PERSPECTIVES ON THE USE OF INDIGENOUS HEALING PRACTICES: AN INDIGENOUS RESEARCH PROJECT

By

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A Thesis
Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements
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Faculty of Social Work
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ACKNOWLEDGEMENTS

Tansi. If you are reading this, than I acknowledge you. I acknowledge that through these words that connect us, that we are related. But these words are not our voices, and I hope that we can talk in the future, because I would like to hear and honor your story that brought you here.

I give thanks to my relationship with the Creator for this sacred journey that has been full of gentle guidance from the Elders, teachers and spirit helpers. I am especially grateful to my advisor, Michael Hart, for his accepting support, kindness, and encouragement as I moved forward with this research project. Michael showed me how to look within myself and to look at research as a journey that stays true to my teachings, perspectives, and experience. I would also like to thank my thesis committee members, Pete Hudson and Patricia Frain for their guidance, expertise, and precious ongoing support.

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ABSTRACT

This thesis reports the qualitative findings from nine Aboriginal individuals involved in a study exploring indigenous perspectives on the use of indigenous healing practices and its relationship with "modern" professional medical care. These individuals were selected because of their active practice of traditional healing approaches and their experiences as patients in the healthcare system. Further, the study selected individuals from a variety of Indigenous groups in order to respect the plurality of perspectives within the Aboriginal community.

Using an indigenous research design which promotes the recognition of indigenous worldviews while honoring of the cultural processes that define the way indigenous people live, learn, and relate to the world, it was possible to shape the experiences and voices of the informants and researcher into a narrative that identifies the issues that are important to realities and future of the Aboriginal community.

The study revealed that traditional healing approaches continue to be an important model of care within the group studied. Respondents maintained a strong affiliation to their indigenous world view of healing based on direct experiences that validated the legitimacy of the practices. Further, perspectives about western medicine were strongly influenced by past experiences, including residential schools and examples of disrespectful relationships with healthcare professionals that had marginalized their beliefs and practices. Participants were also able to contribute recommendations to address the barriers and issues they had experienced. The author brings to a close the study with a personal analysis of the learnings and implications of this study to the practice of social work within health care settings.

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CHAPTER ONE

Introduction

As the Aboriginal Patient Advocate within a regional health authority in Manitoba, I regularly witness the traumatic emotional, mental, physical and social outcomes that Aboriginal people experience because of their poor health status. It is discouraging to see so many Aboriginal people living in poverty with poor health. The outcome of this poor health status eventually leads them to the door of a hospital where they require professional medical care for acute and complex health issues. I see Aboriginal people streaming into dialysis units in their wheelchairs pushed by family members. It also pains me to watch tired family members who are isolated from their home communities and support networks while they stay at the bedside of a member fighting with life threatening illness or injury. Although I frequently see examples of excellent care and treatment within our hospitals, I have encountered too many alone and silent patients who seem to have given up on the possibility of being in control of their own care, healing, and health.

From these care interactions, I wonder how well the current allopathic bio-medical health system or western medical system as it is commonly known, is responding to the unique cultural needs of Aboriginal people. Specifically, I wonder how well Aboriginal people who practice indigenous healing approaches cope with the tension of interacting between two distinct models of care. Within my spirit, I have been imprinted the profound words of an Elder who said to me that "hospitals treat our people, they cannot heal our people".

In response, I began to look for places where indigenous healing practices are protected and respected within hospitals. I asked myself if, where, and how do Aboriginal people find support for their indigenous healing practices and beliefs within hospital environments? I have heard patients say to me in private that their experience as a patient was comparable to their traumatic experiences within residential schools. And that troubles me. This interest in understanding the relationship between the use of indigenous healing practices and western medicine has led me to the development of this research project. This interest is further supported by authors such as Levin and Herbert (2004) who state that "all health care settings create a fear and lack of trust on the part of Aboriginals who often experience discrimination and stigmatization" (p. 174).

In an effort to frame this study within the broader context of healthcare realities experienced by Aboriginal people, it may be useful to look at some of the health status indicators affecting this group. For many years, Aboriginal people have struggled to survive the harm and risks that have been inflicted upon them from years of marginalization:

> Across Canada from coast to coast to coast, First Nations peoples are trapped in a cycle of ill health, inferior health care, lower life expectancy, poverty, lack of resources and despair. Our peoples have extraordinarily high rates of disease, substance abuse and suicide. As Health Canada reiterated in 2000, "Canada's aboriginal people, as a group, are the most disadvantaged and have the poorest overall health status." Pick any health indicator - rates of infant mortality, postnatal mortality, hospitalization, AIDS and TB infection: First Nations peoples' rates are many, many times

> higher than most Canadians take for granted. Our life expectancy remains six or so years lower than other Canadians, a terrible cost of millions of lost potential years of life. (National Chief Matthew Coon-Come, Globe and Mail, February 4, 2003)

It would seem that all the technological advances and investments made in the Canadian healthcare system would lead to an elevated level of wellness for all Canadian citizens. But that is not the case for everyone. The First Nations, Métis Nation, and the Inuit, recognized herein as the Indigenous Peoples of Canada, are increasingly challenged and despaired by the impacts caused by the unfair burden of illness that they carry. A growing body of research has exposed how the disparity in health status of Aboriginal people in comparison to the general population relates to key factors including accessibility, availability, and appropriateness of care (Levin & Herbert, 2004; Manitoba Centre for Health Policy, 2002).

Mokaua and Fong (1994) suggest that of the three aforementioned barriers to quality care that measure the responsiveness of a health care system, the most difficult barrier to effective utilization of service pertains to services that are not delivered in a way that is culturally acceptable to the recipients of care. Often, services may not be congruent with the values and traditions of the users, often leading to reduced access by those who are most vulnerable within the community. Of these three factors, appropriateness of care is often the focus of discourse among Elders, Healers, Aboriginal and non-Aboriginal researchers, health care practitioners, and Aboriginal communities who grapple with trying to create culturally-centered solutions that incorporate indigenous knowledge and healing to positively affect the widening gap in health status.

The disparity in health status between Aboriginal people and the general population is highlighted in Manitoba by the fact that registered First Nations have 1.6 times the physician visit rates compared to non-Aboriginal people (8.3 times versus 5.2 times respectfully), yet the use of specialists is about two-thirds the proportion as compared to non-Aboriginal people in the health region (21.7 percent versus 32.2 percent). Hospital separation rates (the rate of discharge) for First Nation people are more than double that of non-Aboriginal people. Once hospitalized, their total days of care are also double those of other patients (Winnipeg Regional Health Authority: Population Health Profiles, CHA Report 2003). At the Health Sciences Centre, a large tertiary care teaching hospital in the Winnipeg Regional Health Authority (WRHA), it is conservatively estimated that fifty percent of patients are of Aboriginal descent (Aboriginal Service Review Committee, 1992). The percentage of Aboriginal patients is even higher in certain program areas including women's health, pediatric, and renal health. These statistics indicate that Aboriginal people are over-represented within the hospital settings. It also supports the need to explore the needs and realities of Aboriginal people who are a significant client group within these settings.

Aboriginal health scholars and others understand that the third-world health status of Aboriginal people (RCAP, 1996) cannot be simply reduced to individual traits or personal deficits. Rather, the health conditions are symptomatic of a deeply entrenched history of colonial wardship and institutionalized racism leading to the subsequent creation of the reserve system, forced relocation of communities, the placement of children in institutions, institutionalized and systemic racism, and the chronic under-funding of inadequate community-based services within communities (Ajzenstadt &

Burtch, 1990). The definition of indigenous healing presented by the Royal Commission on Aboriginal Peoples (RCAP) in 1996 concurs with the viewpoint of the above authors:

> Personal and societal recovery from the lasting effects of oppression and systematic racism experienced over generations. Many Aboriginal people are suffering not simply from specific diseases and social problems, but also from a depression of spirit resulting from 200 or more years of damage to their cultures, languages, identities and self-respect. The idea of healing suggests that to reach 'whole health', Aboriginal people must confront the crippling injuries of the past. Yet, doing so is not their job alone. Only when the deep causes of Aboriginal ill health are remedied by Aboriginal and non-Aboriginal people working together will balance and harmony – or health and well-being be restored. (RCAP; p. 109)

To fully understand the impact of colonization on Indigenous people, it is important to have a clear understanding of the interlocking processes that define the colonizing experience. Frideres and Gadacz (2001) define a seven-step process of colonization that can be summarized as follows:

a) The uninvited arrival of the colonizer into the territory;

b) The destruction of indigenous social institutions;

c) The creation of economic dependency on the colonizer;

d) The establishment of external political control;

e) The provision of limited and low level social services such as health, education and housing;

f) The use of systemic racism to justify the above; and

g) Weakening of the resistance of indigenous people.

Alfred (2000) expands on this matter to state that colonialism "is not a historical era, a theory, or merely a political and economical relationship. It is a total existence, a way of thinking about oneself and others always in terms of domination and submission...that has come to form the foundation of our individual and collective lives" (p.89).

In light of the impacts of colonization on Aboriginal people, the intent of this project is to contribute to the de-colonization and self-determination of Aboriginal people through the validation and empowerment of Indigenous voices and knowledge(s) hopefully leading to the promotion and the integration of indigenous healing methods and practices into mainstream health care system. In this way respect can be shown for the social, cultural, spiritual values and worldviews of Indigenous people.

This indigenous research study explores and represents the perspectives of Aboriginal individuals as they navigate between two intersecting yet distinct models of health and healing. One belief that gives me hope and that also guided my interest in this study is that despite generations of suffering and inequity experienced by the Indigenous people of Canada due to unwanted colonial legislation and forced marginalization (Brant Castellano, 1993), Aboriginal people continue to make significant investments in improving the quality of their own lives.

Despite the deliberate suppression of indigenous world views, Aboriginal people continue to work towards economic, political, social, community and individual health (Adleson, 2005) through initiatives that promote autonomy, self-direction and governance, and the reclamation of indigenous knowledge, cultural ways of being, and traditional values. Chrisjohn and Young (1994) in their report to the Royal Commission

on Aboriginal People entitled "Breaking the Silence" recommended that Aboriginal people return to their traditional ways as a way of reclaiming their autonomy and wellbeing. There is a growing body of literature that supports the positive social and health impacts that indigenous healing practices have on the lives of Aboriginal people. Some of this literature will be profiled in the next chapter.

Personal Significance of the Study

Consistent with Indigenous research protocols, it is necessary for me as the researcher to share with the reader who I am as a participant in this research study. It is important that I be true to my learning and healing journey as an Aboriginal person. I believe this study would not have been possible at another point prior to where I am now in my growth and development as an Aboriginal person. Before, I would not have been ready to receive and carry the stories and knowledge that was shared with me. Also, I do not believe that I would have had access until now to the particular study participants whose life paths have been woven with my own.

My family and I have been on a healing journey for over twenty-five years, beginning with a commitment to share the land and home that we care so deeply for with the others who needed a natural place to heal and learn. As a pipe carrier and sweatlodge conductor for those many years, I have been witness to the power of healing relationships and the kindness of the grandfathers and grandmothers whose presence and voices can be felt and heard in ceremonies and connection with all of Creation. These experiences have also helped to define who I am as a professional and member of the Aboriginal community.

As an Aboriginal person who began to reclaim my relationships with Indigenous

traditions and knowledges in early adulthood, I have been also been touched by the legacy of discrimination and oppression that permeates through the lives of each Aboriginal person. I have had to reclaim the Cree language as well as needing to restore my relationships with Mother Earth and Creation in order to fully appreciate my place and purpose as an indigenous man. It is with the help of individuals like those who participated in this study that I was able to move forward in this regard.

In my long-standing professional practice as a social worker I have seen the strengths and resiliency of Aboriginal people who continue to struggle their way out from the margins of society in order to assume their rightful governance of the systems that matter in their lives. While working within the federal government, I have facilitated the transfer of health services to First Nation control in the belief that this would empower communities to create culturally-centred solutions to the health issues facing them. I remain convinced that the solutions are within the traditional teachings and practices of each community.

More recently, I have been working directly within a health authority in Manitoba as the Aboriginal Patient Advocate. In this capacity I have encountered Aboriginal patients and families who struggle to have their needs met while receiving medical care in a large urban environment. In my analysis of the issues faced by Aboriginal people, I have come to understand that the conflicts and issues presented by individuals cannot be reduced to communication misunderstandings between care providers and patients. One must look at the culture of healthcare systems and the power structures that support the behaviors and practices of its agents in order to understand the impact on those who come into contact with its policies and care delivery models.

From this understanding came my personal and professional interest to explore the impact of the highly structured and hierarchal medical health care system on Aboriginal individuals who view the world and its relationships from a very different stance. The personal significance of the study was not to engage in a comparative analysis of the traits that define each cultural system of care. Rather, I was called to join my life experiences with those of others and reflect back to the world the perspectives and stories of Indigenous people who still practiced their ancestral healing practices. These interactions with the western medical system would shed light on the status of trust, respect, and safety perceived by Aboriginal patients. It has been a personal worry of mine for some time that the health status of Aboriginal people would not improve significantly until trusting relationships had been restored, based on the inclusion of Indigenous ways of healing into the continuum of care.

Organization of the Thesis

This thesis is organized in the following way. Chapter two begins with an brief orientation to constructs and principles that define Western empirical knowledge and Indigenous knowledge. This is followed by a review of the body of research focusing on defining indigenous knowledge and world views and its relationship to indigenous healing approaches and practices. The chapter closes with an exploration of current literature pertaining to the relationship(s) Aboriginal people have had with the health care system in Canada. This review leads to an assessment of the significance of the current study.

Chapter three presents the indigenous research framework and its methodological considerations that guided the data gathering and analysis processes of this qualitative

study. In chapter four are described the findings of the interviews that were held with nine Aboriginal persons. The information is organized according to the significant themes that emerged. The last chapter of this study engages the reader in a discussion about the significance of this study and explores how the experience transformed the researcher himself. Considerations on how this study applies to social work practice and the delivery of care to Aboriginal people within health care settings are also advanced.

CHAPTER TWO

Literature Review

This chapter is organized in the following way. Firstly, the review briefly looks at the construct of Western knowledge and its underlying assumptions. This is followed by a section exploring Indigenous knowledge and its relationship to Indigenous Healing. The concept and practice of Indigenous healing is expanded upon. In the third part of the review is presented an overview of the studies that have explored the relationship between Aboriginal people and the health care system.

The Literature Review Process

For this study, the researcher engaged in a literature review process that occurred at two different points in time in the research process. Initially, a general review of the literature was conducted to identify the constructs and issues that pertain to the study domain. This aspect of the literature review focusing primarily on the topic of indigenous knowledge, its relationship with indigenous healing, and research materials related to defining the scope and uses of indigenous healing approaches. The literature review in this area occurred prior to the start of data-gathering phase as part of the proposal development and ethics submission process and emphasized the reference to Indigenous researchers and writers in this regard. The rationale for this emphasis was that the first body of work was an area that was within the realm of the my life experience and would likely to be congruent with my worldview. From an indigenous research paradigm, the limiting of research prior to the inquiry phase also protects a researcher from inadvertently developing an "expert" stance and therefore introducing some of the biases that he may have been exposed to in the literature. The decision to proceed in this way

was also congruent with the teaching I had received earlier in my life that states that truth is more like a crystal than it is a pearl. It is my responsibility as a learner to shift my stance in order to receive and understand the stories of others. It would not be fair to others for me to minimize their perspectives by thinking that I 'reduced' their truth to a 'pearl' of universal wisdom, namely my own.

The second part of the literature review process occurred after the data was analyzed and the findings were presented in chapter four of this report. The researcher returned to the body of literature related to the themes associated with the study in order to capture the current state of research activity regarding the relationship Aboriginal people have had with the health care system and describes their experiences in this regard.

It was also decided that the current literature relating to indigenous research design be presented in the methodology chapter of this report as it informed the choice of study design and the subsequent methodologies used to engage in data gathering and analysis.

The Foundations of Western Knowledge

Banks (1993) simply states that "all knowledge reflects the values and interests of its creators" (p.4). Unfortunately, western societies primarily promote science as their tool of choice for the construction of "the world" and thus continue to support epistemologies that "naturally" dominate other cultural groups through the suppression of their histories and knowledges (Sheurich & Young, 1997). In the work of information gathering, knowledge acquisition, and synthesis of human knowledge, Western scientific endeavor has had the tendency to understand the World in an objective manner, leading to

a disconnected and fragmented view of the whole (Battiste and Barman, 1995). The positivistic and reductionist stance of Western scientific activity leads to the development of "objective" paradigms and categorical abstractions of knowledge that is only possible because of the distance that is introduced into the research relationship. Deloria (1991) advances the following misleading claim put forward by science about human knowledge:

> Various fields of inquiry, if taken together, represent the sum total of human knowledge. In fact, almost all of western science is reductionist in nature and seeks to force natural experience and knowledge into predetermined categories which ultimately fail to describe or explain anything. The whole process of science is that of finding common denominators which can describe large amounts of data in the most general terms, rejecting anything which refuses easy classification as "anomalous," existing outside the generally accepted labels and, therefore, not to be given standing or serious attention. This way of gathering information about the work-and ourselves-is, of course, absurd. (p. 11)

Western science and knowledge, as the foundation of allopathic medicine, are underpinned by the concepts of universalism which state that basic scientific laws apply to all of nature. Morgan (2003) describes the central tenets of western thought as being focused on:

> objectivity, true/false dichotomies, and notions of Cartesian-Newtonian science that the "nature" of reality is mechanistic - a series of compartmentalized systems which together combine to form a whole.

> Central to this view is the belief that any of these systems can be reduced to causally significant parts which can be isolated, manipulated, altered or reconfigured, and that as long as the output is consistent with what is expected then the whole remains unaffected. Thus reality becomes in essence only those things deemed causal to an outcome, and all else is irrelevant. This process appears to have been particularly successful in medicine. (p. 38)

Further, western thought production posits that all relationships of interest to science are expected to be impersonal (Garroutte, 1999). The characteristics of race, gender and personality do not affect the outcomes of enquiry, as the Universe "herself" is devoid of personal qualities. Believing otherwise could only lead to the belief in "magic" or "superstition". Western thought production has not always valued the contribution made by researchers who have interpreted the world through the lens of race, gender, and culture from a personal and subjective perspective.

Battiste and Henderson (2000) state that Eurocentric research is grounded in colonial racism whose goal is to perpetuate the inferiority of Indigenous people. These same authors refer to Memmi (cited in Battiste and Henderson, 2000) who describes the following strategies, which have been the staple of western knowledge production and used to maintain power over Indigenous people:

1) stressing real or imaginary differences between the racist and the victim;
2) assigning values to these differences, to the advantage of the racist and the detriment of the victim;

3) trying to make these values absolutes by generalizing from them and claiming that they are final; and

4) using these values to justify any present or possible aggression or privileges.

To this, Sheurich and Young (1997) add that no epistemology is context free and arises out of the social history of a particular social group. Unfortunately, most of the currently legitimated knowledge across disciplines have arisen and have supported the dominance of the White race while suppressing the knowledges of other groups and cultures.

Given this longstanding "civilizational" racism, it is not surprising that Indigenous individuals, healers and communities have increasingly resisted the interests of "outsiders" who want to engage in research to exploit their knowledges.

Indigenous Knowledge and its Relationship to Indigenous Healing

Why is it necessary to explore the relationship between indigenous healing and indigenous knowledge? The answer lies in the fact that indigenous healing is a key part of indigenous science. For some time indigenous scientists have been reduced by Western science to "medicine men", "healers", and "shamans" within the mono-cultural and imperialistic halls of euro-centric knowledge production and discourse. According to Colorado (1988) the "tools of native science have been totally unrecognized, passed off lightly as prayers or described as hallucinogens, rattles, and paint" (p.60).

The deliberate efforts by Western scientific colonialism have served to de-legitimize and discredit meaningful and ancestral worldviews. Indigenous paradigms of thought and their scientific knowledge are seen as inferior. Within this ethnocentric

western scientific viewpoint, only euro-centric endeavors have accounted for the development and advancement of "civilized" nations and societies.

Defining indigenous knowledge is not simple given that it has been shrouded in mysticism that is meant to distance non-experts from ever understanding how Indigenous people think. According to Yellowhorn (2000), Indigenous learning has been "burdened by stereotypes that preserve mystical aura surrounding Indian lore and promote the idea that Indians live with a heightened sense of awareness regarding nature because it is the essence of their culture" (p. 87).

Building on its dynamic and diverse nature, Indigenous knowledge and philosophy is holistic, pluralistic and contextual. Identity, space, time, knowledge, spirituality, learning and assessment are intertwined with each other (Colorado & Collins, 1988). These same authors present the metaphor of the tree to represent how research, information, knowledge can be stored and exchanged within the holistic framework of indigenous knowledge and science:

> Through spiritual processes, it gathers and synthesizes information from the mental, physical, social and cultural/historical realms. Like a tree the roots of Native science go deep into the history, body and blood of the land. The tree collects, stores and exchanges energy. It breathes with the winds, which tumble and churn through greenery exquisitely fashioned to purify, codify and imprint life in successive concentric rings – the generations. Why and how the tree does this is a mystery but the Indian observes the tree to emulate, complement and understand his/her relationship to this beautiful, life-enhancing process. (p. 57)

Within this framework of inquiry, the tools are also natural and inform a personal journey that provides a means to heal relationships that have been harmed by past oppression and disrespect. These simple tools include feeling, history, prayer, and relations. The tools are as old as our Nations and ceremonies and they continue to be within each person and can be called upon as the foundation for ecological healing and wellness.

