

Creating Space for the “Sacred” in Cancer Care

Integrating Indigenous Medicines into Health Care

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Abstract *Indigenous First Voice* is utilized to explore the *Two-Eyed Seeing* (“*Etuaptmumk*”) principle to theorize the integration of Indigenous medicines into health care in Canada. Similar to autoethnography, *Indigenous First Voice* positions the experiences and knowledge of the researcher at the heart of the analysis, while bringing formerly erased, contorted and stigmatized knowledges to the fore. In particular we draw on FOURNIER’s account of a recent cancer experience and exploration of her experiences as a *Métis*’ woman to illustrate tensions that require negotiation in order to avoid being absorbed into a dominant biomedical way of understanding health and wellness. We juxtapose her sensory experiences of using Indigenous healing alongside biomedicine for cancer care and call for a dynamic, multi-eyed seeing framework which more accurately captures the nature of the *Two-Eyed Seeing/Etuaptmumk* principle.

Keywords Cancer, Indigenous, *Etuaptmumk*, *Two-Eyed Seeing*, Aboriginal Peoples, Biomedical Dualism, Critical Medical Anthropology, Aesthetics of Healing

Introduction

“The sound of the drum, the smoke, the smell of burning sage. I feel it beyond the bone, I feel it in my blood, like my blood, is remembering something. I always cry when I hear that drumming not out of sadness, but from a feeling of profound relief.”

This excerpt from FOURNIER’s auto-ethnographic cancer notes serves as an entry point into our paper exploring the integration of Indigenous knowledges/medicines² and healing ceremonies into health care in Canada, while evoking cancer as a trope for colonialism and its aftermath. Drawing on *Indigenous First Voice*, a form of auto-ethnography, we expand on the concept of *Two-Eyed Seeing*, referred to as the *Etuaptmumk* principle in the *Mi’Kmaq* language, and theorize the integration of Indigenous medicines into health care more broadly. *Two Eyed Seeing/Etuaptmumk* is a guiding principle positing that we learn to see “from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the

other eye with the strengths of Western knowledges and ways of knowing, and to us[e] both these eyes together, for the benefit of all” (BARTLETT *et al.* 2012: 335). *Etuaptmumk/Two-Eyed Seeing* is linked to the broader movement of “decolonizing” health care institutions through integrating Indigenous medicines/knowledges and forms of governance, to help foster safer and more inclusive health care access in Canada (cf. BRUNGER & WALL 2016; CHRISJOHN & WASACASE 2009; JAMES 2012; MARTIN-HILL 2003; ROBBINS & DEWAR 2011). Over the past decade, multiple calls proliferated to examine how Indigenous healing differs from biomedicine, and the need to examine how best to incorporate Indigenous medicines/knowledges into biomedical contexts (cf. BENOIT *et al.* 2003; HOLLENBERG & MUZZIN 2010; MANITOWABE & SHAWANDE 2013; ROBINSON *et al.* 2017). This paper is a modest contribution to these calls and more broadly toward overcoming the mind-body dualism of biomedical approaches.

Indigenous?

Before embarking on this journey, we need to clarify our use of the term *Indigenous*, a recently proliferating concept that emerged due in part at least, to the surge of *settler-indigenous* studies. In Canada, it is often used to refer broadly to Aboriginal Peoples, a constitutional category referring to: *First Nations* (registered and non-registered Indians), *Métis* and *Inuit* Peoples. Aboriginal Peoples in Canada have been, and continue to be, in a unique position in terms of International Law due to the *Doctrine of Aboriginal Title* applied in Canada, USA, New Zealand and Australia (cf. OAKLEY 2006). In Canada, colonial and post-colonial practices (NEU 2002) and policies, such as demographically erasing people through the colonial period based on the virulent *Indian Act*, were explicitly designed to assimilate *Aboriginal Peoples* into a *Euro-Settler* norm (MACKEY 1997; SMITH 2012). The *Indian Act* is a Canadian federal governing document, with legal implications, that allows the government to control many aspects of Indigenous Peoples lives including who is considered Indigenous in the eyes of the state. It was and remains part of the assimilationist strategy in Canada (JOSEPH 1991; PALMATER 2011), along with forcing people to take up agriculture instead of gathering, hunting and fishing, enforced sedentism (GRYGIER 1994), banning of essential economic and spiritual practices, (KELM 1999), conversion to forms of Christianity (SMITH 2001), starvation (DASCHUK 2013), forced sterilization (STOTE 2015), shaming and devaluing language/culture, and erasing womens' and off reserve peoples' right to claim Indigenous status (CANNON 2007). All these processes made people more susceptible to opportunistic infections and co-infections (KELTON 2007). While some have referred to these processes as constituting "ethnocide" (SIDER 2014), others name these processes, including infamous "gift" of smallpox (MANN 2009) and scalping proclamations (PAUL 2006), genocide. In addition to this was the residential school system, where Indigenous children were removed from their families and forced into Indian residential schools that were meant to aggressively strip them of their culture, languages, Indigenous worldviews and ways of living (MMWIG Report 2019; SMITH 2001). A paternalistic serial foster care system (CRICHLAW

