

'A Gossamer Web, Is Life': Biomedicine, The Mi'kmaq and the Reclamation of
Traditional Healing Knowledge

By

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ABSTRACT:

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Biomedicine and the traditional healing practices of the Mi'kmaq are outgrowths of their respective cultural backgrounds. In the socialized biomedical milieu of contemporary Nova Scotia this has created unique and nuanced challenges in the provision of health care to Mi'kmaq patients. Additionally, the reclamation of all-but-lost traditional knowledge concerning healing among the Mi'kmaq has proven to be, at times, problematic. This thesis examines these issues, and presents a new interpretive framework within which to approach the regeneration of traditional healing. The result is a valuable and useful contribution to scholarship in the field, and provides insight to those policy-makers involved in the provision of care to Nova Scotia's First Nations citizens.

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Introduction

“All human governments rest, in the last resort upon physical pain...[Indians] are children having human minds just emerging from barbarism.” These words were written in the 1930s by L.A. Audette, a retired judge, as part of a 54,000 word report on the residential school system (Knockwood, 1992, p. 149). While the government of Nova Scotia would later apologize for the suffering of Mi'kmaw students in the residential schools the principles espoused in Audette's report were systemic; the concept of inferior, savage Natives was one that informed all aspects of governmental interactions with the indigenous inhabitants of the province.

First Nations concepts of health and well-being are not cognates of the modern, scientific Euro-Canadian ones that inform the contemporary biomedical industry; rather they proceed from fundamentally different understandings of wellness, disease, illness and the interaction between human beings and the natural world. The traditional Mi'kmaw understanding of these concepts is rooted in their history, experiences, environment and spirituality. Indeed, spirituality and well-being are deeply linked, interdependent aspects of Mi'kmaw culture (Petrou, 1998, p. 94; Choquette, 2004, p. 22).

Similarly the underlying assumptions of many Canadians concerning medicine and health care are shaped by the history of those disciplines in Canada; the socialized health care system of the country; and the view that Canada is a completely secular state (Bramadat and Seljak, 2008; Choquette, 2004). However the Christian tradition in both its Catholic and various post-Reformation permutations has been influential historically in the development and provision of Canadian health care, e.g., many early hospitals, clinics and schools were staffed by nuns and members of other similar orders. This was especially true in both Quebec and Acadia (Bramadat and Seljak, 2008, p. 116).

Therefore concepts of health and health-care are developed systems within specific cultural frameworks. In exploring Mi'kmaw healing practices, and the worldview expressed through them, I will show that they do not easily interact with the Western, Euro-Canadian system.

I have worked in the Canadian health care industry for over a decade as of this writing. My time there has naturally enough shaped my own views and opinions concerning illness, treatment and the provision of care. I think it is safe to say that most health-care professionals are not scholars of religion and vice-versa. I believe this affords me a fairly unique point of view regarding this subject matter.

As a child I was a member of Scouts Canada, an organization which has often employed the mythology of the 'noble savage' in its campfire myths. While attending Camp Lone Cloud¹ I was taught 'Native lore', the vast majority of which reflected this 'mysterious other' and expressed a (white-imposed) pan-Aboriginal worldview that does not survive the penetrating gaze of scholarship, the views of the Mi'kmaq or of other Aboriginal groups. However I did gain an interest in First Nations lore in those days. That interest was renewed by my attraction to ethnobotany and herbal cures, several of which I employ myself and which stem ultimately from the Mi'kmaq.

My education has served to dispel many of the myths I learned as a child and exposed me to the facts of the matter while my extended family through marriage includes persons of Mi'kmaw ancestry. Combined with my career in Canadian health care, these interests and influences have led me to this essay's topic.

¹Camp Lone Cloud, located on an island in Miller's Lake outside Halifax, is named after a Mi'kmaw medicine man whose face, according to Scouting legend, is visible in profile on the cliffs bordering the lake's eastern side.

However I am unable to speak with any sort of authority regarding the Mi'kmaw experience of either the past or the modern world. My cultural background is neither Mi'kmaw nor that of any other First Nations people, nor did I grow up in a First Nations community. Similarly, I am not fluent in the Mi'kmaw language and must therefore rely on others for translation and interpretation. There is no universally accepted orthography employed in writing the Mi'kmaw language; in some cases rival systems have proved problematic. In at least one Mi'kmaw community the debate has affected the ability of schools to offer classes in that tongue (I. Augustine, personal communication). However, in Nova Scotia, the Francis-Smith orthography is accepted by all the chiefs and the Tripartite Forum. That system, then, will be employed within this essay. When a different orthography is used in a quotation, the Francis-Smith spelling will be included in brackets after the quoted word, ex. Micmac [Mi'kmaq]. Any errors regarding English renderings of Mi'kmaw words and similar mistakes are my own.

Despite centuries of oppression and attacks upon their culture contemporary Mi'kmaw communities have been able to preserve a number of their traditions and practices including many related to healing. Today, Mi'kmaw culture and spirituality are thriving again. Traditional ways of healing have not only survived but adapted to modern times, illnesses and ways of healing. We may ask:

- ⤴ How has modern biomedicine influenced the development of contemporary Mi'kmaw healing traditions?
- ⤴ How does this adaptation in modern times occur, in what ways, and what problems (if any) arise from it?

This thesis examines the healing traditions of the Mi'kmaw people as expressive of a worldview that contrasts, and at times conflicts with, the dominant biomedical paradigm extant in contemporary Canadian medical care and education. In the context of the power imbalance implicit in colonialism, this contrast creates a climate of mistrust and distress. The Mi'kmaw people have continued to practice their traditional healing arts, in the process adapting them to their changing needs and circumstances. This ability is a crucial component of the survival of traditional culture and the Mi'kmaw people themselves. Additionally, the failings of the entrenched biomedical system will be considered, in the hope that a path towards integrating traditional practices (or at least a sense of cooperation and mutual ambition), in culturally sensitive and appropriate ways, might be explored in the near future.

Methodology

As a precursor to my research I undertook a review of pertinent literature dealing with the topic of traditional healing. Such literature was not limited to the writings of members of the Academy but also included authors from within the Mi'kmaw community, such as David Gehue and Mi'sel Joe, and publications released by the Native Council of Nova Scotia. Historical sources, such as the writings of French clergy during the early days of contact and federal and provincial laws dealing with Aboriginal peoples and communities, were also consulted.

To broaden my understanding of the topic on a national scale I also reviewed writings dealing with the application of traditional knowledge from other First Nations peoples to the addressing of ills currently plaguing Aboriginal communities in Canada.

In order to interpret the material—especially that written by non-Aboriginal writers—I compared what Native and non-Native authors had to say about similar topics. Doing so gave me a more balanced, and I hope, a less biased point of view regarding the material. Thus prepared, my methodology was to undertake interviews—both in person and electronically—with Mi'kmaw people. These interviews took the form of unstructured conversations, rather than a straight forward question-and-answer format, but did include some specific questions, such as

- ♣ Do you feel there is something in traditional practice you can't get elsewhere?
- ♣ Is the practice of traditional healing in your community the same as in other Mi'kmaw communities or is there variation?
- ♣ Did you feel that your beliefs, needs and practices were respected within the health-care system? If not, what do you think could have done to improve this situation?
- ♣ How do you restore (or replace if restoration isn't possible) knowledge that has been lost?"

Most of the individuals I interviewed were introduced to me by my own friends within the Mi'kmaw Nation, especially Delta Hillyard-Augustine. Interviewees were selected based on their involvement with traditional culture, self-identification as a practitioner or recipient of traditional healing, and experience with government-provided health-care. These criteria allowed for the selection of interviewees who had experienced both streams of care and could therefore compare them. Others, such as Kirsten Nucklaus

(a senior policy analyst for the provincial health department) were kind enough to reply to requests for interviews in their capacity as government employees.

Once my questions and methodology were designed they were submitted to the Research Ethics Board of Saint Mary's University. After receiving their approval, a second ethics review was undertaken by the Mi'kmaq Ethics Watch at Cape Breton University, which also approved of my proposed research and methodology.

During the course of this research I was invited to powwows; I was honoured to serve as a flag-bearer in one. These invitations have allowed me to observe first-hand the positive, community-building nature of traditional culture. I found the Mi'kmaq with whom I interacted to be very warm and friendly; even the children I met displayed no fear at the presence of a stranger and in some cases were quick to invite me for dinner. This is a testament to the sense of safety and security those children felt in their own community.

Chapter One of this work will examine the body of literature that has developed over the last few centuries concerning the healing traditions of the Mi'kmaq and the relationship between their culture and the Euro-Canadian one. Chapter Two will examine the development of the biomedical tradition prevalent in Canadian health care, situating it firmly as a product of western European culture. Chapter Three will examine the worldview of the Mi'kmaq and their traditions of healing and understanding of health, situating those ideas within the wider framework of that culture. Chapter Four will explore some of the problems arising from these different worldviews, and some of the issues affecting many Mi'kmaq people as a result. Finally, Chapter Five will explore the culturally regenerative dynamic that is inspired, and fuelled by, Mi'kmaq healing traditions. In this final chapter I will expand on the central idea of this thesis, namely, that the survival and rebuilding of

healing traditions is intrinsically linked to their very character, and occurs through adoption of knowledge from other First Nations groups and the adaptation of non-traditional modalities and methods of healing, all of which is vetted and assembled into a viable system kept true to its roots by the internal consistency and integrity of Mi'kmaw lore, legends and inherited knowledge.

Chapter One: An Overview of Pertinent Literature

In the fifteenth and sixteenth centuries European fishermen made contact with the Mi'kmaq, drawn to North America by the rich fishing grounds off the coasts of Newfoundland and Nova Scotia.² These Europeans were generally illiterate and left no written journals or records concerning these events and their observations. Literate Europeans arrived with the seventeenth century and at this time the development of a body of literature concerning the Mi'kmaq and their customs began.

The records of the period certainly help to illustrate contemporary daily life of the Mi'kmaq and many contain accounts of healing ceremonies and remedies. However by this time Mi'kmaq culture had already felt the effects of contact and trade with Europeans, whose vessels appeared primarily during the summer months. Engaging in trade with them meant sacrificing time formerly spent filling winter stores, in turn modifying the diet and nomadic lifestyle of the Mi'kmaq. Europeans also introduced grain alcohol and foreign pathogens such as *variola vera* (smallpox)³ (Miller, 2004, p. 258; Paul, 2008, p. 37; Hoffman:1955, p. 591).

These earliest records represent a portrait of Mi'kmaq society situated in a specific period, characterized by nearly a century of intercultural exchange. Additionally the bulk of early information was recorded by French Catholic churchmen, explorers, and merchants. As these writers were “male priests, adventurers and traders” the perspective

² I should note that this statement refers to the period of unbroken contact beginning then and does not include the comparatively brief contact centuries earlier by Norse seafarers. Their settlement in Newfoundland, L'Anse aux Meadows, had been abandoned for centuries before the arrival of French and English fishermen. Additionally, the Norse settlement rested within the territory of the Beothuk, not the Mi'kmaq.

³ Typhus, measles and chickenpox were also introduced by Europeans; the European tradition of animal husbandry likely promoted the development of immunities to many diseases of animal origin among European populations.

of other men, women and non-Europeans in general was not reflected. The social location and intrinsic bias of these writers should be remembered. (Miller, 2004, p. 248).

Three of the most significant European accounts of interaction with the Mi'kmaq date from the seventeenth century. Each of them contains accounts of contemporary life and ceremonies. The earliest of the three, *Histoire de la Nouvelle-France*, was written by French lawyer Marc Lescarbot after a visit to Nova Scotia in 1606. In 1672 French aristocrat and explorer Nicholas Denys published his *Description Géographique et Historique des Costes de l'Amérique Septentrionale*. The third, *Nouvelle Relation de la Gaspésie*, was written by a French priest, Chrétien leClerq, and published in 1691. Each of these authors was favourably disposed towards the positive traits of the Mi'kmaq, citing temperance, honesty, courage and self-determination as their key virtues. However a strong cultural bias shows through the work of all three. Despite offered praise words such as *sauvage* are frequently employed. Mi'kmaw historian Daniel Paul rightly notes that these writers were "...among those with little ability to appreciate the values of a non-Christian culture possessed by a people of colour" (Paul, 2006, p. 17).

Despite these flaws these early writings give a glimpse into the daily life of the Mi'kmaq of that period. Lescarbot tells us that the Mi'kmaq had already abandoned traditional pots and cookware in favour of European ones and Denys describes the making of *cacamo* [qamu] or 'moose butter' (Lescarbot, 1914, p. 194-195; Hoffman, 1955, p. 272, 595; Paul, 2006, p. 35). LeClerq commented on the changing face of Mi'kmaw society, writing,

It is true that this generous disposition is undergoing some alteration since the arrival of the French. The French, through the commerce they have had with them, have gradually accustomed them to trade, and to not give anything for nothing. Prior to this time...everything was

common property among them. (Hoffman, 1955, p. 596; Paul, 2008, p. 37)

Other, similar accounts exist from the time, such as that of Père Biard and other churchmen. All of the writings from this time period display the same collective sense of European cultural and religious superiority. In terms of cultural relations this attitude would colour interaction between Europeans and the Mi'kmaq for centuries.

In 1735 the French-born Catholic priest Abbé Pierre Maillard arrived in Cape Breton.⁴ His *Account of the Customs and Manners of the Mickmakis and Maricheets, Savage Nations Now Dependent on the Government of Cape-Breton* appeared in 1758. Of greater interest is a letter the Abbé wrote to M. de Lalane (his senior in Paris) around 1755. The letter relates a conversation between the Abbé and a Mi'kmaw shaman named Argimaut concerning aspects of pre-contact life. The most valuable aspect of Maillard's letter, in the words of ethnologist Ruth Holmes Whitehead, is that it is "...the only existing record where a specifically named person discusses what life was like before the arrival of the Europeans, or where we hear his actual words" (Whitehead, 1991, p. 10; Lockerby, 2004).

Argimaut spoke Mi'kmaw (as did Maillard) and English translations of the letter mean the words are twice-removed from their original language. Doubtless subtleties of meaning, always difficult to capture in translation, have been lost. Maillard also reveals his own biases by refusing Argimaut and his companions a drink of brandy and subsequently lecturing them on alcohol consumption by Natives. However his writings provide us with a less-biased view of Mi'kmaw culture than previous tomes.

⁴ Maillard's greatest legacy is the system of writing he developed for the Mi'kmaq language. He was later able to produce prayerbooks and catechisms in that tongue.

By the time of Confederation interest in an academic study of the Mi'kmaw had increased. In 1895 American anthropologist and folklorist Stansbury Hager published an article on Mi'kmaw customs, cures and traditions in *American Anthropologist*. His research was based around conversations with two elderly Mi'kmaq men. The article explores some of the contemporary customs of their people but Hager does not always state who provided him with individual pieces of information. Additionally he was a generalist and wrote extensively on various cultures across North and South America. Naturally this limited his interpretation of information to a general sphere. Hager's interviewees were also all male, eliminating the female perspective from consideration. Finally, he wrote the article in an effort to preserve disappearing customs and beliefs; the underlying assumption is a white man might know what is best for the Mi'kmaq and can preserve their culture for them. Hager does not provide insight into why he felt entitled to decide what needed to be saved. However, despite its flaws, the article itself is a classic on the subject and makes for fascinating reading (Hager, 1895). The sense of cultural superiority in this work is lessened compared to earlier writings but still present.

By the 1940s interest had increased concerning First Nations healing practices, often in conjunction with the 'noble savage' mentality that coloured then-current views concerning North American aboriginal people. This was also the time of the residential schools and their atrocities. Again, white Canadian beliefs influenced writings on the topic.

In 1948 Arthur van Wart published 'The Indians of the Maritime Provinces, Their Diseases and Their Cures' in *The Canadian Medical Association Journal*. Van Wart's paper directly examines ethnobotanical healing traditions extant among the Mi'kmaq at

that time, providing a list of ailments and plant-based cures. The paper is also valuable as it presents an ethnopathological snapshot of the contemporary Mi'kmaq and demonstrates the continued use of traditional remedies in the mid twentieth century (Van Wart, 1948). While Van Wart's article demonstrates an increase in interest in Mi'kmaq healing traditions, especially from the academic perspective, it approaches the material from a strictly analytical point of view based in a Western, post-Enlightenment understanding of the concepts of 'health', 'healing', 'illness' and 'disease'. The paper is therefore myopic, failing to expound upon the cultural significance of Mi'kmaq healing traditions, or their underlying operative principles. Instead it offers a straightforward presentation of ailments and corresponding remedies. To be fair, the article's purpose was not cultural exploration. Van Wart was a physician and product of the Western educational and value systems. The lack of attention to the Native voice in this particular article also decontextualizes the very cures it seeks to study. Van Wart, therefore, offers the equivalent of a book on parasites that never addresses the overall physiology of the host organism.

The preceding studies have all, to one degree or another, ignored the Native voice and presented conclusions founded in a European interpretive framework. The non-physical dimensions of human health as understood by the Mi'kmaq were little understood or explored. Instead Euro-Canadian writers treated forms of Mi'kmaq psychotherapy (which will be described in Chapter Three) as superstitious rituals. Potentially richer understandings of Mi'kmaq methods and means were lost when European concepts of 'religion', 'health' and 'illness' were allowed to determine what information was recorded.

