enough simply to treat the symptoms of a sickness. Healing must consider everything.

Medicinal herbs and plants are major components of traditional Mi'kmaw medicine and healing, as are medicines derived from insects, fish and animals. Their uses are varied and complex; so too are the possibilities of how these medicines became integrated into Mi'kmaw society.

The origin of Mi'kmaw medicines is discussed in a story, given by Jessie Jeddore at the Micmac Association of Cultural Studies First Elders Conference in 1973, and translated by Sarah Denny. In this story, a pregnant virgin is deserted by her community in the middle of the winter. In the spring, her infant son is found alive by young men, although the woman has perished. The infant tells the men: "I was sent down by the Great Spirit to help the

¹¹ Murdena Marshall, personal communication, 1997.

Micmac people. Your people are dying of sickness. I have come to show you the herbal medicines of your land.” After showing medicines to the two men, the infant asks them to take him to foggy area near a lake. He tells them he can be found again in a similar area if he is needed to prevent sickness.¹²

Another story concerning medicines is related by Sunset Rose Morris in her book *Our Story Tellers (Atugwewinu)*. Morris retells a story told to her one night when she was a young girl. The story concerns two twin girls, Deer Girl and Gentle Turtle. Before their birth, the twins’ parents receive visions in which they are told their daughters will leave them forever when they reached the age of ten. The vision is fulfilled, and the day after the two daughters leave their parents, they return as a deer and turtle. They have become animal-human people. “The family of four reunited once again,” Morris writes. “But there were two worlds, one of humans and the other of animals combined.” As the story continues, Deer Girl and Gentle Turtle grow sick and die. Deer Girl is buried by a river bank, and the Creator causes alder to grow plentiful at her grave site. Gentle Turtle’s is buried under a spruce tree; her gift is spruce gum. Both are used as medicines.¹³

Morris’s story alludes to the spiritual component of Mi’kmaw medicine and its origins. Her story also reveals the close connection, and interrelation, between human beings, the animal world and medicines. Concluding the tale, Morris writes, “Aboriginal Mi’kmaq story tellers in the past often told tales about their people turning into animals or

¹² Unpublished paper. A copy of the story was lent to me by Trudy Sable. Sarah Denny also showed me a copy in Eskasoni.

¹³ Sunset Rose Morris *Our Story Tellers (Atugwewinu)* (Membertou First Nation: Mukla’qati Books, 1996), pp. 52-59.

things like stones.”¹⁴ This interrelation between the spirits of medicines, animals and people is an integral component of the healing process.

Mi'kmaq also learned about medicines by watching animals. Caroline Gould, a Mi'kmaw elder, said learning from animals might account for knowledge as to which medicines are good, and which are poisonous. She added that when collecting medicines, she finds some that are partially eaten.¹⁵ In a presentation paper entitled, *MicMac People and the River System*, Stephen J. Augustine states: “If you watch these life forms closely, they even have their natural forms of medicines. Moose eat calumus root, beech leaves and cedar buds when they are sick; if they are wounded and bleeding they will lay on dry leaves or roll in the mud to stop from bleeding to death.”¹⁶ Joel Denny reinforced the role animals play in teaching medicines, stating, “It’s something that could be taught by the animals also ... we not only were taught by people, we were taught by animals, which is that we observe the animals and what they eat. So that’s another form of teaching.”¹⁷

Joel Denny said knowledge of medicines has come to the Mi'kmaq through visions, dreams, gifted individuals and the teachings of elders. What is perhaps more important than the specifics of how the Mi'kmaq began using these medicines, is to understand that Mi'kmaw medicines have existed for many years:

¹⁴ *Ibid.*, p. 58.

¹⁵ Caroline Gould, personal communication, 1997.

¹⁶ Stephen J. Augustine, “MicMac People and the River System,” (Presentation paper for the Workshop on Estuaries in the Southern Gulf of St. Lawrence, Kouchibouguac National Park, November 13-15, 1996), p. 2.

¹⁷ Joel Denny, personal communication, 1997.

Ask yourself, why did native people have every name and description of these things? It wasn't something that just happened [snap] 500 year ago, 200 years ago, when the Europeans came here. It must have evolved a long time. And it must have gone through a number of questions before these were accepted. You know? So they must have tested, or discussed ... some sort of form of understanding for these to take place.¹⁸

Regardless of how the Mi'kmaq first learned about traditional medicines, they have been used for generations.

Like all components of Mi'kmaq traditional health care, medicines must be considered holistically. A medicine's pharmaceutical properties are a small factor in the healing process. Medicines exist as part of a web of life in which the person using the medicines, the patient, the community, the environment and spirits are all connected. An individual using traditional medicine understands and works with these connections. Joel Denny elaborated: "It's a very difficult thing to think about. It can take a whole life time to understand it. But again, this person that does this medicine understands, and is able to understand, the spirit of the animals, or the spirits of the medicines that are available.... It takes a long time"¹⁹

Denny also discussed the seven worlds, the seven stages of consciousness, the seven stages of subconscious, the seven life-forces within the body. All of these are connected, and all must be understood to use medicine effectively. Denny continued: "But again, each world occupies, again, some sort of spiritual connection. In order for you to understand that, you

¹⁸ Joel Denny, personal communication, 1997.

¹⁹ Joel Denny, personal communication, 1997.

also have to be able to communicate some form with the spirits. And they teach you within this form, within this medium, of these worlds.”²⁰

Mi’kmaq and native medicines are often depicted in books and articles referring to “folk remedies,” usually including a checklist linking ailments to cures. This approach fails to understand the spiritual component involved in using medicines. Simply being able to identify medicinal herbs and plants means little in the larger healing process. Without the cooperation of the manitu, or life force, of a medicinal plant, the mere form of the plant will be ineffective.²¹

A person using traditional medicines understands this, and she will consider all factors influencing both the medicines used and the patient who is treated. Joel Denny is quoted:

No matter how a person has studied the plants, this person has to identify other things.... And so that’s the part that no matter how people identify medicines and write down whatever somebody else says, has said, about the medicine, that doesn’t matter. It matters, what matters, is that to understand medicine and to realize that native people might have used this, and used it well. Enough to find a way with all the illnesses that they have.... Native people lived a long time.²²

All these factors will influence the way medicines are used to treat a patient. There is no formula that is written in stone, no set prescription that may be followed. Murdena

²⁰ Joel Denny, personal communication, 1997.

²¹ Marie Battiste, “Nikanikin’utmaqñ” in: James (Sakej) Youngblood Henderson, *The Mi’kmaq Concordat* (Halifax: Fernwood Publishing, 1997) p. 15.

²² Joel Denny, personal communication, 1997.

Marshall also spoke about factors beyond a patient's physical symptoms which will influence how a medicine is used:

But sometimes, even though this helped someone one time ago, doesn't mean that it will help you this time. The medicine person knows what will be good for you, after talking with you and having mutual trust. It will come to the medicine person as to exactly what medicines would be good for you now.... The medicine person has special powers, or special understanding of humanity, that they're able to read you and to understand you. Not only from a physical point of view, but also in the mental and the spiritual state. They're able to look at all of that, and that's very important.²³

Simply matching symptoms with appropriate medicines will not work. Two neighbors living side by side, both with the same physical sickness, may be prescribed completely different treatments.²⁴

The healing process involves a cooperative relationship between the medicine, the healer and the patient. The healer may be considered the medicine itself. And the healer may also act as an intermediary, facilitating healing by introducing the patient and the medicine.²⁵

The physical preparation of the medicines themselves also requires extensive knowledge and understanding. A medicinal plant may have seven roots, and within each root will be seven strands of medicine. A strand of medicine may then contain several additional

²³ Murdena Marshall, personal communication, 1997.

²⁴ Murdena Marshall, personal communication, 1997.