There is a shared belief among many indigenous peoples that our way of life, (including our ways of healing), land, ceremonies, and language are of divine origin (Wilson, 2004). Further, the focus of indigenous inquiry looks at the relational patterns between humans, animals, plants, minerals, supernatural beings, Mother Earth, and Creation that lead to a representation of the natural world that is animate and ever-changing (Garroutte, 1999). This relationship must be continually renewed as all beings work together to co-create each day through the maintenance of their spiritual obligations, their words that give and sustain life, and their work. This indigenous worldview is described by Sioui (1992) as the Sacred Circle:

> In the old days, when we were a strong and happy people, all our power came from the sacred circle of the nation and as long as the circle remained whole, the people flourished. The blossoming tree was the living centre of the circle and the circle of the four quarters nourished it. The east gave peace and light, the south gave warmth, from the west came rain, and the north, with its cold and powerful wind, gave strength and endurance. This knowledge came to us from the external world (the transcending world, the universe and with it our religion. Everything done

> by the power of the universe is made in the form of a circle. The sky is circular and I have heard that the Earth is round as a ball and the stars too are round... The birds build their nests in a circular way, for they have the same religion as us). (p.8)

Belonging to the Sacred Circle means that everything is within reach and each part carries within it the whole. When speaking of healing, Allen (1986) states that "the natural state is wholeness. Thus healing chants and ceremonies emphasize restoration of wholeness, for disease is a condition of division and separation from the harmony of the whole. Beauty is wholeness. Health is wholeness. Goodness is wholeness." (p.6)

With this as our understanding of the differences between Indigenous science and knowledge and its Western equivalent, it is possible to better understand the area of Indigenous healing as a central theme of this study.

Definition of Indigenous Healing. There can be no uniform approach or single label attached to the definition of indigenous healing practices, given that it respects the unique geographical, historical, and contemporary views and beliefs of each Nation and community. According to Battiste and Henderson (2000) the indigenous worldview is a valid philosophical, epistemological, and scientific system can only be fully understood by those who traditionally employed its ways of learning, living, and healing. This diversity of histories and traditions must be considered when looking to define indigenous healing.

For the purposes of this study, the following comprehensive definition of indigenous healing, put forward by the Royal Commission on Aboriginal Peoples (RCAP, 1996), defines indigenous healing practices as:

> Practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western "scientific" bio-medicine. When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counseling and the accumulated wisdom of Elders. (p.348)

This inclusive definition reflects the timeless nature and the broad scope of practice of indigenous healing as it applies to the contemporary issues faced by Aboriginal people.

For Deloria (1986) the science and integrity of Indigenous healing and knowledge comes from knowing the power (living energy that inhabits all of Creation) and the peace that comes from the understanding and sustaining of one's personal and particular relationships with all of Creation. Creation is not seen as an insensitive collection of species and inanimate materials, but rather as sacred 'people/beings' with thoughts, feelings, and aspirations as they interact with humans (Garroutte, 1999).

It is important at this point to state that for some Indigenous scholars, healers and Aboriginal communities, the use of the word "traditional" is viewed as a derogatory colonial concept, introduced by academics and institutional scholars to separate and prioritize beliefs that were not their own (NAHO, 2003). Although this is the case, the term appears at times in this research, as it is a commonly used term that many Aboriginal people are familiar and comfortable with. The terms "native medicine" and "Indian medicine" are also commonly used to reflect this aspect of Aboriginal life. I have observed that the term "indigenous healing" is becoming more recognized in some circles

as Aboriginal people become more active in their own research, policy-setting, and program development. The term "indigenous" encompasses a sense of healing that comes from within our place.

Lastly, terms such as 'traditional', 'shaman', 'medicine person', 'Western', and 'healers' are imprecisely defined and described in academic literature (Rhoades & Rhoades, 2000). They also do not always mean the same thing within the Aboriginal community. Some of the confusion rests in the fact that a significant portion of the expansive body of research on this topic was not conducted from within an indigenous epistemology. Studies have been conducted by "outsiders" (Kanuha, 2000; Swicher, 1993) who seek to understand constructs, perspectives and practices that are not endemic to their worldview.

The Nature of Indigenous Healing. Indigenous healing practices are wholistic and natural approaches that emphasize the physical, emotional, mental and spiritual aspects of a person while incorporating as many traditions as possible (Plouffe, 2002). The physical aspect is the body (what is seen and touched), the emotional part is the heart (feelings), the mental part is the mind (thoughts) and the spiritual part is the whole being or self (Phillips, 1999).

Indigenous healing practices are culturally based and cannot be "clinicalized" as a means of transforming the practices from cultures to institutions (Hill, 2003). Stated differently, it is not possible to neatly compartmentalize indigenous approaches into Western therapeutic or practice models, clinical "schools of thoughts" or cognitive frameworks that guide the interventions of clinicians. This tendency within western educational paradigms would only lead to the commoditization and "expert development

"of indigenous healing and its practitioners (Battiste, 1998; Smith, 1999), which is countercurrent to the tenets of indigenous healing itself.

"Traditional" medicine is used as a term to reflect the indigenous healing practices of Aboriginal people while the words "Western" or "Euro-centered" commonly refer to the application of "scientific" principles and technology to the management of disease. Within the indigenous worldview, 'medicine' is a complex system of health maintenance and treatment that is based in indigenous science and includes the realm of spiritual interventions to guide healing, recovery of balance, and the restoration of health.

Wholistic and Collective-Focus of Indigenous Healing. Within the Indigenous worldview, health and wellbeing are constructs that are relational and collective in nature rather than the individual focus as is often the case in mainstream health systems and institutions. A person cannot maintain balance and health without the assistance and support of all human and non-human relationships. Hollowell (1960), in his study of Anishinaabe people in Ontario, explained how the concept of 'impersonal natural forces' was foreign to the people. Simply stated, wholistic wellbeing is maintained through the personal and respectful relationships with all of Creation. For Colorado (1988), "each and every entity in the Universe seeks and sustains personal relationships" (p.55) that have to be renewed every day and not be left incomplete. This perspective also supports the commonly held Indigenous notion that individual healing cannot occur independently of family and community healing.

Aspects of Indigenous Healing. There are many interlinked aspects of indigenous healing that are often presented in the literature. Hill (2003) presented a listing of various Indigenous healing practices that include the special focus of the

spiritualist (focusing on the spiritual health of a person); the herbalist (emphasizing the use of botanicals as remedies); the diagnosis specialist (communication with the spirit world and physical entities to assist in identifying ailments and remedies); medicine person (use of above-noted knowledge in ritual, ceremony, and prayer); healer (healing work using rituals or unique "gifts"); and midwife (specialized knowledge in prenatal care, birthing, and aftercare). These specializations speak to the indigenous sciences that have guided the development of indigenous healing.

It is essential to know that these specializations in practice are often inter-related and always intrinsically linked to the relationships with the land, language, and culture of the practitioner and receiver of care (Battiste and Henderson, 2000; Cajete, 2000). These authors state that the focus of traditional ecological knowledge "is the web of relationships between humans, animals, plants, natural forces, spirits, and land forms in particular locality, as opposed to the discovery of universal laws" (p.44). From within these relationships are found the essence of healing.

Based on my own experience of having worked within these two different health belief systems and traditions of care, I would say that Indigenous healing methodologies are similar to Western medicine in that they require specialized knowledge and training by its caregivers. One of the fundamental differences I have noticed is that an indigenous healer will always prescribe a healing practice or medicine that is unique to the wholistic needs of the individual in that moment. The power of indigenous healing is drawn from spiritual sources, both internal and external, and familial relationships from the past and present to tailor a healing experience that is unique to the individual. The healing process pivots around the person, not the care provider and is wholistic rather than

fragmented in its approach. As stated by Struthers, Eschiti and Paschell (2004), these are resources that Western medicine often fails to tap into.

Relations between Aboriginal People and the Health Care System

The long history of oppression and segregation experienced by Aboriginal people has led to individuals and communities to be challenged by many significant health problems. These individually experienced health inequities are the burden of a collective experience of ongoing discriminatory practices, inequity, and inequality with non-Aboriginal Canadians (Adelson, 2005). It is therefore reasonable to think this that the quality of relationships between Aboriginal people and the health care system has been poor.

O'Neil (1989) states that medical institutions represent for Aboriginal people a powerful symbol of a recent colonial past. As such, they can represent a place of domination over that person's actions, a significant loss of control, and the loss of liberties and rights. In this same study, the author found that the Inuit people who encountered hospital facilities were often dissatisfied with their care experience because health professionals did not always respect and accurately interpreted their worldview and social experiences.

In Manitoba, one has to think back to the incident in 1980 that occurred in a Winnipeg hospital where an elderly First Nation woman awoke from cardiac surgery to find that beadwork had been inserted into her sutures. It is surprising to me that when I raise this event during education sessions with health professionals that I still hear health professionals who believe that the surgeon was a good person and that the issue had been "blown out of proportion". Fortunately, this event and others since have encouraged

health institutions to explore the quality of care offered to Aboriginal people.

The Health Care Experience of Aboriginal People

The health care experiences of Aboriginal people in Canada have not been well described in the literature (Cheung and Snowdon, 1999). A review of the literature on this topic also indicates that this is an emerging area of study. One phenomenological study (Shultz and Farrell, 1998) involving urban Aboriginal families caring for children with chronic renal failure described the themes of relocation, enhancing power, and survival as being features of their relationship with the hospital system. The study also found an interest among families to return to traditional ways as part of the care.

A recent study by Levin & Herbert (2004) that examined the experience of urban Aboriginal people, as described by six Aboriginal health and social service professionals. Some of the findings indicate that health care providers possessed requisite technical knowledge and skills but had deficits in Aboriginal knowledge, wisdom, communication and rapport-building skills to relate to appropriately with Aboriginal clients. Another problematic issue was the western conceptualization of illness and expert stance held among healthcare professionals that led to Aboriginal people experiencing discrimination and racism. Respondents also stated that they felt that health care settings were unresponsive to Aboriginal people and that these settings created fear and mistrust among Aboriginal patients and clients.

In a study by Benoit, Carroll, and Chaudhry (2003) urban Aboriginal women receiving services from urban aboriginal health centres (UAHC's) found that despite the best efforts of various health professionals to articulate and respond to the needs of these women, the women felt that they were not heard when it came to their need for an

integrated service that respected them and gave them an influence in decision-making about their own healing.

Another interesting study (Zubec, 1994) looked at how welcoming family physicians in British Columbia were of Aboriginal patients using traditional medicines. In surveying 79 physicians, the study found that physicians were accepting of traditional healing methods for general health maintenance, palliative care, and the treatment of benign illness. There was considerable disagreement about its use in hospital, especially in intensive care situations. They were however unable to form a definition of traditional medicine and unable to give an opinion about its risks and benefits. It was also revealed that the acceptance of traditional healing practices by physicians increased when they worked in Aboriginal settings or knew of more than five persons using traditional healing. The study called for more research to determine the views of Aboriginal patients and healers.

An earlier but similar study by Gagnon (1989) indicated that over thirty percent of Aboriginal people in Manitoba still used traditional healers. The research also revealed that seventy-three percent of physicians did not discourage collaboration between physicians and healers but strongly felt that traditional healers should not interfere with medical staff.

A study by Gregory (1991) also looked at building collaboration between traditional healers and nurses working in northern First Nations of Manitoba. The author described how federally-funded nurses employed by Medical Services (now known as First Nations and Inuit Health Branch-FNIHB) work cooperatively with traditional healers. They assessed the need for traditional healing and made referrals to healers.

Healers were found to be helpful in certain cases. To this day the federal government provides funding to access traditional healers as part of their Non-Insured Health Benefits (NIHB) program. In my experience with FNIHB, I would argue that although the policy is in place, the approval for these services often hinges on whether the specific health care provider values traditional healing approaches as being valid.

Wilkinson (1987) examined the use of traditional healing and kinship and the healing of disrupted family patterns and concluded that "intergenerational" medicines survive and are still being used, despite "modern" health care. In a population-based survey linking disease risk and protection to the concept of traditionalism, Coe, Attakai, Papenfuss, Giuliano, Martin, & Leon (2003) revealed that among Hopi women (n=559), high levels of traditionalism were significantly associated with disease protective factors such as participation in traditional ceremonies while inversely correlated with negative factors such as smoking. These findings were independent of age, marital status, and education.

The interest by Aboriginal people to access traditional healing services within an urban environment has been studied as well. There have been only a few studies that have focused on the frequency of use of traditional healers by Aboriginal people. Marbella, Harris, Diehr, Ignace and Ignace (1998) explored the prevalence of the use of healers in an American urban, mid-western native primary care centre and found that thirty-eight percent of the150 native patients surveyed saw healers and medicine people. Of the balance, eighty-six percent would consider the use of traditional approaches. Interestingly, it was reported that over 60 percent of patients surveyed rated the advice of their healers higher than the advice received from their medical doctor.

Kim & Kwok (1999) reported that sixty percent of Navajo patients surveyed (n=300) had used a traditional healer at least once in their lifetime. Further, Indigenous healing practices remain an important factor in the definition and wellness of self and community. Waldram (1990) spoke with Aboriginal people in Saskatoon Saskatchewan who expressed a need to have healers as part of the care received in Western-style biomedical clinics. The survey reported that there continues to be widespread adherence to traditional medicine within the urban-based Aboriginal study group. Respondents with high cultural adherence and good English language skills were shown to likely want formal access. This study also posits that the lack of traditional healing services represents a legitimate health need for this population.

In a more recent study, Waldram, Whiting, Kornder, and Habbick (2000) studied the use of traditional medicine among people with diabetes in Saskatoon, Saskatchewan. They reported that participants found traditional healing to be an effective treatment that they used periodically. Interestingly, they found participants more reluctant to discuss traditional healing practices after they had received a diabetes education program. It could be stipulated that the bio-medical focus of the educational sessions were likely at odds with their beliefs that they now felt necessary to suppress.

In 2001, the Prairie Women's Health Centre of Excellence (PWHCE) spoke with five Aboriginal women Elders and surveyed 93 Aboriginal women in Saskatchewan and Manitoba, via a questionnaire, about their health beliefs and practices. Among the findings, it was stated by these women that their health was holistic and involved a balance between self and the land. When asked to contrast traditional healers with medical practitioners, a majority of respondents said that healers were holistic in their

perspective and that the healing was spiritual as well as emotional as well, with the use of plants in their natural form being emphasized. They also felt that medical practitioners only focused on physical ailments and were too dependent on chemical solutions.

Another research study worth mentioning is the work of Riese (2001) that looked at the perceptions of care for Aboriginal patients receiving services within the Health Sciences Centre, a tertiary care facility in Winnipeg, Manitoba. The themes that emerged from the interviews with Aboriginal patients include control and endurance. Simply stated, patients did not feel in control of their experience and therefore had to endure their stay. Racism, separation from family and community, and communication problems were frequent concerns.

This study exemplifies the fact that conflicts because of differences in perception and expectations of care are not new within clinical encounters that occur in health care institutions (Kaufert, Koolage, Kaufert & O'Neil, 1984). These authors and others have advocated for the use of trained Aboriginal medical interpreters within hospitals. These interpreters not only serve to translate language, but are also a vital resource as 'cultural brokers'.

Indigenous Healing Approaches to Address Social Issues

Much of the academic attention given to "traditional healing" in the literature was focused on reporting its usefulness as an enhancement or alternative to Euro-centered counseling and therapeutic modalities that address the negative impacts and outcomes of colonization on individuals. Numerous authors, mostly non-Indigenous researchers, have discussed the usefulness of traditional healing in addressing many health conditions including substance abuse (Abbott, 1998; Kasee, 1995; Lawrence, 2003), sexual abuse

(Heilbron and Guttman, 2000; Vick, Smith and Herrera, 1998), violence and trauma (Brave Heart-Jorden and Yellow Horse, 1996; Dumont-Smith, 1995; Gurley, 2000; Napholz, 2000; Scurfield, 1995), depression and mental illness (Manson, 1992), and diabetes (Ponchillia, 1993; Shultz and Farrell, 1998). There is also a growing field of study related the use of traditional medicine for the treatment and care of HIV/AIDS (Ketting, 1996).

When assessing why there has been such an interest in the use of indigenous healing to address these social issues, it is possible to attribute it to two factors. Firstly, it could be argued that Indigenous people have increasingly been active participants in their care and thus demand that the therapies reflect their values and worldviews. Secondly, as stated by Morgan (2003), it is possible that:

> people's dissatisfaction with Western science has increasingly led to an appreciation of Indigenous wisdoms and knowledges – systems which make no distinctions between fields of understanding of the physical and the spiritual. Many people could see that Western science was not absolute; that answers to questions were constantly under review, and that other interpretations might be more dynamic. (p. 43)

It becomes apparent from the literature review that there is no shortage of historical, current and ongoing research focusing on negative social issues by the application of a "pathologizing lens" to highlight disarray and pathos in the lives of Aboriginal people to address individual behavior and deficits (Bishop, 1997). It is also interesting that many researchers cite the use Indigenous healing practices as alternative

therapies that are useful adjuncts in dealing with "spiritual or religious" issues within multi-cultural settings (Kripper, 1995).

Decolonization as a Focus of Healing Approaches

Some innovative studies by Indigenous scholars have looked specifically at decolonization as a healing process that deconstructs Western scientific paradigms through the "retribalization" of individuals when traditional knowledge and practices are re-introduced (Whelshula, 2000). The author demonstrates how psychopathology re-traumatizes individuals through enculturation. Several authors, including Manson & Shore (1981) have called for new collaborative methodologies to frame research dealing with Aboriginal people whose worldviews lay outside the homogeneity of thought production witnessed within western medicine.

Despite the paucity of research in this area, the findings of these studies suggest that traditional indigenous healing perspectives and strategies continue to be widely used by Aboriginal people, as has been the case for centuries (Struthers, Eshcitti & Patchell, 2004). It is my perceptions that health professionals working in acute and community care sectors underestimate the use of healers. So much so that health care facilities do not consider these practices as an area of care that requires exploration, support, and inclusion into the repertoire of methodologies to be considered.

Summary of the Literature Review

The literature suggests that traditional medicine has been an area of considerable study by non-Aboriginal researchers but that its focus has not necessarily been on the validating its relevance and authenticity as a model of care. Rather, the tendency has been to marginalize the knowledges, values, worldviews, and practices it reflects and thus

disempowering those individuals and groups for who these ancestral practices are still relevant.

Indigenous scholars, leaders, Elders, and healers have however strongly advocated for a reclamation and return to traditional and cultural practices, approaches, and norms as a viable and sustainable path to restoration of health and wellbeing for indigenous communities who have been seriously affected and dehumanized by a documented history of colonization, systemic oppression and racial discrimination.

The legacy of disempowerment created and maintained by cycles of dependency on external systems and colonial institutions and the exclusion of Aboriginal participation in decision-making and self-determination opportunities has been documented in the literature and has become common knowledge. This oppressive and discriminatory process has often resulted in a the creation of a culture of self-hate, blame and shame that many Aboriginal scholars view as an explanation for the poor health status of Aboriginal individuals and communities and an internalized sense of "victimhood". Despite the demonstrated tendency in much of the past research to pathologize Indigenous realities and knowledges, there has been some evidence from the few studies identified in the literature that Indigenous beliefs about health and wellness and traditional ways of healing continue to be viewed as important and viable within communities. The practice and importance of traditional healing ceremonies, medicines, and approaches remains intact, even in urban settings. An emerging interest within health care settings and academic research to support indigenous knowledge and research is also promising.

The next chapter of this report presents the methodological considerations that guided the implementation of the study.

Chapter Three

METHODOLOGY

The purpose of this qualitative study was to gather the voices of Aboriginal people who used traditional healing approaches and who would be able to speak about the relationship between traditional healing and western medicine in their lives. I wanted to ensure that informants felt culturally 'safe' and respected in this process and also needed to feel comfortable as an Aboriginal person in relating with them regarding these topics in a way that was culturally appropriate and respectful. The search for a method of inquiry began with these considerations in mind.

Aspects of the methodology are described in this chapter. The chapter initially describes the significance of the research project and then explores the factors that led me to choose an indigenous research design to frame this study. An overview of the methodological considerations within indigenous research is presented leading to the presentation of the main focus of inquiry for the study. A profile of the participants is offered along with the considerations that dictated the sample size and the selection process. The cultural protocols that were incorporated into the interview process are discussed. The chapter closes with a presentation of the analysis strategy and how the findings will be represented along an overview of the ethical considerations, benefits and risks, limitations, and strengths of the study.

Significance of Research Project

The fundamental aim of this explorative enquiry was to gather the "voices" and experiences of Aboriginal people regarding their worldview of health and their relationship with western medicine in order to contribute to a greater understanding of the

traditions and healing practices of Aboriginal peoples leading to a greater respect for indigenous knowledge and practices within Western bio-medicine institutions. With the paucity of indigenous research in this area, this study contributes to the reclamation of indigenous knowledge and experiences and an emerging body of research in this regard.

Given the oppression that all Aboriginal people have experienced, it is an honor as an Indigenous researcher to explore and represent the strengths and resiliency that Aboriginal people have shown in keeping their traditional practices alive (Hampton, 1995). The knowledges gained from informant stories could contribute to improvements within the health care system and the reductions of barriers through the further development of culturally relevant programs that promote collaboration and the reclamation of and respect for indigenous health values, behaviors and practices.