The colonial and post-colonial powers had a vested interest in settling Native populations on reservations. The offer of Western health care and remedies was intimately tied to this forced settlement and the sacrifice of the traditional lifestyle. Part of this tactic was the use of physicians and social services as ‘agents of acculturation’, a process that had had wide effects on not only health considerations but also the power structure and social dynamic of tribes. Historian Olive Dickason explored such use of social services in 1992, beginning in the post-Confederation period and concentrating mainly on an examination of treaties.

This use of physicians was studied and explained by Peter Twohig in the mid 1990s in his treatment of Mi’kmaw medical attendance (Dickason, 1992; Twohig, 1996). Both Twohig and Dickason note that the superior power of the government, using healthcare and other services as both carrot and stick, was employed to encapsulate the Mi’kmaw people and isolate them from wider Canadian society.

By the mid 1980s and onward an increase in both the amount of academic work regarding First Nations people and the number of Aboriginal scholars in Canada contributed to a body of work now far more representative of Mi’kmaw culture and perspective. The imaginary homogeneity of First Nations culture was accepted as such within the Academy, and the myth of the noble savage was found to be inaccurate and problematic. The interaction between First Nations people and the Canadian government became a prime focus of study.

In Nova Scotia Dorothy Moore published a study of the multicultural policies of the government and its interaction with the Mi’kmaw nation (Moore, 1985). This paper was soon followed by Christine Campbell’s report on the history and accomplishments of

the Native Council of Nova Scotia, which was, and remains, heavily involved in efforts concerning the preservation of traditional Mi'kmaw culture and language—including healing (Campbell, 1987). Both of these studies are valuable for their demonstration of greater attention to the Native voice and the concerns of the Mi'kmaq people. They are indicative of a wider trend within academia from this point on regarding First Nations, namely, the consideration of the perspective of the subject as valuable and possessed of its own historicity, sociocultural context and meaning.

Changes in Canadian society since the counter-cultural movements of the 1960s and 70s also contributed to a deeper popular interest in Native and 'New Age' traditions. Healing modalities on the fringe, or outside of, the Western biomedical industry (such as aromatherapy, therapeutic massage, psychic healing, and so forth) began to develop popular followings. This subcultural trend, enhanced by the lingering concept of the 'noble savage,' created an interest in Native healing techniques. Occasional academic papers advocating not only the use of traditional Native modalities but also their employment according to Native understandings of healing and therapy began to appear.

One such example was penned in 1987 by Phoebe Dufrene of Perdue University. Dufrene's paper focuses on 'creative arts therapy', which is the use of creative expression as a healing and restorative practice—a concept she says is essential to the First Nations understanding of 'art' and 'medicine'. According to Dufrene's understanding of the pan-Aboriginal (if such a view can truly be said to exist) worldview a well-executed work of art possesses spiritual power (medicine), that is, a natural propensity towards healing (Dufrene, 1987).

While works such as Dufrene's continue to display a more attentive view of Aboriginal medicine and treatments, a common flaw lies in the often unchallenged assumption that non-Native individuals should be able to employ these practices as they see fit. Realistically, much of the importance of these ceremonies and practices lie in the community's reverence of them and their internalization. A life time of such respect and association cannot be generated within an outsider in mere days or months. In this sense, while Dufrene and others have nothing but the best of intentions, their call for the adoption of Native healing modalities by non-Natives can be seen as a form of unwelcome cultural appropriation. Andy Smith, a Native woman, has railed against such appropriation in her essay '*For All Those Who Were Indian in a Past Life*' (Smith, 1994)⁵.

The mass communication and rapid exchange of ideas made possible by the internet has also given rise to sources of 'authentic' Native ceremonies for mass consumption. However, First Nations people have also employed the internet to express their own opinions and make their voices heard. One excellent blog, *Native Appropriations*, is written by a Cherokee graduate student and contributes well-considered conversations on the topic (K, 2010)⁶. On the other hand many non-Natives may derive real benefits from Aboriginal practices and feel justified in using any successful method in effecting their own healing. Ultimately the full debate on the issue is beyond the scope of this paper but it certainly continues unabated today.

⁵I should note that Smith's essay has been republished many times in several different publications, from peer-reviewed journals to *Ms. Magazine*.

⁶Ironically, the blog's sidebar contains a haiku, written by the Cherokee author, complaining of cultural appropriation!

The 1990s were witness to a veritable explosion in academic work and well-researched non-academic publications related to the Mi'kmaq and their remedies. Most importantly many of these works were written by members of First Nations communities, or in conjunction with them.

In 1993 Nova Scotian author Laurie Lacey published a small book on Mi'kmaq remedies as a follow up to some similar works he published in the 1970s and 80s. Unlike Van Wort's straightforward presentation of ailment and cure equations, Lacey's book is interspersed with personal observations and the experiences of many of the Mi'kmaq men and women who assisted him. It presents an intimate glimpse into the personal relationship between the individual and the natural world from the Mi'kmaq point of view (Lacey, 1993). As any understanding of traditional Mi'kmaq healing practices must be rooted in their cultural understanding of illness and healing books such as Lacey's provide an excellent spring board for deeper study of the topic. Lacey has followed this publication with further books, which, while based in Mi'kmaq lore, seek to express a vision of Mi'kmaq healing that is effective, environmentally aware (underlining the importance of 'interconnectedness' to Mi'kmaq views of ecology), and potentially viable among non-Native populations (Lacey, 1999).

By the 1990s the medical community in Canada had begun to examine the position of healing within Native communities and its interaction with Western forms of health care. Physician Elizabeth Zubek published a study in 1994 that explored the attitudes of Canadian physicians towards the use of traditional First Nations healing modalities by patients of that background. Her results revealed that physicians generally accept such modalities only in certain situations, such as "...health maintenance, palliative

care, and the treatment of benign illness” (Zubek, 1994, p. 1923). In other words, mainstream medicine tends to allow the use of traditional healing techniques in situations that are either not very serious (such as colds and flus) or are essentially hopeless—ones in which biomedicine has little serious interest in the first place.

Zubek acknowledges the dismal state of health and health care within many First Nations communities and notes that a strong contributing factor to this issue is a lack of understanding of what ‘health’ and ‘illness’ mean to them. She concludes that “...physicians are sometimes reluctant to collaborate with traditional healers, especially in the hospital, because of legal, ideological, philosophical, and financial barriers”. Ultimately, she encourages the medical community to gain a deeper understanding of health in the First Nations context and calls for active cooperation between Aboriginal and Western-style health-care providers to address wider trends in illness and care among First Nations people (Zubek, 1994, p. 1930-1). This acceptance is welcome not only for its sensitivity but also for its challenge to the sense of universal applicability assumed by modern biomedicine and many of its practitioners.

In 1998 Mike Petrou wrote his Masters' thesis *Two Pathways to Health*, an exploration of ways in which the biomedical industry and Mi'kmaw healing could potentially cooperate. He advocates a move towards medical pluralism and acknowledges that such a development would be difficult to put into practice. Petrou's essay is an outstanding treatment of the topic but his portrayal of biomedicine is not wholly without errors. For example, he describes biomedicine as allopathic in nature, which is to say that it aims at producing symptoms or effects that are the opposite of those presented by an illness. In reality biomedicine attempts to return a patient to a 'normal', healthy state

defined by a physiological average or baseline. Biomedical methods of achieving this can be considered allopathic or homeopathic. Despite such minor flaws, his essay remains well-researched and well considered and offers fascinating insights into Mi'kmaw healing.

A more profound understanding of Native healing as a communal and multi-level phenomenon has led researchers to consider applications of traditional techniques to other issues, unrelated to physical illness. In 1996 an article entitled 'Justice as Healing: A Newsletter on Aboriginal Concepts of Justice' was published in the journal *Native Law Center*. In it Russell Barsh, of the University of Lethbridge, considered traditionally inspired strategies to reduce rates of juvenile crime among urban Aboriginal populations and found them effective in both preventing such crime and in reducing rates of re-offense. The development of the academic understanding of First Nations approaches is evident in this article as Barsh directly relates cultural dilution and the breakdown of traditional society to rising crime rates, viewing the latter as a symptom of the underlying disease embodied in the former (Barsh, 1996, p. 3). Ultimately, Barsh suggests a re-distribution of attendant funds to programs encouraging communal solidarity among reservation and off-reservation Native communities. As we shall consider in Chapter Three such solidarity is a key component of First Nations cultures.

Other agencies have also employed the traditional healing methods and practices of First Nations peoples in programs aimed at rehabilitation. Annual reports by the Corrections Inspector have led to the development of the 'Healing Lodge' program, which aims at treating the underlying causes of criminal behavior in First Nations offenders through the use of traditional ceremonies. As this program is quite new its long

term results remain to be assessed. However early reports indicate a high level of success and ready approval of the expansion of the program from inmates, guards, Native Elders and social workers (Wii'nimkiikaa, 2005).

Academics such as J.J.R. Guest and Jennifer Llewellyn have explored the importance of considering First Nations concepts of healing and illness in the treatment of prisoners in all phases of the judicial or penal systems (Guest, 1999; Llewellyn, 2002). This indicates a changing understanding of traditional Aboriginal concepts of health and well-being; knowledge of the cultural importance of such concepts; and their value in healing not only physical but also psychic and communal ills. These studies and reports also illustrate an acceptance of the interdependence of the various aspects of Mi'kmaw culture.

This welcome trend of attentive, sensitive scholarship has continued, both within and without the Academy. Celebrated Mi'kmaw poet Rita Joe, in conjunction with Nova Scotia 'surf poet' Lesley Choyce, gathered various stories and tales from the Mi'kmaw oral tradition and published them collectively as *The Mi'kmaq Anthology* in 1997. Joe's book expresses Mi'kmaw culture according to its own understanding of itself, rather than through a white, Western and post-Enlightenment framework.

James (Sákéj) Youngblood Henderson, an Aboriginal lawyer, wrote *The Mi'kmaw Concordat* in 1997. The book concerns the development of the legal relationship between the Mi'kmaq and the Church of Rome. The value of these collections and works lies in both their exposure of the nuanced Mi'kmaw voice to a wider public and their revelation of the proper context of these teachings in relation to Mi'kmaw society. Additionally the difficulty of divorcing spirituality from daily life in Mi'kmaw society is underscored.

Additional works, both by Mi'kmaq authors and by non-Native scholars, have since paid a good deal more attention to the traditional understanding of healing as a communal phenomenon and as vital in addressing issues plaguing the Native communities of Canada. Studies have addressed the possibility of early alcohol-abuse intervention programs among Aboriginal youth (Musquash et al, 2007); the importance of traditional values in community cohesiveness and its potential to reduce crimes rates among Native populations (Ross, 2005); and the unique issues of women regarding First Nations self-governance (Fontaine, 2002). Each of these facets of society is improved through the application of traditional concepts of health, well-being and treatment.

Other authors have addressed some of the root causes of physical and mental health issues such as alcoholism or suicide on reservations, relating them to the legacy of cultural genocide perpetrated by the government of Euro-Canadians. John Hyton explored the legacy of sexual abuse in residential schools while Sioux scholar Elizabeth Cook-Lynn examined the effect of modern scholarship on Native cultures (Cook-Lynn, 2001). A review of this material is valuable in terms of contextualizing the health-related issues common on reserves.

No consideration of the relationship between Canada and the Mi'kmaq would be complete without consideration of the residential schools. A paper of this size cannot possibly hope to consider all the literature available on that topic and remain true to its aims. However no author has produced an account as honest, frank, painful and poignant as *Out of the Depths*, by Mi'kmaw author and school survivor Isabelle Knockwood. The horror and abuse detailed in her account serves to elucidate the intense psychic trauma inflicted by the staff of the schools (and the federal legislation that allowed and

encouraged their assimilationist policies), and the need for healing—both individual and collective-- to deal with this trauma.

Much of the modern literature written from the Native perspective concerning the schools advocates a return to traditional healing and coping techniques, shunning the Euro-Canadian methods developed and distributed by the same colonial power structure that created the schools in the first place.

Finally, an excellent exploration of contemporary healing practices and techniques, as well as a call for their rejuvenation, is found in the recently-published *Voices of the Tent* by David Gehue. Gehue is a practitioner of traditional medicine and has been involved with the sometimes controversial introduction of new practices to Nova Scotia's Mi'kmaw community. He is very open about the issues he faced as a Native youth growing up in Nova Scotia. He suffered from addictions but, in conjunction with his call to become a healer, worked diligently to free himself of them, attributing his success partly to his use of traditional techniques of healing rather than sole reliance on modern, Western medical treatment programs. Gehue provides one of the most insightful and reflective books available today on the subject of Mi'kmaw and pan-Aboriginal healing. While the author makes it clear he does not present a 'how-to' manual, he does strongly encourage a return to traditional practices by his people as a method of addressing the modern concerns that plague them. Gehue also describes his own experiences within the health-care system, both as a patient and as a licensed therapist. This examination of both sides of the topic, from a Mi'kmaw man, is incredibly valuable.

The fundamental flaws of early scholarship regarding the Mi'kmaq have been mitigated to some degree over the last two and a half decades. Greater attention to the

perspective, considerations and opinions of Mi'kmaq and other First Nations peoples has not only created the potential for more accurate and sensitive study but also for the preservation of indigenous knowledge and practices according to the collective will of the Mi'kmaq. Attention to their experiences allows for the creation of programs and health-care outreach that are more sensitive culturally and stand a greater chance of success. In this vein, there are academic departments, and university-affiliated institutes that have devoted themselves to understanding the use of traditional healing methods within well-established health care systems. These include the Canadian Institute of Natural and Integrative Medicine (Alberta) and the Canadian Clinic for Integrated Medicine (Ontario). However, the local, Nova Scotian medical school, located at Dalhousie University, while maintaining a small library section of books on the topic, is not heavily involved in such endeavors.

Among the Mi'kmaw people, the importance of the oral tradition cannot be understated. It is through this oral tradition that ceremonies, knowledge and history are transmitted; it is at the heart of cultural continuance and preservation. Many of the works cited above draw upon conversations with Mi'kmaw persons and the oral histories of that people, and one Mi'kmaw source underscores the importance of such a tradition:

Sometimes, like the Mi'kmaq, a people may have both a written and an oral tradition. Because people hold the story in their memory, and because sometimes the story changes with the telling, oral histories can be more fluid, more dynamic, more alive, than written histories. This doesn't make them less true than written history, just different...Oral traditions are one way that people make sense of the world in which they live. The stories explain how things came to be the way they are in the world, or in some cases, explain how things are supposed to be. The traditions also help to teach the young the things they need to know to fit in with their society. Because these traditions developed over generations within the boundaries of a society, they are often unique to that society, and help to define who they are and what they believe in as a people. Thus, the oral traditions of the

Mi'kmaq differ from those of any other people in the world, and help to keep the Mi'kmaq unique (Mi'kmaq Spirit, 2007).

Of course a review of such an oral history is beyond the scope and ability of this thesis; however it is vital that we remember this tradition as it is the method through which insider, inherited knowledge is passed down from generation to generation.

With a louder Mi'kmaw voice now being heard within the academic community, the imperative to find solutions for contemporary issues that are not only effective but welcome has become more demanding. Solutions based solely on Western concepts of health and illness have been largely ineffective. Despite calls from Native activists for the acceptance of traditional healing practices by Canadian health-care providers little real headway has been made. Mi'kmaw healing traditions, then, are faced with resistance from the entrenched 'governmedical' system, the cultural background of which will be explored next.

Chapter Two: The Western Cultural Roots of Biomedicine

When we consider ‘health’; ‘well-being’; ‘disease’; ‘illness’ and so forth we are actually considering concepts that are culturally constructed and vary from civilization to civilization, from people to people and from era to era. All of the various, interpenetrating aspects that together form a society or civilization contribute to that specific cultural perspective on health and related concepts. The cultures that gave rise to the modern, Western biomedical tradition and that of traditional Mi’kmaq ways were, and are very different. The two traditions conduct themselves according to very different operational frameworks and through different understandings of health, disease and even the fundamental nature of human beings. This chapter will examine the development of biomedicine.

It must also be remembered that within a community (including on the national level) concepts of health and wellness are not static but continue to evolve. An examination of individual weight and its link to the popular 'picture of health' in Euro-American society illustrates this. In centuries past corpulence was a sign of plenty, of success, and of the ability to feed oneself and one's family well. In the later twentieth century medical research that associated obesity with various illnesses (such as diabetes, myocardial infarctions, etc) contributed to changed public perceptions enough that a slim, slender physique became the modern standard of size-0, calorie-starved beauty.

Health care researcher Wendy Mitchinson noted that even the modalities associated with health-care and healing change over time, writing “...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”(Mitchinson, 1991, p.

4). Biomedicine, then, cannot be viewed as unchanging and rigid for it too changes with the tossing and turning of cultural and social evolutionary tides.

In Canada, the consideration of biomedicine is also important due to the socialized nature of its provision. Biomedicine is endorsed exclusively by the government, which does not employ alternative health practitioners as it does biomedically trained ones. Medicine is also tied to Canadian society through the marketplace, where pharmaceutical and medical supply companies reap large profits; through education, for universities train physicians, nurses, pharmacologists, x-ray technicians and other care providers (notably, most provinces in Canada have closed nursing schools in favour of hiring graduates of BScN programs); and culturally, for the occupation of the physician is a respected, prestigious one. For these reasons, one can safely state that biomedicine dominates health-care in contemporary Canada.