²⁵ From a discussion at my thesis defense with Murdena Marshall, Harold McGee and Trudy Sable, 1998.

strands.²⁶ Other medicines must be left in the sun to neutralize external poisons before use. Some must be picked in the morning, others at midnight, others slightly after midnight. If not prepared properly, some medicines may become toxic.²⁷ David Gehue lives in Indian Brook and practices traditional medicine. “It’s a science to say the least,” he said. “And it takes many, many years to develop the science. And it’s a hands-on science. The elders have taken me out now and walked me through it, and I’ve made some mistakes.”²⁸

As a final note concerning medicinal plants and animals, it should be pointed out that determining the specific pharmaceutical properties these medicines may have involves somewhat contentious issues. Caroline Gould has said she would like to send certain medicines to a lab in Halifax. Others point out that these medicines have been proven and do not need to be judged by Western standards. This view is supported by Joel Denny: “We have gone through thousands and thousands of years of research on this already.”²⁹ Mi’kmaw elder Noel Knockwood holds a similar view: “You cannot put God under a microscope.”³⁰

²⁶ Joel Denny, personal communication, 1997.

²⁷ David Gehue, personal communication, 1997.

²⁸ David Gehue, personal communication, 1997.

²⁹ Joel Denny, personal communication, 1997.

³⁰ Noel Knockwood, personal communication, 1998.

Ethic of Non-Interference

Murdena Marshall describes individual non-interference as “the one concept that baffles non-Natives the most.”³¹ Non-interference involves counseling and giving advice without giving explicit directions. It translates into health care that avoids direction and confrontation. Non-interference is frequently used in treating the mind and spirit. It also means involving a patient in the healing process and respecting their choices.

Lisa Dutcher was one of the first two aboriginal people to graduate from the University of New Brunswick’s School of Nursing in 1990.³² Dutcher is quoted in the May/June 1995 addition of the *Mali-Mic News* as saying: “We have some patients who are traditionalists. If they don’t want to take medication because it is not part of their belief, we inform them of their options and respect their choices.” Two years later, at the 1997 Aboriginal Nurses Association of Canada Teaching Conference, Dutcher emphasized the importance of empowering patients with choice. She said that aboriginal people in Canada have a history of having decisions forced on them and, consequently, will resist a controlling environment in health care. Dutcher attempts to put as much control back into the hands of her patients as possible. “That’s the approach that has worked well for me, working with my people,” she said.³³

³¹ Murdena Marshall, “Values, Customs and Traditions of the Mi’kmaq Nation,” in *The Mi’kmaq Anthology*, eds. Rita Joe and Lesley Choyce (Lawrencetown Beach: Pottersfield Press, 1997), p. 55.

³² Shelly Leighton graduated in 1990 as well.

³³ Lisa Dutcher, personal communication, 1997.

Murdena Marshall stressed the importance of a patient's personal choice in traditional Mi'kmaq medicine. She suggested a patient's personal choices and decisions are more important with traditional medicine than with Western biomedicine. For example, a healer gives advice, not orders. And an individual seeking healing approaches a healer herself. A healer will not approach a patient first.³⁴

Inevitably, conflicts will arise between a belief system that focuses on the direction of doctors, and one that emphasizes the choices of patients. Clara LeBlanc, a Mi'kmaq woman living in Saint John, has run into this problem. I met with Clara LeBlanc in her home office of Aboriginal Futures in Saint John. During our conversation, the phone rings continuously. One man calls to ask if Aboriginal Futures helps people find work. "We help aboriginal people find work," she says into the receiver. There is a pause. "Do you know what 'aboriginal' means?" she asks, "Indian." The man is not an Indian. LeBlanc tells him who to call and hangs up.

Clara LeBlanc described what occurred when she checked herself into the hospital for high blood sugar levels:

I was actually feeling better when I went into the hospital. Well, you know, the doctors, "Oh we're going to book you in right away." "No you're not." Who are you to tell me what you're going to do with me? I need to do certain things before I come in here, and one of them is take my car home, the other one is make sure my family is okay, and the other one is to make sure I'm spiritually all set to come in here." And they were having a fit, because I left and it was 27.9. I wouldn't dare tell them it was 33 the day before that. And the first thing they automatically

³⁴ Murdena Marshall, personal communication, 1998.

want to do is give you insulin....We'll book you in and pump lots of insulin in you....

They wanted to pump the insulin in me, and I said, "No." So I left. And I came home and I started, you know, I walked and I drank distilled water, and just ate meat. And within four days I was down to nine....

When I went in and the doctor said, "We're going to put you in." You know, it's like who ... are you to tell me what you're going to do with me? If he had of said to me, "I think the best thing for you would be to stay for a while, would you consider that?" Then I would have said, "yeah okay, yeah, I'll stay." But he told me what he was going to do with me. This is my life. And I was really upset. I was really upset.³⁵

Intrinsic in the ethic of non-interference is respect for an individual's autonomy in making decisions. Suggestions are given, orders are not. Clara LeBlanc's doctor did not understand this. He assumed he had authority to dictate her treatment. He didn't, and conflict resulted.

Empowering a patient with choice involves more than giving a patient a say in his treatment. David Gehue explains one of the first things he does is instill in his clients the understanding that they have the ability to shape their own lives, to control their own health. In his own words, he gets them ready for their own healing. This empowerment is linked to holistic health and connections between the mind, body, spirit and emotions. Just as an individual with a sick or damaged mind and spirit may consequently become physically sick, so too can a healthy spirit assist in the body's healing.

³⁵ Clara LeBlanc, personal communication, 1997.

Much of Gehue's treatment involves working with a patient's mind and emotions and dealing with factors that inhibit an individual from choosing to heal himself. These factors include past traumas, fear and the effects of social conditioning. What follows is taken from transcribed conversations with Gehue on 31 October 1997. Gehue is quoted directly, with ellipses indicating where passages have been edited for space:

David Gehue: We also believe that when you're sick, or when you get sick, then something that you're processing inside you has turned backward ...

So we believe the first rule in healing is, find out where that person's head's at, emotionally and spiritually, find out where they're at. Okay? Two, start your digging there to find out what's in there emotionally, meaning what's making them tick. Okay? Are they scared of the dark? Why? Scared of fire? Why? Why do they do what they do? The next step is then sorting that out. Because there are some things that are externally induced....

So we have to undo some of the old conditioning. And the old conditioning is, if you're not good God's going to get you.... Old bullshit conditioning. And it was made, Mike, to control the action and behavior of the people that it serves.... Well, we have to undo some of that, because in fact, there's no basis for it, okay? There's no basis for you're going to go to hell.

Mike, I have died on the operating table and I was, and my heart stopped, and I didn't go to hell, okay? There was not angels, there was no trumpets blowing, there was no golden gates . . . Okay? So I know by practical, physical experience there's none. Okay? Now, I start to communicate that to the people that come to see me who are scared to death of dying.

Petrou: What do you say to them?

Gehue: What do I say to them? Well number one, I tell them the story of my next to death experience.

Petrou: What story is that?

Gehue: Well, we'll get to it. Number two, I start to prove to them that the reason you're dying is because you're afraid of it. Okay? If you're afraid of something you become what you're afraid of. The more you push against coming toward it, the closer you get to it....

Okay, here's the story.... Around 1994, I developed a heart condition ... a virus inside the heart, or water inside the heart cavity. Okay? Now, if not dispensed of very quickly, you would drown. Because your heart can't move in the water. You'll actually drown, okay? Now, the night before the surgery, the spirit came and said to me, "Dave, do not be put under anesthesia; you will die." No why, no anything else. I said, "all right, fine."

So the next morning I go down to the surgery, they put me on the table, and they're strapping my arms down, and they say, "Mr. Gehue we're going to put this in your arm," and I said, "Get out of here. Don't touch me with that needle, number one." And that doctor was going to put that mask and I said, "You, get that mask out of my face." They said, "Oh! what's wrong?" and I said, "If you're going to do this procedure, you're going to do it when I'm awake. You're going to do it locally." They said, [you're crazy]. I said, "I might be crazy, but I'm going to be alive...."