2002), overrepresentation in the penal system (JACKSON 1989a; RUDIN 2008), intergenerational trauma (MENZIES 2008) and resulting suicide epidemics (WEXLER & GONE 2016) led to the development of a massive infrastructure governing the health and lives of Indigenous peoples; something that Harlan Lane, in comparing Deaf and indigenous/colonised peoples find themselves subject to "masks of benevolence" (LANE 1999): the perpetuation of infrastructures ultimately designed with assimilation in mind. Much of this surge of information on Indigenous Peoples, has come to public attention in recent years as a result of the UN's Decade of Aboriginal Peoples (1994–2004) and in Canada, the Truth and Reconciliation Commission Report. The *Truth and Reconciliation Commission* (TRC) is a component of the *Indian Residential Schools Settlement Agreement*, which was created with the support of the *Assembly of First Nations* and *Inuit* organizations in which, former residential school students took the federal government and the churches to court (TRC 2015). These cases led to the *Indian Residential Schools Settlement Agreement*, the largest class-action settlement in Canadian history. The agreement sought to begin repairing the harm caused by residential schools. The TRC's mandate was to inform all Canadians about what happened in *Indian Residential Schools* (IRS) in Canada between 1883 and 1996, and to address the ongoing impact of colonization on Indigenous Peoples. Hence, while being aware of the wider implications accompanying the surge of "Indigenous" as generalised terminology that has the potential to obscure the specific focus from Canadian *Aboriginal Peoples* (cf. OAKLEY 2019, 2021), we do use the term in this paper to refer to "those which have a historical continuity with pre-invasion and precolonial societies that develop on their territories, consider themselves as distinct from other sectors of societies now prevailing in those territories [...] and are determined to preserve and transmit to future generations their ancestral territories" (VALEGGIA & SNODGRASS 2015: 119, citing MARTINEZ COBO 1981: 10).

Colonization and Medicine

While it is clear that the elements pointed out above created the foundation for assuredly poor health among Canada's Indigenous Peoples, it is

important to note that the specific experience of colonialization under the Indian Act was accompanied by the penetration of Christian missions and biomedicine into Indigenous communities that was instrumental in the expansion of the Euro-Canadian frontier (cf. KELM 1998; LAUGRAND & OOSTEN 2014; ROBBINS & DEWAR 2011). KELM (1999) argues this happened partially through the construction of imperial biomedicine as superior, while Indigenous ceremonies/medicines were reduced mere superstitious quackery and/or witchcraft. In fact, as mentioned earlier, many Indigenous healing ceremonies were banned and even considered a criminal offense between 1885 to 1951 by the state. Colonialism and colonial processes have been articulated as a social determinant of health (cf. MANITOWABI & MAAR 2018). The legacies of colonization have also left in their wake a significant lack of trust in mainstream biomedicine amongst many Indigenous Peoples in Canada (VOGEL 2015). The TRC calls to action such as the integration of Indigenous medicines/ceremonies into health care are seen by the government as one way to rebuild this lost trust with Indigenous Peoples. This is important in this context as the government is providing millions of dollars in funding for numerous initiatives to help integrate Indigenous medicines/healing into biomedical health care settings. While there are questions to be raised about whether the state will continue to support these programs now that the TRC is closed, and the acceptability of the content of the programs by Indigenous Peoples who use them, it can still be stated that some cultural inroads in public health have been initiated through the funds (cf. ALLEN *et al.* 2020; CAMERON *et al.* 2019; COOK *et al.* 2019).