The Development of the Western Biomedical Tradition

`Biomedicine` is a broad term, essentially synonymous with `theoretical medicine`. Its connection with the practice of medicine is complex; it is a sphere of theory and conceptual methodology more than practice, yet medical practice rests upon its foundations. The bodies of knowledge usually referred to as medicine (both human and veterinary) and dentistry as well as the various biosciences (not limited to, but including physiology, biochemistry, genetics, embryology and even biomedical engineering) fall under its purview.

As the repository of theoretical knowledge and research within the medical tradition biomedicine underpins the twin pronged approach of diagnosis and treatment. As a discipline it is highly regulated by scientific rigour and method and its definition of health “focuses solely on the individual’s physiological state and the presence or absence of symptoms of sickness” (Weiss and Longquist, 2009, p. 113). I would like to note that this definition does not leave room for psychological, emotional or spiritual considerations.

Biomedicine did not spring fully formed from the Enlightenment. Observation has always been essential to healing practices and compiled collections of prescriptions, guidelines for diagnosis and suggested methods of treatment have existed since ancient Egypt. Egyptian physicians were a highly specialized lot with each practitioner treating very specific afflictions (Dunn, 1996; Rawlinson, 2009).

Hippocrates of Cos (460-377 BCE) is traditionally considered the father of (empirical) medicine; he contributed three major developments to the classical medical tradition, the first and third of which remain features of modern biomedicine:

- ⤴ The principle of natural causes for disease and illness, rather than supernatural ones;
- ⤴ The *Corpus Hippocraticum*, a seventy volume work on many aspects of medical practice that encouraged physicians to treat patients as a whole, rather than addressing disease alone; and
- ⤴ An insistence on compassionate, ethical practice as embodied in the Hippocratic Oath (Lonnquist and Weiss, 2009, p. 15; Ackhernacht, 1982; Nuland, 1988)⁷.

⁷The Hippocratic Oath also reveals that medicine and surgery were different disciplines in Classical Greece, for the physician promises not to “delve for stone” but to leave this art to those trained in it.

This model of medical practice and research was innovative in its time and place.

The celebrated philosopher Plato was a contemporary of Hippocrates and argued for a dualistic understanding of the human being. Plato felt that humans consisted of a physical body that gravitated towards the base and material and a spiritual body which strove for the celestial (Schultz and Lavenda, 1995, p. 328; Petrou, 1998, p. 40). Thomas Aquinas also allowed for the separation of soul and body; his teaching was incorporated into the Catholic Church's doctrines. This dualism would continue to influence Western medicine and would be revisited by Descartes centuries later.

Subsequent developments in European medical thought throughout the medieval period were characterized by superstitious beliefs regarding disease causation and the interference of the Church with any practice of empirical medicine. Saints were petitioned for specific ailments while the Church described diseases as Jobian tests of faith with supernatural origins. By the late medieval period medicine had fallen under the jurisdiction of secular clergymen, who proved powerless medically and religiously in the face of the Black Death, leprosy, scurvy and other afflictions (Camp, 1977; Bennett, 2000).

Learned men of the time studied astrology, alchemy and similar pseudo-scientific (or, one might say, pre-scientific) pursuits. One of the leading physicians in Europe during the early Italian Renaissance prescribed remedies made of crushed gems and pearls which, unsurprisingly, were ineffective (Herald, 1981, p. 174).

A great deal of ancient medical knowledge had been lost by European civilization, but preserved within the Islamic world. There it was enhanced by brilliant advances in anatomical and physiological understanding; the development of hospitals staffed by

professional care providers; and even the addition of the first peer review process, which also made possible the first malpractice suits (Hastings, 1974; Spier, 1978, p. 357). This ancient knowledge shaped Renaissance medicine and led to the development of a group of specialized medical practitioners. Physicians were graduates of accepted medical schools and treated the upper class primarily. Surgery was a trade, learned like others through a period of apprenticeship, and was held in lower regard than the academic discipline of the physicians; surgeons dealt with primarily external complaints and the setting of broken bones. Approximately equal in status to the surgeons were the apothecaries. In urban environments they served in a role roughly analogous to the modern pharmacist but in rural environments the functional division between apothecary and physician blurred considerably (Lonnquist and Weiss, 2009, p. 19, 20). In Europe, then, the practice of the healing arts was expressed through three different socioeconomic classes: first, the intellectual, academic and ‘gentlemanly’ pursuit of the physician; second, the apprenticed occupation of the middle-class tradesman; and third the survival of ethnobotanical knowledge, traditional preparations, remedies and so forth through the apothecary, whose presence was strongest among the rural, peasant class. These different classes of health-care providers, then, reflected contemporary European society.

Doubtless many women worked as midwives or village healers; however the patriarchal society of contemporary Europe ignored their experience in the written record. The lack of a contemporary female voice within the medical historiography also marginalizes the contribution of female practitioners, such as midwives, to the healing arts.

The unseen world continued to be influential in medical thought. The continued association of astrology and alchemy with medicine is illustrated, perhaps humorously, with the sixteenth century adage `a night with Venus leads to a lifetime with Mercury`, reflecting a then-current belief that quicksilver would cure syphilis or other venereal diseases (Partridge, 1992). The European approach to medicine and health care would change drastically during the Enlightenment and the Industrial Revolution.

Francis Bacon (1561-1626), among others, argued that systematic observation and subsequent experimentation would reveal rational causes for events, rather than supernatural ones. The application of the scientific method to western medicine soon gave rise to the disciplines of anatomy and physiology.

By the mid-eighteenth century English physician William Harvey had described the circulation of blood and Italian physician Giovanni Morgagni had developed the anatomical theory of disease, which linked disease to individual organs. This theory was a significant—and revolutionary-- development, ultimately replacing the previous humoral theory of disease causation as well as other minority schools of thought (Weiss & Longquist, 2009, p. 20,21).

Historian Mike Petrou and physician-researcher Laurence Kirmayer have both expertly explored the influence of Enlightenment thought on biomedicine. In brief, both argue that various dualisms pervade Western thought and are central to the subsequent development of medical theory and practice. Kirmayer demonstrates lines of metaphysical thinking reaching from Plato to medieval scholars incorporating such dualisms as “reason contrasted by passion, thought by emotion, male by female, free will

by compulsion, matter by spirit, mortality by immortality” and so forth (Petrou, 1998, p. 41; Kirmayer, 1998, p. 76).

Rene Descartes (1596-1650) was of the opinion that the body was mechanical in nature and therefore bound by the physical laws of the universe. The mind, however, was incorporeal and therefore unconstrained by physical laws. The subsequent development of the Newtonian understanding of a mechanistic universe served to reinforce this dualism (Petrou, 1998, p. 41; Gordon, 1988, p. 24). Indeed, this Cartesian model would dominate Western sciences for hundreds of years and forms “...the conceptual underpinning to a medical system that pays attention to bodies as separate from spirits” (Sered, 2004, p. 2).

By the nineteenth century western medicine had found a new milieu in which to operate. While medieval medicine was centred in libraries and centres of learning and that of the Renaissance on the sickbed, nineteenth century medicine was centred on the hospital. The Industrial Age and the resulting poor conditions and overcrowding in many cities emphasized the hospital as a place of potential healing and the concentration of patients in one area allowed for easy scientific observation; the sorting of patients by disease or complaint; and the subsequent reductionist development of medical sub-specialities (Ackernecht, 1982; Weisz, 2003).

Three major nineteenth century advances propelled the future growth of the medical field. First, Louis Pasteur’s development of the germ theory of disease (and vaccination) led to a new understanding of pathogens and contributed strongly to the growth of microbiology. Second, inspired by Pasteur's discoveries, Sir John Lister investigated and described the vital role of aseptic techniques, dramatically decreasing

rates of post-operative infection⁸. Third, the introduction of general anaesthetics such as ether and chloroform allowed patients to endure procedures previously impossible. Early local anaesthetics included ether, ethyl chloride, opiates and cocaine⁹. Separately, these three discoveries were revolutionary testaments to the growth of rationalist, scientific theory and investigation; together they became the basic cornerstone of modern biomedicine (Weiss and Longquist, 2009, p. 23; Castiglioni, 1958).

The nineteenth century saw the completion of the professionalization of medical practice in the industrialized West. In 1800 British surgeons were finally granted a Royal charter and founded their own college—55 years after abandoning their previous primary vocation as barbers. The professionalization of surgery brought two of the major forms of medical practice historically extant in Europe—the work of the physician and the surgeon—together under the medical umbrella. Women were still excluded from medical practice.

The exclusion, and later inclusion, of women in medical schools also shaped modern medicine and related industries. Research on the topic has demonstrated that, as more and more women enter biomedical fields, they change the nature of those fields. One prime example is the pharmaceutical industry. Men, historically, entered the field as entrepreneurs with an eye to running their own businesses while women tend to involve themselves with clinical practice in the hospital setting-- a role as direct-care providers for which, according to some researchers, women seem far better suited than men. This

⁸ In 1847 Ignaz Semmelweis advocated hand-washing before assisting in birthing. This was prior to Pasteur's description of germ theory; Semmelweis was therefore unable to explain *why* his technique was needed or effective. Results alone were not enough to convince his contemporaries (Hanninen et al:1983)

⁹Several modern local anaesthetics are cocaine derivatives, including lidocaine and novocaine. Cocaine is still stocked in some hospitals (including the QE2 in Halifax) where it remains useful in nasal and lacrimal duct surgery. Cocaine is problematic due to its potential cardiovascular toxicity.

has contributed to the rise of clinical pharmacy practice in Canada today (Levy, 2006, p. 953).¹⁰ In recent decades enrolment in Canadian universities (including medical schools) has been predominantly female; how this will affect the future development of Canadian health-care remains to be seen but it is safe to assume that cultural attitudes towards the sexes have influenced the rise of Western medical practice.

The changing nature of western thought and approaches to medicine are revealed in more modern adaptations of the Hippocratic Oath. The modern version penned by physician, professor and administrator Louis Lasagna omits mention of gods such as Hygeia, Asclepius and Panacea and states, “I will respect the hard-won scientific gains of those physicians in whose steps I walk”. The new emphasis on scientific research reflected in this version indicates the value placed upon such research in the modern, rationalist, despiritualized medical milieu (Lasagna, 2010). It also demonstrates that changing opinions and beliefs within a culture lead to changes in the practice of medicine and the understanding of health. It is easy to see how Western European culture shaped the development of biomedicine but, despite its prominence, the biomedical worldview has not maintained its hegemony unchallenged.

Alternate Models

Biomedically a patient's involvement in his or her healing tends to be preventative (“stop smoking”; “lose weight”) or in passively accepting a physician's orders (“take these pills and call me in a few weeks”). Preventative measures that are, one would assume, the responsibility of a patient have often been replaced by commodified

¹⁰This is a complex issue involving socialized gender roles and the socio-economic status of women as a whole. It is well beyond the scope of this essay.

solutions—one might lose weight without a change in diet or lifestyle (via liposuction, laparoscopic gastric bands, abdominoplasty and so forth); quit smoking with neurochemical aids (such as varenicline or bupropion); or address depression not through therapy or modalities that address an individual's psychology and social context but rather through drugs such as monoamine oxidase inhibitors or tri- and tetra-cyclic antidepressants. The mechanistic view of the body allows patients and caregivers to view it as a machine with broken parts that may be swapped out. This medical industry thereby twists the patient into a consumer of commodities as well as a recipient of care. Here, biomedicine meets capitalism and begins to serve economic, rather than health-based needs.

Despite its pervasive influence the biomedical approach has been challenged from within the medical community itself. Writing in 1972 Robert Veatch, a professor of medical ethics at Georgetown University, noted that four possible biomedical relationships exist between physician and patient. The first is an 'engineering' model which approaches medicine as a 'value free enterprise' in which all relevant information is given to the patient who then makes medical decisions. Veatch finds this untenable as it divorces physicians from ethical concerns. The second or 'priestly' model presents the physician as a 'quasi-religious' medical and ethical expert; but this model rejects concepts of patient autonomy. The third or 'collegial' model treats patient and physician as colleagues devoted to a common cause but is problematic due to "ethic, class and value differences" between the two. The fourth and final is the 'contractual' model, characterized by both patient and physician having obligations and expecting benefits from the relationship but in which the patient retains freedom and autonomy. The

potential issue with this approach is that there is no guarantee of “mutuality of interest” (Veatch, 1972, p. 7). Veatch demonstrated the need for a new model and throughout the 1970s academic interest in the topic increased slowly.

One of the key figures in the drive towards alternate medical models has been George Engel, a physician and professor of psychiatry and medicine at the University of Rochester. Engels argues that in order to understand the determinants of disease and create treatments and models of care that are effective a medical model must consider not only the patient but also his or her social context. The physician must also be aware of the contextualized role he or she undertakes in a patient's decision-making process. Engel's argument gave rise to the biopsychosocial model of medicine (Engels, 1977, p. 132).

Following Engel's work, other researchers honed the concept of such a model. Timothy Quill, also a physician-professor at U of R, offered four principles which distinguish the biopsychosocial model from biomedicine:

- ⤴ The patient is addressed as a whole person, whether or not she or he has a disease.
- ⤴ The doctor-patient relationship is continuous, at all stages of the patient's life, through sickness and health, until either the physician or the patient dies, moves, or decides to terminate the relationship.
- ⤴ The physician utilizes both biotechnical skills and interpersonal skills to help the patient.
- ⤴ Both the patient and the physician make explicit, then negotiate, their respective needs and expectations (Quill, 1982)

Subsequent research has underscored the need for this new model. Robinson and Roter (1999) demonstrated that up to half of patient visits to physicians include psychosocial complaints. Barsky (1981) noted that most of these complaints include life and emotional stress; social isolation; a need for a sense of belonging; and need for information. Frowick et al (1986) found, through one study, that patients desire the involvement of their physician “across a wide range of psychosocial issues but typically do not expect it to happen”. Good, Good and Cleary (1987) noted that more than 70% of patients felt it appropriate to seek psychosocial care from primary physicians but that fewer than one third had tried discussing these issues with their GPs, who usually failed to recognize emotional issues. Roter, Hall and Katz (1988) found that less than 10% of the time spent with a physician involved conversation concerning patients' lives or psychosocial concerns. Williamson, Beitman and Katon (1981) examined the roots of these issues after attempting to teach the biopsychosocial model to physicians. Major stumbling blocks for physicians included a focus on biomedical practice (“I treat organic disease”; “psychosocial concerns are not medical issues”) or on misconceptions concerning patient complaints or expectations (“Patients will become dependent on me”, “Patients want me to rule out organic issues”).

The work of these researchers demonstrates awareness within the medical field of entrenched biomedicine's limitations as well as the need to transcend them based on patient needs and desires. The growth of the biopsychosocial model shows a willingness to address these limitations by abandoning the mechanistic, Newtonian view of the human being. As we shall see, the biopsychosocial model has a great deal in common with Mi'kmaw views on the subject.

Summary

Biomedicine is the product of a long tradition of health-care and related practices in Europe and North America. Its operating assumptions and theoretical framework have been shaped by historical influences and concepts that are powerful and pervasive in Western thought including the development of the scientific method; rationalism; the professionalization of medicine; and the social changes of the Industrial Revolution. The historical marginalization of women and non-Europeans as healers has limited the insights and experiences available historically in medical literature and education. It is clear that biomedicine is itself a product of Western culture and society.

Within the western medical community a minority have called for new models of patient-physician interaction that are more attentive to individuals and their orientation as multidimensional beings, undivorced from their social and communal contexts. The need for such a model is supported by the concerns and needs of patients, who seek a broader spectrum of care from physicians. When the social, economic and communal contexts of patients are ignored in favour of a purely mechanical understanding of injury and health, physicians find themselves being trained to cure, but not necessarily to care, becoming in effect mechanics of the meat¹¹.

¹¹Psychiatry addresses mental issues, but often deals with them through physical means—psychoactive drugs, for example. While its operative arena is the mind, the underlying scientific basis of psychiatry remains biomedical in origin.

Chapter Three: The Mi'kmaw Healing Tradition

In this treatment of the Mi'kmaw understanding of the world and the role of people within it, I must again remind the reader that I am not Mi'kmaw myself, nor have I grown up among them. I am not qualified to describe the worldview of the Mi'kmaq authoritatively and instead present a description based upon the writings of Mi'kmaw persons and those scholars with whom they have shared their views. Additionally, I would like to note that phrases such as 'Mi'kmaw worldview' or 'in the traditional understanding of the Mi'kmaq' are not meant to imply that all Mi'kmaq believe the same things. Not all Mi'kmaw persons follow traditional ways, or live in reservation communities. I hope the reader will bear this in mind when reading this chapter and remember that seemingly collective and all-inclusive terminology is employed for the sake of convenience, not generalization.

The Traditional Mi'kmaw Worldview

For thousands of years the Mi'kmaq have inhabited what are now the Maritime Provinces of Canada. Long before contact with Europeans they developed a rich culture and spirituality based on communal interests, tied to the land and environment in which they lived. This worldview continues to exist today and provides the conceptual background that gave rise to traditional healing.