Now, what they did is, they started the procedure by putting lots needles around the heart, okay? And they went just under the ribcage here on the left. They made an incision, and they punctured the heart pouch, and they took a wire and they brought it all the way around your heart like this, and I didn't think my heart was that big because that wire was over three feet long. Holy. But when it got to

about right here, Mike, everything went black. And I heard my mom's voice in my ears, and she said, "let's go home." "Oh ..." I said, "well, let's go then...."
[laughter]

So when you die, you don't go up this way, [straight up] you go up on almost a 45 degree angle, and you go up as if you're on a ski lift. You know? You just go steady. And you're just walking. Well I don't know, we wasn't walking, we was floating, I guess. Now when we got way up there, I could hear this woman's voice, as if she was way behind us, saying, "What about your babies?" ... "Ma, Wait! I can't go with you," I said. "What about the girls? You know who's going to take care of the girls. Who's going to make sure they're safe and grown up? I can't [go] But when they're all grown up, and they're all safe and everything, well next time I'll come home with you."

It was not a millisecond [slap] I was on that table again. And just all the bells was going and people was running. "He's back!" So I know, Mike, from my own practical experience ... Now I'm not the same man that I was when I went in there. I came out a different man, yes I certainly did. And hopefully I came out for the better.... So I know from practical experience.

Once you give that, once you are able to instill that in a person that's sick, nine out of 10 of them want to get well. Remember what I said about the power of choice? And that's what it is -- the power of choice....

What's all that got to do with healing? Now remember the first thing? This? [head] This has to be in good functioning order. Once it's in good functioning order ... It tells the body to heal itself. It also can tell the body to kill itself. Okay? It also can.

David Gehue continued to say that a lot of sickness, particularly cancer, often stems from holding rage inside the body because of a trauma. Dealing with this trauma, and finding peace, will allow the mind to start making choices about healing the body.

Gehue: ... Again, we have found the origin of the problem, haven't we? Okay, origin meaning this happened many years ago, and it still affects the body. Because justice was not done; the mind did not see justice being done. So it continued with its overload program. And its overload program was self-destruct. You see? Once you deal with that, now I have some people I work with, Mike, who didn't start to work on their sexual abuse until they were in their late sixties. You see? And then they died about a year or so later because they were well and they were able to make decisions ...

Now, you might say, well, Dave, what was the use of you going for that two or three years of therapy. You know what it was? It was giving that person the freedom of choice. You see it? One of the greatest gifts we can give, isn't it?...

So, it's very simple, how the formula works. It works this way: You have to know the past, your history, to know the future, so it doesn't become the future. You have to know the past. And you got to know all the ins and outs of that past.... So you got to know the past, so it doesn't become your future. And the present, then, gives you the power of choice. Okay? And that holds a lot of power, Mike.

At a later visit Gehue discussed the effects a patient's belief system can have on the healing process.

Gehue: Again, with any medicine, or any treatment of any sort, the philosophy in native treatment is this: let's treat the mind, the emotions, and let's treat the belief system.

Now treating the belief system does not mean asking you to give up your belief system, it's putting in perspective your belief system. Okay? Okay. Let me then give you an example of what I'm talking about. Often in theology it is said, if you commit a sin you go to hell. Now if that's drilled in you every single day as a five-year-old kid, until you're 20, anything you perceive, anything you do wrong, or someone else perceives you've done wrong, where do you believe you're going? To hell.

A myth. It's a myth. All right. And it's a myth because it was a form of control. You see. Well, now then, you have to sit down with them and you have to work on the emotions so that you can destroy the myth, so that person can be OK with themselves....

So those myths and fears have to be destroyed. Once they're destroyed the body knows what to do with itself. Okay, the body knows how to heal. And it'll help you heal. Like that doctor quoted: 'The doctor dresses the wound, and God heals it.' And I think that's one of the best quotes I've ever heard. That's exactly what happens.³⁶

Much of what David Gehue spoke about concerning a healthy mind and spirit's ability to heal the body is echoed by other individuals involved in some aspect of traditional Mi'kmaw medicine and healing. Some also have contrasting opinions. Gehue has been quoted extensively here to convey information from someone directly involved in the healing process.

³⁶ David Gehue, personal communication, 1997.

A Healer's Relationship to Patient and Community

There are two main points that should be understood concerning a healer's relationship with others. First of all, there should be a bond, an intimate understanding, between the patient and the individual treating this patient. The healer must understand her patient as completely as possible before proper diagnoses and treatment can take place. Ideally this bond will extend to the patient's family and community. Secondly, in traditional Mi'kmaw society, recognition of a healer's role must come from within the community. It cannot be self-defined.

That a community must recognize an individual as a healer or care giver is very much tied into the ethic of humility. Indeed, Murdena Marshall said people who make a big deal about their own role as healers probably aren't recognized or respected by the community. "I don't think you should be fooled by people...." she said. "There's a lot of wannabees out there.... Who want to be the medicine person, or who want to be the spiritual director. That carries a little bit of weight in the non-native world. It doesn't carry no weight in the Mi'kmaw world. You don't need an introduction; you don't need a title. People will recognize you for who you are." Marshall went on to say:

Not everybody can be a medicine man ... A medicine man is only a medicine man or a medicine woman when the community has recognized them. The community has to recognize them. If the community doesn't recognize them, then they'll never make it. The community is very important in selecting a medicine man or medicine woman.... Your knowledge of medicines, or your knowledge of how they're prepared, or your knowledge of where you can find them, is not the criteria for being a medicine person. It's just part of it, a small portion of the whole thing. What you have to be to be a medicine man is how well you serve

your community, and how long have you served your community.... It's a different way of selecting. The selection process is far different than in the non-native world.³⁷

Murdena Marshall's comments are reinforced by Larry P. Aitken, a Minnesota Chippewa and co-author of *Two Cultures Meet: Pathways for American Indians to Medicine*. Aitken writes: "Traditionally, medicine is not a choice pursued by an individual, but it is a choice accepted by an individual."³⁸ The 'choice' comes from the spirits and the community. Aitken continues to say that this difference concerning pathways to the healing profession is so profound that many aboriginal people entering the mainstream medical system suffer a kind of "self-banishment" resulting from cultural suppression. In consciously deciding to join the healing profession, they feel they are overemphasizing their own role in this process.³⁹

A healer's relationship to a patient is tied into the larger concept of holistic healing. To properly treat a patient, a healer must understand her mind, emotions and spirit. This, in turn, requires the existence of a connection, an understanding, between patient and healer. Lea Bill is a traditional practitioner from the Pelican Lake First Nation in Saskatchewan and is the current president of the Aboriginal Nurses Association of Canada. At the Aboriginal Nurses Association's 1997 teaching conference, Bill discussed the exchange of tobacco

³⁷ Murdena Marshall, personal communication, 1997.

³⁸ Aitken and Haller, p. 4.

³⁹ *Ibid.*, p. 94. Issues concerning conflict and cooperation between traditional medicine and the orthodox medical profession will be discussed in chapter five.

between a patient and healer as representing this connection. According to Bill, when a traditional healer accepts the tobacco, she is accepting responsibility for that person's healing and is establishing a spiritual connection. With the administration of treatment, the responsibility for healing is given back to patient. If responsibility is not given back, she explained, the healer would remain spiritually connected to her patient. A healer's spirit ties would then become too stretched out and she would be open to sickness.⁴⁰

An example illustrating the benefits a connection between a healer and patient have comes from David Gehue. A man had come to see Gehue with a hand that was crippled because of an earlier stroke. David's treatment involved a sweat lodge ceremony, and the man's hand was completely healed. Explaining the successful results, Gehue said:

Now could it have been, well I don't think it was the steam, okay? I don't think it was the heat. I don't think it was the rattle. I don't think it was a blind man that was on the other end of the rattle. You know what? I think it was all those things trapped into one. Could it have been somebody cared enough and that opened him up enough? Well it certainly could have been, couldn't it?⁴¹

David Gehue said this man was ultimately healed on his own accord; he simply helped the patient heal himself. However, perhaps it was the existence of a bond, a demonstration of care, that allowed this healing to take place. As Gehue stated, the patient opened up and allowed himself to heal. It's unlikely a similar process could have occurred in a walk-in clinic.