Methodology

Given the context discussed above we want to examine, how can sacred healing spaces, spaces of hope, be created, while dealing with cancer? What are the tensions that require navigation and how can they be theorized using sensory aspects of healing to build on existing understandings? Within these spaces can methodology become an embodied experience as well as an intellectual exercise? We explore the *Two Eyed Seeing/Etuaptmunk* principle and query the need to accentuate/

highlight the spaces and tensions *between* “Indigenous” and “Euro-centric” ways of knowing rather than their integration, while drawing on notions of embodied space (cf. LOW 2003). We also suggest that in this instance we must move beyond mere physically embodied space to include other aspects of being, such as spiritual, emotional and historical realms, or toward a “*wholistic*” embodiment (cf. BLACKSTOCK 2011; WALTERS *et al.* 2011).

In order to explore our questions, we draw on FOURNIER’s experience of a recent cancer diagnosis while also exploring her awakening identity as a *Métis* woman.³ Specifically, we juxtapose FOURNIER’s “wholistic embodied” sensory experiences of engaging with Indigenous healing approaches alongside biomedicine for cancer care to help develop *Two Eyed Seeing/Etuaptmunk* towards a more dynamic *Multi-Eyed Seeing* framework, which more accurately captures the intended essence of the *Two-Eyed Seeing/Etuaptmunk* paradigm according to Elder ALBERT MARSHALL (cf. BARTLETT *et al.* 2012). Throughout we draw on the literature that explores the *aesthetics of healing*, as well as theories of embodiment to help develop our argument (cf. CSORDAS 1990, 1993; NICHTER 2008).

We employ an Indigenous and decolonizing approach, (*i.e.* Indigenous First Voice) informed by Indigenous scholars such as BULL (2010), CHILISA (2011), KOVACH (2009), SMITH (2012), and WILSON (2009). A decolonizing approach entails privileging throughout the research process Indigenous worldviews and knowledges that come from an Indigenous paradigm, and not just an Indigenous perspective (WILSON 2001). An Indigenous paradigm derives from the “fundamental belief that knowledge is relational” (BLASTOCK 2011; WILSON 2001: 176; cf. JOSEPHIDES & GRØNSETH 2017). We also draw on BUROWAY’s (1998) extended case method, which encourages a reflexive model of research/science that emphasizes, rather than tries to underplay or obscure, the intersubjectivity between researcher and “subject.” BUROWAY’s extended case method purposefully blurs and even tries to erase the bounded spaces of “researcher” and “researched” and is in line with Indigenous methodologies and relationality (cf. CHILISA 2011; KOVACH 2009; SMITH 2012; WILSON 2008). In this regard we dig deep into our pasts to salvage the

knowledges undermined by the processes of assimilation in Canada through the *Indian Act*.

DENZIN *et al.* (2008) define Indigenous decolonizing methodologies as “research by and for Indigenous peoples, using techniques and methods drawn from traditions and knowledges of those peoples” (*ibid.* x). Indigenous methodologies also highlight the role that past and present forms of colonization, imperialism and globalization play in the construction of knowledge, and help illuminate the ways that Euro-centric paradigms tend to carry with them “imperial power” over vulnerable populations (CHILISA 2012: 8). SHAWN WILSON (2008), a *Cree* scholar, maintains that Indigenous research needs to be enacted as a form of ceremony in itself, a pathway of learning and healing in its own right (see also CORNTASSEL & T’LAKWADZI 2009). While LINDA TUHIWAI-SMITH (2012), a *Māori* scholar, argues that we deconstruct Western scholarship through carving out spaces for Indigenous peoples to tell their own story in their own way. Indigenous methodologies, including *Indigenous First Voice*, helps honour this goal as it brings to the fore a relational ontological stance to understanding the world; a stance that opens space for Indigenous perspectives and ways of understanding disease and wellness, where the person is considered an inseparable part of a wider social, and natural world; a world where one is also connected to a spirit realm.