The research project contributes to the growing interest in exploring the cultural dimension of patient perceptions of care and patient satisfaction as was studied by several authors including Riese (2001) who interviewed Aboriginal patients about their experiences within a hospital setting. Using an Indigenous research design contributed to a greater sense of cultural safety for study participants and revealed unique insights and concerns. As an Aboriginal investigator, I incorporated Indigenous knowledge acquisition and research protocols, traditional teachings and methodologies into the research process in order to enrich the gathering, validation, and representation process conducted the study.

Choosing of Method

The search for a method of inquiry to guide this study did not come easily for me as an Aboriginal researcher. I reviewed several quantitative and qualitative paradigms,

but found their processes to be too linear, focusing on sequence of steps that usually begin with a review of the literature leading to the formulation of a research question, the choosing of a design, followed by the conducting and analyzing of date leading to formulation of conclusions and implications. Further, I felt that mainstream research enterprises and frameworks could be, as stated by Bennett (2004), insufficient and oppressive in how they tended to alienate, oppress, and exploit Aboriginal people. In my heart I knew that the positivistic, empirical, academy driven and culturally myopic research could not lead to the self-determination of Aboriginal people (LaFromboise & Plake, 1983).

As an Aboriginal person, I came to the research topic and its methodology from an "emic" stance, which meant that I would bring an informed subjectivity and an interest to take the time necessary to share knowledge with people who could share their "truth" about the topic of study. (Grenier, 1998, Headland, Pike & Harris, 1990). The use of the words "insider" or "outsider" in the context of research refers to the "emic" versus "etic" perspective that guides the process of inquiry. In research that is "emic/insider", the researcher assumes a stance that is subjective, informed, and influential. This is in contrast to an "etic/outsider" stance that is more objective, distant, logical, and removed from the project (Headland, Pike, & Harris, 1990).

The "etic" perspective has often led to a misleading and incomplete understanding of indigenous life and the denial of realities that are not easily measured with Eurocentric scientific methods (Frank, 1997). Further, references to "traditional" medicine in the literature often refer to practices that western researchers believe were only "authentic" during pre-contact times and thus seen as "artifacts" of culture within the contemporary

context.

The process of engaging in this research was initiated by the offering of tobacco to the Creator and spirit world to seek the guidance of "spirit helpers" who would guide me to a topic important to my learning and sharing. I knew that the guidance would come and that I would be supported. It is with this guidance that I was "led" to consider and explore the use of an indigenous research paradigm, with its ethics, methodologies and protocols, to guide this study.

When I began to seek out my methodology, I was intuitively resistant to the volumes of available "outsider" research. I was also led me to consider frameworks that were more qualitative, participatory, collaborative, and transformative in design. I was attracted to the features of qualitative research that can provide the depth, openness, and detail of understanding to the human experience not attainable from quantitative methods that require the use of standardized measures to fit the experiences of people into a limited number of predetermined response categories (Patton, 1990).

I also explored the research regarding contemporary trends in qualitative research that could influence this study. Denzin & Lincoln (2000) have outlined a chronology of qualitative research movements, beginning with the traditional (1900-1950), the modernist period (1950-70); blurred genres (1970-1986); crisis of representation (1986-1990); post-modern with experimental and new ethnographies (1990-1995); and the future, which is now. Current emphasis is on responsive research geared to moral imperatives. Since the modernist period, qualitative research methodologies have increasingly integrated the importance of voice, worldview and culture, and the location and representation of the "the voice of the other" and "ways of knowing". It became

apparent to me that the more inclusive qualitative research becomes, the more congruent qualitative research will be to the aspirations of Indigenous people.

Bishop (1998) has posited that the shift of paradigm from quantitative to qualitative research does not necessarily eliminate the "colonizing discourse" of "other" by continuing to hide the researcher under a veil of neutrality or objectivity that conceals the power, interests, and interest of the author to determine the outcome of the research to remain hidden in the text. Bishop's democratic research stance declares that the good intentions of researchers to "empower" willing or unwilling participants of research remain a neo-colonial act of racism. The key to reciprocity in research is the deep appreciation that the key to understanding is the world-view in which the researcher must immerse her/himself. Due to this awareness of this colonizing discourse, I continued to seek out a more appropriate methodology, specifically an Indigenous one. I was looking for a methodology that would not conflict with my ways of being and doing. As states Weber- Pillwax (2001):

> Any research that I do must not destroy or in any way negatively implicate or compromise my own personal integrity as a person, as a human being. This integrity is based on how I contextualize myself in my community, with my family and my people, and eventually how I contextualize myself in the planet, with the rest of all living systems and things. Without integrity, I would be outside the system. I don't survive. I destroy myself. I am isolated. (p. 168)

Indigenous Research Methods

The most recent contribution to the qualitative research movement and discourse

has been the emergence of Indigenous knowledge research as a valid paradigm with its own worldview, knowledges, methodologies and protocols (Graveline, 2000, Grenier, 1998). Indigenous research is not a subset of the dominant Eurocentric knowledge production paradigm. Wilson (2001) posits that one of the unique characteristics of Indigenous research and the knowledge it produced is that it is relational rather than individual in focus and must therefore be shared with Creation. Denzin (2003) acknowledges the significant contribution and influence that the "sacred" epistemologies of Indigenous peoples will play in research as it accounts for humanity and other ways of knowing. This author states that knowledges that have historically been marginalized will become more central and those paradigms that have dominated will lose their power to marginalize. From this change will emerge new forms of understanding and knowing.

For Indigenous authors, including Antone, Miller & Myers (1986) and Sinclair (2003), research is often described as a process of receiving and sharing of knowledge that is guided by natural laws and complex relationships between self, others, and the cosmos. Research that is grounded in Indigenous knowledge is scientific, in that it is empirical, experimental, and systematic. Yellowhorn (2000) describes how tribal people amass knowledge from the natural world in a way that is not random and trivial. Rather the knowledge is derived from a systematic analysis of nature that requires a particular thought process.

This knowledge also differs from western knowledge in two important aspects: it is highly localized and it is social (Battiste and Henderson, 2000). This form of research emerges from the web of interdependent relationships within a specific place, and thus cannot be tested for "global generalities or universal laws". Bishop (1998) adds that it is

the "very worldview within which the researcher becomes immersed that holds the key to knowing" (p. 208).

Weber-Pillwax (2001) presents some methodological principles and protocols and considerations that will be very useful to the proposed research project. The author states that it is important to establish relationship or kinship (real or symbolic) with the informant/consultant so that these bonds will overshadow external differences. This can occur at the individual, community, or nation level. It is also important that the actions of the research lead to action or benefit the community in some way while not negatively implicating or compromising the integrity of the researcher. Weber-Pillwax further adds that Indigenous research starts from a point of "synthesis" and must end with a return to "synthesis", thereby avoiding the pitfalls of deconstruction and the development of "grand narratives".

The relationality and reciprocal accountability inherent in Indigenous research speaks to the importance of not limiting each participant's involvement and participation in dialogical discourses. To do so would limit genuine sharing and maintenance of deep and meaningful "relations" (Wilson, 2001). Further, relational accountability requires that the researcher refrain from answering questions of validity or reliability and the making of judgments of "better or worse". The central question to be asked is "how am I fulfilling my moral responsibility in this relationship?" Also, it is important that the researcher not enter the research process with a stance of being wiser than others as this would disturb and dishonor the balance and ecological nature of relationships.

Simply stated, indigenous research inquiry is not an abstract pursuit. It is the building of a sacred relationship with the research topic and those who carry that

knowledge. The sacredness of the relationship is underscored by the fact that responsibility accompanies all knowledge that is given and generated (Grenier, 1998). It can only be done with patience, time, trust, and respect, through collaboratively constructed stories emerging from discourse spirals (Bishop, 1998).

It has been said that Indigenous research favors depth over breath of inquiry (Grenier, 1998) in its efforts to look for local "truths" rather than "universal" laws. In my opinion, Indigenous research is also not solely focused on assessing what is or was "traditional". Rather, it seeks to understand how traditional ways of receiving, representing, and transferring of knowledge can be used to attend to current realities.

Main Focus of Inquiry

The focus of the project was to explore the relationship between the use of traditional indigenous medicines and the use of western bio-medical treatments and medicine. The insight into how Aboriginal people view their health, healing, and illness and the subsequent use of traditional medicine may assist health care professionals to become more competent in meeting the needs of Aboriginal people better. The study also aimed to contribute to a clarification and integration of the role of traditional healers within health care settings. It was hoped that the de-stigmatization of Indigenous healing will lead to strengthening of indigenous philosophies and belief systems, leading to greater willingness by Aboriginal individuals to recognize that the source of healing are within themselves and their cultural traditions.

Having reviewed some of the literature focusing on the use of indigenous healing approaches by Aboriginal people the following initial research question became of interest to me: How do Aboriginal people who use Indigenous healing practices speak

about these practices and the relationship of these to the care they receive from western medical professionals?

The present research inquiry focused on the following five central questions that were explored through dialogical conversations that included a) participatory dialogue, b) story-telling, c) the use of symbols, d) dreams and ceremony, and e) intuitive questioning. As an Aboriginal person with many years of experience in ceremonies and teaching circles, I was comfortable with conversations that include references to the dream world and spirit beings. Also, it was anticipated that some of the information shared would come through ceremony and stories that would be imprinted with symbols. This spiraling reflective dialogue could at times be outside the realm of critical thinking that tends to value oral knowledge as compared to written information (Hampton, 1995). Cardinal (2001) eloquently speaks of these matters:

> The Elders would talk about their dreams. They would say something like, "I saw this bear walking around the mountain and I was standing there and he took me by surprise." And so forth. The other Elders would listen closely, trying to understand what this could mean. Then they compared information from their dream or vision work. They realized that the various symbols were dictated to them from a different part of their being. And suddenly they would come up with an answer. This whole process of Circle work and Dream work are methods: Indigenous methods that speak clearly to an Indigenous perspective, an Indigenous world view. (p. 181)

The questions that follow were not tested with key informants prior to study

because they were only meant to open reciprocal dialogue rather than focus on specific interests of the researcher. The five central questions were:

(a) How are you using "traditional" medicines and healing approaches to help you restore and maintain your health?

(b) In what way(s) is the use of "traditional" medicines and healing approaches important to you?

(c) How are these healing approaches connected, if at all, to the care you are receiving from other health professionals?

(d) How comfortable and/or safe do you feel in discussing your beliefs and practices with health professionals and other health professionals?

(e) What do you feel are some of the barriers that prevent you from using healers, Elders, and ceremonies?

The retrospective nature of the questions was meant to focus the discussion on the relational nature of past care interactions, with an emphasis on the impact of these interactions on the perceived respect or disrespect for indigenous beliefs and practices.

Ellerby (2000) offers a word of caution when preparing a set of questions to be used as a template for data gathering and "meaning-making" during interview process. The dialogical and reciprocal nature of these interactions and knowledge exchanges reminds the investigator to be focused on "thought-mining" rather than scanning. In his experience, Ellerby found that questions are a useful guide to initiate but not direct the conversations.

Profile of Study Participants

Nine people who self-identified as Aboriginal were interviewed for this study.

Seven interviews involved single participants and one interview involved two individuals who were life partners. All participants were interviewed in either in their home, workplace, a restaurant, or outdoors. In three cases the interviewer traveled to communities outside of Winnipeg to meet with participants in northeastern Manitoba, western Manitoba, and north-west Ontario. The four remaining interviews (4) were held in Winnipeg, Manitoba with people who were originally from other parts of Canada but who now resided in this city.

Of the nine Aboriginal participants involved in this research project, three were women and six were men. The youngest person was in their mid-thirties while the oldest person involved was over seventy years of age. All informants indicated that they had been actively practicing traditional healing approaches as adults for more than twenty years with seven among them being recognized as healers and Elders within their communities. The two remaining informants were respected as "helpers" and active cultural role models within their communities and workplaces. The demographic profile of the study sample came from prior knowledge and relationships with the informants and therefore did not form part of the interview process.

I purposely sought out individuals from various Aboriginal cultural groups in order to gather varied Indigenous perspectives. Interviews were held with persons who belonged to the following First Nations in Manitoba: Plains Cree (n=1), Swampy-Cree (n=1), Ojibway (n=2), Mohawk (n=1), Oji-Cree (n=2), Blackfoot (n=1), and Lakota-Sioux (n=1).

The participants entered this research relationship with a broad range of life experiences that had imprinted them and defined who they are as Aboriginal people.

Several persons had never left the land that defined them while another had been erased by federal policies that denied them First Nation status upon marriage with a non-aboriginal person. Some individuals had lived in an urban environment but called elsewhere home. One person lived as a "two-spirit" person. The term "two-spirit" is often used in the Aboriginal community to acknowledge gay, lesbian, and trans-gendered individuals. Some were seen as relations of mine because of longstanding involvement in my live as uncle, auntie, sister, and younger brother. All were sacred to me.

Participant Selection Process and Determination of Sample Size

The sampling strategy for this study was purposeful in order to select information-rich participants who could contribute to the exploration of the topic of study as deeply as possible (Patton, 1990). Consistent with Indigenous worldviews and research protocols, I made direct contact with individuals who I had prior relationships with and who he was aware had received services within the health region where I worked. These potential participants were not connected to the researcher's role as the patient advocate within this health authority. These persons were personally asked whether they would be interested in voluntarily contributing to the research project. In a few cases, initial contact was made by telephone. A copy of the initial telephone contact script is attached as Appendix "A".

The invitation to participate was made without any persuasion or coercion, as this would have compromised the integrity of the existing relationships. Anticipating that recruitment process may not have generated enough participants within the available time given to data gathering, the researcher was prepared to ask each interviewee for the names of other potential participants. A script had been prepared if this situation had occurred

and is attached as appendix "B". Initial contact with additional participants was to be made by making reference to the mutually shared relationship(s). Fortunately, this situation did not occur, as sufficient participants were involved in interviews.

Given the purpose of the study was to describe the "deep" meanings received from a small number of individuals, in-depth and unstructured conversations with a small sample of subjects was seen as being reasonable in order to achieve saturation of the field of study (Polkinghorne, 1989). The research project continued to invite participants until such a point where it is felt by the researcher that there was something worthwhile to be shared with a broader audience. The data collection phase of the project continued until I felt that there had emerged enough teachings that could be shared and incorporated into my life.

Interview Process and Cultural Protocol. Before the actual day of the interview, I discussed with each participant the focus of the study and had shared with them the guiding questions. A meeting with each participant was set according to a pre-determined time and location that was convenient and comfortable for the informant. Each interview session began with a detailed review of the consent process. A copy of consent form used for this study is attached as Appendix "C".

Issues regarding publication were also addressed during the consent discussion. Interviewees were informed that the research would result in the publication of an academic report and that articles may be produced from the outcomes of the research. Participants were also informed that they could access an audio copy of their interview. Once a signed consent was obtained from the informant, the researcher engaged in a culturally-significant process described below in order to re-affirm the relationships that

had brought them together and those guiding "spirits" that were watching over the process of sharing knowledges and stories.

Time was also allotted initially to establish and confirm access, safety, and relationships between the informant and the researcher. This occurred through the sharing of stories and mutually-shared experiences that confirmed kinship ties or symbolic bonds between the researcher and interviewee. Once comfortable, the two parties engaged in lengthy dialogical interviews to solicit perspectives and insights relevant to the topic of study. The open and conversational style of the discussion process was usually led by the person being interviewed, out of respect for what they felt was relevant and meaningful to them.

Knowledge Sharing Approach and Protocol

When considering what activities/processes would be used to gather and share information, it occurred to me as an Indigenous person who attends and participates in healing ceremonies that some of the interview tools were within my "bundle" or cultural repertoire of practices. In particular, I looked to the sweatlodge ceremony to describe the series of steps that would ground and guide the dialogue and interactions with informants. These steps included a) acknowledging the presence all healing relationships; b) giving thanks for the gifts received; c) acknowledging the Self as sacred; d) connecting with others; e) asking for help to come once one is ready to receive; and f) giving thinks for restoring of relations. The decision to follow culturally-centered protocols was supported by the methodology used by Keewatin (2004) and Struthers (2001) that had successfully used this approach when interviewing Elders and healers.

Prior to meeting with each informant, the researcher engaged in a private

"smudge" ceremony to clear away any negative energy that could interfere with the upcoming meeting. In cases when it the setting made it possible to do so or when requested by the participant, the session also opened with a "smudge" comprised of sacred medicines meant to cleanse the mind, body, spirit, and heart of the participants. The smudge was also useful in creating a sacred and ethical place or "spot" for the relationships to be strengthened.

Each session began with the offering of tobacco to the participant by the researcher, so that an ethic of reciprocity could be established that will lead in the sharing of "stories" (Michell, 1999). Within an indigenous research paradigm, the offering of tobacco is in no way viewed as a way of coercion on the part of researcher. In fact, it establishes the integrity of intent and responsibility of the researcher to respect all aspects of what is shared, both in the present and in the future.

Once the tobacco was placed between the researcher and the informant(s), introductions occurred and served to establish connection and kinship. The focus of the study, the intentions researcher, and matters of reaching consent, ownership of outcomes, permission to audio-transcribe, and representation of findings were expanded upon and re-confirmed. The interviewee was given time to ask questions or clarify points of concern and then given an opportunity to pick up the tobacco offering. Offering of tobacco is also sacred in that it acknowledges that research involves taking from Nature and that this disruption to the "great" balance must be without ill-intent and self-interest. As stated by Cajete (1994), the offering of tobacco also creates a "ceremonial dialogue" that is symbolic of the co-existence and interdependence of the spiritual and physical worlds.

Once participants were comfortable and ready to engage in a dialogue, the audio-taped interview began. Guided by the five focus questions presented earlier, the interview proceeded with the reception and capturing of information that may be revealed through rich oral narratives, life stories and dreams, and experiences (Kanuha, 2000). This interchange of information was often supported by food and tea that was made available to nourish the all wholistic nature of those involved.

To capture the observations, personal reflections and status of the relationships that emerged from the reciprocal dialogue, I kept field notes that were used to inform future interviews. The keeping of these notes within a reflective journal allowed me to reflect on the essence of what had been personally received within the research relationship. This is consistent with indigenous research approaches that emphasize the relational nature of narrative inquiry. Out of respect for the informants, I did not engage in note-taking during the interviews, preferring to engage in active listening that would immerse them into the worldview of the participant.

All the interviews were held in the English language and did not involve the use of language interpreters. At the end of each interview, the participants were ask to reflect on what had been shared and to identify any topic, event, or piece of information that they felt needed to be left out of the report. Respectfully, I accommodated these requests and directed the person who transcribed the session into text to delete this information from the final transcript.

Schedule and Length of Interviews

Following Ethics approval, the knowledge gathering process occurred over a six-week period that was followed by a two-month period of analysis, validation and review,

and development of a final report. This process was completed in early August 2006. The participant interviews lasted between thirty minutes and two hours and were characterized by informal, free flowing open-ended conversation whereby the researcher made full attempts at being fully attentive and in the moment while using active listening skills. The interviews lasted until the person felt there was nothing left to describe or share. There was no need expressed by participants to meet again to continue discussions. One person did however state that they would provide the researcher with written notes of his reflections and teachings, but these were not received within the life of the research project.

Analysis Strategy and Representation of Findings

The steps that were used in this study for the analysis of findings are consistent with procedures that are generally accepted within qualitative research (Creswell, 1998). This said, this same author states however that there is no consensus among qualitative researchers about how to analyze interviews transcripts. For this study, the digital audio files were professionally transcribed verbatim into written English text using Microsoft Word™ software. These computer files, with their accompanying audio file, were then meticulously reviewed by the researcher to ensure exactness of content, intonation, and possible meaning. Over a period of one week, the final written transcripts of the eight interviews were read and re-read several times and reflected upon.

This information was purposefully reviewed and analyzed using a general analysis spiral process described by Creswell (1998) that would organize the collected data in such a way to eventually lead to the development of a narrative. The analysis spiral process enables the researcher to "move in analytical circles rather than using a fixed linear

approach" (p. 143). A two-level coding process was used in this study.

First-level coding. As described by Tutty, Rothery and Grinnell (1996) an old-fashion "cut-and-paste" method was then used that involved the use of scissors to cut the typed transcript into meaningful segments or "chunks" that would later enable me to create categories that were based on a comparative analysis of the data. These initial units of information are described by Tutty et al (1996) as "pieces of transcript that are meaningful by itself" (p.101) to the participant and require no analysis by the researcher.

Second-level coding. The next phase of the analysis moved from reading and organizing to a process of describing, classifying, and interpretation (Creswell, 1998). The process involved the creation of descriptive and interpretive categories that compared and contrasted each segment of interview data until significant meaning and explanations for the data was arrived at from the experience for the researcher and the participants. Groups of data emerged that reflected a common perspective or issue. Some of the data that did not fit these categories was set aside for later consideration. Each category was given a name that captured the essence of the group. The researcher also returned to his field notes to ascertain the meaningfulness of the categories that emerged.

Interpretations. As a last step, the researcher analyzed the generated categories of information and looked for themes that described the relationships between categories. The researcher used these themes and his personal journal and notes to develop a rich narrative that represented the "essence" of the research experience while preserving the accuracy of the participant narrative and experiences. The emerging themes from this analysis process are described in the next chapter of this report.