⁴⁰ Lea Bill, presentation given at the 1997 Aboriginal Nurses Association Teaching Conference in Dartmouth, Nova Scotia.

⁴¹ David Gehue, personal communication, 1997.

When considering bonds between a patient and a healer, it is also important to recognize that an individual playing a role in the healing process must be doing so for someone else's benefit. Taking part in the healing process should be a selfless act. This is not a philosophy that is restricted to healing practices, but one that is a component of a larger Mi'kmaw world view. Vaughen Doucette talked about this:

But when I got into native spirituality, I found out that's not what it's about. Traditional Mi'kmaw pre-European spirituality, and even forms of Mi'kmaw spirituality that exist here in Eskasoni, it's not about taking care of you. It's about helping other people. It's about helping your family. It's about helping your elders. It's about helping your community. Then, on the larger scale, it's about helping other people, whether they're French, whether they're English, whether they're black, whether they're yellow. There's no restriction on that. It's about helping human beings.... And that's an old, old principle that goes back tens of thousands of years. The underlying principle of Mi'kmaw society, the understanding, the bottom line, in Mi'kmaw society is helping people. Taking care of the earth and helping the people.

Concerning the healing process, the ethic of putting others before yourself manifests itself in a number of ways. One result is that an individual will generally not make medicine for personal use. Margaret Johnson said that medicines work best when they are made for someone else: "If somebody else makes a medicine for me, I'll be cured .. But if I make it myself, I couldn't heal myself."

This ethic is also reflected in sweat lodge ceremonies. Prayers that are said in a sweat are always given for someone else. Your own suffering is exchanged for someone else's benefit. Murdena Marshall describes sweats as a process that teaches endurance and helps

cleanse the minds of those involved. She also emphasizes the importance of praying for others, not yourself: "And we also believe that while you're in the sweat, you're not in there for yourself. You know, you have somebody in mind who is in terrible pain, or who is dying, or something like that. And so all the men go into the sweat, and they pray for that person, or they're enduring for him."⁴² Vaughen Doucette described this process as well:

You're exchanging your pain for a wish, or a prayer. Whether you're praying for somebody who's dying of cancer or somebody who's fighting an addiction, or whatever the problem may be, in a sweat lodge, you're suffering, because it's hot in there and you can't breathe, and you're uncomfortable....

You don't pray for yourself as an individual, you pray for other people. If I want some kind of prayers for myself, I have to ask another person to pray for me. Anything in this traditional way, you don't do it for yourself, you do it for other people.... You don't pray for yourself, you don't pray for money, you don't pray for relationships, you don't pray for love, you don't pray for sex, you don't pray for money, you don't pray for houses, you don't pray for anything material. Everything you pray for is for the benefit of other people....⁴³

Intrinsic in the ethic of praying, and suffering, for others is the importance of connections with others. Healing is not a process undertaken by an individual.

When health care involves non-native practitioners and native patients, the development of proper bonds between a patient and care giver may be jeopardized and conflicts can arise. These can take the form of communication problems resulting from

⁴² Murdena Marshall, personal communication, 1997.

⁴³ Vaughen Doucette, personal communication, 1997.

language differences, and they may also stem from different protocols concerning children.⁴⁴ They may involve a native patient being uncomfortable in a room that hasn't been smudged, in a hospital that doesn't allow any form of smoke in the building. Sometimes hospitals have set visiting hours and will only allow immediate family members to visit a patient. What such a policy fails to understand is that, in Mi'kmaw society, the community is often considered family. Furthermore, many Mi'kmaq feel a sick individual shouldn't be left alone, regardless whether or not visiting hours are over. Staying with a patient becomes more important if a patient is terminally ill. Being surrounded by friends and family, prior to and immediately following death, will help the individual make a peaceful transition to the spirit world.⁴⁵

Sometimes, however, proper bonds between a patient and care giver cannot be established simply by virtue of the two individuals belonging to different cultures. Clara LeBlanc said:

I go to see a psychologist every six months because I believe in mental health, but I have to go to Montreal, because that's where I can find a native psychologist. I'm not going to tell a white person that doesn't understand my culture my beliefs. I have to sit there and give him a history lesson before he can even help me. I feel like I've helped him more then they've helped me, you know, and I'm the one that needed the help.⁴⁶

⁴⁴ In Mi'kmaw society affection can be shown to a child by sniffing the child's hair. Murdena Marshall said nurses in pediatrics in Sydney are now becoming aware of this when they treat Mi'kmaw children.

⁴⁵ Murdena Marshall, personal communication.

⁴⁶ Clara LeBlanc, personal communication, 1997.

Occasionally conflicts arising from cultural differences lead to tragic results. One such example involves the experience of a Navajo couple in the United states. The couple had brought their sick child to see a doctor in Page, Arizona. Upon arrival, the couple was scolded for stopping to see a medicine man on the way to the hospital. The doctor went into a rage and shouted, "It will be your fault if your child dies!"

The two parents were shocked and upset. The following morning they asked that their child be transferred to another doctor. The doctor refused to see them, and the couple felt they had no choice but to remove their child from the hospital. One parent explained: "The doctor does not feel good about us. How can he feel good about our baby? We will take our child to the Indian hospital in Tuba City."

The doctor did not realize that the child's parents viewed healing as a process in which the doctor, the child, the parents and the child's community all played a role. The child died on the way the hospital in Tuba City , and criminal charges of involuntary manslaughter were filed against the Navajo couple. They were later dropped.⁴⁷

Any discussion concerning a healer's relationship with her patient and the community brings up the issue of gender. Both men and women are involved in the healing process; however, Murdena Marshall says women play a larger role.⁴⁸ She says this is a reflection of Mi'kmaw society in which women are a vital and powerful force, pointing out that more

⁴⁷ C. A. Hammerschlag, *The Dancing Healers* (San Francisco: Harper and Row Publishers, 1988), pp. 126 - 129.

⁴⁸ It is interesting to note that early European chroniclers only described the involvement of men in the healing process. This likely reflects the authors' biases.

Mi'kmaw women are social workers and teachers than are Mi'kmaw men.⁴⁹ The heightened importance of women in the healing process also stems from the closer ties women have with their community. Marshall explains: "They're with the community all day, when the man might leave to go hunting.... But the woman is there with them. What will happen if somebody becomes ill and the man will come back in four days time? Or five days time? And so women are far more trained, because they're right there. That's why, I do believe."⁵⁰

The importance of women to the healing process in Mi'kmaw society may also stem from their ability to have children, ultimately to give life. Vaughn Doucette said Mi'kmaw women are respected for being creators. Murdena Marshall also emphasized the importance of giving birth: "The elders say the highest point in your life is when you give birth. That's when you have done what the Creator has asked us to do, and that's to be life-givers."⁵¹

Traditionally, in Mi'kmaw society, the birthing process was the domain of women.⁵² Only in the last century has giving birth in Canada become something controlled by doctors, usually males. In the past, Mi'kmaw children were delivered by midwives. As Margaret Johnson, a Mi'kmaw elder, said, "there's no medicine for that. It's just natural." Margaret Johnson also described "maternity teepees" where women would go to give birth: "They

⁴⁹ Marshall, p. 61; also, personal communication, 1997.

⁵⁰ Murdena Marshall, personal communication, 1997.

⁵¹ Murdena Marshall, personal communication, 1997.

⁵² This was true of most First Nations. Faye North-Peigan, a Cree from northern Saskatchewan currently working in the capacity health director on the Peigan Nation, has researched traditional beliefs of Peigan elder women concerning pregnancy and child-bearing. She made a presentation at this year's Aboriginal Nurses of Canada Teaching Conference in Dartmouth, Nova Scotia.

have teepees, they used to have birch bark teepees, and one is for women, the ones that are going to have a baby. They take her there when she's ready to have a baby."⁵³ Mi'kmaw women were traditionally in control of bringing life into the world. Perhaps the role of a healer for women is a natural extension of this.