In the traditional understanding we do not live in a dualistic, divided world in which matter and spirit are separate, or in which spiritual and temporal worlds are segregated. Spiritual considerations and concerns permeated all aspects of Mi'kmaw society. Canadian religious scholar Robert Choquette (2004) writes,

...[Native] spirituality was so much a part of everyday life, so enmeshed in personal, communal, political, economic and military activities, that it oftentimes became difficult to recognize the specifically religious factors in Amerindian life. (p. 11)

While the prevalent Christian traditions of Western Europe portrayed human beings as fallen and destined to eternal reward or punishment Mi'kmaw spirituality did not conceive of the world, or its inhabitants, as base. Instead it views the world as fundamentally good by nature—an 'undivided reality', and remains so as long as the essential equilibrium of things is maintained. The balanced world is at once both spiritual and material. The dualisms that permeate western thought are not found in this worldview. In her Masters thesis, Saint Mary's University professor Trudy Sable (1996) commented on this:

A number of dualisms—physical / mental, intuitive / intellectual, rational / emotional, objective / subjective—inherent in Western science, are missing. Implicit in the [Mi'kmaw] word for heart, is the notion of mind. You cannot have mind without heart. The question arises whether anything can be extracted and isolated from the relationship or constellation in which it occurs, e.g. can a father exist without a son? (p. 86, 87).

The verb-oriented Mi'kmaw language therefore presents a linguistic map of the world, in which all things are interdependent and linked together conceptually and grammatically. For example, the word 'father' exists as an independent grammatical concept in English. Sable tells us that there is no similarly independent word in the Mi'kmaw language. The word *nuij* for example means 'my father'¹² and '*wunjanip*' means 'a father who has lost a child'. Even in death, the concept of a father requires, and is integrally linked, to the concept of a child. Mi'kmaw linguist Bernie Francis also provided other examples of this inalienable possession; *Kisu'lkw*, rendered in English as

¹²Possession is indicated by prefixes in Mi'kmaw. The 'n' is a possessive prefix.

'Creator' actually means 'the one who created us' (Sable, 1996, p. 79). One cannot simply say 'a fingernail' or 'an axe' in the Mi'kmaw tongue without contextualizing it in relation to a possessor. One must say *nqosi* 'my fingernail' or *kutmikn* [kutmi'kn] 'your axe'; the individual forms **qosi* and **tmikn* are grammatically incorrect without the possessive prefix (Native Languages, 2007).

The language also lacks gender consciousness. It is an expression of the underlying worldview of a people, reflecting a mindset that considers relationships, not independence; that assembles rather than deconstructs. It “resonates the importance of relations and relationships ...the verb based language provides the consciousness of what it means to be Mi'kmaq [sic] and the interdependence of all things” (Battiste, 1997a, p. 148).

Knowledge and those who possess, teach or learn it are not separated. The language and culture both reflect a worldview founded on the interconnectedness of all things. First Nations writer and psychology professor Rod McCormick writes of a “...pan-Aboriginal definition of interconnectedness that we as Aboriginal peoples have with family, community, nation and creation. It is a clear declaration that we are all in relationship with one another in this world.” McCormick also believes the widespread expression 'all my relations' expresses the same idea. These relations may include not only people but also earth and sky, plants and animals, ancestors and spirits, creating '...an affirmation of our interconnectedness to all of creation” (McCormick, 2009 p. 3,4; Kipp, 2002). David Gehue ends his book with the same phrase in Mi'kmaw, *nogumaw* [no'kmaw].

All things have a common origin in the ‘sparks of life’ and are worthy of, and accorded, respect. As interdependent parts of the natural world the Mi’kmaq recognized that nothing could be taken without a subsequent giving-back (Choquette, 2004, p. 14; Paul, 2006). Offerings were made to the spirits of animals killed in the hunt and no part of it was wasted. When plants were collected for medicinal use an offering was also made, for without the willing cooperation of the plant's spirit, healing cannot take place (Battiste, 1997b, p. 15).

This ethic of reciprocity also applied to interpersonal relationships. Gift-giving was, as Choquette calls it, “...the key to the social universe and generosity a highly praised virtue” (Choquette, 2004, p.15). In addition to ensuring the circulation of goods this practice also helped to unite family and community. Mi’sel Joe, chief of the Conne River First Nation in Newfoundland, recalled,

Growing up, if you were out of butter and you got sent to a family to borrow a stick of butter, you’d say, I’ll be back with the butter next month, or next day, or next weekend...it was dignity and pride in taking care of family and friends and community because that’s what it was all about. It wasn’t just about hoarding what you had just for you (Anderson and Crellin, 2009, p. 15)

Joe's words also demonstrate that expressing one's need in Mi'kmaw society represented not surrender of pride but the ability to rely upon one's neighbours and fellows; this is an attitude consistent with a communal rather than personal focus.¹³ Maintaining positive, healthy interpersonal relationships took priority over any individual need to be right. Referring to those falsely claiming the insider knowledge of a Mi'kmaw healer, David Gehue (2009) writes, “They say 'if you live in a glass

¹³ Cornelius Jansen noted that this ‘institutionalized hospitality’ was also frustrating to missionaries, who often found that conversions were only superficial and accepted in order to please the guest (Jansesn:1984:60; Paul:2006:25).

house, don't throw rocks'. A [healer's] spirit house is made of very fragile glass, you can't even throw pebbles” (p. 29).

At the heart of the community is the family, concerning which Mi'kmaw author Marie Battiste (1997a) has said,

The family is the critically essential base of Mi'kmaq [Mi'kmaw] culture. A family in a Mi'kmaq [Mi'kmaw] community is not just a mother and a father, for a family is a large set of relationships, grandparents, godparents, aunts and uncles, brothers, sisters and cousins...Each child is special and each child will receive the nurturance of many significant others who will protect and nurture the child's growth through their growing years” (p. 150)

McCormick believes the emphasis on family and community strengthens First Nations peoples: “...it is not surprising that what promotes resilience in Aboriginal communities originates outside of the individual, that is, in family, community, society, culture and nature” (McCormick, 2009, p. 3,4; Andersson, 2009). Psychiatrist Charles Brasfield writes that a mentally healthy First Nations community “... would be established on traditional lands, share a conceptual language and have maintained a range of appropriate rituals for ingress and egress to the community” (Brasfield, 2009). Community is obviously a vital component of wellness in the First Nations understanding.

Understandably, then, the erosion of community and culture have had negative effects. Patricia Vickers links years of erosion of First Nations culture with the issues facing those communities today. She writes that we must “...connect the disruptive behaviours, such as alcoholism, drug addiction, rage and neglect, to dehumanization that is associated with cultural oppression.” She also notes that the effect of these actions on individuals has a strong communal component, for internalized colonization precludes a healthy sense of self, and “...without respect for self, others and the land an individual is

lost or spiritually unbalanced”, and is at this time most at risk from the afflictions she mentioned above (Vickers, 2009).

Mi'kmaw traditionalist Joel Denny voiced the same opinion to Petrou, noting that “...one's spirit can suffer from the influence of external issues, including the loss of culture, language, or community cohesiveness. All these things...are interconnected and are significant parts of good health” (Petrou, 1998, p. 94). We can liken the nature of Mi'kmaw culture and its various aspects to a spider web. Each strand—spirituality, health, community, each person, and so forth—intersects with many others. Nothing can affect part of this web without affecting the rest of it.

The principles of reciprocity, interpersonal respect, and interdependence also inform the healing practices of the Mi'kmaw people, which shall be considered next.

Interconnectedness, Spirit and Wellness

As we have seen, the biomedical tradition understands the human being, theoretically and practically, as a biological machine. The traditional Mi'kmaw understanding of the human is multi-layered and reflective of a broader perspective. Each individual is made up of several components. In addition to the physical dimension there are mental, spiritual and emotional ones. All are combined into the complete human being. In the words of Murdena Marshall to Petrou, “These four have to jive in order for one to have health” (Petrou, 1998, p. 94). Each of them can be injured and different forms of care developed to treat them.

Physiological health, then, is but one factor in the overall health of each individual. As each person is an integrated part of family, of tribe and of the wider world, so does his or her well-being depend upon that of the other strands of this psychological, spiritual and social web (Choquette, 2004, p. 22).

Marie Battiste (1997b) tells us that every living thing was given three gifts, collectively the 'spark of life':

- *Ktinin*: a physical body that decays and vanishes after death;
- *Manitu* [Mntu]: a soul or life-force that survives death and travels to the next life;¹⁴
- *Wtansalewimka*: guardian spirits, who lend aid to living things. (p. 15)¹⁵

It must be remembered that *ktinin* and *mntu* are not indicative of a dualised division in the human being. Rather, they point to two modes of being which occur simultaneously and between which there is an exchange of energy. Vaughen Doucette, a practitioner of traditional spirituality in Eskasoni, has described this outlook:

...imagine yourself standing on the ground. Your feet are on the earth and 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 part of a cycle...So the ideal, the ideal exchange of energy, would be in a circle (Petrou, 1998, p. 94).

Battiste (1997b) also tells us that just as there are three parts to the spark of life, so too do the Mi'kmaq see their lives as having three parts, each of which is separate but inter-related. She writes,

¹⁴ Battiste also tells us that the Church transformed 'manitu' into a symbol for the Devil. 'Manitu' can also refer to the spirit that is found in inanimate objects as well, such as rocks or trees.

¹⁵ While modern medicine often views such arrangements as superstitious and unscientific, the Mi'kmaw understanding of the human being is very similar (but by no means identical) to that found in other socially advanced indigenous populations. For example, compare the Haitian concepts of the *ti bon ange*, *gros bon ange* and *met tet* or the Classical Egyptian *ba*, *ka*, *ren* and so forth.

The Mi'kmaq identify them as *wjijaqami* [wjijaqmij], the life force or seat of life; *mimajuaqn*, the shadow or external soul; and *wsk-tiekmew*, the free soul, or shadow of life...the Mi'kmaq believe that all people must be balanced: strong and weak, happy and angry, physical and spiritual. Balanced consciousness creates the best possible human beings. It is through the alliances forged by the life soul that such balance is achieved. (p. 15, 16)

David Gehue put it simply, “...there's a balance and that balance must be maintained. You never get somethin' for nothin'” (Gehue, 2008, p. 122).

Spiritual power or 'medicine' is said to reside, in varying degrees, in all things. When European traders provided the Mi'kmaq with iron kettles, thus saving hours of labour in creating kettles from logs, the might of the new object was not in its shape or process of construction. It was due to the 'spirit of iron', that is, the 'medicine' or spiritual force inherent in the metal (Upton, 1979, p. 12).

This power could also manifest within human beings as well. There are different ways in which this power can manifest. However the translation of terms related to those forms is complicated by the biases of colonialism.

First, those people possessed of great personal strength or endurance were called *kinap*.

Second, a talent for healing could be developed. The power of traditional spiritual healers was different and “focused more on healing, divination, and, at times, shamanic retribution” (Chute, 1999).

Third, a kind of figure, called the *puoin*, possessed great power—a power which Chute calls 'dangerous and unpredictable', unlike the steadier or more reliable power of the healer or the *kinap*. Due to this seemingly sinister nature some writers have translated 'puoin' as 'wizard' or 'witch'. However *puoin* also refers to 'medicine' in the context of spiritual power, without any value judgements placed upon it; it does not indicate the

strange and mysterious as do *wigwasik* or *biltuasik*. The hardwood maple, *unkwoktc* [pq'u'qt], out of which game bowls are made, possesses puoin; so does the punk (*mespibaan*), which is dug in low places and is used as tobacco or as tinder (Wallis and Wallis, 1955, p. 156). Puoin also refers to the unity or constancy that lies behind all things—as men and women grow old and pass away new children are born; the individual may die, but the People remain. This permanency of cycle is puoin as well. English is simply not equipped with a word that can adequately represent puoin with its various and nuanced meanings.

Fourth, a form of power or blessing called *keskmsit* is granted to an individual through varying means, manifesting perhaps as a special skill, or good fortune, or an unusual capacity, the origin of which must be kept secret if the blessing is to be maintained. Sometimes *keskmsit* manifests as a propensity towards healing but at all times specific ritual rules must be followed in order to maintain this received blessing (Wallis & Wallis:1955:162-166).

Fifth, one able to divine the future is known as *nikani-kjijitekewinu*. There are even spirits who possess the ability to manifest in human form, and are called *mi'kmuesu* (Kekina'muek, 2007, chapter 6).

The diversity of spiritual practitioners of various types within the Mi'kmaw worldview reveals a highly advanced spirituality and a multi-faceted understanding of the interaction between the human and spirit. While these forms of spiritual energy or power infused the entire world and the objects within it, those specialists in its use for healing filled the tribal role of shaman, or medicine person.

Implicit in the forms and procedures of colonialism is a dynamic of power and authority. In traditional Mi'kmaw culture the healer possessed an honoured place in tribal society. This internal dynamic was certainly exploited—intentionally or not—by colonial figures. Upton describes how European churchmen subverted the authority of the shamanic healer by knowing how to treat illnesses introduced by Europeans; within traditional society this indicated a stronger spiritual force on the part of churchmen, who could then claim to act with an authority and ability beyond that of the traditional healer. Even without an overt claim traditional thinking could, and did, make this connection (Upton, 1979). The contemporary authority of the physician is very much a continuation of such a dynamic. The concept of 'power-over' did not arise during the interviews I conducted, perhaps due to a shift in thought among the Mi'kmaq, or a reluctance to share such information with an outsider—but it is a dynamic that cannot be ignored in approaching the subject matter. Indeed, this point will be made more explicit in the chapter concerning legislative and governmental issues.

Injury, Illness and Treatment

When exploring traditional views on disease and well-being authors such as Choquette and Lacey describe three causes of ill health as understood by the Mi'kmaq. In the first category are 'cause and effect' issues—the mechanical ones with which biomedicine is so concerned. Physical complaints such as fractures and lacerations fall into this category, as do colds, flus and similar afflictions. Lacking a physical cause, ill-

health could be defined in psychological terms;¹⁶ the cause of this type of affliction is usually unfulfilled desire. The third category includes supernatural afflictions, caused by the introduction of a ‘foreign substance’ or an illness-causing spirit, sometimes by the hand of a shaman (Choquette, 2004, p. 22; Lacey, 1977a, p. 10,11; 1977b, p. 182; Twohig, 1996, 20).

Traditional Mi’kmaw knowledge possesses well-developed and effective methodologies for treating each type of illness in light of the entire organism. Physical complaints were treated with a wide variety of medicinal preparations derived from floral and faunal sources, many of which are valid from the Western scientific perspective. For example, parts of the balsam fir (*abies balsamea*) are high in tannin, which acts as an astringent. R. Frank Chandler noted that liquid derived from chewing bits of fir was spat into wounds, while the pulp served as a poultice and the under bark as a wound dressing (Chandler, 1983). Trees such as white pine (*pinus strobus*), alder (*alnus crispa*, *alnus rugosa*, etc) and spruce (various members of genus *picea*) are high in naturally antiseptic oleoresins¹⁷; birch bark (*betula allegheniensis*) and bloodroot (*sanguinaria canadensis*) contain small amounts of methyl salicylate (wintergreen oil) that is useful in combating some infections. Various kinds of willow leaves (genus *salix*) contain high quantities of salicylic acid, the precursor to modern aspirin. Each of these cures, and many others, are found in Mi’kmaw healing lore.

¹⁶ Centuries before Freud and the beginnings of Western psychoanalysis.

¹⁷ Naturally occurring mixtures of resins and oils that can be extracted from various plants and trees.

Many parts of the same plant were often employed in the treatment of injuries.

Writing in the early eighteenth century the Sieur de Diereville (1968) noted how multiple parts of the birch tree are used in the treatment of fractures:

...the bones are reset evenly, and large pads of soft, fine moss are made, which are saturated with their Turpentine, and wrapped around the broken limb; outside of that is placed a piece of birch bark, which readily conforms to the shape of the part; splints are not forgotten and, to hold all this secure, they use long strips of thinner bark which make suitable bandages (also, Twohig:1996:22)¹⁸

Yellow birch bark was steeped and used as a rub for rheumatism or taken internally to treat dyspepsia, diarrhoea and other gastrointestinal complaints; sutures were made from the inner bark of some trees or from deer tendons (Lacey, 1993, p. 51).

It is quite obvious that the Mi'kmaq were adroit in the discovery and employment of natural remedies, some of which originated by watching the behaviours of animals. One imitative treatment for epilepsy, originally recorded by LeClerq and repeated by Lacey, involved scratching the patient behind the left ear with the hoof of a moose who had done the same (Lacey, 1993, p. 105). Other cures have been discovered by observing the moose, which eats "...calmus root, beech leaves and cedar buds when sick" and rolls on leaves and mud when injured to staunch blood flow (Augustine, 1996, p. 2).

New plant species introduced by Europeans were quickly absorbed into the tradition and their healing properties isolated; burdock (*arctium minus*) and witch grass (*panicum capillare*) are two examples. Despite the importance of tobacco to modern Mi'kmaq spirituality, the plant itself is not indigenous to the Maritime Provinces and was a later introduction. Prior to this its ceremonial and societal role was filled by a plant *lobelia*

¹⁸ Unfortunately the author does not note which kind of birch was used; several species are present in Mi'kmaq'í and can vary considerably biochemically and chromosomally.

inflata, commonly called 'Indian tobacco' (Lacey, 1993, p. 77; Mi'kmaq Spirit, 2007). This ready incorporation is indicative of a healing tradition which is dynamic and adaptive, not codified and rigid.