Some of the participants had been contacted after the data gathering was

completed in order to discuss the preliminary findings of the study. Initial comments from some participants were that the themes reflected the essence of their experiences. In addition to this thesis, the plan is to return to the informants and provide them with a summary of the findings and be give them an opportunity to provide feedback to me. A feast will also be held to acknowledge the available participants and to give thanks to Creation for the completion of this step in the researcher's learning.

Establishing Trustworthiness and Authenticity

Positivistic research relies on the constructs of internal and external validity, reliability and objectivity as measures to assess the "accuracy of the account, discuss the generalizability of it, and advancing the possibilities of replicating a study" (Creswell 1994, p. 157). The author also describes how qualitative researchers have developed "their own language to distance themselves from the positivistic paradigms." They have proposed four constructionist standards that provide evidence of trustworthiness. Tutty et al (1996) identifies these standards as "credibility (truth value); transferability (applicability); dependability (consistency), and confirmability (neutrality)" (p. 126). These also parallel to the four quantitative research constructs mentioned above. These four dimensions of trustworthiness as they pertain to this study are discussed here.

Credibility. In order to demonstrate the credibility of a qualitative study, Tutty et al (1996) recommends various strategies that will ensure that participants will be able to "interpret the realities outlined by the researcher as reflecting their own experience" (cited in Hart, 1997, p. 111). The four techniques that were used in this study were prolonged engagement, peer debriefing; member checks; and referential adequacy (Tutty et al, 1996; p. 126)

Prolonged engagement requires that the researcher remain involved with the participant in order to prevent misinformation, distortions, or presented "fronts" by immersing oneself in the context of the informant so that trust can be established (Hart, 1997). As an Aboriginal person who has participated in indigenous healing ceremonies for many years, I have had many opportunities to relate to the participants on spiritual and cultural matters of mutual interest. During this study, I traveled to the homes of most participants in order to relate to them in their own environment. In one case, the participant and I traveled to several sacred sites in the area in order to meet significant Elders in their lives and to continue our discussions. Many of the past relationships with the participants have focused on mutual support and learning.

Peer debriefing entails the engagement of persons not involved in the study in order to discuss the progress, issues, concerns, and outcomes of the study within a supportive environment. This process also helps to periodically clarify the stance that the researcher has taken in response to stresses of the interview and research processes.

During the life of this study I have had the fortunate opportunity to seek out the counsel of peers who are working in healthcare settings and elsewhere. They supported and encouraged me in interactive discussions that led to alternative interpretations of the issues raised during interviews. This was a good way for me to take inventory of my value stance biases. In one case, these discussions helped me to identify a central theme that had not been obvious to me initially. I was also privileged to have access to a few Elders and spiritual teachers who assisted with the interpretation of some of the data.

Member checks refer to the need to establish credibility by periodically touching base with informants so that they can ascertain the accuracy of the information collected

and conclusions that have been drawn (Hart, 1997). During the study, I contacted some of the more accessible participants to update them on the status of the project and share some of the information generated. They consistently stated how the findings were reflective of their statements.

Verbatim quotes were also consistently used in the presentation of the findings. The use of detailed quotes enables the reader to judge the credibility of the conclusions drawn from the data. I did not edit the quotes as this could compromise the full meaning of the statements made by participants. Simple language was also used as often as possible.

Transferability. As stated by Tuffy et al (1996), transferability refers to the ability of the reader "to judge whether your findings are based on case material that is similar to his or her own context" (p. 126). This is accomplished by providing rich descriptions of the study. It is up to the reader, in their own context, to determine the transferability of the findings.

Great effort was taken in this study to provide detailed descriptions of the stories that were presented by the participants. This included past and present situations that they encountered and experienced as Indigenous persons. Ultimately, it will be the responsibility of the Aboriginal community and other readers to determine the transferability of the findings and conclusions drawn from this study.

Dependability. Dependability is similar to the construct of reliability in that it concerns the stability of the data over time (Hart, 1997). The dependability of this study is relatively high given that there were no changes in the methodology and design of the study. Also, the data gathering process occurred over a relatively short period of time (six

weeks). The factors stated above in the credibility criterion also improve the dependability of the study.

Confirmability. Confirmability relates to the ability of the researcher to remain "critically aware of the energetic and dynamic relationship between the researcher and the research participant." (Tutty et al., 1996, p. 127). Confirmability can be achieved through the keeping of a journal and the use of verbatim quotes show that the data, interpretations, and outcomes are rooted in the original sources (Hart, 1997).

The issue of confirmability was addressed in the use of verbatim quotes and in the narrative of the study that explored my experiences with indigenous healing as well as my role in the health care system. The journaling process was also useful in capturing the impact that participants had on me.

From an indigenous perspective, the trustworthiness of the information gathered is enhanced through a reciprocal relationship and dialogue based on "truthfulness". The concept of truthfulness requires that each person engage in first person singular discussions, emphasizing the use of the word "I" instead of "we". It would be disrespectful to speak of the truth that belongs to others. The personal truth and context of that truth is acknowledged and validated. The truth that is shared is also grounded in that person's history and story.

Ethical Considerations

The proposal that guided this research study was approved in May 2006 by the University Of Manitoba Psychology/Sociology Research Ethics Board (PSREB) that was chaired at that time by Dr. Bruce Tefft. A copy of the approval certificate is attached as Appendix "D".

Research involving human subjects requires informed consent. In this study, informed consent was obtained from all participants prior to their participation in the interviews. The researcher provided each individual with verbal and written information about the focus of the study, confidentiality, and freedom to withdraw from the study. Although it was the researcher's intent to ask each participant how they would like to be identified in the final report, the issue was not broached during the interview. Within the consent, each participant had agreed to remain anonymous, and request was honored. For this reason, a conscious effort was made not to identify the participants and alphabetic codes were used. It is acknowledged that some of the demographic information (gender, age, and place of residence) would have enriched the stories and helped the reader better understand some of the issues. Unfortunately, there was some fear by participants that they could be identified if this information was provided, as they all were connected to the researcher.

The interview data was aggregated and identifying information was masked to protect the identity of each participant. As stated earlier, the transcripts did not contain any personal demographic data. A brief demographic profile of the informants as a group was created from information was gathered from previous relationships with the informants. This profile appears in the next chapter of this report. All gathered information was stored in a secure filing cabinet and the all data, including notes, transcripts, and audio files were destroyed after completion of the study.

The use of indigenous research methodologies and protocols by me as an Aboriginal person who shares a common history, values, perspectives and explanatory model with the participants strongly offsets the impacts and ethical concerns raised by

doing research with marginalized people. Although it is true that Aboriginal people have been overly studied by persons outside the cultural group, the researcher carefully engaged in this research with an acute consciousness of the impacts of stigmatization that can occur from academic research activity. I truly engaged in this research process with a humble interest to learn from the experiences of the participants.

The indigenous research design is endorsed by the literature that supports the implementation of culturally-centered ethical guidelines in participatory research that protect the subject and culture from external control of the research process and misuse of findings (Macaulay, Delormier, McComber, Cross et al., 1998). The principles of collaboration and sharing of control were also incorporated into the present study. The products of the research belong to those who participated and the challenge was to prevent from engaging in a research methodology that would become the "child of western imperialism" (Menzies, 2000). It was critical that the outcomes of this research not contribute to further marginalization of participants who may feel powerless while maintaining a sense of social inequity among participants.

Benefits and Risks

The fact that I am an Aboriginal person who is very familiar with Indigenous healing practices was a benefit to the study. This likely facilitated a sense of cultural safety for the participants during interviews. There was minimal risk that the information shared by participants would not be kept confidential. No medical records were accessed and no deception was involved in this study. None of the participants were compensated in any way for their participation in this study.

There was a chance that participants might have requested culturally-centered

supports or counseling because of the focus of the interview. The researcher had arranged for these supports to be made available but none were required or requested.

Limitations of Study

The limitations of this study are similar to that of qualitative research in general. While providing a rich resource of information about a particular experience within a particular context, the findings cannot be easily generalized to other groups or other settings. Each narrative is unique and specific to a given person. Potential bias by the informant towards the researcher, who is a person working in the health care system, could have impacted which aspect(s) of his or her life the participants chose to share. It is possible that some people may have felt that I was representing the interests of the hospitals. Also, the researcher's gender and age may also have been influencing factors in some cases, given the belief by some people in the Aboriginal community that it may not be proper to ask certain things to an older person or someone of the other sex. It is also possible that the perceptions of the participants have been altered by the passage of time. They may have been selective in their recall of events and perception of care.

It is also possible that the fact that I am not fluent in one of the Aboriginal languages of the area may have an effect on the comfort and safety of some informants and may have prevented them from speaking openly about their beliefs and experiences.

Strengths of the Study

This study design contains some strengths that need to be stated. Firstly, the pre-existing relationships between the study participants and myself are an asset in that it enabled an easy entry into discussions. I have known each participant for many years, in

some cases in excess of twenty and as such could relate with them on many levels. In the past, I have participated with some of them in ceremonies and cultural events. The trust within the relationships was also sustained when mutual respect was established through cultural protocols that are used consistently in these events. Interviewing participants from various cultural groups is also a strength of the study. Participants were able to speak with confidence of their spiritual and cultural practices and understood that other participants would practice their beliefs differently.

This completes this chapter on the methods used in this study. The next chapter presents the findings of the study.

CHAPTER FOUR

Findings

In this chapter I will present the findings from the eight semi-structured interviews that were held with Aboriginal participants. The information shared is organized according to the main themes that emerged across interviews from the five general questions (see methodology chapter) that were explored within the interview process. The interview results will paint a picture of the perspectives, worldviews, and lived experiences that flowed through these open discussions. Further, this section will present the concerns and recommendations that were brought forward by the participants on how to improve the healing and care relationships within the health care system.

The first part of this chapter is an exploration of the Indigenous worldviews that were presented within the interviews. The themes I advanced within this first section include: The Path of Healing; Life experiences with traditional healing; the Healing Power of Relationships; Sacrifice and Self-Care as Part of Healing and Wellness; The Impact of Residential Schools on Indigenous Healing and Knowledge; and finally, Pride, Cultural Revival and Knowledge Transfer. The section closes with a brief discussion on the significance of the topics presented.

In the second part of this chapter I present the outcomes of discussions that focused on the relationship between traditional healing and western medicine. These discussions revealed a set of perceptions about the differences between the two models of care. Discussions also ensued regarding people's comfort in discussing their cultural values and perspectives with health care providers. Within this section I

present the themes entitled Respect for Western Medicine; Complementary Healing Relationships; Spirit as the Source of All Healing; Mistrust in the Health Care System; and Disrespect for Sacred Healing. The brief discussion that closes this section comments on the significance of these themes and provides my initial impressions when I heard these perspectives.

The third part of the chapter gathered the identified barriers that the informants felt prevented Aboriginal people from accessing quality care within hospitals. These discussions were also an opportunity for participants to provide recommendations that would improve care for Aboriginal people. Barriers and recommendations for improvement are organized according to the following themes: Building Understanding and Sensitivity within the Health Care System; Building Understanding within the Aboriginal Community; Creating Supportive Environments; Improving the Hospital Environment; Building Relationships with the Aboriginal Community; Building Awareness of Services; and Building Relationships with Healers and Elders.

Out of respect for the nature of the rich dialogue within these discussions, quotes have been not been edited significantly in order to preserve the context and nuances of the comments. Quotes from the interviews are identified by random alphabetical codes (A- S) indicating the different participants. In one interview involving two informants, the alphabetical code is followed by the number "1" or "2" to distinguish the different speakers. The letter "I" is used throughout the interviews to indicate my comments.

Exploring Indigenous Perspectives on Healing

The Path of Healing. When asked to speak to the role that traditional healing played in their lives, the interviewees shared a common perspective that healing was a guided life journey for them. Within each interview were consistently woven statements reflecting the indigenous perspective that healing is a path that is integrated within a wholistic way of life. To enquire as to the significance of traditional healing in people's lives, I asked "how traditional medicines and approaches helped them to restore and maintain their health?" One person stated:

> S: I think everything with traditional medicine basically, first of all, begins with a whole mindset connecting with your spirit and understanding what that spirit was brought here to do and how our mind guides that spirit and allows it to either do the work it's supposed to or hinders the work it's supposed to do. So it's extremely important that the whole traditional medicine lifestyle and that doesn't mean that it's always going to be perfect, that doesn't mean that it's always going to be working the way I want it to work because it was never about what I want it was about what path has been placed in front of you and how you are going to walk that path.

To this perspective another informant added how their current perspectives on health were significantly linked to traditional approaches that they had been exposed to since childhood and that these came out of a need to define themselves and a give meaning to their relationship with the world:

> A: I was proud to be an Indian but I tell you, if you call me one... 'cause to me Indians got drunk, beat up their wives. There weren't many positive role models at all. I discovered my first Pow-Wow at 15...discovered my first sweat lodge at 19 ... that's when I decided to quit alcohol and drugs.
>
> I: Just to walk that path?
>
> A: Yeah, just to walk that path because alcohol and drugs are not a part of that part of our lives so, you know that idea of being clean

> spiritually, physically, and preparing yourself for ceremonies and things like that. So, yeah, since the time I was 19 years old I did the best I could to immerse myself.

Yet another informant shared a strong belief in traditional healing approaches because of a lack of trust in "western" medicine:

> S: I basically use them very consistently. I have for quite some time. I fully believe in the traditional approach. I really struggle with the western medical model and I will use it, but I have a hard time using it because with a lot of my experiences through other members of my family having to have that type of medicine and health methods administered. There has not really been a lot of trust established there, so I tend to believe more in the traditional approach.

Life Experience with Traditional Healing. For all respondents the belief in indigenous healing and the integration of this knowledge into their current lifestyle was deeply rooted in their family and childhood experiences. For everyone, traditional healing approaches continued to be very significant in their lives. So much so that each person could clearly recall specific situations that exemplified and confirmed for them the authentic power of these approaches.

One person was asked how they had learned about traditional healing, to which the following dialogue ensued:

> D: I've been doing this since my early teens, but for mostly the last 20 years now.
>
> I: It's in your family?
>
> D: Yeah on both sides of my family, my Mom's side and my Dad's side and all sorts of grandparents were all healers. So it's been in our family for generations.
>
> I: So you've learned through your family.
>
> D: Not so much learned, you're born with it, you just know it. That's the difference, you just know it.

I: You know it's in you?

D: Yeah, you don't study it or learn from books.

When asked if they recalled the use of traditional medicines within their family, one person clearly recalled the following memory of their grandfather from her childhood:

> F: My grandfather...yes, for different purposes. I remember once we all had diarrhoea and grandpa made us this solution and my grandmother, we called her grandmother, she was my Mother's Aunt, and she made us this drink. She mixed, I don't know what it was, these roots cause I remember her knife and little pieces cutting them up, mixing them up and throwing them into there and the water was boiling and she boiled that in there. After a while she cooled it and I remember her straining it and she gave it to us to drink.
>
> I: It worked?
>
> F: It worked. So what it was I don't know. I wish I did but I was so small then. So off and on it was kind of medicine like that, and using skunk oil.
>
> I: For colds?
>
> F: My dad was diagnosed with TB and he was placed in hospital. At that time they didn't have Child's Cancer Hospital up North the way they have now so they use to treat the patients in the hospital on the reserve, so Dad was in the hospital and.... he just told my mother to get my brother out of residential school and get him home. So once that happened, my grandmother told my mother "get him out of the hospital. Get your husband home. He doesn't have to stay there. He's not going to get better at all" you know that all of our people that go to that hospital die there.
>
> I: They die there...
>
> F: They have TB. It just gets worse. You don't want your husband to die. You take him home. I am going to treat him, but he has to want to do this. So my mother told him...she asked him what she was going to do. She said "I am going to use skunk oil. " Well you know skunk and then my mother talked to my Dad and my Dad said "Sure,

anything". He was willing to try anything.

F: So he got home and my grandmother killed a skunk and she rendered the meat and fat and all that fat came, that skunk fat and skunk oil never hardens."

I: It stays liquid...

F: It stays liquid. So she would pour some and she told my mother "You just pour some into a spoon and have something like an orange ready to take with it. So, three times a day he had to take that oil and you know that cured him. He got better...and of course grandmother always said that she's (aunt) was a holy woman, she knows it all.

This quote and the one that follows also speak to the fact that the belief in traditional healing continues to be a source of strength in people's lives, despite the loss of specific knowledge in some cases. During another interview, it was very clear that traditional healing approaches were still very much part of their family life and health maintenance across three generations. As a result, they had rarely needed to leave their community for treatment:

M-1: I guess that what's helping us is our medicine. We don't spend much time in the hospital, me and my wife.

M-2: Right. My parents grew up healthy and never got sick and never been in hospital.

I: You don't have to go to the hospital!

M-1: You know what she said one time (pointing to daughter). She was saying, she's 21 years old, 'you guys have been my doctor ever since I grew up. Traditional medicine. Our medicines are all around here.' We use them.

M-1: Like I was saying, they never got sick, really sick.

I: So you've never had any bad experiences at the hospitals? Never been there?

M-1 and M-2: No.

Repeatedly, interviewees gave specific and insightful examples of how they had witnessed and in many cases experienced successful treatment and cure of medical conditions using indigenous methods and approaches. The curative powers of traditional medicines mentioned by informants included treatments for headaches and colds (F,D), migraines (F), management of diabetes (M), hypertension (F) and respiratory conditions (M), skin conditions (M), end-of-life pain management and care(S), cancer(J, H), brain tumours(H), skin lesions and sores (M), addictions (C), and the restoration of life itself, as described here:

> D: From what my parents told me the doctors had written me off. That I wasn't going to make it through the night.
>
> I: They didn't expect you to survive?
>
> D: No. I was about 6 months old at the time.
>
> I: Oh. You were just a baby?
>
> D: Yeah, about 6-8 months, Mom had said. So she said that she stayed there and Dad gone home to get grandma and brought her back into Brandon and she did her ceremony there. The next morning everything was gone and I was ok."
>
> I: "They brought you home?"
>
> D: "Yeah."
>
> I: "Wow, that's powerful."
>
> D: "Well, that's all we've ever known. That's what we grew up with."

Some of the respondents shared more recent experiences where they were able to help others with their knowledge and relationship with traditional medicines:

> M-1: Other people ask us to make some medicine and we've seen a lot of people. There was one time a couple of years ago, there was this

man from Sandy Lake and he called us to send him some....I think he (husband) went to see him...

M-2: First.

M-1: He (pointing to spouse) went down to Sandy Lake to see him with his medicine and afterwards... He had this problem with his legs. The doctors couldn't do anything about him.

M-1: He had an ulcer on the leg. He was bedridden already. He couldn't walk and he asked for the medicine and to see him, and he would phone us every time he ran out and we would send it out. In about a couple of months after he got to visit he was walking around.

M-2: They were going to amputate his leg, but it was very good to see him walking around.

I: Just from the traditional medicines you used?

M-2: Yes. Even my wife had an ulcer and that's what I used, traditional medicine, when she couldn't even walk. I guess it was part of my life that I used traditional medicine from trees. There's so many things but people don't know we have those things, like, we can help people. People don't know that yet. I guess some people are shy.

The Healing Power of Relationships. Reference to the theme of relationships came up many times during interviews. Participants spoke of inter-connected relationships within self and with others, Mother Earth, the Creator and spirit world, and with the illness itself. Within these insights into the wholistic nature of healing and health, the important role of respect as the foundation of healing consistently emerged.

In one interview, the participant vividly described the work of their grandfather who was a healer. The participant explained how people would come to the family home for remedies and healing. Even after the medicines had been prescribed, patients would return to visit the healer to thank them and inform them of

the outcomes. In this way, the personal healing relationship between helper and patient would be maintained:

> F: Like my grandfather had them in the buckskin bags, little bags made out of buckskin and he had a tie for each of them and when somebody comes to see him, like women who have problems, and he would listen and then he would say "just sit" and he goes into this room and gets this little box. He had this box, no cover, just the box and in there he had all his different pouches and he would look at them, take this one and this one. There was nothing marked on top but he knew what was what and he would take them and start pouring water and then he would take a little bit of this and a little bit of that and mix it up and tell them to drink it..
>
> I: He prescribed that.
>
> F: He did, and he said if it works ...quite often he would give them a little cup and say "you take this home and you heat it up before you drink it and you drink so much and so on and if it works, come back. I'll give you more.
>
> I: And the people came back?
>
> F: A lot of them come back and a lot of them just come back to thank him and tell him that they are fine, they don't need anymore.

This quote illustrates how the healer-patient interaction is viewed as a natural process that was relationship-centred with the emphasis being on maintaining communication and respect. For others, the relationship between the person and Mother Earth was evident. In one case, this relationship was very intimate and sacred, as it was the source of all healing. Further, these medicines were seen as powerful and living healing beings with spirit:

> M-2: We've been using Indian medicine for a long time now already. An old man was teaching me about traditional medicine that's how I got these medicines and there's lots of them.
>
> M-1: For every illness it's different kinds of medicine. Like, if you knew all the medicines you wouldn't know where to step or walk.

I: You couldn't go out in the bush without stepping on something?

M-1: Yeah. I found that sometimes it's pretty hard for me to walk.

For many participants, the healing process always incorporated an aspect of ceremony that recognized the relationship between self and the healing spirit(s):

> C: I guess it's the belief of these ceremonies. The ceremonies have been with the Anishinaabe people for thousands of years and this is how they did things for healing. We are surrounded by medicines, the trees, the birch trees, Jack pine.
>
> I: So it's all around.
>
> C: It's all around, these medicines and some of the people that are more knowledgeable can identify each plant and what it's for, what it's used for.