⁵³ Margaret Johnson, personal communication, 1997.

Conclusion

During the winter of 1535-36, the three ships of Jacques Cartier were frozen fast in the ice of the Saint Lawrence River, not far from what is now Montreal. By mid-March, 25 of Cartier's 110 men had succumbed to scurvy, and the rest appeared headed for death. Fortunately for Cartier and his crew, the local Indian population intervened. Tea was made by boiling the bark and branches of what was likely hemlock or white pine, and the Europeans were restored to health.⁵⁴ This story is often related as an introduction to newspaper articles or books about traditional aboriginal medicine. The intent is generally to demonstrate that native people were able to combat sickness with natural medicines before Europeans arrived.

These kinds of depictions completely miss the point of what medicine and healing involves in traditional medicine. Health and health care mean more than boiling hemlock to treat scurvy. They are directly tied to a community's culture. They reflect a people, and they reflect a way of seeing the world. Traditional health care involves a person's mind, body, emotions and spirit. It involves someone's family and community, the environment and the spirit world. All these things are part of traditional Mi'kmaq culture and world view, and all consequently effect the way health care is undertaken. This chapter is built on the premise that a community's cultural framework will have a profound effect on the way medicine and health are perceived. A number of cultural perceptions are discussed as they relate to health

⁵⁴ Virgil Vogel *American Indian Medicine*, (Norman: University of Oklahoma Press, 1970), pp. 84-86.

care. Most of the information in this essay comes from individuals who have shared thoughts and insights with me. What is written reflects what I have been told.

**Chapter Five: Exploring Potential Relationships Between Mi'kmaw
Traditional Medicine and Western Biomedicine**

Introduction

On May 15 and 16, 1993 the Aboriginal Nurses Association of Canada convened a workshop in Winnipeg, Manitoba to discuss and develop a strategy for incorporating traditional aboriginal medicine within a primary health care framework. Participants were invited from across the country and included traditional healers, physicians, nurses, aboriginal health centre managers and academics. Viewpoints were polarized between aboriginal and non-aboriginal participants, between biomedically trained practitioners and traditional healers, and also among aboriginal participants.¹ After two days of intense debate, those attending the conference were unable to agree on a strategy for association between biomedicine and traditional aboriginal health care.

Nevertheless, the Aboriginal Nurses Association of Canada came away from the workshop believing such an association should occur. A month later the following recommendation was included in their submission to the Royal Commission on Aboriginal Peoples:

A.N.A.C. maintains that a process must be established which will enable traditional practitioners and biomedical practitioners to work together. These recommendations are made with the hope that Aboriginal organizations, traditional medical practitioners, and mainstream health care providers will begin the long process of working together so that the health care needs of Aboriginal people will be met.²

¹ Aboriginal Nurses Association of Canada, *Traditional Aboriginal Medicine and Primary Health Care*. Submission to the Royal Commission on Aboriginal Peoples (Ottawa: Aboriginal Nurses Association of Canada, 1993), pp. 10-11.

² *Ibid.*, p. 17.

Despite the daunting complexity navigating this association would entail, the Aboriginal Nurses Association believed it to be a option worth considering. I believe they are right.

In this chapter I will explore how an association between biomedicine and traditional aboriginal medicine might occur. This is a question of national significance; however, much of the primary research for this chapter focuses on Mi'kmaw traditional medicine in Nova Scotia. My goal is not to produce a firm blueprint for action. I will establish the foundations necessary to consider if association between the two systems is possible and desirable. I will outline potential barriers to this association, and I will discuss options which may make such an association feasible.

Why Medical Pluralism?

Before beginning a discussion on the possibilities of medical pluralism,³ it is fair to ask: What is the point? In other words, is there any reason for more than one system of health care to exist in a society?

There are those who argue that, because we all belong to a single species, the health care needs of humanity are universal and can therefore be treated by a common health care system. This approach sees the ideal medical system as rational, objective and scientific. It is neither defined nor constricted by religion or culture. As such, the implication is that one medical system can be applied with equal success in any social or cultural environment; it can transcend cultures because it is not built on one.

I have shown that this is not possible. As demonstrated earlier in this thesis, perceptions of illness and healing reflect a given culture's spiritual and ethical assumptions about reality. Health and health care are culturally constructed. Just as traditional Mi'kmaw medicine and health care are closely tied to traditional Mi'kmaw world view, so too is biomedicine pervaded by a value system characteristic of a Western industrial-capitalist society. Given that this is the case, it seems foolish to expect Western biomedicine, which is directly tied to Western world view, to have similar success in communities which may not share a common cultural framework.

If the Canadian government and orthodox biomedicine are committed to providing the highest level of health care possible to all Canadian citizens, a system that recognizes and supports alternative methods of health care should be considered.

³ "Medical pluralism" refers to the practice of using the services of more than one medical system.

In a society comprising more than one cultural group, some form of recognized medical pluralism may be the first step toward developing a health care system that benefits everyone. Medical pluralism may also empower a patient. Increased choice over which medical system and medical practitioner to use gives the patient greater control over her own health care, and it allows the patient a say in the cultural context of healing.⁴ Furthermore, medical pluralism has the potential to benefit both orthodox physicians and traditional healers, both of whom can learn from each other and improve their respective credibility.

⁴ James Waldram *et al.*, *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995), p. 211.

Toward Medical Pluralism

In Canada, medical pluralism has always existed in practice, if not in theory. Aboriginal people have had functional systems of health care dating back prior to European contact. Traditional aboriginal medicine has survived and evolved through to the present, in the face of efforts by the Canadian government and orthodox biomedicine to outlaw and discredit its practice. Despite this history, in recent years practitioners of traditional aboriginal medicine and orthodox physicians have made tentative steps toward collaboration, sharing and working together. This chapter will now explore where these first steps might lead.

Any discussion on the possibility of associations between biomedicine and traditional medicine becomes irrelevant if there is not a desire on the part of biomedical physicians and traditional practitioners to work together. This is a contentious issue, involving difficult questions of trust and respect. The polarization of viewpoints demonstrated at the Aboriginal Nurses Association of Canada conference in Winnipeg reflects the diversity of opinions held by traditional healers and biomedical practitioners across the country. On both sides there are those who would prefer isolation, and who are sceptical of the benefits cooperation might bring. On the other hand, numerous examples of integration and cooperation are occurring, and it seems this trend will continue in the future.

One of the most widely known examples of formal cooperation between biomedicine and traditional aboriginal medicine exists at the Lake of the Woods Hospital in Kenora, Ontario. A plaque in the lobby of the hospital reads, "We believe

traditional Native healing and culture have a place in our provision of health services to Native People.” In 1980 the Ontario Ministry of Health provided funding to hire an aboriginal healer to work in the hospital. The move was a controversial one. It provoked much media attention and public response, including an anonymous letter sent to the hospital which ridiculed the hiring of a “Quack.”⁵

Some aboriginal people also argued against the hiring of a traditional healer at Lake of the Woods. According to an unpublished evaluation report on the program, written in 1983, the following complaints were made:

The hiring of a single healer did not recognize that healers, like physicians, have areas of specialization.

It was breaking traditional practice for the government to pay for the services of the healer as it is the responsibility of the person who is consulting the healer to provide payment.

The flurry of media attention at the outset of the program has detracted from the healer’s credibility within the native community.

The location of the healer in the hospital did not meet the approval of the Elders.⁶

The program was later refined to arrange for services according to family preferences and the specialization of the healer. Aboriginal input was also increased in an effort

⁵ Judith Major, “The Mountain That I Take Away With Me,” MA thesis, University of Toronto, appendix.

⁶ James Waldram *et al.*, pp. 205-206.

to avoid the conflict that arose with the program's inception. Nevertheless, the early controversies at the Lake of the Woods Hospital demonstrate the complexities cooperation between biomedicine and traditional aboriginal medicine can involve.