The second kind of complaint—the psychological—presented rarely among the Mi'kmaq according to historian Daniel N. Paul. He writes (2006),

...the rarity of mental diseases...was a direct result of the secure and stable lifestyles they enjoyed, which were the most conducive to keeping them exceptionally well-adjusted. When mental illness did occur, it bore no social stigma (p. 23).

Psychological complaints among the Mi'kmaq were considered the result of unfulfilled desires; some of these cases were sexual in nature while many others were not. Once a shaman had diagnosed such an ailment the cure was effected rather simply—by seeing to it that the root desire was fulfilled. In the event that this proved impossible offerings or the performance of certain rituals were employed instead.

While it is not possible to determine the historical rates of such afflictions, Paul also notes that the Mi'kmaq had a much healthier view of both sex and nudity than the far more repressed Europeans. When considered in light of the psychological understanding and treatments available to the Mi'kmaq it is fair to conclude that far fewer psycho-sexual issues were extant among them (Paul, 2006, p. 23,24; Choquette, 2004, p. 23).

However, one's personal sense of honour, and the esteem in which one was held within the tribe and the family, could, when offended, lead to psychological distress. LeClerq underscored the importance of personal honour to Mi'kmaq men. One particular incident is worth recounting in full:

Such were the feelings of a young Indian who, on account of having received by inadvertence a blow from a broom being used by a servant who was sweeping the house, imagined that he ought not to survive this imaginary

insult which had become greater in his imagination in proportion as he reflected upon it. "What," said he to himself, "to have been turned out in a manner so shameful, and in the presence of so great a number of Indians...and after that to again appear before their eyes?"

"Ah! I prefer to die! What shall I look like, in the future, when I find myself in the public assemblies of my nation? And what esteem will there be for my courage when there is a question of going to war, after having been beaten and chased in confusion by such a maidservant from the establishment of the Captain of the French? It were much better...that I die."

In fact, he entered into the woods singing certain mournful songs which expressed the bitterness of his heart. He took and tied to a tree the strap that served him as a girdle, and began to hang and strangle himself in earnest. He soon lost consciousness and would have...lost his life if his own sister had not happened to come by chance...to the very place where her miserable brother was hanging.

She cut the strap promptly, and after having lamented as dead this man in which she could not see any sign of life, she came to announce this sad news to the Indians who were with Monsieur Denys. They went into the woods and brought to the habitation this unhappy Gaspesian, who was still breathing, though but little. I forced open his teeth, and, having made him swallow some spoonfuls of brandy, he came to himself...

His brother had formerly hung [sic] and strangled himself...in the Bay of Gaspé, because he was refused by a girl he loved tenderly, and whom he sought in marriage. For, in fact, although our Gaspesians...live joyously and contentedly...some among them fall occasionally into a melancholy so black and so profound that they become immersed wholly in a cruel despair, and even make attempts upon their own lives (Hoffman, 1955, p. 274; Paul, 2006, p. 27).

This account illustrates those causes of psychological distress upon which we have touched. Firstly, the protagonist of the story, feeling that his honour has been besmirched, laments, his usefulness as a warrior and his honour as a man are at an end. His ability to function as a valued and useful member of his own tribe has been called into question in his mind. We have already seen that community cohesiveness and a 'secure and stable lifestyle' helped prevent mental illness. It stands to reason, then, that a perceived ejection from the stable community—or a personal sense of uselessness-- would produce the opposite effect, just as it did in the case of this young man. Secondly, when we read of this man's brother, who ended his own life over a matter of unrequited love, we are

immediately reminded that the Mi'kmaq considered unfulfilled desire to be the chief cause of such psychological maladies.

Depression could be treated through good-natured ribbing. LeClerq tells another tale in which a depressed and angry Mi'kmaw man was asked by his fellows if he intended to die in such a state, or if he thought it should pass from him eventually. When the afflicted replied that it would depart in time, his fellows laughed, saying, "Well, my brother, thou hast no sense; since thou hast no intention to weep nor to be angry always, why dost thou not commence immediately to banish all bitterness from thy heart and rejoice thyself with thy fellow-countrymen?" LeClerq also noted that this was usually enough to restore good cheer and peace of mind to the "most afflicted of our Gaspesians" (Hoffman, 1955, p. 591; Paul, 2006, p. 36). Again the importance of community involvement in effecting one's healing is emphasized.

In modern times, many psychological issues among the Mi'kmaq can be attributed not to unfulfilled desire but to unresolved grief and internalized pain. The savagery of the residential school system; the systematic destruction of many traditional beliefs and practices; and the marginalization of the Mi'kmaq (and other First Nations) in modern Canada have all created deep wounds which affect not only individuals but also communities. According to Mi'kmaw author Lottie Marshall First Nations patients who have suffered from depression tend to define it "...in words reflecting hopelessness and despair about the future and not entirely in terms of the clinical syndrome." This shows that the Mi'kmaw understanding of this illness is not the same as the biomedical one.

Additionally, this malady is directly linked to the erosion of traditional beliefs. Marshall continues, "Without Native spirituality to help as a guide through troubled

times, the problem of depression in the Native person expands to spiritual illness” (L. Marshall, p. 67, 69). Like a metastasized cancer an untreated affliction can affect other parts of the human being.

Traditional ways offer methods to deal with the psychological illness of unresolved grief. David Gehue recounts one such story, involving a woman who had terminated an unwanted pregnancy and was suffering from depression afterwards. Gehue (2008) recounts:

What the spirits instruct is that the woman go to a department store and hold two sets of baby clothes, one for a boy and one for a girl. She will know inside her if it was a boy or a girl she destroyed. The woman purchases that set of clothes, takes it to a tree, and facin' east with the tree in front of her, she places the clothes on her left, north, either tyin' them to the tree or buryin' them in the ground. With the clothes she places a pipe-full of tobacco, gives the aborted child a name, and promises never to do it again. After making the offerin' she walks around the tree completely once and then walks out of the area and does not look back for anything...this ceremony has helped a great number of women and it is one of the most effective ones to alleviate the hurt and shame (p. 76).

In contemporary times, then, traditional methods that address psychological ills continue to be effective. This is especially interesting in light of the biomedical approach which separates body and mind from each other, yet continues to study the placebo effect without always drawing the conclusion that the mind and body are interconnected—Cartesian duality is, apparently, a highly addictive substance.

The third form of complaint, supernatural afflictions, is naturally enough the category with which modern science finds the most fault. While biomedicine is a product of post-Enlightenment thought and divorces itself from so-called 'superstitious' beliefs, the traditional Mi'kmaw worldview does not reject the existence of a spiritual dimension to life. The shaman's deep knowledge of the spiritual world and the use of medicine allowed him or her to treat the supernatural ailments that could result from ritualized

attacks. Persistent illnesses, or those lacking an obvious physical cause, were their province. With his or her medicine bag¹⁹ in hand, the healer would arrive to attend to the sick individual. If the diagnosis revealed a supernatural cause to the malady the shaman would work to exorcise the malevolent, disease causing spirit or 'spiritually intruded object' from the patient. Chants, songs and ritual dances were employed and the shaman would blow or suck upon the affected area of the body in order to draw forth the cause of illness (Miller, 2004, p.257).

Many eastern woodland First Nations people believed that jealousy was often a prime motivator behind spiritual attacks; this could be curtailed by sharing what one had with the wider community (Choquette, 2004, p.23). We can see, then, how the Mi'kmaw emphasis on gift-giving also served as a preventative measure, reinforcing individual, interpersonal and communal health. The interconnectedness of all aspects of Mi'kmaw life is again illustrated.

The links between individual and community mean that individual illness can metastasize into communal affliction. In these situations ceremonial interventions are often aimed at the entire community. David Gehue recounts one such intervention, undertaken at Elsipogtog in New Brunswick after a spate of suicides. He tells of a great spirit serpent that hid near the reservation, "collectin' all these suicides". Boarding a boat and travelling around the community (the river surrounds it), Gehue and a friend smudged the area with sweetgrass to "kill that spirit of death". He ended his story with the words, "...a protective smoke of sweetgrass...dissipates the spirit of death. For a long time, there were no more suicides; it worked" (Gehue, 2008, p. 147-151).

¹⁹A bundle containing various objects revered for their inherent spiritual power and, therefore sacred.

Selflessness is another quality that is emphasized within Mi'kmaw healing. Gehue defines his role as a healer, writing, "A [healer] is a person who can be of service to others, is willin' to put his life on the line at any given time knowin' that he could go into that tent and never return" (Gehue, 2009, p. 27). Mi'kmaw woman Margaret Johnson illustrates this emphasis on selflessness as well, saying "If somebody else makes a medicine for me, I'll be cured...but if I make it myself, I couldn't heal myself." Similarly Murdena Marshall describes the sweat lodge as a place where people pray for others, not themselves, and Vaughen Doucette has said that "[in the lodge] everything you pray for is for the benefit of other people" (Petrou, 1998, p. 114, 115). Thus healing is a gift, shared among members of the community.

This gift is, however, for the willing. Johnathan Dewar, director of research for the Aboriginal Healing Foundation, discusses funds available to help First Nations patients but states that "Only people who are ready to begin, or who have started their healing journey, can benefit from the fund" (Dewar, 2009, p. 28). The idea presented, then, is one of powerful communal support in healing that is offered, but never forced and can only be chosen by the individual.

Ritual and Respect

Despite the deep connection between the Mi'kmaq and the natural world it should not be assumed that they viewed Nature as a modern pharmacy, where one takes a place in line, picks up a medicine, and returns home. The collection of natural medicines was a process that involved expressions of respect towards the source of the remedy. Lacey

recounts a story concerning Stephen Bartlett, a Mi'kmaw man, who claimed to have seen a plant called *meteteskwewey*—possibly the segabun, or Indian turnip (*arisaema stewardsonii*). The following day he returned to find the plant had disappeared, for Bartlett had “neglected to perform the proper ceremony, or to approach the plant in the correct manner” (Lacey, 1999, p. 104).

Wallis and Wallis relate a similar tale in which those who discovered a sought-after plant blazed a nearby tree so they could find it again. When they returned the plant had gone. An elderly Mi'kmaw woman advised them, “You must put a penny on the ground, over the roots. The plant will then not go away. In the old days people placed the kneecap of an animal over its roots and the plant would then not go away” (Wallis and Wallis, 1955, p. 129).

In his early treatment of Mi'kmaw herbal cures, Hager noted that bark was gathered from the trunk of trees at certain times and from specific sides of the tree. Those areas of the trunk that received the most sunlight were most potent “for the sunlight purifies the side it touches, but the shadow is hostile to life” (Hager, 1895, p. 174). The attribution of abilities such as locomotion, invisibility and volition to plants reveals a Mi'kmaw understanding of plant life that is spiritualized and radically different from the biomedical one.

Similarly respect for animals that provide healing materials is also vital. Animals are brothers and sisters to human beings and are therefore accorded the same respect as all other things. Without proper respect shown to the spirit of the animal, it might withdraw its medicine from the people seeking it. Healing, then, proceeds from, and is

fostered by mutual respect between the afflicted, the healer, the method of healing and the wider context in which they combine.

Summary

Mi'kmaw society is based heavily in communal ties that unite not only human beings but also the natural world, including flora and fauna, as part of one great system that includes sun, moon, land, sea and stars as well as plants and animals. The importance of relationships between things is reflected in language and ceremony and forms a fundamental cornerstone of the Mi'kmaw worldview, as well as approaches to health. The ties that unite this community allow individual illness to acquire communal significance but also create networks of support in effecting healing. Spiritual energy permeates all things, some of which act as reservoirs and contain powerful medicine, but proper respect for the spirit of any object is required before its propensity for healing may be activated. The sense of colonial power and authority, exercised since the beginning of European colonization in the region, has proven to be subversive to the practice of traditional healing.

The healing traditions of the Mi'kmaq are of great depth and address a variety of complaints that can affect any aspect of the multi-layered human being; as part of the great social web, one's illness can affect others, and it is to others one turns for help.

While there are many forms of illness, and many ways to acquire injury or disease, the Mi'kmaq have found cures and treatments in the natural world that surrounds us all and have developed a community-based outlook that supports, strengthens and maintains their traditional worldview and the interconnectedness of all things within it. The

emphases of traditional medicine are quite different from those of biomedicine. It is clear that the two are products of their respective cultural traditions and cannot be truly understood outside of that cultural context; indeed we might wonder how one tradition can seek to heal adherents of the other without sharing the same essential definitions of health and illness.

Chapter Four: Conceptual Barriers and Hurdles

Easy cooperation between Mi'kmaw healing traditions and the biomedical healthcare system is far from normative. The preceding description of the two demonstrate that they differ not only in their understanding of disease but also in their foundational concepts concerning the nature of human beings. In contemporary Canada biomedicine dominates the medical landscape and its provision is a governmental responsibility. While traditions of healing among the Mi'kmaq have survived, the rise of professionalized, socialized biomedicine has created a culture of health-care provision that is alien to traditional Mi'kmaw society. This chapter will examine a few of the major points of contention between them—specifically, the rise of professionalized medicine; patient-healer interaction; and governmental resistance.

Legal and Governmental Framework

According to section 92 of the Canadian Constitution Act, the provinces have a legislative responsibility to provide health-care within their borders. Facilities, recruiting and hiring of staff (including physicians), and provision of medical care are funded and supported at the provincial level, as are insured benefits. Nova Scotia is further divided into nine health authorities, each possessing operational autonomy within its own jurisdiction.

Section 91 places Indians (and the term, as contrasted with First Nations persons should be noted) and their lands under federal jurisdiction. This creates two problems. First, the Mi'kmaw people have never given up their rights to Nova Scotia's land through any treaty. Thus the concept of reservations is problematic and lacks the treaty-based support used to isolate First Nations communities in other provinces. Despite this,

reservations have been established in Nova Scotia, and following federal legislation, provision of First Nations rights have been tied to them. In 1954 the federal government began to consider the reorganization of the Mi'kmaq into smaller, independent bands, according to the provisions of the Indian Act, which infers that such legislation was not completely applied to them prior to this date. Consultation with the Mi'kmaw people did not take place until 1957, at which time Mi'kmaw leaders agreed to the reorganization, part of which included the right to distribute their lands as they saw fit. However, in 1967, the federal government, in a unilateral decision, combined several of the smaller mainland Mi'kmaw bands into a single one. The consent of band members was not sought, or given. None of these changes were approved by band members through a vote, and by 1984 this forced merger bore sour fruit as members of the Annapolis Valley Band separated to form the Horton Band, based on a sense of being independent prior to 1958 and the changes it brought (Paul, 2011). Additionally, land transfers require band consent, which was not provided in the split. Therefore the matter may, one day, end up before the courts.

An issue of freedom of movement was also raised by the changes of the 1950s. Previously, a Mi'kmaw family living in any reservation could simply move to another one. After the implementation of Indian Act-based changes, each band was considered a separate legal entity, and families were required to apply for permission from the new band; permission could be denied without stated reason or appeal. Daniel Paul notes that, within Canada, such restriction on movement is only applied to First Nations people (Paul, 2011b). When we recall that no land was ceded by the Mi'kmaq in Nova Scotia, it becomes readily apparent how draconian and dictatorial such actions were. It also

displays the paramount authority assigned to the provisions of the Act by the federal government. The Indian Act also states that the Minister of Aboriginal Affairs has the ability and authority to “determine whether any purpose for which lands in a reserve are used is for the use and benefit of the band”. This displays the pervasive authority of the federal government in the managing of what should be autonomous First Nations affairs.

Second, Canadian Aboriginals, including the Mi'kmaw people, are provided health benefits under the Canada Health Act (1984). Among First Nations groups the federal government is viewed as having a fiduciary responsibility regarding the provision of health care. However, the federal government disagrees, considering assistance a matter of policy, rather than obligation. The federal case is supported by the wording of the Indian Act. While providing a legislative framework regarding First Nations health care, the Act states that “The Governor in Council *may* make regulations...”[italics mine] concerning the provision of “medical treatment and health services for Indians...compulsory hospitalization and treatment for infectious diseases among Indians...” and so forth (Indian Act: Section 73; Nucklaus, personal communication). Historically, Canadian law tends to view such permissive language as a strength, allowing for a rapid response and an avenue for “policy discussion, change, and implementation.” (Blake Wright, personal communication). The issue here is in the nature of the wording of such subordinate legislation; if care is provided as a matter of policy it can be easily revoked through a change in policy, and this removes a sense of certainty in the provision of health care.

Provincially-insured benefits are provided on reservation when possible or required (such as acute home care) but other health services, such as laboratory and diagnostic

procedures (including x-rays, MRIs, etc) are not, and are distributed in a region under the direction of the local health authority. Due to Nova Scotia's small size no community is completely isolated.

The provision of care is not without flaws. In 2009 Nova Scotian periodontist Lynn Ellis submitted a claim to Health Canada regarding treatment of an adolescent, autistic Mi'kmaw boy (Nucklaus, personal communication). While she reported that the patient suffered from a variety of conditions that increased his risk of bacterial endocarditis following surgical interventions, all funding was refused with the exception of a routine cleaning. Eventually Ellis was able to win funding for a gingivectomy,²⁰ a procedure she described as “not a cure” and which would “only cause further trauma to the boy's mouth”. Ellis went on to note that in the last decade none of her periodontal surgical claims have been “approved by Health Canada under their First Nations benefit program” (Pottie, 2009).