Another person eloquently added:

> H: Traditional ways is not a religion it is a way of life. There's a difference. A lot of people assume the traditional way of life is a religion but it's just a way of life. Going back, I trust this, our ancestors; there was no violence, just kindness. The traditional ways was just about all was lost, the people, maintaining this way of life. Respect Mother Earth. That's what we ask of society as a whole. Every time we take medicine we have to do an offer for taking your life. Makes sense. We used to have to pray to the Creator, ask to give us some understanding why we destroyed that plant, to heal. That's how I have a traditional past.

Traditional Healing and the Spirit World. It was explained by one participant that a person's traditional healing process and relationship with the healer was deeply rooted in the spiritual domain. He shared, as a healer, how important it was for a person to always follow the guidance and direction received from the spirit world:

> D: A lot of them know it through their dreams and are pointed that way 'cause I try not to be known for that (being a healer). I figure if

somebody really needs it they will know where to come.

I: ...you don't advertise?

D: No, I don't advertise and I tell people not to say or tell anybody else otherwise I'd never have any rest. So I just tell them 'Don't tell them where you've been unless someone really needs to know' 'cause I've had people come because of their dreams and that is where they are supposed to come so they come.

I: They find you through their dreams?

D: Yeah. Like I know a lady from Brokenhead a couple of years back. I ran into her. I was at a meeting in Winnipeg, I think it was an education meeting, and this lady was across the table and she was looking and staring at me. Finally at coffee break time and she came over and said "Sorry I apologize. I didn't mean to stare but I'm just trying to remember where I know you from 'cause I know you." She just didn't know from where. "Then when you started laughing I remember you were in my dreams last week, but I thought I'd let you know I have cancer and in the dream they told me I was to come and see you today to help me with it." So that's how she knew me. She said "and then I remembered when you started laughing 'cause I remembered you laughing in my dreams." So it happens quite a bit like that.

I: That people recognize you or know you, and they know that you're there to do some work with them.

D: Yeah, I get a lot of that. But like I said that's why I try to tell people not to say anything about where they've been so...

Another informant shared a similar perspective about the direct relationship between indigenous healing and spirit world:

M-2: Like, for me we had this teacher, a grandfather, and for me, I used to tell him afterwards I used to have visions about an old man telling me what to pick and also saying this person is going to ask for that medicine and usually I would try to figure out ahead of time and get that medicine.

I: And wait?

M-2: Yep and that person would come along and I kept having these

visions all the time that someone was going to ask for these medicines and it was there for them.

I: It comes through those visions to look for certain plants or looking for something?

M-2: Yeah.

I: That was in the vision. Is that the same for you?

M-1: Yes.

I: That's why it must be hard sometimes to find (medicines)?

M-1: Yes. Like this Fall, she had an ulcer on the leg. I wasn't sleeping yet but I saw my wife taking off that thing that she was wearing, her sickness, she took it off."

I: Like...she undressed....like it came off?

M-1: Yeah, she took it off cause.... I wasn't sleeping yet. Then I saw a medicine, what to take and the tree....what he used on her. Then I came back. I gave her that medicine. I started treating her 'cause I knew she wasn't going to get better. The doctor was saying "we are going to amputate her leg" and I kept taking care of her leg, like, putting that medicine on there and she did get well. She's walking, she couldn't even walk. Like, up to her waist, it was all sores like cracks."

One interviewee articulated what others generally felt regarding the power of indigenous healing that they had witnessed and its impact on their core beliefs and values:

I: So it sounds like the traditional approaches are really, really important to you? It's a big part of your life?

C: Yeah, it is. I have great respect for the culture and some of the things that I have seen at these ceremonies I don't question anymore. The things that you hear at ceremonies, the spirits that you hear when they speak, it is real.

In another interview, it was stated that the power of indigenous healing can be seen in its protective and sustaining qualities of respectful relationships:

H: When you meet people who are on the same path they are very strong, they have protection, great respect...for me it's my beliefs and my religion are one in the same. With religion, you never speak of the respect for Mother Earth. With the traditional path you see respect, that's what's being taught, the path.

Sacrifice and Self-Care as Part of Healing and Wellness. Many interviewees stated how traditional healing and restoring wellness was not an easy lifestyle. In fact, it often came with a great personal cost and required an investment in self-care and healing to maintain a balance in their lives:

A: Its just....always helping people, always taking care of others, all those things at the expense of myself and that was one of those things that we had talked about in the past. I was bending over backwards and every time I fell...

I: Living for other people.

A: And because every time I fell nobody was there to pick me up and then I had to pick myself up and that made it difficult as far as that was concerned. Now that I'm a little more mature and a little bit further along in my understandings and better about self-care is that I can still be that person who was helping everybody but at the same time ensuring that I am taking care of myself. But it is a hard road again, I have a wife, I have children, I have responsibilities as an employee. I have responsibilities as an employer, of being a supervisor and I have responsibilities as being an uncle, a cousin, a friend, a son.

I: All these relationships...

A: All those relationship...I'm exposed to it and because having that empathy and having that genuine concern you take a little bit of that with you.

I: You don't want them to carry it so you take it...Lessen their load a bit.

A: And now what do I do with it...I am able to let it go in this way or when I'm smoking the pipe or when I'm singing, dancing pow-wow, sweatlodges, fasts, those things are really good for myself, but it is a hard life."

Others also echoed that their commitment to traditional healing was not a choice but a gift that came with significant responsibilities:

> H: Well, it's just not an easy path to follow. You have to let go of a lot of things, like gambling and nice things ...you're gonna get hurt at the end...can't mess around...the medicine and beautiful things.....Mother Nature.
>
> I: So it's not an easy path?
>
> H: No. You've gotta watch out when you walk that path...In a way I help people who have a tumours in the head and people that go for surgery I work on them so they can have successful surgery, they were so sick and didn't know what to do about it. I don't consider myself special; I don't have powers...And those powers were given to me from the Creator and it's limited too. That's the traditional way and the path.

You notice in the above quote that the person says that "they have no power" but then says that "those powers" were given from the Creator. This statement may seem to be contradictory, but in fact reveals that they do not believe that they have any power. They see themselves as a conduit for the power/energy of the Creator and as having a gift they must be responsible for. Expanding on this issue, one person added that from an Indigenous perspective, the commitment and responsibility to traditional healing often shortened the life of the healer:

> I: I've had to learn that teaching the hard way for myself, if I can't take care of myself then I can't take care of others.
>
> D: I see that (the issue of taking care of self) as a contradiction or I don't know what the proper word would be, a western approach to it, I don't know. For an example one of my adopted mothers, her husband from 48, he passed away a few years ago, but he was a medicine man. He was allergic to a lot of things like the feathers and such but in the end it cost him his life because he couldn't stop. Even though he was allergic, he still had to do this work and in the end it cost him his life because he had to try and work though that, still do the ceremonies. He knew it would cost him his life but he still went ahead and did

these things. He died at like 55.

I: That's young. It's because he couldn't stop doing the work?

D: Yeah, he couldn't stop doing the work, like you said, 'if you can't take care of yourself'... but you can't stop either. His faith there is that the Creator will take care of me.

Impact of Residential Schools on Indigenous Healing and Knowledge. The theme of residential schools consistently came up in all interviews. This was interesting given that this topic was never addressed directly. The negative impacts and ongoing residual effects of those experiences within families and communities were acknowledged in many ways. Further, the impacts continue to be felt to this day. For one person, the negative impact was experienced by the lack of open communication within their family that resulted in gaps of understanding and knowledge transfer from one generation to the next. When asked if they were acknowledged within their family for their traditional healing gifts, one person stated:

D: I've never really talked to anyone (within my family) about it. Although we knew it, we never talked about it cause my parents were brought up in residential schools and they understood and they know that we practiced it but they never really practiced it.

For one person, the severed relationships between generations caused by residential schools meant a total loss of the indigenous practices that are needed to stay well.

F: His mother died three years after they were there, so he was raised by his uncle and placed in a residential school very early on.

I: Your story is similar to my Mom's story because I never knew she believed in the old medicine and until recently cause I guess she never needed it, but recently there has been all this talk of pandemics and she's come to me and said "I would like you to find those medicines I used to have when I was a girl. I want you to find those medicines for

me. I need those.

F: Yes I think so because my mother was telling me at her young age she knew about those things but she wasn't that comfortable, interested because of the residential schools. She was taken away for eight years so all these things were lost.

I: They were not seen as good things.

F: No that's right.

Later, this same person shared how they had been talking with their physician about the abuse they had experienced as a child in the care of residential schools:

F: He (family doctor) just happened to ask me if I had seen the article about residential schools in the paper that everybody's getting, at a certain age, compensation. I said "yes, if it's coming, I'll take it." ...We were talking about infections and I told him that at the residential schools, one of the nuns threw me down the stairs cause I was talking, I committed two sins cause I was talking loud and I was talking in the hallway and it was forbidden to speak in the hallway and I was thrown down the stairs and I bumped my head on the corner of the bench and my knees. I said I was bleeding and of course when you see blood you think you are going to die, so I was crying. She just washed my face and patched me up and sent me to bed. So we were talking about disinfecting and stuff like that.

This horrifying account also reveals how this person's perception of healthcare providers was imprinted in their early experience as a traumatized child living in an oppressive institutional setting.

With a third person interviewed, a clear understanding of the link between the past cultural harm resulting from oppressive and assimilative practices of residential schools, missionaries and the subsequent years of mass apprehension of Aboriginal children by child welfare agencies has led to the current and ongoing erosion and loss of indigenous beliefs and practices within families. Speaking from their experience as a childcare worker, this person spoke of the persistent negative perceptions that

have been internalized within families:

> C: So with those things (cultural practices and ceremonies) ... I try to promote it all the time and it seems that what's happening right now from what I can see is that these children that are in care with Children's Aid and even the ones in group homes, they're all asking questions now of who they are.
>
> I: They want to know, eh.
>
> C: And a lot of them want their names and there's been several that have received their names already, these children. The other negative influence is religion. The born again Christians. A lot of them are against the culture and they still say it's evil, it's bad."
>
> I: I don't know why they're so fearful, eh?
>
> C: I don't know. Well, it's because of residential schools. We were taught to know the language was evil, our ceremonies were bad, devil worshippers and all this stuff, and it's carried on.
>
> I: They still believe that.
>
> C: Yeah, they grew up hearing that, they grew to believe it and that's what they're teaching their children now is that it's bad.

Pride, Cultural Revival and Knowledge Transfer. Despite the harm and loss felt by participants, a strong sense of pride came through each interview. Each person spoke of the urgent need to reclaim and transfer their knowledge, languages, values and practices to their children and others.

> C: I try to promote the culture as much as I can...One of the things that I learned from the Elders was that even getting your Indian name is healing in itself. And also the current system and a lot of people don't know what that it is. Every tribe had a form of clan system.

To this, another person added the following comment about the deterioration of family clans that led to a need to gather family genealogies and stories within their community:

> F: We were meeting and the kids just happened to say "Oh, you're related to so and so" and yes, he is related to them too". So we were talking about it and we said "You know it's unfortunate that so many of the kids don't know who they are related to." That's why there's so many marriages now marrying your second cousin or their even a third cousin and that's not supposed to be, because they are cousins back home and brothers and sisters.

When asked if it was a challenge to teach their children about indigenous healing and traditions, one person shared:

> C: It's a challenge sometimes. I don't force them to go to ceremonies or anything like that, but I ask them if they want to come and most of the time they say no, but sometimes they say yes and they do come into the sweat, sit down for maybe for 1 round or 2 rounds and then they come out. They are still very young.....They have all kinds of questions that even I can't answer. They ask sometimes, for instance, when they ask about the colours, that's a new one and I don't know the answer to that one or how it came about. There are families that have their own colours, some have 3 colours, 2, some have 4. I don't know too much about that one about how the colours came about or where it came from or when it started, but I can't answer that one. A lot of this was lost because of residential schools.

Despite the many concerns and factors that had impacted the wellbeing of families and communities, the participants remained resilient and maintained a deep commitment to the wellness of others, as expressed in the following statement:

> S: I'm constantly affirming myself that "yesterday you did as good as you could" and if there are issues where I didn't feel that I did do as good as I could yesterday, today you'll do better because you are good man, you are a good person, you are a good father, you are a good grandfather, you are a good partner, you walk as a blessed human being and by doing that and offering that thanksgiving back out to all the created order just the fact that you even want to do that shows that you have goodness in your heart right there and that's good medicine and I do that every day all day long. I drive into town and I see all of them...some of the Indian people on the streets having a hard time ...or they're busted up or whatever and the first thoughts that always come out of my mind are not critical thoughts. You know there is a brother struggling, Creator, you've blessed me this morning, look what I have, bless him as well. Help him make it through the day and have this day

be even better than yesterday.

Discussion of Participant Perspectives on Indigenous Healing. It is difficult to capture and do justice to the rich knowledge, insights, and experiences that were shared during the interviews. I have tried to present the some of the significant perspectives among this culturally diverse group of individuals in order to acknowledge the vibrancy and intactness of Indigenous healing approaches. What came forward was a clear and confident view among all respondents that healing and wellness was a powerful life process that was natural and interconnected through wholistic and deeply respectful relationships with all of Creation. This knowledge and conviction of belief was grounded in the lived experiences of each person and supported by the positive outcomes they had repeatedly witnessed in their lives. Not only were these experiences recalled from their earlier lives, they were also very current and relevant to the needs of today.

The next section presents the perspectives of participants on their relationship and experiences between Indigenous healing and contemporary medical health care.

Relationship between Indigenous Healing and Western Medicine

Each participant was invited to explore their personal experiences within hospitals and to highlight the relationship between their perspectives on healing and the care and treatment that they had received in these medical institutions. This led to a dialogue about the similarities and differences between these two models of care and healing and impressions on how comfortable participants were in sharing their world view with health care professionals.

Respect for Western Medicine. Most respondents, confident in their own

beliefs, spoke respectfully about western medicine:

> A: I have that strong connection to my traditional and cultural beliefs but also I understand we don't live in teepees, we don't travel by horseback, we don't follow the herds anymore and there has been contact now with another group of people who have done really well at advancing.
>
> I: In certain aspects of care.
>
> A: Yeah, that certain aspect of medicine and talking about the gifts that were given to each of the Nations and I'm really blessed with having a grandmother and a mother that was all about "there's no difference"... absolutely no difference. The only difference is in skin colour or attitudes. Well the only difference is the colour of skin or their country of origin.
>
> I: But the rest are choices.
>
> A: The rest are choices and again there's no difference. They're not better than you and in the same breath you're not better than them. So I have a very open mind. I have no problem talking to a health care professional or ask them the questions.

Guarded Respect for Western Medicine. It was stated by some participants that they respected western medicine, but felt that these methods were sometimes harmful to the wellbeing of the whole person. On this topic, a person stated:

> M-1: I'm not saying it's bad.....I'm ok with their medicine cause it comes from the same plants.
>
> I: Comes from the Earth too.
>
> M-1: Yeah, it comes from the earth. I'm ok with that but there are times their medicine is really bad for a person.

The above comment highlights the commonly shared concern that western medical approaches often caused harm to individuals by neglecting to address the wholistic needs of the person. Further, it was repeated by several respondents that health professionals often devalued traditional practices and compromised healing

when ignoring the benefits of traditional healing:

> S: By just choosing to go only to one of the doctors or practitioners of western medicine I really feel that they have severely limited the potential healing benefits that they can get if they were to also work with a traditional healer and I believe that by combining the two we have a more complete method of treating whatever illness or imbalance that they're dealing with. But to talk to them and explain that to them is difficult because there has been such an emphasis put on traditional alternative medicine as being "quackery and false".

Complementary Healing Relationships. It was often stated that it was important that the two models of healing and treatment work closely together to help and support the healing process:

> C: Both sides compliment each other, the contemporary, the white medicine and the native medicine, they help each other... It's just when a person is going to go for surgery, and I've done this myself too, I go to a sweat and I ask the spirits to help the doctor guide the knife, to hold his knife when he's cutting and for the doctor to be helped to be successful in the surgery.
>
> I: That the spirits help them do their work.
>
> C: Yeah. So that's what I mean by both systems, whatever you want to call it, they help each other.
>
> I: It would be interesting if a doctor heard you say that ... that you are actually going to a ceremony offering prayers for him or her ... it would change the relationship, right, to think that they weren't alone, that they were being guided.
>
> C: Yeah, and we also ask for the healing to be quick, for the person to be up on his feet and well... Not to suffer and to be healthy again.

One person expanded on the tendency of faith and health institutions to minimize the validity and merits of traditional healing approaches as they shared how their religious teachings had for a long time prevented them from fully accepting their traditional healing practices and ceremonies:

> F: I think I see a lot of similarities ...I always like to work with similarities so I don't see anything wrong with it. I believe in the roots because we had them back home...roots and sage, those things I believed in but I did not believe in the smudging. I didn't believe in it. I always thought that it was something that was totally foreign to Catholics. I thought it was almost like…
>
> I: Anti-Catholic?
>
> F: Yeah ... and since then I started trying to look at the similarities and trying to find out what is wrong with it. Something that is wrong is not going to be like the others, that's not going to make it similar and I couldn't find anything wrong and then I started thinking it's the same. It's so much alike and once I accepted that fact, then I use it. No problem.

In this quote, you will notice that I as the interviewer used the word "anti-Catholic" during this part of the interview process. I had noticed that the interviewee was struggling to describe how the use of traditional healing had at one time in their life conflicted with their faith beliefs. My use of this word does not reflect a bias on my part as an interviewer, given that I shared a common experience with this person regarding this issue. The neutral comment was only meant to assist the person in moving forward with her thoughts.

Spirit as the Source of All Healing. Fundamentally, participants consistently felt that healing was universal to all nations and faiths, as it was a spiritual process guided by the Creator. The expressed difference was in the approaches that each culture emphasized. Informants were keenly aware that science-based technological processes had marginalized their beliefs in wholistic and spiritual healing:

> D: The help is there whether it's western medicine or traditional medicine.
>
> I: There are some people who find that they're so different that they can't connect?

D: I see it. I think it's a lack of understanding between our cultures and cultural traditions. It's all the one Creator, the one God. They don't understand that. They tend to see it's our God and their God, and you see and hear a lot of that, but it's all the same. ... The ways of healing are different 'cause the question with western medicine is with the body where we try to focus more on all three aspects.

I: Spirit, mind and physical.

D: So that's a different approach. So the healing is still the same.

In one person's struggle with cancer, the process of deciding to blend both western and traditional healing approaches caused significant anxiety, given that she knew that it may not be supported by members of her family. Further, the harm caused by having possibly disrespected one's own parent was unbearable:

J: I have a lot of faith on my traditional ways of the medicines and I've done a lot of praying and I've done a lot of pipe ceremonies and I've done a lot of sweats also. I would sweat twice a day, twice per week which was even very hard during my chemo and I had a very hard time to decide to go both ways on the western side and my traditional ways because my mother was very traditional. She had told me if I did let them operate the cancer will spread right away and which I believed that if I followed what my doctor told me I would survive and also I had my traditions. I had my ceremonies. I had a lot of faith on that and it was me that had decided, I had to take both and in both ways I win. I had that surgery, they removed my breast and I went through chemo. I went through 8 chemos and in between time I drank a lot of medicines and I know both of them were going to help me the same time, even though it was said to me at one time of my life, if I take both that traditional wouldn't work... but it did for me.

When asked whether she discussed this decision with the care team, she responded:

J: It was very hard for me because all the specialists ... at the Cancer clinic didn't know nothing about the culture, the traditional medicines and it was very hard for me to show up knowing I was going to be very ill and there was no smudging in the hospital and there was no medicine I could drink before my chemo had started. I didn't tell my doctor right away that I was taking some alternative medicines until I

> felt comfortable with her, that's when I told her I was taking alternative and she wanted me to stop taking my medicine during my chemo, but I didn't want to, because she said it might interfere with chemo... but it didn't. Both the medicines helped me to heal. It was very hard. It was a big struggle.

Mistrust in the Health Care System. One significant theme that consistently emerged within the interviews was the mistrust that many informants felt as a result of the harm caused by the disrespect for their beliefs that they had experienced in their relationship with the healthcare system. One person described a painful episode involving their daughter's struggle with cancer:

> S: with my daughter's illness, one of the doctors ... we asked him when we began to work at trying to deal with her cancer, we were very heavily into promoting traditional medicine only to be told by this doctor and all of these organizations that you can not use that.
>
> I: It's not allowed.
>
> S: It's not government sanctioned and it's not allowed. And so we began to question them about what we can do to treat her because with this type of cancer her radiation and chemotherapy didn't work. They wanted to do the chemotherapy and radiation and use her as a guinea pig and she refused.
>
> I: She was a very young child. She knew what she needed.
>
> S: And she was astute enough to be able to speak up for herself because we had always taught her that she has a voice, she has a body, that's her body. We can't do anything or force her to do anything unless she's agreeable to it and she basically said 'no'. They got to the point where ... here was this thing about laying out your agenda on someone else...ok if you aren't going to play ball with me the way I want you to since I own the ball, then I'm going to apprehend your daughter and take her out of your home, or in this case since she's at home and being cared for by the family since you are the one that's arguing with us, we are going to remove you so that you can't live at home and the rest of your daughter's illness and we will punish you because you haven't participated with us. But we aren't offering you any positive treatment to you or healing or anything. We're saying we want to use her for a guinea pig so down the road someone else gets

this disease has a better chance of living.