The Native Healer Program at the Lake of the Woods Hospital in Kenora is by no means the only example of cooperation and consultation between the two medical systems in Canada. Aboriginal healers and biomedical practitioners have been working together (especially in western Canada) in increasing frequency since the early 1980s.

It would be misleading, however, to suggest that all successful relationships between biomedicine and traditional aboriginal medicine involve direct association. Given the problems inherent in attempting to integrate medical systems which may have very different cultural foundations, successful collaboration occasionally requires both systems to operate independently.⁷ Clients are then free to decide which system they wish to access. Two teaching hospitals in Winnipeg have utilized this approach by the hiring of aboriginal 'medical interpreters.' The work of these medical interpreters includes arranging patient access to aboriginal healers. Medical interpreters make the arrangements for a patient to see a traditional healer, and they mediate between the two medical systems when conflict arises.⁸ The relationship between biomedicine and traditional medicine may be cooperative; however, the

⁷ John O'Neil, "Referrals to Traditional Healers: The Role of Medical Interpreters," in *Health Care Issues in the Canadian North*, ed. David E. Young (Edmonton: Boreal Institute for Northern Studies, 1988), p. 29.

⁸ *Ibid.*, pp. 29-38.

cooperation exists between two independently functioning systems, rather than one integrated whole.

David Gregory has suggested a similar approach is utilized by Medical Services Branch nurses and band-employed nurses in Manitoba. Gregory conducted a study to examine the extent of interaction and collaboration between the nurses and aboriginal elders and traditional healers. This study included a survey of all Medical Services Branch nurses and a number of band-employed nurses. The results are recorded below:⁹

Nurse-initiated client referral to elders	52% (27)
Nurse-initiated client referral to traditional healers	39% (20)
Inclusion of elders in health programs	42% (22)
Inclusion of healers in health programs	19% (10)

It is significant that this collaboration occurs on the initiative of nurses, without formal government support or intervention. Additionally, 92 per cent of nurses surveyed by Gregory said they would be willing to collaborate with elders, especially if this practice was supported by their superiors.¹⁰

A comparable study has been carried out by Yvon Gagnon to examine physicians' attitudes toward collaboration with traditional healers. Gagnon's study

⁹ David Gregory, "An Exploration of the Contact Between Nurses and Indian Elders/Traditional Healers on Indian Reserves and Health Centres in Manitoba," in *Health Care Issues in the Canadian North*, ed. David E. Young (Edmonton: Boreal Institute for Northern Studies, 1988), p. 42.

¹⁰ *Ibid.*, p. 42.

involved surveys and open-ended interviews with physicians and medical students involved in treating aboriginal clients. Gagnon found most respondents were in favour of some form of collaboration with traditional healers. However, a reluctance to relinquish control was evident in statements such as, “the physicians would have to have the last word.”¹¹

As questions became more specific, greater variation in responses emerged. Most (77 per cent) of the respondents said they would utilize a traditional healer if a formal referral system was in place. But only 15 per cent had actually referred a native patient to a traditional healer. This statistic is disquieting given that 57 per cent of the respondents believed traditional healers could provide cures for some illnesses which did not respond to biomedical treatment.¹²

Gagnon suggests that the more knowledgeable physicians believe collaboration with aboriginal traditional healers is potentially beneficial. It is true that certain patterns are evident among the respondents depending on the context in which they practice medicine. However, significant variations in attitudes toward collaboration persist, regardless of the experience or background of the physicians.

Among traditional healers, attitudes toward collaboration with biomedicine are equally diverse. There are traditional healers, and individuals knowledgeable about traditional medicine, who would prefer complete isolation from the biomedical

¹¹ Yvon Gagnon, “Physicians’ Attitudes Toward Collaboration with Traditional Healers,” *Native Studies Review: Native Health Research in Canada*, 5 (1) 1989, p. 181.

¹² *Ibid.*, 184.

system. The Aboriginal Nurses Association's report on the Winnipeg conference of 1993 states a division existed among the traditional healers who attended the conference: "Strongly evident was a conservative element which was desirous of isolation, suspicious of the intentions of the participants, and sceptical of the benefits of discussion and dialogue."¹³ It is also significant that only a few traditional healers came forward to speak to the Royal Commission on Aboriginal Peoples.¹⁴ Given the history of suppression and hostility by the Canadian government toward traditional healing practices, this apparent desire for isolation is understandable.¹⁵

There are additional reasons why practioners of traditional medicine would prefer isolation from biomedicine. There is a long history of non-aboriginal professionals scraping aboriginal communities for information and then giving nothing back in return. Noel Knockwood said the attitude among some aboriginal people today is to "tell them anything they want to know, whether it's a truth or a lie, because we're not going to benefit anyways."¹⁶ Concerning potential cooperation between orthodox medicine and traditional medicine, Knockwood believes the

¹³ Aboriginal Nurses Association of Canada, p. 11.

¹⁴ Canada. Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples*, v. 3 "Gathering Strength" p. 212.

¹⁵ Traditional aboriginal medicine, like any health care system, is intimately tied to the culture in which it operates. Consequently, cultural assimilation policies employed by the Canadian government directly and indirectly targeted aboriginal traditional health care practices. Brian Titley's *A Narrow Vision: Duncan Campbell Scott and the Administration of Indian Affairs in Canada* (Vancouver: University of British Columbia Press, 1986) provides a good exploration of many of these policies and their effects.

¹⁶ Noel Knockwood, personal communication, 1998.

potential for exploitation is large: “If they get it from the native people, they patent it and give nothing back to where they got the information. . . . Pharmacology is all ears. They find it, they patent it, and they get rich.”¹⁷

Nevertheless, there are traditional practitioners who believe the two medical systems can, and should, work together. Conferences between traditional healers and orthodox physicians are now becoming more common, as the two groups seek to understand each other and to build bridges between the two medical systems. David Gehue has practiced traditional medicine extensively, often in cooperation with biomedicine. He is quoted directly: “Again, I believe that Western medicine and traditional medicine can work very fine together. If mutual respect for both fields is always present.”¹⁸

And indeed there are examples of biomedicine and traditional aboriginal medicine successfully working together. The Lake of the Woods Hospital in Kenora is one example. The work of David Gehue is another. An example that hasn’t been discussed in this paper so far is the Eskasoni Health Centre in Cape Breton, which is currently in its development stages. According to Eskasoni Health Director Peter Stevens, the new centre will combine orthodox biomedicine with many aspects of traditional medicine and healing, including herbal medicines and possibly a sweat lodge.¹⁹

¹⁷ Noel Knockwood, personal communication, 1998.

¹⁸ David Gehue, personal communication, 1997.

¹⁹ Peter Stevens, personal communication, 1998.

Aboriginal and Western healing methods have worked well together in a variety of capacities. However, the precise relationship that should exist between the two systems remains a debated issue. Several models have been suggested, involving shifting degrees of cooperation and control. Some see traditional medicine as a supplementary treatment service. Others see traditional medicine as a full partner with orthodox medical services, possessing a degree of independence in specific roles. And some would prefer that traditional medicine remains separate from biomedical health services. In this option, the two systems would operate in a state of respectful independence, making referrals to one another and occasional cooperating to treat clients where appropriate.²⁰ The *Report of the Royal Commission on Aboriginal Peoples* identifies a fourth option whereby traditional and biomedical practitioners would “work together to develop techniques and practices to promote and restore health, using the best elements from both systems or recombining those elements into wholly new ways of approaching health and healing.”²¹

It is worth emphasizing that any relationship between Western and aboriginal medicine involves negotiating issues of power and control. Yvon Lamarche, Treatment Coordinator at the Georgian Bay Friendship Centre and a Registered Nurse, spoke to these concerns during hearings for the Royal Commission on Aboriginal Peoples in 1993:

²⁰ Canada. Royal Commission on Aboriginal Peoples, pp. 213, 358.

²¹ *Ibid.*, p. 358.