Blunders made by different levels of government have offended Native populations. Recently this insensitivity was showcased when, during the H1N1 flu scare, the federal government provided large stores of body bags to reservations as part of the restocking of medical supplies (White, 2009).

While both levels of government, provincial and federal, contribute to the provision of health-care to the Mi'kmaq, these examples demonstrate legislative and bureaucratic challenges to be overcome.

²⁰ Removal of the gums.

Professionalization of Medicine

As considered earlier, the development of biomedicine in the last two centuries has produced a highly professionalized group of health-care providers. By the mid-to-late nineteenth century physicians entered a realm of greater authority and popular acceptance. Nova Scotian researcher Colin D. Howell explored how the rise of an expert, professional class allowed physicians to extend their influence into non-medical areas of concern, such as immigration, politics, justice and education. He also describes how in the face of competition from other care providers and modalities physicians sought to institutionalize their authority and discredit their competitors while sometimes adapting their treatments (Howell, 1989, p. 58-71). By 1900 even birth had been pathologized and brought into the realm of biomedicine; women began turning to hospitals as a place to give birth under the care of physicians rather than remaining home and employing the services of a midwife.

At the same time traditional Mi'kmaw healers were placed in a difficult position. The Indian Act ensured that 'upstart' Native healers would be unable to legitimize their own practices in the public eye. Section 86 of the act makes this clear:

Any Indian who may be admitted to the degree of Doctor of Medicine, or to any other degree by any University of Learning, or who may be admitted in any Province of the Dominion to practice law, either as an Advocate or as a Barrister, or Counsellor, or Solicitor, or Attorney, or to be a Notary Public, or who may enter Holy Orders, or who may be licensed by any denomination of Christians as a Minister of the Gospel, shall ipso facto become and be enfranchised under this Act.

In other words, any attempt by Mi'kmaw healers to enter 'legitimate' medical practice brought with it the automatic surrender of Indian status—a sacrifice of cultural identity

and an open separation from culture and community. To don a white collar—whether that of the physicians and lawyers or that of the priest—was to become white, like it or not. This forced enfranchisement was not reconsidered by legislators until 1961.

Other examples of the efforts to maintain the hegemony of physicians abound. In 1852 Mi'kmaw healer and herbalist Peter Paul Toney Babey appealed to the provincial government for payment for his on-reservation work, like that received by white physicians. Babey was openly mocked for his efforts on the floor of Province House. Twohig notes that Babey employed the language of the emerging medical class in his appeal, but to little effect (Petrou, 1998, p. 29; Twohig, 1996, p. 83).

A decade later Frederick W. Morris, who served as resident physician at the Halifax Visiting Dispensary was expelled from the Halifax Medical Society²¹ (of which he was a former vice-president) for the unforgivable sin of advocating the use of a smallpox remedy received from one John Thomas Lane, a Mi'kmaw man. Morris stated that the remedy was effective if applied within the first few days after the eruption of symptoms, which might indicate that he had some clinical knowledge of its use and effectiveness. Morris was only allowed to continue medical practice after signing a letter pledging to refrain from using 'such remedies'; the letter was distributed to the public (Howell, 1989, p. 55; Twohig, 1996, p. 95; Petrou, 1998, p. 30). Lane, who had previously published various testimonials concerning the efficacy of his treatment in *The Novascotian*, published the last such account the day after Morris was publicly declaimed by the HMS. Within a month both were called to appear before an inquisitory body examining the death of a Mi'kmaw child from smallpox. Despite the published

²¹ This body no longer exists and has been replaced by the Medical Society of Nova Scotia.

testimonials supporting Lane's treatment the orthodox medical establishment addressed this perceived assault on its status with a hammer designed to crack skulls rather than test reflexes. Considering this treatment, in light of the passage from the Indian Act considered above, the hostility towards Mi'kmaw traditions is plain.

Despite biomedical resistance to these medicines little was offered in their stead. In 1847 physician Edward Jennings described an outbreak of typhus among Dartmouth area Mi'kmaq. None of these invalids were provided with medicine beyond their own remedy--"the decoction of some astringent barks"--and were left to die (Whitehead, 1991, p. 180; Petrou, 1998, p. 86).

Jennings' account, as well as the tale of Morris and Lane, demonstrate clearly that not only did traditional medicinal treatments continue to exist and grow within the Mi'kmaw community but also that resistance to such treatments was widespread among the sociocultural elite of contemporary Nova Scotian physicians. Professionalized medicine as an industry was not willing to accept the potential of Mi'kmaw cures *as such*.

In modern times some Mi'kmaw cures have interested physicians; Lacey recounts a story told him by an elderly man who instructed him in botanical cures. This man claimed to have cured diabetes through the use of skunk cabbage (*symplocarpus foetidus*) and claimed a physician in Bridgewater had asked him to sell the secret of the remedy, an offer which was refused (Lacey, 1993, p. 5).

As medical bodies began to license physicians and require advanced degrees for practice lawyers entered the picture with malpractice suits. A system of credentials and education developed that was foreign to traditional culture. Mi'kmaw healers are accepted as such among their people based on their successful work and popular reputation; a

healer works under the mandate of his or her community not that of a licensing body. As First Nations writer Larry Aitken (1990) wrote, “traditionally medicine is not a choice pursued by an individual, but it is a choice accepted by an individual” (p. 4). David Gehue (2009) expresses a similar sentiment, writing that “ I must have been chosen before my birth, as are most shakers ” and “I now believe the spirits were takin' me to school even before my conception” (p. 27, 79).

This is obviously quite different from the biomedical tradition and its systematic education and licensing. Many Mi'kmaw healers today are forced to deal with this system; a lack of professional credentials also means a lack of legal protection. Some have dealt with this issue by obtaining such credentials; Gehue is also a trained therapist. He practices traditional medicine by working for the good of his community, either *pro bono* or accepting trade for his work, but when working for the government he charges a fee comparable to other professionals (Gehue, 2009). In this way, many Mi'kmaw healers, working from a tradition that sees the world as an undivided totality, are forced to work within a second sphere that does not value their skills or contributions.

Language and authority are features of the scientific, biomedical milieu which are problematic for many patients, including the Mi'kmaq. The average patient does not have the background knowledge or access to facilities with which to gauge the advice of a physician. There is little choice then but to passively accept what is offered. Many patients seem conditioned to accept the word of a physician as Holy Writ; naturally, this is a result of the public assumption that those who have trained in a field for years are experts with more valid opinions. Conversely, many Mi'kmaq are familiar with the plants and cures around which they have grown up and the language of their healing traditions is

not mired in a polylinguistic patois that is frequently unintelligible to the supposed beneficiaries of care. The Mi'kmaw patient, working within his own tradition, is taught to understand his own illness and take charge of his own healing.

The professionalization of medicine, then, has directly impacted the Mi'kmaw healing tradition by establishing a system of education and credentials from which Mi'kmaw healers were historically barred; adopting a rigid scientific orthodoxy which ignores the psychospiritual, emotional, ethnic and social dimensions of human beings; and in directly assailing challengers to biomedical hegemony. Each of these conditions serves to marginalize Mi'kmaw healing—a central part of traditional ways—in favour of the sense of automatic superiority associated with the modern scientific physician. This superiority is a constant message in a modern age where physicians are sometimes depicted as adventurers (such as CNN's Sanjay Gupta, Leonid Rogozov, or Albert Schweitzer). Even our entertainment expresses a fascination with biomedicine—*E.R.*, *Nurse Betty* and *Grey's Anatomy* have dominated ratings in recent years, not *T.P.*, *Nurse Googoo* or *Kluskap's Anatomy*.

The scientific basis of biomedicine is continuing to exert an influence in modern Canadian health-care training, often at the cost of patient care. In the last decade and a half it has become increasingly impossible to become a registered nurse by attending a nursing school in most of Canada. Today university degrees are required for the new generation of R.N.s. These graduates arrive on the job with training in disciplines they will likely never use—such as biochemistry—and less training in direct patient care than their predecessors. While in the past the reductionist and mechanical approach of the physician was mitigated to a degree by the bed-side care and compassion of the nurse

today's educational system has moved the nurse closer to the physician in training and outlook and further away from interaction with patients as individuals with individual contexts.²¹ Recent research has made it clear that the bedside compassion of the nurse actually does ease pain (Grey, 2012). The changing focus of nursing education may well have a negative effect on the experience of patients. For a Mi'kmaw patient used to traditional, community-based modalities, close interaction with care providers and traditional models of care the hospital can be a lonely, isolating place. Changes in nursing training may further shape the experience of Mi'kmaw patients. To this experience we shall now turn.

Patient – Healer Interaction

The experience of being a patient within the governmental medical system in Canada is familiar to most Canadians who have visited an emergency room or a GP. The biomedical approach is one in which the patient is essentially a passive participant in his or her own care. Mike Petrou argued that a patient changes their social role when entering the hospital. In this section, I expand upon Petrou's point and will illustrate it from an insider's perspective.

Let us consider the process through which a non-trauma patient passes upon arrival in the E.R.²² He or she is first *assessed* in triage, generally by a paramedic. Note that the use of the word 'assessed' implies an outside judgement on the part of health-care

²² The urgency of serious traumatic injuries usually necessitates an abridgement of the process described herein.

providers²³. The seriousness of a patient's situation is not gauged simply on his or her own input but also on the opinions and experience of the paramedic assessing him. At this point, a gulf begins to appear between the patient's normal, day-to-day social self and his or her passive role as biomedical patient. One does not 'enter' the computerized system, but is 'entered into it'--in other words, this baptism into medical care is done *to* the patient. He or she is object, not subject. The patient does not volunteer information but is asked for it via a series of questions and is thereafter identified by a number—initially that found on one's government-issued health card.

Next, the patient moves into the second phase, assuming his petition is of sufficient severity. He moves into a smaller venue—a room in a medical unit, possibly the ER itself. As part of this process the clothing that forms part of one's social identity is removed and replaced with the Invalid Pilgrim's penitential Johnny shirt. He has spoken with the paramedical deacons of healthcare and passes on into the 'Holy' beyond the waiting room. Now his or her care is provided by the next group of practitioners—the registered nurses, who have trained longer within our educational system than the paramedics and have attained a higher status.

A bracelet containing the patient's identification number is issued. The importance of these forms of numerical identification to the medical system cannot be stressed enough. In the course of my own work within the health care system I am often called upon to bring a patient to the O.R.s for surgery. A ritualized ID check is a central part of this process; before the patient leaves his ward a nurse verifies that the number recorded

²³ An examination of medical literature and experiences within the health care system have shown me that 'disease' is something a physician identifies while 'illness' is what a patient describes. A patient may describe symptoms but it takes a physician to diagnose their cause and determine their severity.

within the patient's chart is identical to the one found on his or her bracelet²⁴. One has lost, to a degree, even the ability to identify oneself in a way satisfactory to the medical establishment.

Finally, the patient moves conceptually into the Holiest of Holies—the presence of the physician who arrives clad in his white coat of office, armed with his ritual stethoscope, pulse oximeter and other tools that extend his senses into realms beyond those available to typical human beings. Whole laboratories full of scientific soothsayers are at his service to divine the causes and effects of illness based on strings of numbers, analysis of blood sugars, electrolytes and so forth. Up to 80% of medical decisions regarding treatment are based on these and other laboratory tests (Stinebaker, 2010; USM, 2009).

Yet rarely is the sociocultural context of the patient even known. The movement away from the social self to the role of patient also serves to pigeon-hole the patient and his or her medical needs within the honeycomb of modern health care. Biomedicine obeys the reductionist trend of scientific specialities and sub-specialities—nephrologists treat only the kidneys and cardiologists only the heart. Specific diseases create broad areas of practice (e.g. immunology, bacteriology) and subspecialties (e.g. oncology); as do periods in one's life (pediatrics, gerontology); physical sex (e.g. gynaecology); or choice of hobby (sports medicine). A patient's treatment can lead them through a dizzying array of specialists and sub-specialists. This passing from hand to hand makes the development of a personal rapport with a physician far more difficult, even unlikely.

]Once categorized, the patient may be sent to the appropriate specialist, who will treat

²⁴ This catechism is then repeated in the operating theatres with additional factors, such as site of surgery and proper consent, added to the list of verified information.

only the symptoms or concerns relevant to their own speciality. Even general practitioners serve as a sort of medical filing system, referring patients on.

This is not meant to suggest that specialization does not exist within the Mi'kmaw healing tradition, for as we have seen it does. However to the Mi'kmaq people are multifaceted beings; specialization therefore refers to dealing with a specific aspect of the individual human totality—emotions, mind, body or spirit—within the wider context of familial and communal considerations. This is quite a different form than that taken by biomedical specialization, which remains based on a mechanistic view of the body and divides it up like the world in a game of *Risk*.

Additional aspects of care continue the process of depersonalization. The very process of surgical draping—used to ensure a sterile field and to prevent contamination of the operative site—conceals the form of the patient from the surgeon. That which remains uncovered is a squared-off area prepped for an incision and presenting not an individual but a collection of faulty parts, exposed and ready for repair.

The passive role of the patient is by no means an easy experience, even among those who have internalized the concept of the all-knowing physician. Consider for example the well-known phenomenon called 'white coat syndrome'. When patients are approached by a lab coat-clad physician the increased level of anxiety they often feel is clinically and medically significant. Medical literature demonstrates that systolic and diastolic blood pressure read on average 27 and 15 mmHg higher respectively and heart rates increased by an average of 16 beats per minute when a patient suffers from this 'white coat hypertension' (Spence, 1999; McGrath, 1996)²⁵.

²⁵ Whitecoat syndrome is pervasive. Despite being an orderly, not a physician or even a nurse, patients tend to ask me questions concerning their own healthcare, expecting authoritative answers simply because of my

According to my own observations, a surgeon preparing to amputate a limb rarely says to a patient, “I’ll make an incision just below your knee,” but rather, “I will make an incision just below *the* knee.” It seems that by divorcing the leg from the rest of the human being a physician is better prepared, psychologically, to perform an amputation. The very need for such an emotional defence mechanism reveals that the operative framework of biomedicine takes a toll on the physician as well.

Biomedicine approaches death as the enemy, as something to be prevented at all costs. The loss of a patient therefore strikes many physicians as a personal failure rather than a logical conclusion to life. Recent research has begun to address the affect of ‘unanticipated perioperative deaths’²⁶ on Canadian anaesthesiologists. Researchers have noted that following a UPD an anaesthesiologist is often expected to continue on with elective cases despite the psychological trauma inflicted by the death. 62% of anaesthesiologists polled in the study felt that they should not participate in further cases on the day of a UPD yet 46% reported continuing their work due to a variety of factors. The authors of the study noted the effect of this unaddressed psychological trauma on anaesthesiologists: “In addition to concerns for the well-being of the physician, patient care may be suboptimal when an anaesthesiologist continues to work following a UPD” (Todesco et al, 2010, p. 366). It is clear that the death of a patient is a traumatic experience for a physician; one must wonder how much this trauma would be lessened if

lab coat—the uniform alone lends a sense of professional authority to anything I might say. One of the most common phrases I utter to patients is, “I’m not actually a doctor, but I’ll make sure your concerns are mentioned to one.” In many instances, a patient’s personal concerns are unknown to the physician until I pass them along.

²⁶ UPDs are defined as any instance in which a patient dies intraoperatively without previous indications that such an outcome is likely, or more than a remote possibility.

biomedicine approached death as a natural part of living, rather than an enemy to whom one must never yield.

Traditional Mi'kmaw culture accepts death as a natural part of living and as the beginning of another phase of existence. A Mi'kmaw healer, then, may view the death of a patient as a natural result of illness, age or injury rather than as a personal failing.

Among the Mi'kmaq dying can be a communal activity. One publication of the Confederacy of Mainland Mi'kmaq demonstrates this:

...a dying person should not be alone. All family members are encouraged to be with the dying person during their final hours. A candle is lit in the room to signify the light which was given at birth, and to help the person find the path to the Spirit World. Each family member must seek peace with the dying person so he or she can go to the Spirit World completely at peace. When the time of death is close, the Elders will tell everyone not to cry until the person has passed to the Spirit World (Kekina'muek, 2007)

Additionally the surrender of the self is not found in Mi'kmaw medicine, with its emphasis on patient involvement in care—the call of a Mi'kmaw healer may well be expressed as 'Patient, heal thyself!' Powerful communal ties, personal volition, and active involvement in traditional healing preclude such a sacrifice. The idea of surrendering control over one's own health and treatment is one that Mi'kmaw authors have railed against in their writings. On the topic of non-interference, Murdena Marshall wrote told Joe and Choyce (1997):

This is the one concept that baffles non-Natives the most. They cannot understand how one can be counselled if there is no verbal direction to take. A Mi'kmaq [sic] counsellor will use the metaphorical approach instead to show another Mi'kmaq [sic] how the situation...occurred...and provides necessary information to make judgements accordingly” (p. 55).

For the Mi'kmaq, a healer helps one to make an informed decision, rather than provide a ready-made model of care²⁷.