In this paper we specifically draw on *Indigenous First Voice* excerpts from FOURNIER’s cancer journal, to frame the research within the personal/subjective realm, an important element of Indigenous and decolonizing approaches to research (CHILISA 2012; GRAVELINE-FRYE 1998; SMITH 2012). *Indigenous First Voice* also requires that we examine our self-in relation, to all that surrounds us, our experiences, and to view the people, places and things we encounter as interconnected; so intertwined that we cannot possibly separate ourselves or other research “subjects” as objects (cf. WILSON 2001). Knowledge is relational (*ibid.*). In the words of GEORGE SEFA-DEI (2013), “ideas develop through relations we have with others” (*ibid.* 29) and not just human others, but the natural world and all of our experiences.

Embodying Methodology

In her book *Lost Selves and Lonely Persons*, ANNE SIGFRID GRØNSETH (2010) highlights the importance of emotion and the body in the research experience; for example, using body language, embodiment, and a felt, or subjective sense of what is happening when gathering data, as well as when engaging with research participants. This perspective purposefully places the “self-in-relation” as one of the center points, of not only the research process, but findings as well: “to recognize the embodiedness of our ‘being in the world’ is to discover a common ground where self and other are on” (JACKSON 1989b, quoted in GRØNSETH 2010: 10), a place where our interconnection with others, the earth, animals and plants is *felt* rather than just theorized, and where theorization is as much an embodied experience as it is an intellectual exercise.

CSORDAS (1990), on the other hand, argues for a paradigm of *embodiment* that transcends methodology. In this sense the “body then is not an object to be studied in relation to culture but is to be considered as the subject of culture, or in other words as the existential ground of culture” (*ibid.* 3); our self-in-relation to culture. In keeping with Indigenous perspectives this “subject” of culture must also include our emotional and spiritual bodies; a wholistic embodiment of “self” which does not separate or even see as separate, the body/mind/spirit and emotions. In this study FOURNIER’s body, mind, emotions and spirit are an integral instrument of study, an instrument that explores *through* her experiences from inside out, as well as in relation to the broader social, political and economic structures around her (cf. ELLIS 2004; WHITINUI 2015) from outside in.

Decolonizing Cancer Care

“Dear cancer, I hate you—you make me feel like I am a bad person that I did something wrong to deserve you sneaking up on me like you did and shattering my trust in myself, my body, and the whole universe. I hate you so much. All the people you sneak up on and take away, many good people, kind people. I think you are mean and careless—you should be more discerning. You take so much without asking.”

This emotive *Indigenous First Voice/ auto-ethnographic* entry from FOURNIER’s cancer journal at the first stage of her diagnosis is used here as a trope for the sense of disempowerment one tends to internalize resulting from biomedical ways of understanding and explaining cancer. Within biomedical approaches the “patient” tends to be reduced to a helpless victim of genetics and family medical histories and for FOURNIER this contributed further to a profound sense of bewilderment and lack of control over her health. This is in sharp juxtaposition from the way she has experienced local Indigenous perspectives and ways of understanding disease and wellness, where the person is considered an inseparable part of a wider social, and natural world; a world where one is also connected to a powerful spirit realm, part of a broader collective rather than an individual whose body has become dis-eased. In this understanding, illness, including cancer, is seen as originating first in the spirit (cf. ISEKE 2013), and cannot be reduced to mere cells going haywire as is it often explained within biomedical paradigms.

We consider cancer a trope for colonialism, assimilation and capitalism, since, like cancer, these can profoundly impact one’s being; they reshape or annihilate one’s sense of self, and ways of living in fundamental and sometimes invisible ways (cf. COULTHARD 2014; HO 2011). SCHEPER-HUGHES and LOCK (1987) suggest that “cultural constructions of and about the body are useful in sustaining particular views of society and social relations” (*ibid.* 19). The body, and its various diseases, are also potentially a terrain, where capitalism manifests and shapes how we relate to, and feel about our bodies, and our health (cf. HO 2011; KLAWITER 2008). For example, our bodies tend to be valued based on their productivity, rather than their ability to sense and feel (LEVIN 1985). According to LEVIN (*ibid.*), MARX “formulated with remarkable awareness and understanding the most central goal: to ‘humanize’ or ‘spiritualize’ the senses, and bodily life in general, as part of the process of self-development and self-realization” (*ibid.* 237; cf. BAER *et al.* 2013; COBURN & NAVARRO 2015; COLLYER 2015). According to CSORDAS (1993), theories of embodiment, for example, may fall short as they may exclude or obscure other interconnected realms, such as the spiritual and emotional. Drawing on MARX, LEVIN (1985) ar-