I: Like an experiment.

S: A guinea pig... she (daughter) spoke against it and ... the only way we got out of it was that we had the neurosurgeon who had done her surgery come and tell them that this child is dead already. Let the parents take her home and let them do what they want to do with her for as long as they can because she is not going to survive this. She is going to pass away.

I: It's only after they give up that they allow ... instead of working together.

S: And that was the thing that infuriated me the most because we were honest and upfront throughout the whole thing, laying everything on the table. I said "We have talked to you from day one about treating her with traditional medicine as well as the western medical medicine and you guys were adamantly opposed to allowing us to do it" even to the point we were threatened, that we would be held legally liable if we did that. She was no longer ours until she spoke the words saying "I'm sorry but, I'm going home. You can do what you want but I'm going home and play for as long as I can play ... And when I go up to the sky world, I'm going to go and there's nothing you can do about it but I am going to set my house in order in the way that I need to do it.

I: You took her home?

S: Exactly, and that's what we did. We took her home and then we began using the traditional medicines and even at the point of her death with these traditional medicines, she was passing cancer like crazy out of her system ... it was this whole process of where our traditional medicines and we had individuals that sent us medicine that said "I have worked with cancer patients for 40 years and this medicine will take that cancer and knock the living tar out of it. At least it will give her a fighting chance to work at the other areas to get better. But by that time it was already too late. Her brain must have been pretty much gone by then.

For another informant, the mistrust of health care staff had resulted from the collision worldviews regarding medicine and healing. Healthcare providers often dismiss traditional practices, resulting in disrespect for the person's beliefs and

culture:

> M-1: I never talk about my traditional medicine to the nurses... I don't talk about it.
>
> M-2: With my Diabetes, a nurse asked me "are you taking anything for your Diabetes?" and I said 'I am taking Indian medicine'.
>
> I: Did she seem ok with it?
>
> M-2: Not really. She wanted me to take their medicine, so I didn't bother to say anything but the other nurses, those native nurses, they understand.
>
> I: And you've been able to manage your Diabetes using the traditional medicines?
>
> M-2: Yeah. Every time I check my blood sugar, it's normal, 5.

Western medicine often views traditional healing approaches as unclean and unsafe. One person described a situation with his daughter while in the hospital:

> C: From my experience, what we encountered was with my daughter and I forget the doctor's name too ... and he didn't allow our medicines into the unit because of, I think what he said was because they might be contaminated, I don't know what's the right word. What we felt was this is medicine. It's not dirty, it's not polluted, its medicine. I guess what he was concerned about was the infection, because it was supposed to be, the unit is sterilized and everything and he didn't want any contamination.

Disrespect for Sacred Healing. Several interviewees felt that western medical practitioners did not always respect the "sacred" or spiritual nature of traditional healing. Curious and sometimes disrespectful inquiries about specific medicines could not be responded to because of instructions from Healers not to reveal the source or nature of the medicine:

> A: I was told not to talk about it, but when I do speak of it and say "thank you but I'm going to take this" and leave it as herbs, traditional medicines, and if they talk about getting a little bit more specific, and

> again this is my windigo-can (contrary spirit) in me to say well, some of it will be root, some of it will be bark and some of it will be leaves, or petals. But again, I won't be specific as to what plant that is being used. So that tends to frustrate them a little bit but at the same time again, and for me it's not because of this is our way and I'm not going to share. For me, this is because this is something this is sacred to me and I have to be careful who I tell it to.

Another person's experience with cancer was similar:

> H: When I was diagnosed with having cancer in my kidney, it had to be removed. It was understood that I told the doctors that I was seeing a medicine man about it and then I got looks..I said to the doctor: "help me" and the doctors said "by all means go ahead. I leave it up to you." But then after I went in and saw the nurse in there and they looked and it got rid of a good percent of the cancer and I told them about it and they were impressed because they saw the results. Before I went in there and they took a CT scan, and there was four spots of cancer in my lungs and when I got back there was only one. So that says something. I gotta go back to that old man and show them back that I need more help. I'll let you know about it in July.
>
> I: They must have been surprised to see the results?
>
> H: Yep and the guy (medicine man) told me was "Don't tell them where you got the medicine. ...But I told the doctors, they wanted to know what happened. I told them....Even if I told you, you wouldn't believe me. It was a medicine man and what he did for me."
>
> I: They're curious.
>
> H: Yep. They wanted to know who the guy was and what his name was. I told them I couldn't tell them.

One informant revealed how one could not share traditional knowledge until trust had been established and that the person would use these medicines respectfully. If someone who wasn't genuine in their intent had misused the knowledge, they would be held accountable in the spirit world:

> I: Is that the way you were taught that you can't talk about some of the medicines?"

M-2: Yep.

I: By the old man, your teacher?

M-2: Yeah. He told me to wait, that there will be a time for you to talk about your medicines. There will be a time for you to pass it on to somebody. That's the way it went.

In support of this perspective, another respondent added:

I: I think some of the traditional healers are worried a little bit about working with doctors.

H: Yeah they are. There is no doubt they are worried and I guess, no respect. It took them that long to train. It's their way of life. What if someone abuses it?

I: And they (healers) pay the price.

H: Oh yeah.

In speaking about undergoing surgery, one person spoke of the breach of trust caused by individuals and a system that did not understand and accommodate cultural beliefs:

J: People that don't follow the culture wouldn't understand the meaning of the tobacco and I couldn't even have a braid of sweet grass when I was going for my surgery.

I: That's like 7 years ago, not like 50 years ago.

J: Yeah... because nothing (sweetgrass and tobacco) was sterilized. Everything has to be sterilized when a person goes in for surgery and I think that's very wrong because you know I followed my voice ever since I was a child and not having that sweet grass, well I was full of fear and not to be understood is another thing because I did try to speak for myself that I needed something to hang on to while I was going through that surgery because there was a lot of fear.

Lack of Cultural Safety. For many respondents the lack of cultural safety created by the power differential between care providers and the patient was evident

in their experience with healthcare providers. In one case, the person described how they felt they had no choice but to listen to the directives of the nursing staff, even if they felt that staff did not know how to truly assist the patient. They feared that there may be repercussions if they contested the authority of the care provider resulting in giving up control and ownership of the healing process:

> M-2: I saw a medicine, what to take and the tree....what he (spirit in a vision) used on her. Then I came back. I gave her that medicine. I started treating her 'cause I knew she wasn't going to get better. The doctor was saying "we are going to amputate her leg" and I kept taking care of her leg, like, putting that medicine on there and she did get well. She's walking, she couldn't even walk. Like, up to her waist, it was all sore like cracks.
>
> I: Is that from Diabetes that you were getting ulcers and stuff?"
>
> M-1: No, I was in bed and my granddaughter jumped on the bed and stepped on my ankle. I could just feel the pain and it was about a month after the doctor saw my x-ray and said there was a chip in my bone in my ankle.
>
> I: And that's what caused the sores, and it surfaced and then it spread?
>
> M-1: Yeah.
>
> I: Wow! You had seen it in a vision, knew to look for that plant and you treated it. What did the doctor's think? Did you ever talk to them about it?
>
> Male: "No, I was thinking "I wonder what they were thinking" cause I got here, and the ulcers, it was traveling all over her body. Then one time those nurses came around, home care nurses, they told me to stop it, and I didn't feel good about that, 'cause they were saying it was giving her a rash on her shoulder, but I knew what was wrong with her, so I stopped, 'cause they wanted me to stop. That's the conflict of Indian medicine and white medicine.
>
> I: Why did you stop? Just out of respect for them?
>
> M-2: Yeah.

I: Maybe they were right? You didn't think they were right?

M-2: No.

I: But you started again?

M-2: No, I just stopped treating my wife and after that, that little hole there it didn't heal inside so her neck …that part here, went to her head and all those little blisters came up.

I: It just moved.

M-2: Yeah. I kept saying to myself, maybe I shouldn't have stopped with my medicine 'cause I knew it was helping her.

I: It had helped before. She must have been in pain...

M-2: Yeah but they wanted me to stop and out of respect I did stop. I don't like it when they ask me to stop.

Discussion on the Links between Traditional Healing and the Care Received from other Health Professionals. In reviewing the statements and themes that emerged from these discussions, I make the following observations. The Aboriginal people interviewed were generally respectful of practitioners of western medicine but felt that at times that these approaches were somewhat frightening to them because of the harm that occurred from the medications and practices. They viewed indigenous healing and western medicine as complimentary approaches that shared spirituality as a common point for effective treatment. This reflects their strength of beliefs as Indigenous people.

A major theme that emerged from the interviews was that of mistrust of the system, based on past events that had been disrespectful to their beliefs. On this point, it was often difficult for me as a researcher to not be affected by the stories that were shared. Participants stated that their beliefs had been marginalized and

disrespected by health care staff. Also, several participants indicated that there was at times a curiosity among care providers regarding Indigenous practices, but that this interest did not always feel genuine. One person did state that they were able to speak about their past life experiences with their family physician and engage that person in a dialogue leading to a balanced approach to care. This comfort with the physician had been cultivated over many years.

Given the past disrespect of the practices of indigenous healers, many stated that they did not speak in detail about their practices or disclose the remedies they were taking. They did not feel safe with their provider of care and often did not believe that the western approaches prescribed to them were effective and warranted, as they saw the illness or harm as originating in a different dimension of the person. One interesting point that was raised several times was how participants believed that the illness was a living "being" and that they were in a relationship with that being. Respect needed to be the essence of that relationship if healing was to occur.

Barriers and Opportunities for Improvement

Participants were asked to identify the issues factors that acted as barriers to culturally-centred care within hospitals. These issues would contribute to the climate of mistrust, lack of cultural safety, and disrespect that had been identified earlier as characteristics of their relationships with health care settings.

Building Understanding and Sensitivity within Health Care System. For many persons interviewed, the lack of understanding among health professionals was presented as a major barrier. The person also acknowledged how the lack of understanding had eroded the trust and possibly limiting the advancement of more

comprehensive treatment and care approaches:

> H: I'm sure if people would have an understanding of what the power the traditional medicine have, that understanding would be a good combination and be comfortable with medicine men and doctors working together because you have to *send* medicine....A medicine man can do almost more than a doctor can do. A doctor treats a patient whereas the medicine man heals. They heal instantly. They know how to heal the body without cutting it.
>
> I: So if they were working together at least it would be a powerful relationship.
>
> H: Yep, it would be. There would be a benefit. It would help health Organizations as a whole.....help. It's not going to be easy. It's going to take some time and work because the traditional healers, they don't like to expose their ways.

The lack of understanding led some people to assert their beliefs and challenge the views of health professionals, as seen here:

> J: I find that with aboriginal people, there's a lot of fear yet to talk about the medicines with their doctor cause until that.....I didn't tell my doctor for the longest time I was taking some medicines. It's very difficult to be open with the doctor there because right away they are going to tell you it's going to interfere with their efforts.
>
> I: You feel that they won't support you?
>
> J: No.
>
> I: Or they're going to want to analyze it.
>
> J: Yeah and I have a doctor here in Winnipeg that's treating me with Diabetes and my Diabetes is out of control right now and I had asked him if I could take the alternative medicines that the Creator had given us and he told me I can not take those because they're not sterilized and then I took a look at him and I said "Well, not sterilized? Look at all the chemicals of pills you're giving me. ... He didn't say anything. He just looked at me and I said "Well doctor, no matter what you think I will take my cultural medicines, my traditional ways.

Another person added:

> C: As a matter of fact being somewhat militant in my beliefs as well, because it was denied from me, is kind of where I developed that sense, because it was denied from me for so long it was something that I really really looked for and I did know how to look for it and I really missed it.

The above examples illustrated how the lack of sensitivity and understanding can result in an adversarial relationship and a missed opportunity to work collaboratively. Further, the lack of understanding was also perceived as a direct attempt by health professionals to maintain the power differential within the care relationship.

> C: the power struggle. I had that situation but me personally, I've always had a fairly assertiveness to me where I am able to say "no" and also a good enough sense of humour. ...The hospital system has a definite hierarchy, doctors...."
>
> I: The power stuff.
>
> C: Yeah, the power stuff, the hierarchy of power whereas the doctors is the omnipotent, and all knowing.
>
> I: Has all the answers?
>
> C: Yeah and he's not willing to give any so sometimes there is that definite hierarchy, that power structure, that sense of " I've been to school for this long and you haven't therefore I know more than you therefore, you listen to me.
>
> I: I'll talk, you'll listen.
>
> C: Precisely.

Another person commented on how negative perspectives of healthcare providers towards traditional healing were also seen as disrespectful of the authentic credentials of the traditional healer who was involved in their care:

> D: I mean these doctors and nurses went to school for how many years to get that piece of paper to be called a nurse or a doctor, whereas the healers themselves is a lifetime.

As a reasonable response to the lack of sensitivity and understanding, some informants suggested that healthcare providers participate in Aboriginal healing ceremonies in order to better understand the worldview. Experiencing these events was seen as far more beneficial as learning that came from presentations or readings:

> C: I guess the best thing that I could suggest to the doctors and nurses is for them to come to a ceremony. They don't have to participate inside in going to a sweat, they can sit outside and watch and learn. If they want to go in, fine. And even to go to a shaking tent or to go see how these, to see these ceremonies to broaden their understanding, broaden their horizons."

Another interviewee recommended that health care staff who interact with Aboriginal patients be required to access cultural proficiency training, reflecting the trend occurring in other human service organizations:

> A: In terms of dealing with the medical profession or the educational system or any of these others systems, take Child Welfare for instance; there's been a huge change over. It's getting more open and there's been that push for cultural proficiency. As a member of the Circle of Courage we provide workshops and promote that cultural proficiency.

One of the key learnings that would come from an improved relationship with traditional healing approaches would be a realization by health care providers that the power of western medicine is limited and that its practitioners need to humbly acknowledge the parameters or limitations of their knowledge and expertise, as inferred in the following statement:

> S: What is not understood and realized is that the doctor in order to maintain his credentials for the license that he's been given to practice medicine has to operate out of a box. He's been given a box and he's been told as long as you maintain and you're a member of this surgeon's or whatever and you've gotten your license and you follow this, this is the box in which you operate. You do not go outside of it because this is government regulated, this stuff isn't and this is how we work here. This is the medicine you practice and it really describes

> itself when.....I remember an Elder of mine that I used to visit whenever I had the chance, Rufus Goodstriker. I was at his house one day and he had a young doctor pull up and come in to visit and during the visit Rufus all of a sudden got him up and took him into his little medicine room and he had all of these cans filled with different medicines and the doctor kept talking about his practice "my practice as a doctor" and Rufus finally, laughingly, told him, he says "Well, when the day comes where you're done practicing come and see me because I doctor people, I don't practice.

Building Understanding within the Aboriginal Community. It was also acknowledge within the interviews that there needed to be efforts made to build understanding within the Aboriginal community regarding the use of traditional healing approaches and the process to access healers and Elders. Due to the erosion of this knowledge in the past, many Aboriginal people require support with the reclamation of indigenous knowledge and practices. As stated by one person, many Aboriginal people may not feel supported in their needs:

> C: I am not sure if it's difficult for a healer to go into a hospital. They're doing what they are asked to do but, it's the people themselves that don't know how to approach this, who to see, what to do.

Some of the uncertainty within the Aboriginal community was attributed to the lack of clarity about the criteria that are used to recognize and access healers and Elders. The following quote also acknowledges the fact that traditional healing has been "commodified" and thus compromising its credibility:

> S: I was looking at ... the barriers that prevent me from using healers, Elders and ceremonies sometimes really are accessing Elders. There's a big discussion about accessing Elders that are credible. Elders that really really know their work and because right now there is a lot of money to be made from some individuals going around and professing to be an Elder, professing to be a healer and you end up sitting around the fire in each direction for seven days and your healing will come and at the end of 28 days you realize that all you are is hungry and thirsty and nothing's happened because you've denied yourself food

> and water while you sat around the fire for seven days in each direction. I can understand why someone would put that forward as a matter of doing the introspective work but some of the stuff I hear sometimes just makes me shake my head and it really leads to an understanding why it gives the opposite side more evidence that people should not use Elders and healers."

Another person shared a similar viewpoint and emphasized the need to educate people about the need to find authentic healers:

> C: Many people don't know how to help, who to see, who are the medicine people. Sadly, you know, the other thing that I find too is, just like in the white world there are fake doctors, quacks or whatever you want to call it. But the same thing is true in our culture, there are fakes.
>
> I: Those who are not really helping.
>
> C: Yeah, the songs are real, the feathers look real, the drum is real, the rattles…
>
> I: But they may not have the gift.
>
> C: Yeah, they don't have the gift and things and they pass themselves off as real medicine people. ... So the important thing is to do research, to go look around and ask questions about this person "What has he done?" "Who has he helped?" "What does he do?" I find that the people who are healers, they keep quiet. They don't come out themselves "I can do this, I can do that"

Creating Supportive Environments. Respondents identified several issues from their experiences within health care settings that they felt impeded their recovery. For one person, the strong sense of being "lost" without their spiritual resources within a foreign system was very traumatizing:

> J: All by myself with, of course with my children and they weren't able to smudge so they went into the car to smudge during my surgery and it would be very nice if the western world could take a look at that and have the people to be smudged before they go into surgeries or to be prayed with or to have ceremony because especially with a thing like that, with the cancer, you don't know if you are going to survive or

not.

I: That must have been so difficult in that you are feeling alone because it's life and death right?

J: It's very difficult cause there's no place to put tobacco because it's all cement and gravel and you can not give to the trees because either the flowers are stronger than the trees or it's gravelled and you aren't allowed to walk on the lawns at all so, it's very difficult because I see my daughters had struggled through that because they want to put some tobacco out into nature

I: It's like you're trespassing.

J: Yeah. They had to smudge in the car. They brought a smudge bowl and they put some tobacco in there but they weren't able to bring it out and they weren't able to come in and smudge me and that was the very scary part of it. It would be nice if there was one room to be set aside in all the hospitals that do big surgeries for people to go in for comfort before their surgery knowing they're in the next room or it doesn't have to be in the same floor, but knowing that there in the same building...in a single place. ... In most hospitals you can't smudge and even in the chapel, you can pray in the chapel but you can not smudge in the chapel and you can not leave tobacco in the chapel because the people that don't follow the culture wouldn't understand the meaning of the tobacco and I couldn't even have a braid of sweet grass when I was going for my surgery.

The sense of loneliness was accentuated when Aboriginal people presented with language barriers and cultural traits that were misunderstood or not validated:

F: I think it's talking in the language and also the way we do things a lot of times even with expressions. Sometimes we're translating from the Aboriginal language into English so the expressions are totally different. It's not the same as talking to someone in Ojibway, it's different when you're talking in your own language. Then you have people that speak Cree, Ojibway or whatever and the meaning is lost there and so there's miscommunication many times. That's why it's so nice, like I mentioned, I'm concerned about people not being visited. That's what I really think, not going for spiritual care but just the visiting with someone who speaks the language and they just cheer up."

I wish I could speak Cree and Ojibway and all of those, but they need that and the hospitals don't understand that. I think if you

had more interpreters they would be ok but then I don't know their role and how much contact they have with patients. I think there should be people visiting the patients more. I don't know if there is anything from this that could happen. The language is always a barrier.

I: I don't think the hospitals understand the power of visiting, the healing power that a person can bring.

F: I don't think they do. I think some do. I think some people are good but there are the others. They don't understand.

I: Or they're so busy they don't see the benefit.

F: They don't want to understand.

Because of the often unwelcoming hospital environment, the care of some Aboriginal people may be compromised as these may not view the hospital as a healing place. One person stated this fact succinctly:

M-1: Talking to the doctor when I was in the hospital I told him "If you want me to get better, send me home."

I: That's what you said to the doctor?

M-1: Yeah and that's what he did and I got better when I got home.

I: You didn't think they would really do anything good for you? It wasn't going to be helpful to stay in the hospital?

M-1: No, I told him to just let me come home and I felt better after.

I: So, what is it about coming home that was going to make you feel better?

M-1: Being around familiar surroundings and family. It doesn't do any good for a person to be lonely out there. It just gets worse and you get homesick.

I: It starts working against you when you start missing your family.

M-1: Yes and it doesn't help. You get all these medications from the doctor and get treated, but it still has to come from the heart.

Improving the Hospital Environment. Many informants made suggestions of changes that could be made to the physical environment of the hospital that would be sensitive to the needs of Aboriginal people. One suggestion was creation of places where Aboriginal people could perform various sacred ceremonies without having to be away from their family:

> J: I had an experience a few years back where my mother was very ill. She had a big knee surgery and where she had done the surgery it came open so there was a lot of blood and she was ambulanced and I was home that month and I went with her with the ambulance and when we got to the hospital I felt so sad because she told me "Don't leave me. Don't leave my side. I'm scared." And I said "Mom I wish I could smudge you but I couldn't and I couldn't leave her side so I had to wait for my family that came in for me to be able to go and smudge. I went into the car and smudged. There was no place to smudge. There was no place to put tobacco for my Mom. I had to leave about a half hour from where my Mom was...
>
> I: To go do that work.
>
> J: Yeah and at those times it's really critical that you do a smudge immediately when they do ask for it. It's not been easy.