The idea of personal involvement and volition in healing is also touched upon by Mi'sel Joe, who returns to the idea again and again in his book. Joe tells us that “We had to learn to heal ourselves”, and “...it would help the people of Conne River to heal ourselves” (Anderson and Crellin, 2009, p. 69). He also explores the relationship between health and community. In Conne River a program exists that delivers meals to elderly members of the reservation community. The delivery of food is not the main focus of this program; Joe tells us, “When somebody brought the meal he or she would sit down and have a chat, because part of the job was to see how you're doing...the meals were more important for company rather than the meal itself” (Anderson and Crellin, 2009, p. 136). David Gehue (2008) returns to this idea throughout *Voices of the Tent*, telling us that, “For our own healin', physical, emotional or spiritual, we don't give ourselves enough credit. The Great Spirit gave us the ability and the tools to use.” He continues, on the subject of his role as healer, “I don't do any healin'. I get people ready so they can receive the healin' directly from the spirits” (p. 55, 87).

The alien nature of the Canadian health care system colours the accounts of Mi'kmaw persons who have passed through it. In these accounts personal autonomy is emphasized, as well as traditional ways of knowing and of healing. Mi'kmaw issues with the biomedical model are made explicit. I will relate two such experiences. Mi'sel Joe tells us,

²⁷ Designing these ready-made care plans is part of the clinical experience of modern, university-based nursing students.

I seriously believe that if I went to the hospital and if I wasn't treated according to some of my beliefs, I would suffer. If I showed up at the hospital with my feather, my sweetgrass, the things that I believe in, if I wasn't allowed to keep those things with me as part of my own healing, I believe that a doctor could do serious harm to me. Modern day medicines are fine medicines but there's something else that goes along with that. Treatment is far more than handing out pills. It's the way the doctor hands you those pills, it's how he receives you in his clinic, how he is able to relate to some of the things you are talking about. (Anderson and Crellin, 2009, p. 131)

Joe also underscores the importance of community in positive health-care outcomes for the elderly members of his community, writing, “We know that if you take them from the community, into some clinic or hospital away from the family, that it may kill him or her...we do everything we can within the community system itself to provide very service possible to ensure that people stay” (Anderson and Crellin, 2009, p. 134).

David Gehue (2008) writes of his own experience with the health-care system, as well as the racist attitudes he found within it. Although his account is of some length, it is worth recounting in full:

Back in 1997 I developed a condition which was water on the heart.²⁸ I was at our local hospital which I affectionately call 'The Bump and Bruise Motel'.²⁹ They had almost caused the end of my existence on Earth as we know it. Their concern was on how much alcohol I had presumably drunk because of their prejudices about Natives and not on how much or where my body was swollen. When the doctor on call asked me how much I had drank that day my wife grabbed the doctor by his arm, pulled him outside the curtain and explained to him, “My husband hasn't drank in almost 30 years. Just because he is a Native you presume his condition is alcohol related. Well, I've got news for you—you're wrong.” Full of a great deal of fluid and havin' difficulty breathin' I asked my wife to call my family doctor with the instructions to get me out of this place today or I'd be dead. In a half-hour I was on my way to the Victoria General Hospital in Halifax. On arrival they worked on me for about 15 minutes in the emergency until my breathin' was almost 100 percent. I was admitted to the heart unit where preparations were made for surgery. The night before surgery, Albert, my teacher, came to warn me not to be put to sleep for I would surely die. I agreed to his advice.

²⁸ Perhaps pericarditis or Dressler's syndrome.

²⁹ Colchester Regional Hospital, in Truro.

The next morning at 5 a.m. they wheeled me to the operatin' theatre, strapped my arms as if I was being crucified, and put a needle in my arm. Boy, it was cold in that room. I think you could have hung one of those tools on my nipples; they were standin' up just like icicles. The smell of disinfectant filled the air. Suddenly the mask was comin' towards my face.

'Get that goddamn thing out of here. And take that needle out of my arm,' I said.

'And if you're gonna do this, you're gonna do it locally.'

The surgeon said, 'You're crazy.'

'I might be crazy, but I'll be alive.'...

...They began the procedure in the upper left chest just a little left of center where they froze the area with a local anaesthetic. They made an incision, placed a tube with a wire in it and began to push them forward. I could feel the tube and wire goin' around my heart...they got a little over three quarters around my heart when I felt a severe pain.

I could hear my mother's voice in my left ear, 'I've come to take you home.'

'Well, fuck, let's go then.' (p. 68-72)

As Gehue's story goes on, he chooses to return to the world, telling his mother that his responsibilities to his children³⁰ were too important to ignore. He woke just as the surgical staff prepared to apply a defibrillator. He finishes the tale:

My hospital stay was an additional six weeks durin' which I learned over 45% of my heart muscle had been damaged and the spirits repaired it in four days. When I had my final exam by my heart specialist he said, "I don't know what kind of man you are. Your heart is back to 100% healthy. You have no restriction in what you can do. (p. 72)

Gehue's story shows that not only do racist attitudes still rear their heads when the health care system deals with Natives but also the integral place Native spirituality holds in his life. By holding on tenaciously to his traditional beliefs, and traditional sources of knowing, Gehue was able to force the biomedical machine to address his needs according to his cultural context and personal desires.

³⁰ Gehue has children by birth but a great many more to whom he is an adoptive fatherly figure, each of whom he considers to be his child.

It is apparent that the requisite sacrifice of personal identity and autonomy on the biomedical altar is not one that is required, encouraged, welcomed or accepted among Mi'kmaw healers. However attention to traditional culture and beliefs, when and where it exists, is not lost on them. While each health authority has made an effort to educate staff in Mi'kmaw culture and the needs of patients of that background, some health-care centres are better positioned to put these lessons into practice. The land that makes up Bear River reservation straddles county lines, placing its inhabitants within both the South-West and Annapolis Health Authorities. Despite a greater distance to the Annapolis Community Health Centre (in Annapolis Royal, compared to Soldiers' Memorial Hospital in Middleton) many of the Mi'kmaq of Bear River choose it for their health care, for its staff is considered more respectful of traditional ways (Nucklaus, personal communication). Clearly, a respectful approach to First Nations culture is important to reservation-dwelling Mi'kmaq; this approach is inborn within traditional culture but quite lacking in mainstream biomedicine. It is obvious that many Mi'kmaq people find the biomedical system to be impersonal, flawed and inadequate in understanding and treating them.

When considering this issue Mi'kmaw scholar and academic Randolph Bowers (2008) has this to say:

As a counsellor, educator, and natural healer I cannot separate these socio-political realities from peoples' mental, emotional, and spiritual health. What the Canadian authorities need to understand is that they collude in harming Mi'kmaw People, and that this must stop. New pathways must be opened up. Real injustices and imbalances must be addressed in the areas of health, education, economic development.

These issues continue to underscore the need for traditional ways of healing that are both effective and attentive to the context of the individual patient and the community of which he or she is a part.

Summary

The biomedical industry in Canada, by its very nature a social and governmental institution, has created a climate resistant to the inclusion of Mi'kmaw medicines in off-reserve healthcare. The marginalization of First Nations medicines and the rise of a professional, highly specialized medical class with a vested interest in protecting its own position have combined with bureaucratic resistance and multi-level governmental confusion to create a climate of cooperative infertility. Pressure on the Mi'kmaq and other First Nations to abandon their own practices and culture (as demonstrated by the Indian Act and subsequent legislation) has, until recently, functionally limited the use of such treatments to the Mi'kmaw on-reserve communities and simultaneously discouraged many from entering the echelons of university educated physicians.

The underlying assumptions of biomedicine, and the professional, culturally-influenced relationship between physicians and patients combine with our health-care system to further alienate many Mi'kmaq who are used to traditional ways of healing, care and community. Even physicians are not immune to the negative effects of their purely rationalist worldview. All of this has limited the accessibility of biomedical care to the Mi'kmaq. Mi'kmaw medicine has subsequently endured within this climate, which

has served to concentrate traditional healing practices in reservation communities, supposedly isolated from the rest of Canadian society.

Chapter Five: Mi'kmaw Medicine Today – Transmission and Preservation

In the preceding chapters we have considered both Mi'kmaw traditional healing and the modern biomedical industry as expressions of their respective cultures of origin. We have also examined some of the major issues arising in the interaction between these two cultures in the arena of health care. This background provides the context within which Mi'kmaw healing traditions operate today. In the face of cultural and biomedical resistance they have persevered predominantly within reservation communities where the need for them is rooted in both efforts towards cultural preservation and the practical need for effective, accessible health-care. However by interacting with both First Nations and non-Aboriginal cultures Mi'kmaw healing traditions are introduced to new forms of expression and new directions of application. The dynamic nature of the tradition allows it to adapt and grow in the face of the changing needs of the people it serves and to engage with, and learn from, other cultures. Part of this engagement involves reclaiming, or relearning, knowledge that was lost through years of cultural erosion and the oppression of a generation in the residential schools. Sometimes the impetus for reclamation comes from outside the community. Cree teacher Albert Lightning (one of David Gehue's teachers) visited Mi'kmak'i in 1984-85. Lightning felt that the Mi'kmaq were losing touch with many of their traditions and since his visit a renewed interest in traditional ways has blossomed (Googoo, 1998).

Today the tradition is growing and finding new ways to address the damage of the last few centuries and engage with the surrounding Euro-Canadian society. All this is accomplished while remaining true to Mi'kmaw beliefs and practices. The modern growth dynamic is expressed through three broad streams: the *adoptive*, which is restorative or supportive in nature; the *adaptive*, concerning pro-activity towards contemporary ills; and

the *intuitive* (or, perhaps, *mytho-intuitive*), which provides foundation and continuity. These categories are by no means firm and clearly delineated, nor are they a reflection of Mi'kmaw ways of thinking. They are instead a very loose, artificial framework imposed by myself to aid my own way of thinking. Each category shall be considered in turn.

Intuitive Practices

The intuitive stream within traditional medicine represents, in part, those forms of treatment and diagnosis with which biomedicine finds it most difficult to relate. The intuitive includes communication and advice received from spirits; information revealed in dreams or trance states; and the psycho-spiritual aspects of ritual and communal ceremonies. Each of these is of great importance within the traditional worldview of the Mi'kmaq and is internalized over time, often through myths and legends which illustrate important cultural principles such as the bravery, generosity and cleverness that characterize the stories of Kluskap. These are the “stories everyone knows” (see Spicer, 2006 and Partridge, 2009).

The intuitive stream provides the framework upon which traditional society is organized and grows. This concept of a framework that shapes and guides culture over generations, even as individuals age and die, is a part of Mi'kmaw belief. As we considered in chapter three, the concept of *puoin* represents both spiritual power and the unity or constancy—the cyclical permanence--that lies behind all things. The result of this constancy, combined with the dynamic and adaptive nature of Mi'kmaw society, has created a system that is in many ways flexible, while remaining true to its core ideas and belief structure. Due to this flexibility each healer works as he or she feels is best

within the same underlying cultural system. The effect is similar to that of several cooks preparing the same meal with the same ingredients, but seasoning it to their unique and individual tastes. David Gehue deals largely with the spiritual aspects of healing while Yvonne Wysote (whose work is discussed below) concentrates on the psycho- and aroma-therapeutic use of traditional plant remedies. Laurie Lacey's teachers focused predominantly on the use of plants to treat physical afflictions. Each emphasizes a different aspect of medicine, expressed individually but according to shared, inherited and internalized teachings.

The intuitive stream rests upon this oral tradition, through which the core teachings and identity of the people are passed to the next generation. Concerning the importance of the Elders' teachings, Nova Scotian Yvelle Dupere writes,

It is a struggle to remember to involve the spirit when trying to heal, or get better. The native elders try to pass this down to the younger generation. Many native ceremonies involve the healing of mind, body and spirit, all interconnected. Nature takes care of us, if we listen to the elders. (Dupere, personal communication).

The adopted and adapted practices considered below are integrated into Mi'kmaw practices through the intuitive stream. This is the channel through which spirit and ancestor alike speak, and try to keep healers from faltering or straying from their cultural path. Gehue expresses this idea: "For me, I would hear a voice in my thoughts knowin' it's not my voice. In extreme situations the voice has been external if I'm about to make a major error...that's when I would hear the spirit's voice sayin' 'Don't do it!'" (Gehue, 2008, p. 28). Intuitive knowledge, in this instance, acts conservatively, as a warning, preserving the integrity of cultural practice.

When new illnesses present themselves, or an issue arises for which a healer has no solution, turning to the spirits is a way to discover a new remedy. Wysote notes the importance of spiritual communications in healing: “I would ask the spirits to help me and show me the [proper] plants...in time it all just came together” (Wysote, personal communication). Through such communication spirits provide personal advice and medicines specific to both ailment and patient. In the words of one resource,

...in more serious illnesses a spiritual element is required in addition to the botanical element, and the combination of medicines for one person may not be the same as for another person with the same condition. A true Healer or Medicine Person will receive guidance from the spirits regarding what combination will work in a particular case. For this reason, it is generally ineffective (and possibly dangerous!) to try to use Native American healing preparations that have not been given specifically to you for your condition. (Mi'kmaq Spirit, 2007).

Spirits, then, enhance healing traditions by contextualizing individual remedies according to the individual's personal social, medical and spiritual location.

Communication with the spirits can be facilitated by entering a state of purity. One method of achieving this is through fasting; another is the sweat lodge which, as we have seen, is a place to work for the benefit of others (NCNS, 2010). The various means of reaching out to the spirits involve selfless sacrifice, for example, of food during a fast or time, energy and ego during a sweat lodge ceremony. This reinforces the communal focus and ethic of Mi'kmaw society, providing continuity of custom and practice and reinforcing collective ethical and moral orientations, over generations.

A fine illustration of an intuitive practice that has been described publicly is the shake tent ceremony. Gehue says it takes place within a tent about seven feet tall, wrapped in canvas or hides inside which a person may sit. The spirits are called into the

tent and dispense advice through the shaker (who leads the ceremony) and his assistant(s), who translate the words that emanate from the tent.

Gehue learned how to perform the ceremony in Barberry, Manitoba in 1986 but had heard tales of it a quarter century earlier, in Nova Scotia. Donald Marshall Sr., then Grand Chief of the Mi'kmaq, once told the young Gehue, “That [shake tent] ceremony began here in the East way back in the beginnin' of time and it was handed to our brothers who were going westward so they could protect the ceremony. It's waitin' for someone to bring it home.” Gehue devoted himself to this task and accomplished it in 1986 (Gehue, 2008, p. 9, 13). He describes the ceremony as the *ne plus ultra* of traditional healing and the 'Indian High Court'; its powerful connection with the spirits provides what Adrienne Fox calls the 'final word' on healing matters (Fox, 2009). The origins of the ceremony are disputed, and its use among the Mi'kmaq is somewhat controversial.

Through the ceremony the participants are thought to gain direct knowledge of a situation, such as special instructions for the creation of a medicine or advice concerning the future.³¹ Gehue also notes that he was required to complete many purifying rounds in the sweat lodge before he could perform the ceremony and that its effect varies in strength and character: “You would think that every tent is the same. The ritual we do is the same, but the variety of spirits that come are all different” (Gehue, 2009, p. 14).

The intuitive stream of Mi'kmaw medicine provides a shared conceptual platform upon which practices originating outside Mi'kmaw society can be contextualized,

³¹ Gehue includes a list of some of these recommendations in his book's appendix.

absorbed and internalized within the Mi'kmaw tradition. Since this worldview is a relational one effective practices must be so contextualized, otherwise they remain isolated and apart from the wider web of interdependence that characterizes Mi'kmaw cosmology. In the example of the shake tent, brought from the tribes of the West, a ceremony has found a home among some Mi'kmaw healers, drawing upon the indigenous belief in spiritual communications and trance states to contextualize it.

This intergenerational knowing is the yardstick against which new practices are measured when absorbed by Mi'kmaw healers; it provides the infrastructure upon which unique, idiosyncratic methods of healing are supported. When a practice is introduced that cannot be readily contextualized the intuitive stream can help identify it. One such example will be considered, along with other adopted practices, next.

Adopted Practices

Included under the heading 'adoptive' are those practices which did not originate with the Mi'kmaw people but with other First Nations cultures, the spread of some of which can be traced to the Pan-Indian movement of the twentieth century. Adopted practices are employed throughout Mi'kmaw society and are often culturally restorative in nature. They are most easily adopted when they mesh with the preexisting web of Mi'kmaw belief and understanding.

An obvious and sometimes controversial example is the dream-catcher. Originating with the Ojibwa the dream-catcher is an object devoted to psycho-spiritual health, a state it promotes through filtering the dreams of a sleeping individual (Andrews, 1998, p. 204). Since dreaming is believed to be an interactive state between spirits and the living the conceptual importance of the dream-catcher to healing

becomes clear. Its purpose is supported by Mi'kmaw beliefs concerning dreams, allowing for easy integration. It has also been used as a symbol of pan-Aboriginal solidarity and an awareness of Native ethnicity that crosses tribal lines. The super-tribal sensibility to which it contributes has proved to be a source of great psychological strength and integration into a wider community for many First Nations people, providing a socially stabilizing influence (Nagel, 1997, p. 83-157). The dream-catcher has performed a dual role—filtering dreams and symbolizing a connection and identification with First Nations cultures across the continent. However it has also been appropriated by many 'New Agers' as well, reducing its effectiveness as a symbol of pan-Amerindianism (Jenkins, 2004).