gues that the body and the body politic are “an inseparable existential unit” (*ibid.* 237) and that we must change the political economy before we can evolve our potential to develop what he calls a “radical ontology of embodiment” (*ibid.*) and we argue here for one which includes these other realms as a way to resist the oppressive forces of colonialism and capitalism.

The impact of colonialism and capitalism includes limiting what kinds of health care is accessible, and to whom, how one navigates “care” when sick, and how the content of health care influences the ways we think and feel about our bodies and selves in relation to particular illnesses (cf. BOURASSA *et al.* 2004; COBURN 2010; KLAWITER 2008). While the reductionist hallmark of biomedicine is to separate the mind and spirit from the body (GRØSNETH 2001; HORDEN & HSU 2013; MOL 2003; SCHEPER-HUGHES & LOCK 1987; LUDTKE 2008; WELCH 2003) this imposed division represents another form of colonization and ultimately impacts how we conceptualize particular symptoms, and illnesses, including the tendency to reduce illness to just the cellular level (cf. HOKOWHITU 2009; JAIN 2013; LOCK & NGUYEN 2018). For example, reducing cancer to mere genetics, cells gone haywire, erasing the impact of not being able to access affordable, healthy food, diminishing the devastating impact of environmental degradation, industrial deregulation and the presence of known carcinogens in our food and water supplies, and so on. At a local and global level, these erasures obscure the role of government and industry from being held accountable for the continual and excessive extraction and polluting of resources from the earth for profit.

In an effort to “decolonize” cancer care for Indigenous Peoples, CANCER CARE ONTARIO (CCO), a provincial organization in Canada, implemented an *Indigenous Navigator* program in 2013 to help Indigenous Peoples navigate the heavily colonized and increasingly corporatized Canadian health care system (COBURN 2010). CCO formally recognizes the brutal treatment of Indigenous Peoples in residential schools and Indian hospitals, the criminalization of healing ceremonies (cf. KELM 1999), and ongoing experiences of racism and discrimination in the Canadian health care system (cf. TANG & BROWNE 2008). The program is available to anyone with a cancer diagnosis who self

identifies as Indigenous. It also helps link Indigenous people to *Indigenous Elders* and healers, as well as provides support and helps patients navigate the biomedical health care system. An Indigenous *Elder* is someone who is a respected member of an Indigenous community and is considered a “knowledge custodian” of their community’s history, traditional teachings and ceremonies. *Elders* can also act as leaders, teachers and healers.

Through this program FOURNIER has been able to access an *Elder*, and a healer, both of whom have been profound mentors for her healing journey, which has included honouring her *Métis* ancestry and culture and resisting the impact of colonization in her own family. CCO is pivoted on providing a means for enhancing people’s connection to a wider healing collective that draws on drumming, singing, shake tents, smudges, sweats, and other Indigenous spiritual practices considered essential parts of healing that must be embodied through all aspects of the self: physical, mental, emotional, spiritual, as well as community and the connection to land (cf. AUGER 2016; BARTLETT 2005; CHILSEA 2012; GRAVELINE-FRYE 1998; SMITH 2012; WANE *et al.* 2011).