I want to be very clear that there are significant political differences [about] . . . the issues of establishing a comprehensive health care delivery system which seeks to bring traditional medicine into the fold, so to speak, as opposed to the view of bringing western medical knowledge into the healing circle. . . . I believe that the ideal model is one which aims to bring western medicine into the circle versus one that aims to bring traditional healing into the western medical framework. I believe that in choosing the latter we choose to give away our power.²²

Lamarche's concerns are well founded. Too often, when the balance of control rests with the biomedical system, acceptance of traditional medicine is limited to mental health, or it is seen as an appropriate alternative only when all other options have been expired. David Gehue is quoted: "Now a lot of times they wait. People wait until the medical society can't do anymore. . . . And the doctors and the physicians and the expert people are saying: 'Go back to your Indian roots.' Is it too little, too late? Well, it certainly is, in a lot of cases. And I tell people, 'Why didn't you come to me first?' I don't have a lot of miracles in my pocket that I can pull out like a pack of cigarettes."²³

If we step back and look at the bigger picture, it seems that there is sufficient desire among both traditional and biomedical practitioners that collaboration and cooperation will increase in the future. Nevertheless, significant barriers remain. Unfortunately, many of these are related to questions of money and power.

²² *Ibid.*, p. 214.

²³ Dave Gehue, personal communication, 1998.

Health care in Canada is a billion dollar industry. Orthodox biomedicine enjoys a virtual monopoly on the provision of health care, a monopoly which is funded and protected by the state. Securing such authority has been a difficult process, beginning with moves toward medical professionalization in the nineteenth century. Since then orthodox physicians have established a web of institutions and litigation supporting their hegemony and monopoly over health care. Hospitals, credentials, Medicare, universities, malpractice insurance and pharmaceutical laws all work to protect the control of orthodox physicians over health care.

Alternative systems of health care have had a difficult time overcoming this imbalance of power to establish themselves as viable health care alternatives. Alternative medicine's difficulties have not stemmed from lack of public interest or support. A 1997 Angus Reid nation-wide poll found that 42 per cent of Canadians use alternative medicine and practices, and the use of alternative medicines and practices among Canadians has grown by 81 per cent over the past five years.²⁴

Despite growing public support, alternative medical options such as midwifery, homeopathy, acupuncture and chiropractic have not fared well in head to head engagements with biomedicine. Any confrontation begins with the scales of power tilted in favour of orthodox physicians. This holds true in the relationship between biomedicine and traditional aboriginal medicine. There are many factors preserving the monopoly orthodox physicians have on health care in Canada.

²⁴ Heather MacLeod *et al.*, "A Survey of Alternative/ Complementary Medicine in Canadian Medical Schools," unpublished, 1998. p. 2.

The first barriers to any formalized relationship between biomedicine and traditional aboriginal medicine are legal ones. As such, the issue is directly tied to questions of aboriginal sovereignty versus Canadian federal and provincial legislation.

Under the current system, even on-reserve aboriginal people are subject to provincial laws of general applicability; aboriginal people are also subject to federal legislation by virtue of Section 91 (24) of the *Constitution Act*.²⁵ This poses potential problems for practitioners of traditional medicine. The federal *Food and Drug Act* makes it an offense to advertise any food, drug, cosmetic or device to the general public “as a treatment, preventative or cure for any diseases, disorders, or abnormal physical states” as defined in the act, including “alcoholism, gout, depression, diabetes, gangrene, influenza and obesity.”²⁶ Furthermore, the legislation of most provinces makes it an offense for anyone except a licensed physician to practice medicine.²⁷

²⁵ Waldram *et al.*, p. 221.

²⁶ James C. Robb, “Legal Impediments to Traditional Indian Medicine,” in *Health Care Issues in the Canadian North*, ed. David E. Young (Edmonton: Boreal Institute for Northern Studies, 1988), p. 135.

²⁷ The position recently adopted by the Government of Ontario in its aboriginal health policy states that traditional aboriginal healing will be “protected from government regulation.” However, beyond this statement it remains extremely vague. It is not clear if legislation to protect aboriginal healers will be passed, and it is not clear if Ontario is guaranteeing aboriginal healers and patients protection from lawsuits. Ontario’s policy demonstrates that complexities of the issue, and shows little evidence that these complexities have been thought through. (Waldram *et al.*, p. 224.)

Once again, assertions of self-government throws federal and provincial legislation on shaky ground. Nevertheless, fundamental questions remain. For example, can an aboriginal healer obtain liability insurance? Can a traditional healer work with a physician and be covered under his or her insurance? What legal protection exists for traditional healers, and what protection from fraudulent healers exists for the patient?²⁸ These questions will have to be addressed if biomedicine and traditional aboriginal medicine are to work together.

Perhaps more meaningful than the specifics of civil and criminal liability are the tangible effects that the legal uncertainty surrounding traditional medicine can have for those who practice its use. It is probable that legal impediments to the open practice of traditional medicine are surmountable. However, the current lack of clarification can no doubt create a measure of unease. Caroline Gould, a Mi'kmaw elder living in Waycobah, is quoted:

You know, I don't like to cure anybody too much . . . especially when they take something like this [a medicine that you drink], but salve I don't mind. Because they could sue me. Supposing if I make a gallon of this ... and supposing if that person dies or something, the relatives, they could sue me. Because I don't have a license or anything. . . . So I don't know, it would be nice if they could get something that, you know, for protection.²⁹

²⁸ Aboriginal Nurses Association of Canada, p. 16

²⁹ Caroline Gould, personal communication, 1997.

An additional issue which should be addressed if traditional medicine is to play a larger role in providing medical services is that of the certification and regulation of traditional healers. This is also a contentious issue. Many traditional practitioners are strongly opposed to formal regulation.³⁰ This opposition makes sense. As Murdena Marshall said earlier in this thesis, validation of a healer's ability is derived from community support; formal recognition means little in comparison to how well a healer serves her community. Under such a system, fraudulent healers are simply not accepted, and are therefore unable to practice. Moreover, learning about and practicing traditional medicine is continuous. In Noel Knockwood's words, "It's not a degree type of learning. . . . You never graduate because it's a lifelong process."³¹ In this context, formal credentials make little sense.

However, there are arguments in favour of more rigid accountability. Currently, there exists a profitable industry, related to 'New Age' trends in promoting and selling aboriginal medicine and philosophies. Charlatanism is a real concern.³² Some aboriginal organizations have taken steps to combat this. In 1980 the Traditional Elders Circle of Indigenous Nations of North America passed a resolution warning that many self-declared 'medicine people' lacked the proper knowledge and authority to heal. The American Indian Movement, a United States-based activist

³⁰ *Ibid.*, p. 355.

³¹ Noel Knockwood, personal communication, 1998.

³² Waldram *et al.*, p. 219.

organization has also condemned charlatan healers, and has even named specific individuals.³³

A final issue to be discussed here is that of payment for healers. It is noteworthy that many practitioners of traditional medicine perform similar services to those of biomedical practitioners; however, most traditional practitioners do not receive financial support from Canadian governments. And current federal health policy does not reliably cover the costs incurred by those who consult traditional healers.³⁴ Some financial support is available through Medical Services Branch and the Non-Insured Health Benefits (NIHB) program. However, obtaining this funding is difficult, and its availability is often inequitable. At the Winnipeg conference held by the Aboriginal Nurses Association of Canada, further complexity arose surrounding the issue of payment as the traditional healers attending were reluctant to place a dollar value on their work.³⁵

Issues of validation, accountability and payment are difficult and complex, especially given the currently evolving relations between First Nations governments and those of Canada.³⁶ Health services are increasingly falling under the control and

³³ *Ibid.*, p. 219.

³⁴ Canada. Royal Commission on Aboriginal Peoples, p. 354.

³⁵ Aboriginal Nurses Association of Canada, p. 16.