A second example more specific to the Mi'kmaq is the drum. The roll of drums punctuates the atmosphere at powwows but drums are not historically part of Mi'kmaw culture.³² Introduced in the mid to late twentieth century by individuals such as Frank Augustine the ceremonial drum has quickly found a home among the Mi'kmaq (F. Augustine, personal communication; Diamond, Cronk, and von Rosen, 1994). The very beat of the drum begins a communal bonding that is emphasized by the rest of the ceremony. At one powwow I attended in Elsipogtog three drumming circles were formed, each composed of drummers with similar skill levels. As the drummers played and sang, the participants began to dance in a wide circle around them. I was advised by Frank Augustine, who took pity on my sorry attempts to mimic the steps and rhythms I saw around me:

³² Historically the Mi'kmaq used various, non-membranophonic percussion instruments

Frank: Don't try to dance to the drumbeat or with the people around you. Dance to your own heart beat instead.

James: When I do that my heart beat starts to match the drum beat. It's not easy to tell them apart.

Frank: Yeah, it's the same for everyone.

James: So we start dancing as individuals, but the drum beat eventually unites us? Through the drum a community gets one heart beat?

Frank: Yeah, that's it exactly. It's pretty simple but it works very well. Funny that, huh? Everyone starts out doing their own thing but we end up doing the same thing. Powwows are good for that. Its one of the reasons we have them at the school.

The use of drums in conjunction with dance unites the participants in a way that engages all the varied aspects of the human being—the body dances; the mind is stimulated by sounds and sights; the heart shares its beat with the others present; the spirit connects with the community. The adoption of drums also represents a pan-Aboriginal sensibility like the dream-catcher.

The shared ceremonial dances, punctuated by the rhythm of the drums, strengthens the psycho-social safety net that protects its members from social isolation. Drums provide a method to achieve this connection communally and singly, even among participants of other tribes or ethnicities. Of course the effect of the drum is not new to Mi'kmaw society; just the instrument has changed. The established use of percussive instruments among the Mi'kmaq allowed for the drum to be adopted easily into modern practice.

A third example of adoption is the growth of ethnobotanical knowledge and remedies, the use of which is a shared feature of First Nations groups across Canada. As plant materials are exchanged so are ideas and traditions concerning their use (F. Augustine, personal communication). This ability to absorb such knowledge from other

tribes is illustrated, perhaps most effectively, by the use of tobacco and its paramount position within Mi'kmaw traditions. As noted earlier the plant is not indigenous to Mi'kmak'i and was introduced some time in the past. Prior to this its ceremonial role was filled by 'Indian Tobacco' (*lobelia inflata*) (Lacey, 1993, p. 77; Mi'kmaq Spirit, 2007). Here the ceremonial role remained while the species filling that role changed to one now commonly found and also shared by many other tribes.

Other botanical cures are also adopted readily. Burdock and witch grass, introduced originally by Europeans, have found a place in Mi'kmaw botanical lore. However remedies may require plants that never were, or are no longer, available in Mi'kmak'i. To this end a sort of botanical underground railroad has developed, carrying plant materials from person to person beyond Mi'kmak'i to other tribes and back again (F. Augustine, personal communication). The expansion of knowledge along 'Root 104' provides additional options for Mi'kmaw herbalists and new treatments for illnesses and physical complaints both new and old. Traditional botanical knowledge also provides a source of income for some; Laurie Lacey offers nature walks in the Nova Scotian countryside and seminars during which he educates participants on indigenous herbal remedies and lore (Lacey, 2010).

A common feature of adopted practices is the role they fill within Mi'kmaw culture. Each of the adoptions considered above—dreamcatchers, drums, and new botanical knowledge—reinforces and supports an aspect of Mi'kmaw healing that is already present. In the case of dreamcatchers Mi'kmaw beliefs concerning dreams allow their adoption. Drums now fill a percussive role always present within Mi'kmaw ceremonies; the percussive role remains while the instrument has changed; and this is

the same kind of change seen in the displacement of *lobelia inflata* in favor of tobacco. New botanical remedies add to an already rich ethnobotanical tradition. Mi'kmaw healers are able to replace knowledge lost from their own traditions with analogues from other tribes. However the adoption of practices is not always unproblematic or without controversy. Without acquiring a new context within the Mi'kmaw nation—one that reflects that nation's understanding and knowing—a new practice can be detrimental and diluting. Mi'kmaw author Daniel Crowfeather (2005) finds this a source of concern, and writes,

[Adopting practices from other tribes] can lead to further loss of [our] own culture, and to a great deal of confusion caused by potentially conflicting beliefs. As an example, there is a growing circle of Mi'kmaw people who have adopted the Sundance from the plains Nations. The Sundance was originally intended to honour the buffalo, which we have never had here in the Maritimes. Because the Sundance tradition is not strongly rooted in the Mi'kmaw culture, it is also being changed by the adoption: I have heard a Mi'kmaw Sundancer claim that nobody can become a Medicine Person for the Mi'kmaq unless they have completed a full commitment to the Sundance. Apparently the Mi'kmaq have been doing it wrong for over ten thousand years. However, in the Plains culture there is no such belief attached to the Sundance. In this case, the adoption of someone else's tradition has created confusion and, worse yet, has created rifts between different segments of a Nation.

Crowfeather raises an important concern. The Mi'kmaq do not have historical experience with the buffalo, and that animal does not appear as a figure in their traditional legends. In this instance the intuitive stream is unable to provide firm incorporation into Mi'kmaw beliefs. The end result, according to Crowfeather, is a fragmentation within the Mi'kmaw Nation. The effect is incoherence and division, the opposite of that encouraged by the intuitive stream.

Concerns about dilution of tribal consciousness and knowledge remain a topic best suited to the consideration of Mi'kmaq and other First Nations people; as an

outsider there is little I can add to this conversation other than to acknowledge its existence. However, despite its controversial nature the adoption of practices from other tribes has allowed Mi'kmaw traditions to grow and expand. How that culture is changed in the long-term by these adoptions remains to be seen.

Adapted Practices

The adaptive category concerns new ways of applying traditional healing knowledge to the concerns of today's Mi'kmaw community. These adaptations also provide a meaningful method through which Mi'kmaw people are able to engage non-Aboriginal culture.

One example of adaptation is found in the work of Yvonne Wysote, who is currently based in Montana. Wysote combines traditional botanical knowledge with a variety of products such as soaps, body washes, creams and so on. All contain sweetgrass (*hierochloa odorata*) in addition to other ingredients and are intended primarily for women. Indeed, Wysote believes her products are more accessible to modern women, especially Aboriginal ones, than biomedical remedies:

James: Do you feel traditional ways are more sensitive to the needs of women than the government-run health care system?

Yvonne: Traditional ways are the only ways for Aboriginal women to address their needs and connection to the 'Mother Earth'. Plants were our way before there was a government health care system, so when [women] see someone like me, it is much easier to talk and deal with the issues. Instead of a [doctor's] recommendation. (Wysote, personal communication).

Wysote's products also reflect a traditional understanding of the human being for they are designed to treat not only physical complaints but psychological ones. An example

from her website³³ is called 'Awareness Cream' and is made of such ingredients as ylang-ylang oil, cedar, and lemongrass. It is intended to "...heal resentment, anger, abandonment and feelings of imperfection".³⁴ She also produces a cream that addresses "over-protectiveness, neediness, and lack of self esteem". In other words these products are psychotherapeutic, reflecting the Mi'kmaw understanding of mind, heart, body and their interaction. To this end she also produces a sweetgrass oil for massage therapists, adding aromatherapeutic practices to the physical treatment embodied in massage.

These products, and ones like them, represent a blending of traditional botanical knowledge and understanding with forms of treatment that are still on the fringe of mainstream medicine, in order to address modern issues. Through such products Mi'kmaw patients are also able to employ sweetgrass when they might be prevented from burning it, such as in hospitals—a serious concern raised by Mi'sel Joe in the last chapter. Since Wysote's products present traditional healing in a form more accessible to the marketplace they also represent an avenue of economic interaction with non-First Nations cultures.

A second example of adapted Mi'kmaw practices is found in the interaction of Elders and governmental departments. Recognizing the importance of social (re)integration in reducing rates of offense and re-offense Mi'kmaw elders have entered into a partnership with Corrections Canada. As considered earlier in this essay successful integration into the wider Mi'kmaw community acts as a form of preventative medicine and healing. The shared goal of Elders and the government was

³³ [Http://www.Mi'kmaq-essence.com](http://www.Mi'kmaq-essence.com)

³⁴ Descriptions of Wysote's products are from her website.

the creation of a program designed to approach Native offenders in the earliest stages of their interaction with the penal system and promote this integration and its hoped-for benefits. The preliminary results were set forth in *Strategic Plan for Aboriginal Corrections: Innovation, Learning and Adjustment 2006-7 and 2010-11*. The program is based on the spiritual and cultural practices of Canadian First Nations tribes. Indeed the very heart of the plan is based on the importance and position of familial and cultural ties among First Nations people:

Aboriginal community research indicated that the major factors contributing to Aboriginal offenders' success upon release were their participation in spiritual and cultural activities, as well as, programs (preferably delivered by Aboriginal people) and the support they received from family and community. (CSC, 2006)

Among the Mi'kmaq the use of sweat lodges has been highly effective in this work. In September 2008, such a lodge was created for the use of Mi'kmaq and Maliseet prisoners suffering from addictions in Maine prisons. Initial reports concerning the program have been positive, including amazement among the guards at the sudden 'turn around' in Native prisoners attending the monthly lodge (French, 2008). As considered earlier in this essay sweat lodges are places where one prays for others; the ceremony reinforces the ethic of selflessness. In so doing it promotes the healing of the individual through integration and the community through the re-addition of a unique and valuable member.

While the distant ancestors of today's Mi'kmaq could not have conceived of the horrors and pressures placed upon their descendants, the same ceremony they practiced is used today to heal wounds of a very different kind than those they faced.

Between the work of Wysote and the Elders-Corrections Canada partnership the adaptability of traditional healing is apparent. Arising from traditional ways and beliefs and expressed through contemporary techniques, adapted practices allow Mi'kmaw healers to engage the modern world and the issues that arise from it. Wysote's work demonstrates the applicability of traditional techniques to such quintessentially modern issues as body image and self-esteem. The sweat lodge program demonstrates the same point effectively by successfully treating prisoners through societal reintegration. Just as adopted practices reinforce preexisting aspects of Mi'kmaw culture so too do adapted practices allow them to engage the contemporary world and its issues without sacrificing traditional ways, worldview or identity (both individual and collective). Additionally these adaptations underscore the vitality and efficacy of many Mi'kmaw healing techniques. Adapted techniques also provide an avenue through which Mi'kmaw healing is able to legitimize itself in the eyes of many non-Mi'kmaq who, historically, have viewed these traditions as primitive superstition, or bereft of scientific validity.

SUMMARY

In the contemporary world Mi'kmaw healing traditions are not only alive, but dynamic and evolving. These traditions have been damaged severely by years of oppression and a campaign of dominance on the part of the biomedical industry. In reaction to these influences Mi'kmaw healers have drawn upon the practices of other tribal groups in restoring their own traditions and found ways to incorporate newer modalities and forms of treatment into traditional knowledge. Additionally, traditional knowledge has been reinterpreted in a modern context, to treat modern ills, such as

criminogenic social problems or issues of self-esteem. Throughout this process the internalized, shared knowledge of Mi'kmaw cultural beliefs works to ensure cultural continuity—the intuitive stream attempts to contextualize new practices within the Mi'kmaw worldview, ensuring that, despite their origins, they become truly part of the Mi'kmaw tradition. Through adoption and adaption this vibrant tradition connects with other First Nations cultures and interacts with wider Canadian society.

The incorporation of new practices is not wholly unproblematic. As Crowfeather pointed out ceremonies such as the Sundance, focused on the buffalo, do not have a place within Mi'kmaw society, which has no historical experience with that animal. Additionally changes in wider society can also influence the effectiveness or acceptability of new treatments, as shown in the example of the dreamcatcher and its appropriation by non-First Nations groups as a symbol.

Despite this issue contemporary healing practices among the Mi'kmaq remain vibrant and dynamic today, adapting to modern concerns and providing an avenue of care that is not only effective but culturally considerate, appropriate and capable of both healing and preventative measures. Had Mi'kmaw culture been less dynamic and less adaptive and instead rigid and static its unlikely these healing traditions would have survived as they have. Their dynamism has allowed them to quickly adapt to new illnesses and challenges; to absorb new methods of treatment and to, in the end, continue to serve the people who rely on them, as they have for uncounted millenia.

CONCLUSIONS

The title of this essay--"A Gossamer Web, Is Life"--comes from a poem by Mi'kmaw poet Helen Sylliboy. In the course of this research the vital importance of interconnectedness to the Mi'kmaw conception of the world was underscored dramatically. Good health, wellness and community are inextricably linked phenomena that are in turn connected with all other things that exist. The Mi'kmaw healing tradition was born from this understanding, just as biomedicine rose from a European one, each situated within unique and largely exclusive streams of historical, religious and governmental influence. While neither form of health-care is capable of answering all the needs and complaints of Canadian citizens, among the Mi'kmaq at least their time-tested and loved traditions have been preserved and passed on through the community for generations, growing and adapting according to their changing needs. This growth dynamic involves the absorption of practices from other First Nations peoples and the reconfiguring of traditional knowledge to address contemporary ills; both of these phenomena occur against the background of the inherited and internalized teachings that are passed intergenerationally and ensure a continuity. By its very nature, then, Mi'kmaw society provides a sort of template or matrix against which it can repair itself against damage. Drums may replace hollowed logs or tobacco replace another plant but the percussive beat and the most sacred of plants are ideas—foundational concepts of knowledge and practice—which remain and endure. This core of cultural tradition and knowledge can adapt readily while remaining true to itself. Yet its interaction with biomedicine remains a pressing concern.

Some, like Petrou, have suggested a form of medical pluralism be implemented, in which Mi'kmaw healing and the biomedical industry might cooperate to one degree or

another for the general improvement of patient outcomes. However there are legal and cultural pitfalls that might make such cooperation difficult. The issue of licensing and professionalization is significant in terms of legality and malpractice. It also represents a system of selecting and training healers that is alien to traditional Mi'kmaw ways. Within the socialized biomedical milieu issues such as personal volition; governmental confusion; and the focus on reductionist and mechanistic understandings of health, injury and disease, have served to marginalize Mi'kmaw healing practices and alienate many. The conceptual underpinnings of the two systems are radically different and it seems that, despite the effectiveness of both traditions, ready and normalized cooperation would have to come at the expense of those very things that make Mi'kmaw medicine uniquely Mi'kmaw. Without some compromise there is little potential for cooperation. The preservation of Mi'kmaw healing has been able to occur partially because of efforts to preserve wider Mi'kmaw culture; this very goal precludes further compromise on its part. Instead the needed compromise is on the part of the biomedical industry and educational system that forms its tributary. The biopsychosocial model (considered in chapter two) offers modern physicians a model of enquiry, understanding and care that is not only reflective of the needs of modern patients but is also better prepared to interact with the Mi'kmaw tradition. Both share an understanding of the human being as multidimensional and possessed of individual and communal social, historical and cultural contexts. The true path towards cooperation lies in a biomedical acceptance that Cartesian mechanistic views of the body are inadequate. Since Heisenberg and Einstein modern physics has reevaluated its understanding of the universe, moving from strictly Newtonian to relativistic and quantum understandings of the universe. Physics has entered a universe

unbound by Newtonian mechanism, a universe where subatomic particles can affect each other over galactic distances and wink in and out of existence seemingly at random; where simple observation can change the outcome of quantum events. In light of this is an acceptance that human beings are more than biological machines really that great a stretch for biomedicine? Or that traditional ways of knowing, however they are explained, can provide valuable and accurate insights? Of course the forum in which this change must be implemented is the medical school, where the values and mores of biomedicine are instilled in each new generation of physicians. They might find a great deal more offered by traditional ways than plant cures that can be exploited as commercial supplements and lab-duplicated pills.

As things currently stand, governmental interference in Mi'kmaw healing should remain limited. The Mi'kmaq themselves have proven to be the best guardians and students of their own lore, as well as those best suited to apply it to a variety of situations and governmental systems of regulation are anathema to traditional healing. Shared goals would be best served by addressing the root causes of ill health among the Mi'kmaw people. Efforts to improve conditions (and thus overall health) within many poor reservation communities will always be doomed to failure so long as the surrounding social, legislative and political milieu remains indifferent or hostile to their culture. As explored above, authors such as Patricia Vickers and Joel Denny link ill health to the erosion of traditional culture. The logical course of action, then, is to lend whatever assistance can be provided to restore traditional culture as well as the pride and dignity of First Nations peoples. Governmental efforts have rarely been preventative and tend to be reactive; this form of health-care is simply too little, too late. While Mi'kmaw culture and

tradition seeks to repair itself along with its practitioners, the needs of all would be best served by a consolidation of governmental efforts. The division of issues and responsibilities among departments of health, Aboriginal affairs, education, and so forth has proven ineffective; a reevaluation and a new approach are desperately needed. Consolidated governmental efforts should be guided by an overall strategy aimed at a general improvement of living conditions and the elimination of socioeconomic inequalities that directly contribute to ill communal and individual health, and all of this required direct and detailed involvement from First Nations persons. Legislation and negotiation must be undertaken fairly and without duplicity. The powerful healing dynamic considered in this essay has already proven itself capable of repairing damage done to the Mi'kmaw people. It is with this current that governmental efforts must be focused, not against it; the government role should be accepted as supportive, rather than paternal. It is this essential dignity and self-respect that has been called for by First Nations for years, and it is only through them that lasting change can be effected.

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