Later in the interview, this same person shared their vision of a safe hospital environment:

> J: The only last comment I could make is that I pray and hope in the future the hospitals will have rooms for people to smudge and for pipe ceremonies and to burn their tobaccos. That's my hope.
>
> I: That would be your vision. That would be nice.
>
> J: That would be my vision and for the doctors and nurses to understand. They totally....
>
> I: They miss it.
>
> J: They don't have to understand the traditional ways but to accept what is ours and what we believe in and what we should use during the hardships.

Building Relationships with the Aboriginal Community. Another person suggested that the hospital establish stronger relationships with Aboriginal health organizations that could assist with the needs of patients, including transporting them to ceremonial sites:

> A: They (hospitals) have courtyards and stuff. Some places will try and have that little bit of green space and things like that but yeah, if you could incorporate that where there is an offering space because again, when you talk about offerings, it's not necessarily just the tobacco its cloth, it's wood, it's food there's a whole variety of things where it would be really nice to...
>
> I: ...have somewhere private. It's like you going to a street corner and making your offering.
>
> A: Yeah, tie a yellow ribbon around....
>
> I: There's a lot of privacy around that stuff so you don't want an audience and that's hard to find in the hospital.
>
> Male: "Yeah cause that's actually one of the things we had talked about and one of the things we had recognized and of course in some of the work that Neil (an Elder) has done and I've helped him with there is talk that you need to take this out to the bush. But you're talking about an inner city family with no access to these places, and even with transit maybe you can go to Assiniboine Park or Kildonan Park, but you may be trespassing and there's also the idea that you don't want it to be desecrated. One of the things we looked at and often times in the community you will see Norway House Medical Services, Southeast Medical Services, Pinaymootang, and you see all these medical services vans, so that was one of the things we were looking at possibly doing is having a way that medical services can take you out to Little Mountain Park or just take you out a little ways out into the bush and things like that. Again it is a part of our medical services.
>
> I: It's part of our care.
>
> A: Part of our continued care and the idea of when we do that ceremony that in order for us to make sure we've done it properly that the offering is made and we can do all the shaking of the rattles and the smudging we want but until the offering is made....again because you

> are inviting the spirits and in a part of inviting the spirits you have to give them those things.
>
> I: It won't be complete until that part is taken care of.

Building Awareness of Services. Participants also stated that many patients and families were not aware of the services that existed within hospitals and that these services needed a higher profile. In producing and making accessible pamphlets, posters, and signage, patients would feel more comfortable in asking healthcare workers for assistance to access the needed services. For some respondents the lack of materials and supportive assistance made them feel that the services available to Aboriginal people were something that had been kept hidden from them:

> C: A lot of times the Aboriginal part of the hospital is not known.
>
> I: Is it not very developed?
>
> C: It's not known, it's not visible. It almost seems that the hospitals are hiding it and when these families end up in there, whom do they see, where do they go and how can they access the services? For the Aboriginal workers that are working there a lot of them don't know about this area (traditional healing) either themselves.

Building Relationships with Healers and Elders. The last important issue that was consistently proposed was the need for hospitals to improve their relationships with Elders and healers. Among those interviewed, there was a consistent interest in participating in the care of patients and families, but that they would need to feel welcomed. As one person stated:

> H: There would be a benefit (to work together). It would help health organizations as a whole.....help. It's not going to be easy. It's going to take some time and work because the traditional healers, they don't like to expose their ways. How many people (medicine people) have gone over (passed away), ok let's try to work together...if they could work together and just be nice. I would be part of the team. I had one

> guy that said to me "my health is back".....be a participant with doctors ...could start it, see how a joint venture of medicine people and doctors would work.

Another person shared a similar interest:

> J: There's a lot of the fears in their eyes (patients) like you know, they should have people to be with them, traditional people be with them in the hardship like that and the fear and you know they have a lot of fear when it's their turn to have their surgery they kind of tighten up on the bed just like they were tiny little bodies and you know they pray
>
> I: And they're not ready cause they know they haven't been able to do certain work.
>
> J: And I would love to do that work. To go and talk to people that are very ill and to be with them during their hardship even if they don't want to talk but just to be with them, just to be present.
>
> I: To be present.
>
> J: Yeah, just to be present and that would be nice to be able to have a place where you can talk to them and smudge at the same time. To give them some hope and happy and to believe in the Creator and the grandfathers, that they will stand by you.

Discussion on Barriers and Opportunities for Improvement. Participants were keenly aware of the issues and barriers within hospitals that impact on the provision of culturally sensitive care. Although individuals did not have an intensive or ongoing relationship with the healthcare system, each person was able to use their own experiences to make suggestions for improvement. I was impressed by the scope of recommendations made by the informants, suggesting to me that Aboriginal people want to participate in the development or improvement of care services. The community is an important resource to the healthcare system that may be wishing to become more responsive to the needs of an increasingly diverse community.

What was clear among participants is that health care settings and professionals need to improve their relationships with Aboriginal patients and families by creating welcoming environments, engaging in respectful communications, improving the profile of Aboriginal services, emphasizing cultural competency training and actively involving healers as part of the care team. Several persons unfortunately shared that they felt marginalized when their approaches and their gifts were only recognized as 'last-resort' measures. My spirits were lifted however by the interest among informants to participate in the hospital settings and to freely share their gifts.

As the interviewer, I was humbled by the openness and sharing nature of the informants. They discussed their personal stories and often shared specific information about many medicines and their uses. On several occasions, I was gifted with medicines that the person felt I should carry on my own healing journey.

The next chapter presents a discussion on the significance of the findings in relation to the reviewed literature along with an assessment of the outcomes of the study. The impact on this indigenous research on the researcher is also explored. Further, the implications of the study to health care delivery and social work practice are discussed along with recommendations that could lead to improvements in care. Areas of further research are also suggested.

CHAPTER FIVE

Discussion

This chapter is organized in the following way. In the first part, a discussion is opened regarding the significance of the findings that came forth from within the study. This discussion is organized according to the emerging themes that were presented in the findings chapter of this study: Indigenous Healing Approaches; Relationships with the health care system; and barriers and opportunities. Secondly, this discussion is followed by a section that reflects on the strengths of the indigenous research design that used and my learnings in this regard. Thirdly, a section captures the significance of this study to the practice of social work within health care facilities. The chapter closes with recommendations that emerged from the research experience and my experience in the health system as an Aboriginal professional.

Discussion on Emerging Themes

Indigenous Healing Approaches. Longclaws (1996) categorized Aboriginal people into categories that include the "traditionalist" who maintains their pre-contact culture; the "new traditionalist" who has been re-born into their Aboriginal culture; the "assimilated" person who is without ties to their culture; and the "universalist" who blends both worlds. The author further describes an "anomic" group of Aboriginal people, who he believed to be the largest and most unfortunate segment of the Aboriginal community. These are individuals who are spiritually "bankrupt" and unhealthy. This study disputes these definitions that have been used to define our community. This study involved individuals who actively practice indigenous healing approaches but who would not neatly fit into these categories. The belief in the effectiveness of Indigenous healing

was not limited to those who practiced a "pre-contact" culture. Nor was it viewed as a "new-age" revival movement. Although these definitions are often referred to by health care professionals in their attempts to understand Aboriginal people, they only serve to label and divide the community. Further, these definitions minimize the possibility that indigenous healing is an important part in the daily lives of many Aboriginal people, regardless of how others may perceive them. From the "emic" stance of this study, the issue of how a person would define themselves in relation to above categories could not be broached with a person, as it would have tarnished the relationship.

The findings of this study also reveal that indigenous healing practices reflect a wide range of ceremonies, remedies and medicines, cures, therapeutic processes, and ways of living that continue to be viable in addressing current health conditions. The study participants spoke of numerous experiences that strengthened their beliefs and confirmed for them the demonstrated authenticity of these practices. Participants also consistently linked these practices to the theme of indigenous metaphysics or spirituality that enables the wholistic healing to occur. This perspective concurs with authors like Deloria (1986) and Garoutte (1999) who explored indigenous metaphysics and Strutters, Eschitti and Patchell (2004); Plouffe (2002); and Phillips (1999) who state that indigenous practices continue to be important for many Aboriginal people today.

The numerous references by participants to the impact of residential schools supports the literature that highlights the deep harm caused during those painful days of our past. This study also suggests that the harm is close to the surface of people's existence and still affects their lives, as direct victims or descendants of this legacy. What is significant is that participants strongly felt that returning to indigenous practices and

approaches offered not only bring healing but a doorway into a future of wellness. This would occur through the transfer of this knowledge to their children and others.

Indigenous healing was seen as a community and collective asset and not simply an individual resource. This is consistent with the literature that looks at the interconnectedness of Creation and thus the source of healing. Harm and disrespect to one is harm to all. Healing of one is healing to all.

Relationships with Western Medicine. Consistent with Indigenous beliefs and cultural protocols, it was not surprising that all participants spoke respectfully and without judgment about western medicine. I don't believe that this is a case of "don't bite the hand that heals you." This recognition of the value of western medicine reflects a keen understanding of its roots in the Earth, to which participants felt a strong relationship. Their respect for the practice of western medicine was guarded in that they recognized the limitations of this knowledge and practice base. Some of these limitations include the narrow focus of intervention (physical), and the lack of acknowledgement of spirit and relationships as powerful healing tools.

Participants strongly viewed Indigenous healing as being complimentary to western medical care. No one saw indigenous healing as less than or inferior. To the contrary, many stated that indigenous healers could contribute significantly to the joint development of medicine. The negative and traumatic interactions that participants have had with the health care system have resulted in a mistrust of the system. This mistrust is deeply rooted in the past oppression and ongoing disrespect and disregard for the beliefs of Aboriginal people. Examples of marginalization were given that reflect the need for institutions to change and become more inclusive of alternative beliefs, as reflected by

Adelson (2005) and Battiste and Henderson (2000).

Misunderstandings and communication barriers were cited as a source of disrespect. (Ellerby, 2001; Kaufert, 1990; Riese, 2001). Communication errors are preventable within health care settings if providers demonstrate a visible commitment to genuinely understand and respect the worldviews of their patients. In my experience, professionals who invest in relationships with their patients not only reduce the professional-patient distance, they dramatically reduce the rate of misunderstanding.

Barriers and Opportunities. Participants were able to identify many barriers that impeded good relations between Aboriginal people and health care professionals. The principle barrier was a lack of understanding leading to perceived disrespect and adversarial relationships. This lack of understanding was not only disrespectful to the individual but showed disrespect toward all the relations of that person, including family, Elders, and medicine people. To counteract this lack of understanding, several participants encouraged health professionals to develop meaningful relationships with Aboriginal people who could expose them to cultural knowledge and practices. It was also suggested that health care staff receive cultural proficiency training to become aware of their own biases and to alter misconceptions about Aboriginal people. These types of suggestions are consistent with past reports and the literature that promotes increased awareness of diversity within healthcare settings.

Participants also supported the need to create supportive and welcoming environments within hospital settings. Participants often felt lost and without resources in their time of need and crisis. Further, these environments do not clearly identify the resources available to Aboriginal people who may need assistance and access to sacred

spaces to do their healing work. There has been some progress in this regard as some health care facilities have dedicated space for ceremonies and relaxed policies regarding the use of traditional medicines in hospitals. I have observed this within certain hospitals in the health region I work in. An increase in cultural sensitivity among health staff often leads to more accommodating behaviors. Many hospitals, however, could improve public and patient awareness of the services that could benefit Aboriginal people. These services include interpreters, spiritual care providers, Aboriginal volunteers, and Aboriginal staff who could assist in the mediation of conflicts and concerns.

Finally, participants encouraged hospitals to strengthen their relationships with the Aboriginal community and with Elders and healers. These relationships would be an investment in the development of new services and would serve to heal past harms. As well, this is the only way that the Aboriginal community will understand the culture of health care and therefore avoid false expectations.

The barriers and recommendations presented by participants were reasonable in their intent and focus. What was clearly evident was the fact that Aboriginal people want to be equal participants in their care. They no longer want to be only viewed as recipients of care. The next section explores the learnings that I received as an Aboriginal person who engaged in an indigenous research project. My insights about the significance of type of research are also presented.

Reflections on Indigenous Research Design

This research was an exploration of the relationship between Indigenous healing and western medicine. I firmly believe that the indigenous methodology enabled me as the researcher to access information that may not have been available otherwise. The use

of cultural protocols and approaches utilized in this study were effective in establishing safety and reciprocal respect between both parties. Menzies (2001) describes indigenous research as a powerful intervention and relationship that cannot be carried out at a distance. It is based on important constructs and practices that anchor the process and outcomes into the histories of both the researcher and the participant. Further, it respects the fabric of the lives that give meaning to the information that is shared.

Engaging in indigenous research was an opportunity for me to humbly immerse myself into a different system of knowledge. Although I had been a participant in many traditional healing practices in the past, the study created a "space" where I could deepen my understanding of practices and experiences that were at times new to me. The opportunity to dialogue with participants about unique local remedies and meaningful life experiences expanded my relationship with indigenous knowledge. In my journal I often tried to make sense of the significance that this new information had in my life. The process called on me to prepare myself for future responsibilities that I may be asked to assume.

One of the unique benefits of using Indigenous research methods that I experienced was the "deep" sense that things would go well and that I would be guided through the research journey. As Bishop (1998) states, "immersion into the worldview holds the key to knowing" (p. 208). From the beginning I had turned with confidence to my own traditional "bundle" of knowledge and cultural experience to frame ideas and solve some of the problems I was encountering. The process of offering tobacco and then being patient for the guidance to come meant that I did not feel that I needed to know everything before I proceeded.

In the research relationship with participants, that same sense of comfort and safety was experience. I knew that I had been guided to these persons and that we would both gain from the opportunity to discuss these matters. I was not there to observe. As Lassiter (2000) states, "the emphasis moves from observation of the Other to the observation of the very human relationship between Self and Other" (p. 608). This engaged dialogue enabled me to become acutely conscious of the context surrounding the words. The flow of the exchanged words carried the fragrance of past relationships with each other and with Creation. It felt safe to be exploring knowledge that I knew reflected shared values and beliefs.

As a researcher, the research process also exposed some personal feelings and vulnerabilities regarding the racism and discrimination that came through the discussions. Indigenous research empowers its participants to bring forward painful events from their past in such a way that they can process them in a safe "circle" of support and understanding. Given the discomfort in the community at large to discuss the personal stories of Aboriginal people regarding systemic racism and discrimination and the legacy of colonialism, the research process respects the authenticity of their story. At no point in the discussion did anyone feel they had to change the topic in order to suppress a sensitive issue. The process is free of judgments as these would only compromise the relationship in the moment and into the future, and thus reduce the healing resources and relationships that could be accessed. In this way the process values at a very personal level a person's right to self-determination while emphasizing collaboration that is not based on a perceived power differential.

The research study brought me in tune with my own relationship with

colonization. I began to see more clearly its features and structures within my environments. I became more sensitive to my role and responsibilities towards decolonization and the restoration of harmony within our community. Within my work in healthcare, the paradigm of indigenous research enabled me to better understand the negative dynamics and relationships that often reveal themselves in care encounters. It confirmed my responsibility to be a participant in the restoration of harmony and balance in an environment that had many of its roots firmly entrenched in colonial interests. It also helped me understand the sense of "ethnostress" (Antone, Miller and Myers, 1986) that came from working in an environment that cannot meet certain cultural needs. Having these needs "frozen" only leads to stress between people, regardless of their race.

An indigenous research design is a meaningful paradigm in the production of indigenous knowledge. The process respects the heterogeneity within the Aboriginal community and values the use of unique stories, symbols and alternative language that are grounded in oral tradition as a valid "place" where culture, values, and traditions can live and be shared. On several occasions I was gifted with stories from the life journeys of the participants. All were real, regardless of which dimension they had occurred in. One person shared how they had cried as a child when they realized that the stone they had "skipped" over the water was a grandfather who had possibly taken five hundred years to reach the shore. The person was forever moved when they heard the voice of the grandfather speak to them and from then on a new relationship was formed with this part of Creation.

Hearing another person speak of the intensive healing work that they freely shared with others and the impact this was having on their personal health and family life was

humbling to me. This life work had advanced their relationships with the spirit world in ways that I knew were beyond my development and scope of understanding. I realized that it would take time for me to fully appreciate some of the stories and experiences that were shared with me. I felt I needed to stop thinking about the information and work at being present. It also confirmed the timeless nature of indigenous healing and how it remains current because of these relationships with the past and the cosmos that are carried into the current realm.

The indigenous methodology described in the literature by Colorado and Collins (1988) spoke to me early in my search for a framework of inquiry. The author speaks of four dimensions: feelings, history as a tool, prayer as a medicine, and relations. As a researcher, it was my feelings that told me "when I was ready, whether the situation was right, whether the location was correct, and whether there was balance" (p. 58). My feelings also confirmed the sense that the trust was there between us and that I was would be able to complete the research with integrity and accountability.

History was an invaluable tool within this study. It was useful when needing to share how the participant and myself were related through our clan, through our past experiences, our common experiences as communities, and our relations and kinship through the teachers we had had in common. History is the vessel in which our stories are held. We call upon our ancestors every day to re-create our world and to do so with respect to all our relations. In this way, we can totally live in the moment, which is a technique that is useful when interviews with individuals who have painful events that they need to shed from their being.

Prayer helps to create the "spot" within the person that Colorado (1987) compares

to the hole in the stream where all is still. Prayer is medicine in my life and was used consistently as an offering to mark the beginning and the end of my moments of learning. Prayer teaches us to recognize the voice and not just the words of a person who shares information with us. Words are the carriers of feeling that wrap the experience of the spirit. Relations create stories that cannot belong to a single person. Stories reassure us that someone has walked before us. Relations confirm the deep feeling of connectedness. As an indigenous researcher, the construct of relatedness was re-affirmed.

Lastly, at no time did I feel that the Indigenous design used in this study would be alienating to non-Aboriginal readers. I felt confident that the process would be as liberating to others as it was for me. This is because of my understanding that we all have to decolonize ourselves together and that this approach could lead to improved relationships between individuals and cultural groups who acknowledge each others gifts and contributions to future generations.

Relevance of the Study to Social Work Practice within Health Care Settings

Davidson (1990) states that social work practice within health care settings has developed a "fund of knowledge that has influenced patient care by promoting recognition of the psychosocial components of healthcare" (p. 233). Having said this, the role of the social workers in hospitals often remains unclear within these settings. Egan and Kadushin (1995) explored the perception of social work practice by nurses in hospitals and found that there was disagreement about the role. Disagreements clearly centered around which profession was responsible for the assessment and management of emotional and psychosocial concerns of patients and families receiving care. The overlapping of roles often led to competitive and territorial behavior that impedes the

collaboration that is required in these complex and hierarchal environments. The impact can be felt with patients who may present with unique cultural perspectives and needs that fall outside of the consciousness and scope of experience and practice of these professionals who feel challenged in their roles.

Larouche and Flaherty (2000) identified advocacy, counseling, crisis intervention, and collaboration as the main features of the social work role within hospital settings. It needs to be acknowledged that the social work role may often be at odds with the culture of health care settings where the emphasis is on the specialization and the advancement of medical science. It may be difficult for social workers to pursue a mandate of social and structural change within these environments. There is pressure to reduce role of social work to one that conforms to organizational norms and the unquestioned acceptance of procedures and protocols (Faith, 1999) while maintaining the power and privilege relationships that exist.

Of the four roles identified above, the one of interest to this study regards the scope of advocacy work that occurs within these settings. Advocacy work in social work practice is grounded in the ethical standards and principles of the profession that protect the self-worth and dignity of each individual while protecting their right to self-determination, autonomy and individuality (Canadian Association of Social Workers, 1994). It is inherent that the practice of social work has a duty to respect and protect the indigenous world views and practices that form the spirit of Aboriginal people. In times of crisis, as is always the case when a person enters a hospital, it is imperative that the unique beliefs and practices of the person be explored and integrated into the care and treatment. If not respected, as was shown in the experiences of the participants in this

study, mistrust will result and all future relationships with individuals, their families, and the Aboriginal community will be compromised.

Social workers in hospital settings have a duty to explore cultural experiences and indigenous beliefs and to convey these realities to the care team. This assessment and care process could be facilitated with the utilization of tools such as the "culturagram" as presented by Congress (2004) to respond to diverse needs of patients and families. The tool comprehensively explores cultural dimensions including health beliefs; contact with cultural and religious institutions; values; language preferences and fluency; family structures including power, myths, and rules; and historical factors such as relocation and membership in the community. All these factors influence the person's interpretation of the crisis event. Two areas of dialogue not included here that I would recommend exploring would be the person's past experience(s) with the health care system and their perception of these settings, along with the person's use of traditional medicines and healing approaches. This analysis leads to a more respectful relationship with patients and avoids the common problem within healthcare of making generalizations about Aboriginal people that are usually based on the provider's own history with this population.

It is also advisable that this exploration be conducted within a relationship of trust so that the care provider is not seen as an outsider. This obligates the social worker to be comfortable with their personal cultural 'story' and that this is shared with the client in order to reduce the social distance within the relationship. In my work as an advocate, I have often heard from social workers and other professionals that they are not comfortable sharing this part of themselves and that they do not see the benefits of these

discussions. I interpret this type of response as reflecting the culture of health care settings that emphasize well-intentioned practices that value the protection of boundaries, privacy of the provider, and culturally-sanitized interventions guised as generalist approaches. The harm inherent in taking this stance is that significant dimensions of the person may be dismissed or suppressed. For Aboriginal people, this is reminiscent of past experiences in residential schools, TB sanitariums, the child welfare system, and elsewhere. It brings into the present this oppressive history and confirms for them the belief that they will not be respected and protected.