³⁶ Paramount among recent changes is the Indian Health Transfer Policy, announced by Health and Welfare's Medical Services Branch in 1986. This policy is highly controversial. For criticism and discussion see: "The Indian Health Transfer Policy" by Dara Culhane Speck (*Native Studies Review* 5 (1) 1989); and Catherine R. Bruyere's

responsibility of First Nations. As this process accelerates, these issues will be directly confronted by traditional practitioners and aboriginal health authorities.

Conclusion

After all the benefits, barriers and options are discussed, the question remains: Can it work? Is it possible for traditional medicine and Western biomedicine to collaborate and work together. I believe that it is possible, and that cooperation between the two medical systems will increase in the future. Two reasons lead me to believe that this is the case.

Traditional medicine and biomedicine have successfully collaborated in the past, and continue to do so in the present. There are many legal, practical and philosophic concerns that have the potential to frustrate a cooperative relationship. However, these have been shown to be surmountable. There is little reason to believe that future obstacles will not be overcome as well.

Secondly, the process of self-determination in health care will continue, and will likely speed up, as dwindling health care resources are transferred to aboriginal communities and organizations. With increased local control, it seems probable that aboriginal communities will utilize the best components of both biomedicine and traditional health care. The planned Eskasoni Health Centre is an excellent example of how this synthesis might be achieved.

In conclusion, the possibilities of increased collaboration between biomedicine and traditional medicine look favourable. It will require trust and respect from both sides, as well as openness to what both medical systems can learn from each other. The specifics of how new relationships might develop can only be decided by those involved.

Closing

Closing

I began this thesis with the assertion that there is more than one way to heal. It is my contention that medicine and health care are intimately tied to the culture in which they operate. To explore this concept I have looked at two health care systems: traditional Mi'kmaw medicine and Western biomedicine. I have tried to show that both medical systems have a strong relation to the cultural beliefs and values of the communities in which they exist.

This thesis has a further goal, which is to explore the potential for connections and cooperation between orthodox medicine and traditional Mi'kmaw medicine. To this end, I have tried to show that although the cultural philosophies guiding orthodox medicine and traditional medicine are often at odds with each other, there have been examples of the two systems working together in the past, and this trend will likely continue in the future.

Any discussion concerning associations between traditional and orthodox health care inevitably raises questions about power, politics, money, trust and respect. Yvon Lamarche is quoted in chapter six of this thesis concerning potential relationships between orthodox and traditional medicine. Lamarche believes the ideal association between the two systems “is one which aims to bring western medicine into the circle versus one that aims to bring traditional healing into the western medical framework.”

Lamarche's comments encapsulate some of the questions facing the future of relationships between traditional and orthodox medicine. Who will control these

relationships? And who will they really benefit? These are questions traditional healers, orthodox physicians, aboriginal health authorities, aboriginal governments and Canadian governments will confront if a successful relationship is to evolve between traditional and orthodox medicine.

What is almost certain, however, is that some kind of association between the two medical systems will develop in the future. Already there are traditional practitioners who work in conjunction with orthodox physicians, and certain institutions attempt to utilize components of both traditional and orthodox health care. These examples are discussed in the thesis.

Furthermore, the relationship between Canadian and aboriginal governments is changing rapidly. As aboriginal communities assume increasing control over health care resources, it is likely that the way in which health care services are provided will change as well. Perhaps combining elements of both traditional and orthodox health care will be a result.

In the time I spent researching and writing this thesis, I often found myself trying to understand what really makes a person healthy or sick. After almost a year I still have not come to any firm conclusions, but I am beginning to believe that Western medicine has only scratched the surface.

Good health depends on more than advances in medical technology. Being healthy is about every facet of being alive. It is about balance and good social relations. It is about family and community. It is about personal comfort and hope. It is about security and peace. Healing is a social phenomena. And any health care

system that denies these aspects of the healing process ultimately denies the patient a potential pathway to health.

I believe this is the lesson we all must learn. Health and health care cannot be considered on their own. The health of an individual is tied to the health of the family, the community and ultimately the entire world. We are all connected, and we might begin realizing that our health as individuals depends on the health of the world at large. In the end both are the same.

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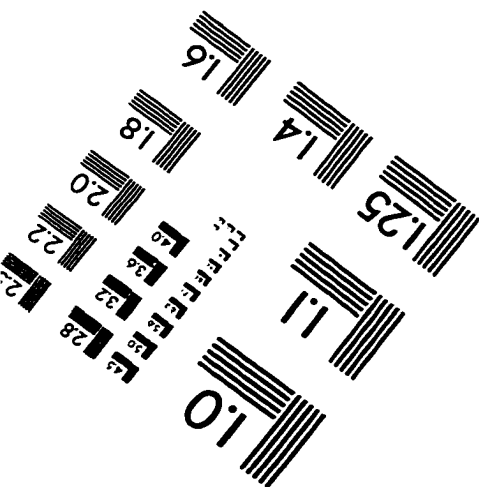
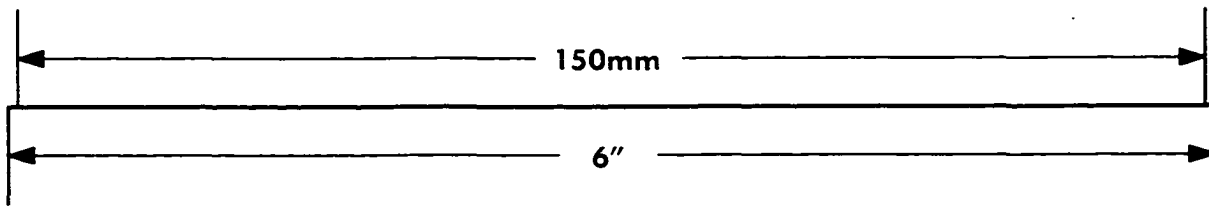
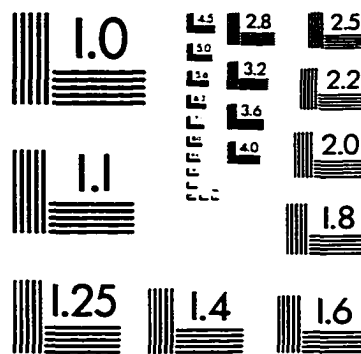
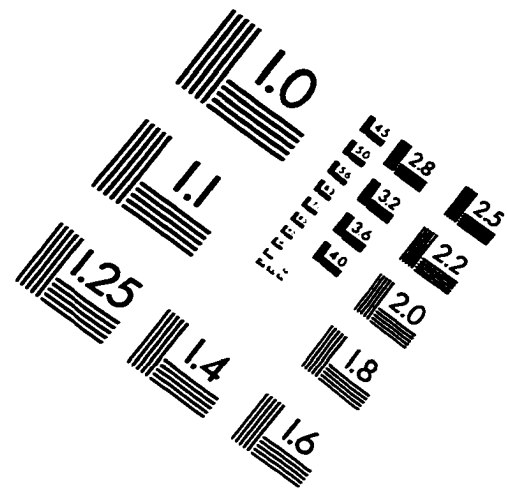
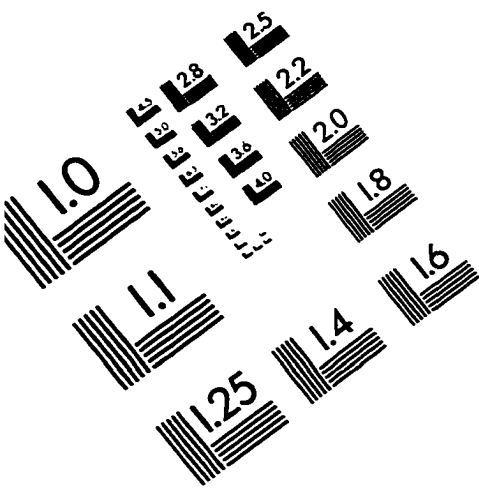
The Micmac News

Radio:

CBC Radio One: "Prayer and Healing." Tapestry, 11 January 1998.

CBC Radio One: "Walking Around Eating." Ideas, 13 July 1998.

IMAGE EVALUATION TEST TARGET (QA-3)



APPLIED IMAGE, Inc.
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

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