Understanding that this shift in practice would improve care relationships with Aboriginal persons who comprise the majority of patients served, it goes without saying that competency in this regard would benefit all cultures and races receiving care, including Caucasian individuals who also return to their core beliefs and values when in crisis situations. For example, this has often been witnessed when interacting with the older client population in the hospitals which highlights the inter-generational aspect of cultural diversity.

Recommendations

There are several recommendations that in my opinion emerge from this study. Given the strength of perspectives that were shared by the participants, it is evident that considerable work needs to occur within health facilities, the Aboriginal community, within the profession of social work, and in the field of research regarding the protection and promotion of indigenous healing within the healthcare system. These recommendations build on the guidance and wisdom that was provided by the participants who identified barriers and made valuable suggestions that are supported by

the current literature on the topic.

Education within Health Care Facilities. Health care facilities need to come to terms with their history of poor relationships with the Aboriginal community. This understanding requires that they be aware of the organizational, functional, and human factors that have perpetuated the marginalization of Aboriginal people. The hierarchal nature and patriarchal tendencies of these organizations have contributed to the devaluing of alternative world views that should be welcomed as assets rather than complicating factors within the health care relationship. It is only through education, training, and positive experiences involving the Aboriginal community that health care staff will better understand the worldviews and assets of Aboriginal people. This would lead to more culturally proficient relationships that acknowledge the privileges and inherent power that comes from being part of a privileged minority which is supported in organizations that perpetuate the status quo.

One suggested action in this regard would be that health care facilities and programs, including acute care, long-term care, and primary care sectors undertake a thorough process of organizational and program self-assessment to identify policies, services structures and processes that may be covertly or overtly oppressive because they are not reflective of the cultural and historical realities of the Aboriginal community. The issues that are raised need to be framed within the language of ethics so as to promote advocacy as part of mandate of all health professions.

Health care staff and facilities must also be accountable for behaviors that discriminate and stigmatize those who present, feel, or live differently. Individual and program performance discussions should also include a review of issues that relate to

cultural miscommunication and client care concerns that have a cultural dimension. It is my belief that cultural awareness and sensitivity training is ineffectual if it does not lead to a personal self-assessment of race-based privilege and its resulting oppressive tendencies. Awareness means very little if it is not linked to a demonstrated commitment to take action and become an ally in dismantling the structures of racism. Resources currently exist within healthcare settings that need to be built upon and supported. These include spiritual care departments, patient representatives, and Aboriginal staff who need to come together to mobilize resources and raise awareness.

Work in the Aboriginal Community. There is a strong movement within the Aboriginal community to define ourselves according to our own realities and knowledges. It is recommended that the health care system participate in this process by increasing its participation in this community. It is no longer acceptable that healthcare facilities function independently of its community as they ignore the changes that are occurring outside its walls. Increased participation includes an ongoing commitment to increase employment of Aboriginal people within the health care sector. Meaningful activities are happening in this area, but these efforts need to be supported and sustained. The presence of Aboriginal staff within health care settings significantly increases the cultural safety of Aboriginal patients and clients. It must be said that Aboriginal staff would also contribute significantly to the changing of the "culture" of health care if these efforts were supported. The Aboriginal community needs to stand behind these initiatives and increase its participation in healthcare settings as demonstrated by demanding an active involvement in the design, co-management, evaluation of services, and research. The community needs to continue encouraging youth to train for health careers while

emphasizing that they stay true to their traditions and cultural perspectives.

Another area of improvement that emerged from this study was the need to build awareness within the Aboriginal community regarding the use of traditional healing practices. This is an area of care that is rapidly growing in the Aboriginal community and requires further work to ensure that individuals are supported and that they receive authentic traditional healing from healers who will not exploit a person's vulnerabilities. This is an emerging area that requires further research.

Social Work Practice. It is recommended that social work professionals working in health care settings declare their leadership and show their commitment to advocacy work that leads to structural change within health facilities. It does not suffice that social workers be available to assist with discharge plans and crisis matters that emerge while in care. Social work practice must re-emphasize those aspects of the role that relate to social action and change. Social work practice is often the 'window' of the healthcare system in its role of linking it with the community. As such, social workers need to open the window of change and communicate the realities of the community in ways that lead to a cultural shift within health care settings. In order to do so, social workers must ally with the Aboriginal community and work collaboratively towards changes that respond to the community.

I find it particularly interesting that a recent study looking at hospital social workers experiences with ethics and ethical decision-making (Ashcroft, 2005) neglected to emphasize the ethical issues that emerge because of the very different worldviews that interface in healthcare settings. The only mention to Aboriginal people is a reference to how social workers acknowledged "the role that values associated with ethnicity and

culture might have in overall ethically based discussions" (p.163). I am keenly aware that social work practice in healthcare settings needs to expand its perspectives and resist the pressure to sanitize the care encounter of any cultural dimension. This often leads to a stance of cultural blindness that devalues both the provider and recipient of care as well as often perpetuating the power divide. Increasing the presence of Aboriginal social workers within these settings could contribute to change in this regard.

Social workers have a responsibility to understand the worldviews of the clients and families that they serve. This understanding cannot be grounded in a "deficit" perspective that is often seen in health care. It must come from an understanding of the historical issues as well as the cultural nuances that affect communication patterns, decision-making, and active participation in care. This current study speaks clearly to how Aboriginal people deeply feel the disrespect and oppression that they experience in these hierarchically structured mainstream organizations. It must also build on self awareness of how the worker's own life experiences will affect how Aboriginal people are viewed and served.

Social workers would be in a good position to promote cultural proficiency within hospitals. They are able to interpret cultural norms and the impacts of poverty on the wellbeing of Aboriginal families and the community. As part of a multidisciplinary team, they can also influence decision-making by demanding active involvement of Aboriginal Services in the care of patients and clients.

Future Research Activity. It goes without saying that more research is required to build on the growing body of literature about indigenous knowledge, indigenous healing, and the interaction between these systems of care. More research would help to

better understand the use of traditional healing methods within urban environments and with women. I would posit that the usage of indigenous healing is increasing within urban environments, but this would have to be further explored. This type of research could lead to the development of new programming and services that support the unique needs and realities of this population. Such an analysis would also serve to better support existing and innovative culturally-centered services within health care settings such as the traditional healing clinic at the Health Sciences Centre in Winnipeg, Manitoba.

Further study would also be encouraged within health care settings to ascertain the use of complimentary and alternative medicines and approaches within the patient and client population. Currently, these practices are significantly 'out of sight' of the medical system and need to be assessed for their benefits and risks. It may be surprising to find that there exists a hidden layer beneath the medical layer of care that people do not want to relinquish control of. This should lead to more integration and collaboration between these approaches rather than further marginalization as is often the case now.

The area of cultural safety is a theme that needs to be further explored within health care settings, based on the comments made by the participants. The power differential is significant within institutions like hospitals. This power has been established over many generations and is often difficult to acknowledge by well-intentioned care providers. But for Aboriginal people who are continually reminded in the media and in their interactions with systems of their place in the margins of society, power imbalance is a very real phenomenon that needs to be addressed if equity of care is to be achieved. The literature supports and validates the experiences of Aboriginal people in this regard.

This study also suggests that Aboriginal people be encouraged and supported in every environment to initiate and conduct indigenous research that would better interpret their lived experiences and worldviews. Indigenous research activity is part of the decolonizing discourse and should be promoted as such. Another emerging area of research relates to the growing attention given to cultural proficiency training within our community and the need to assess how it contributes to positive organizational shifts and the promotion of anti-oppressive practices.

Closing Comment

In looking back on this research study, some readers may question some aspects of this study. Someone may question why so much attention was given to the differences between indigenous healing and western medicine. Why not focus on the similarities between the two models of care and use these similarities to strengthen the relationship between them? Also, would it not have been important to measure the outcomes of indigenous healing in order to compare these with western medicine? Could this not lead to new areas of collaboration? I would like to offer here my perspectives regarding these concerns.

This study did not set out with any intent to dismiss the important contributions made by western medicine to the lives of Aboriginal people. All participants were very respectful of its benefits and the expertise of its practitioners. What was revealed within the study is that many Aboriginal people maintain a different worldview that can be at odds with the underlying principles, values, and stance of western medicine. This has led to a sense of mistrust for health care staff who disregard indigenous ways of being. The experience of many indigenous people has been that focusing on similarities between

their beliefs and beliefs grounded in Eurocentric knowledge does not lead to significant change. Rather, this perspective is often guided by an interest among those with power to maintain the status quo by disregarding, minimizing and devaluing the fundamental differences between the knowledges. Focusing on similarities does not require that the person in power shift from their place of privilege and let go of that power. With their power still intact, they can still comfortably define the reality facing them. This stance rarely leads to significant changes or improvements, if at all.

A second issue worth discussing at the close of this thesis is that of outcomes. The literature shows how many researchers, in their pursuit of understanding, have been fixated in the past on assessing the outcomes of indigenous healing practices and comparing these to western approaches or treatment modalities. This well-intentioned interest has not led to any significant support for or acknowledgement of Indigenous practices and world-views. Rather, it has usually resulted in a misappropriation of this knowledge for the benefits of non-Indigenous interests. Indigenous practices are blended into Eurocentric schools of thought and practice to further perpetuate their position of power and privilege. The only change that occurs is that they can now use indigenous knowledge as a credibility "prop" to further perpetuate the perception that they truly understand and "care" for Aboriginal people. There is rarely a genuine interest to support Indigenous self-governance over their own lives and knowledges. Indigenous people are acutely aware of this reality and are reluctant to participate in these endeavors.

Focusing on outcomes is a complex issue for other reasons. It is important when assessing outcomes to examine who will determine what constitutes a positive or negative outcome. Outcome measures are comparative measures and thus are value-laden

in their interpretation and presentation. Participants in this study confidently stand behind the positive and demonstrated outcomes that traditional healing in their lives at an individual and collective level. It would not have been useful that I ask participants to give me evidence of these outcomes. These discussions would have been reduced to "true" or "false" perspectives that could be challenged by others for their validity in "scientific" terms. I could already hear someone dismiss the merits of the indigenous perspectives by citing the lack of research or evidence. The fact remains that no one can render false the beliefs of these participants in the way western science and medicine disputes the truthfulness of science. Despite the claims made by western knowledge, all of science is falsifiable.

It is also important to determine which paradigm researchers will use to evaluate the outcomes of Indigenous healing. If indigenous practices and medicine are evaluated within the disease model, then they may fail to show their merits because their knowledge is not grounded within this paradigm that is controlled by science. I am not saying that Indigenous healing approaches have not been shown to be successful to treat and cure medical conditions and diseases. Indigenous knowledge of the medicinal properties of plants and the natural world has been exploited by economic and scientific interests for many generations.

Assessing the outcomes of Indigenous healing approaches within the "illness" model could lead to greater validation of its power and merits. This is because the construct of "illness" allows for a subjective definition that could include the perceptions, values, and world view of the individual who is experiencing the event. Unfortunately, the illness model is often seen as an adjunct of the disease model. Most health education,

self-care promotion and treatment approaches reinforce the disease model and do not challenge the underlying values of this worldview. In fact, these efforts lead to a suppression of indigenous knowledges and perspectives. The emphasis is usually on treatment rather than healing.

What would be of interest among many indigenous researchers would be the study of outcomes from within an indigenous paradigm. Understanding that the power of indigenous healing lies in the restoration and reclamation of relationships of trust between self and Creation could lead to better understanding of the healing benefits and not just the treatment benefits of these approaches. Indigenous healing practitioners understand that wholistic health and wellness are maintained through a personal and respectful relationship with all of Creation. From within this trusting bond are the resources to attend to disease and harm. As a start, it would be more useful to assess the outcomes of respectful and egalitarian relationships between western medicine practitioners and indigenous healers. Once the benefits of these relationships are understood, new areas of learning will emerge from within this circle of respect.

This research was only one small facet of the complex crystal that is my reality as an Indigenous person and the reality of many Aboriginal people. The opportunity to share this time and process with others through deeply respectful relationships have transformed me and renewed my commitment to help in the full restoration of indigenous knowledge, ways of knowing and being, and ultimately, a way of life that will carry our communities and society into a future where indigenous gifts are shared and used to their full potential. This process began with a sense of synthesis and returns to a place of synthesis within my person and spirit. I brought to this study all of myself: my thoughts

and feelings, my past and present. I brought with me on this journey all my relations and tried to make sure that these were taken care of. I worked to maintain balance and never felt the need to distance myself from the connecting forces in my life. I explored stories deeply with myself in others. The research was integrated into my visiting and sharing food for the body, mind, and spirit. I shared my learnings as I moved forward, integrating them into my daily life and nourishing my relationships. I was not called to keep for myself any of the gifts that were offered to me. To do so would have disrespected the wishes of the giver and the merit to the recipient(s). I learned what I knew in the beginning: that knowledge that I could not integrate into my live would have no life. Learning must lead to ways of being. In sharing these thoughts and word with you, I offer my tobacco and give thanks. Sawee Ni Mishinan Kitchi Manitou, Sawee Nimishinan Ni Moosum, Sawee Nimishinan N'totumuk.

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APPENDICES

Appendix A

INITIAL CONTACT SCRIPT

The researcher will make contact by telephone with eight to twelve volunteers and invite them to participate in an in-person interview with the researcher. If the potential interviewee agrees to an interview, a future date and time will be set. The script for the initial telephone conversation follows:

"Hello, my name is Louis Sorin. I am currently doing a research project as part of my Master of Social Work program with the University of Manitoba. I would like to talk to you about my thesis project and ask you if you would be interested in participating in an interview. Let me take a few minutes to review with you the focus of this interview.

I would like to dialogue with you and ask you some open-ended questions about your use of indigenous medicines and healing approaches and western medicines. The five general questions that guide this research are:

- How are you using "traditional" medicines and healing approaches to help you restore and maintain your health?
- In what way(s) is the use of "traditional" medicines and healing approaches important to you?
- How are these healing approaches connected, if at all, to the care you are receiving from other health professionals?
- How comfortable and/or safe do you feel in discussing your beliefs and practices with health professionals and others?
- What do you feel are some of the barriers that prevent you from using healers, Elders, and ceremonies?"

I am the principal researcher for this project. Professor Michael Hart from the University of Manitoba is my thesis advisor for this project.

Your participation in this interview is voluntary. You are free to withdraw from any part of the study at anytime. This interview should not take more than 1 ½ hours of your time."

Explanation regarding confidentiality, findings, participation, reporting, etc.:

- Your identity will not be disclosed in any way
- You are free not to answer any question if you so choose or choose to stop the interview at any time
- The information collected will remain confidential
- Notes will be stored in a secure place and will be destroyed when no longer needed
- I will be audio-taping this interview and will be taking notes.
- You will have the opportunity to review and provide feedback about the information you shared with me.

You have the opportunity to ask any question about this study. If you have further questions, you may contact Professor Michael Hart at xxx-xxxx or myself at xxx-xxxx at any time. Thank-you.

Appendix B

SUPPLEMENTARY PARTICIPANT INITIAL CONTACT SCRIPT

(In Person or by Telephone)

(Telephone contact) "Hello, this is Louis Sorin calling, may I speak with _____ please. This is Louis Sorin calling, how are you?
(If person has been referred by another participant) "I was given your name by _____ who has been an interview participant in a study that I am conducting. _____ thought that you may be interested in contributing as well. Are you comfortable with _____ having given me your name? Are you comfortable with me contacting you? (If no to either questions then researcher will end telephone discussion. If yes, researcher will proceed with following script)

"I'm calling to ask if you would be interested in participating in a research project that I'm involved in. I am doing a research project as part of my Masters program at the University of Manitoba that is looking at the relationship between traditional healing and western medicine and would like to know if you would be interested in doing an interview with me. I have five questions that I would like to ask you and the interview would be about 1 hour long. The interview would be held at a time and place that is convenient for you. Is this something that you would be interested in assisting with?"
_____yes _____no

(If no) "I understand and respect your choice. If you should change your mind, please feel free to call me at (204) xxx-xxxx. It was nice talking to you. Goodbye."

(If yes) "I'm pleased that you are interested. Can we set up a date and time to meet now? When we meet, I will bring with me a consent form for you to review and sign. I will also take some time to explain in more detail the focus of the research project to you. I appreciate very much your interest and look forward to meeting with you. Thank-you. Goodbye."

(In-person contact) Hello _____, it's good to see you. If you have some time I'd like to ask you if you would be interested in participating in a research project that I am conducting as part of my Masters in Social Work program. Is this something you'd be interested in?"
_____yes _____no

(If no) "I understand, and respect your decision. If you should change your mind, please feel free to contact me and I'll gladly discuss the project with you."

(If yes) "As I stated before, I am doing a research project as part of my Masters program at the University of Manitoba that is looking at the relationship between traditional healing and western medicine and would like to know if you would be interested in doing an interview with me. I have five questions that I would like to ask you and the interview would be about 1 hour long. The interview would be held at a time and place that is convenient for you. Is this something that you would be interested in assisting with? Can we set up a date and time to meet now? When we meet, I will bring with me a consent form for you to review and sign. I will also take some time to explain in more detail the focus of the research project to you. I appreciate very much your interest and look forward to meeting with you."

Appendix C

PARTICIPANT CONSENT FORM

Research Project Title:	**Indigenous Healing and Western Medicine**
Researcher:	Louis G. Sorin, Principal Researcher
Thesis Advisor:	Professor Michael Hart Faculty of Social Work University of Manitoba

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

This research project is a Master's thesis and is part of the researcher's Masters of Social Work program of studies. Your participation in this research is voluntary and declining to participate will have no negative consequences for you.

I understand that I will be having a dialogue with the researcher and will be answering open-ended questions about my use of indigenous medicines and western medicines. The five general questions that guide this research are:

- How are you using "traditional" medicines and healing approaches to help you restore and maintain your health?
- In what way(s) is the use of "traditional" medicines and healing approaches important to you?
- How are these healing approaches connected, if at all, to the care you are receiving from other health professionals?
- How comfortable and/or safe do you feel in discussing your beliefs and practices with health professionals and others?
- What do you feel are some of the barriers that prevent you from using healers, Elders, and ceremonies?

I realize that the interview will be recorded on audio-tape and that notes will be taken. I can request that my interview not be audio taped, but that notes be taken and transcribed immediately. The gathered information will be used to build understanding about the relationship between traditional healing and western medicine for some Aboriginal people. I understand that this information will be used for thesis research and that it will be shared with a committee at the University of Manitoba. I know that I can have a copy of my interview transcript and will be given the opportunity to give feedback and I will receive a copy of the written transcript to look over after the interview. I will also have the opportunity to review the final report to confirm that what I said was accurate.

I acknowledge that the interview will be conducted according to traditional protocols. I know that I will have the opportunity to decide if and how I would like to be identified in the final report. I understand that the digital audio recording, written transcript and notes will be kept in a locked file to

ensure confidentiality. Only the researcher and the thesis advisor will have access to these materials. All study data (audio-transcripts, notes, and written transcripts) will be destroyed after the final thesis report is published (October 2006). All written data will be shredded and digital audio files will be erased.

I understand that I am free to withdraw my consent, without reprisal, and to end my participation in the research project at any time. If I choose to withdraw, any audio recording, transcript, and notes of my interview will be destroyed immediately.

My signature on this form indicates that I have understood to my satisfaction the information regarding participation in the research project and agree to take part as a participant. In no way does this waive my legal rights nor release the researcher, sponsors, or University of Manitoba from their legal and professional responsibilities. I am free to withdraw from the research project at any time, and/or refrain from answering any questions I prefer to omit, without prejudice or consequence. My continued participation should be as informed as my initial consent, so I should feel free to ask for clarification or new information throughout my participation.

I can contact Louis Sorin (Principal Researcher) at xxx-xxxx or Professor Michael Hart (Thesis Advisor) at xxx-xxxx.

This research has been approved by the Psychology/Social Research Ethics Board of the University of Manitoba. If you have any concerns or complaints about this project you can contact any of the above-named persons or the Human Ethics Secretariat at (204) 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

I understand that I can receive, if I desire, a summary report of the study and a transcript of my interview. The summary report of the study will be available in October 2006. Please indicate below which document (either or both) you would like to receive and how you would like to receive them.

I would like to receive (check off which document):

- _____A transcript of my interview by: _____email _____fax _____mail

- _____A summary of the study by: _____email _____fax _____mail

Please provide the necessary information where you would like to receive the requested documents (mailing address, fax number, email address):

_____
_____
_____
_____

_____ _____
Participant Signature Date

_____ _____

Researcher Signature Date

Appendix D

PSYCHOLOGY/SOCIOLOGY RESEARCH ETHICS BOARD (PSREB) APPROVAL CERTIFICATE

APPROVAL CERTIFICATE

19 May 2006

TO: **Louis G. Sorin** (Advisor M. Hart)
Principal Investigator

FROM: **Bruce Tefft, Chair**
Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2006:033**
"Perspectives on the Use of Indigenous Healing Practices: An Indigenous Research Project"

Please be advised that your above-referenced protocol, as revised, has received human ethics approval by the **Psychology/Sociology Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval has been issued based on your agreement with the change(s) to your original protocol required by the PSREB. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Kathryn Bartmanovich, Research Grants & Contract Services (fax 261-0325), including the Sponsor name, before your account can be opened.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**