One particularly potent element is the “shake tent”⁴ a ceremony, which involves connecting to the spirit realm for healing (STRUTHERS & ESCHITI 2005). The shake tent is usually held on the land in the dark⁵ by a healer with the help of an *oshkaabewis* (“ceremonial attendant”). FOURNIER experienced what is referred to in English as a “doctoring” during a shake tent indoors. This included laying down on the floor, covered with a coarsely textured, yet strangely inviting, brown bear pelt in a pitch dark room surrounded by sacred medicines and artefacts, with about twenty women, including two healers and other women from the community, standing around her in a circle, drumming and singing loudly. This was done to put her cancer “to sleep,” remind her spirit that she is part of a community and is surrounded by ancestors and helpers, and needs to remain on this earth longer; it was done to help her spirit heal. Shake tents are re-emerging as an important method for healing trauma as a result of colonization within many Indigenous communities (cf. STRUTHERS & ESCHITI 2005). The following *First Voice* excerpts highlights the sensory components of FOURNIER’s experience:

“As soon as I saw that bear pelt I went right over and touched it and immediately started to cry. It felt course and soft at the same time – so thick and welcoming. I laid down on that pelt and cried for a long time; I felt so safe. I can’t explain it, but I was drawn to it, and while I was lying there surrounded by medicines and all that fur I felt connected to something more powerful than I know how to even explain.”

Then later during the “doctoring” ceremony:

“The room is pitch dark and I am asked to lay down on this soft fur—it feels so warm and inviting and I feel myself relax and immediately and I just start to cry. There is a circle of women around me including a healer, holding space while drumming and singing. I can feel the energy in the room and I feel safe and surrounded—I cry for what feels like a long time and the singing and drumming keep getting louder and louder. Then it suddenly stops and everything gets quiet[...].”

Both of these quotes highlight an embodied sense of connectedness and safety that is integral to the healing ceremony. A critical component to FOURNIER’s recovery and relief from the profound sense of bewilderment a cancer diagnosis caused. In contrast, here is another excerpt focusing on FOURNIER’s sensory experience of biomedical cancer care:

I go into a small room and take off my clothes and put on the gown. I enter the room and am told to lie down. I lay down on a cold metal slab of a bed, the room is so bright and stark, and I feel really scared. I start to feel the drugs entering my body I feel them burning in my veins...then burning all through my body, it feels like I have no control and my body is burning up from the inside out. I feel so alone, I am alone. I close my eyes and try to breathe through it. Then the attendant comes back in the room, takes out the needle and escorts me out of the room.

One of the striking elements of difference between these experiences is not only the stark difference in their sensory aspect, but the emotion that is evoked in each: the contrasting sense of community and sense of aloneness, the sense of pain and fear and the sense of warmth and healing. The healing ceremonies evoke a sense of connectedness to something beyond everyday experience, a sense of belonging and support that extends beyond the physical into the spirit realm,

and also the emotional release that the ceremony helps bring about. All aspects of the self, the physical, mental, emotional, spiritual as well as a sense of belonging to community and connection to land are central to this healing ceremony.

In the biomedical encounter, one is placed in a queue, often there is a separate waiting room, where one sits quietly amongst other patients, and although there is a sense that we are all there for a similar reason, there is little or no conversation, and the anxiety in the room is deafening. There may be an occasional knowing or understanding look, but there is no space for connecting even in this common waiting area, yet we are likely all connected by anxiety and fear. We sit in our own chairs which are set up linearly in rows, and the walls have posters that remind us to get our flu shots, or to not speak loudly, and to turn off our cell phones. The medicine they give you tastes metallic and leaves a lingering bad taste in your mouth. For FOURNIER, making sense of these vastly different experiences requires compartmentalizing each form of care, however, she is intimately involved in each; her body, mind, spirit is profoundly impacted by both, yet in vastly different ways. This compartmentalization is only partially successful however, as she is the subject of both and as such she must navigate and linger in the in-between spaces to become whole—to bring the experiences into some form of cohesiveness.

Navigating care from both biomedical approaches and Indigenous healing ceremonies forces one into these liminal spaces: making sense of a bewildering disease, as well as finding a sense of internal reconciliation between these vastly different approaches. In one instance the sensory experience of care is immediate and inclusive. The living experience of the “doctoring” ceremony is empowering and rich with a sense of feeling a part of something larger than just a mere physical body, a sense of being “surrounded,” being part of a larger collective, as well as being in a space of hope rather than just fear. In the biomedical experience one is part of a protocol of care that is standardized based on the particular cellular level characteristics of the cancer one is diagnosed with and has little to do with one’s “self”

Two-Eyed Seeing and Holding Space for the Sacred

Two-Eyed Seeing/Etuaptmumk is one of many Indigenous epistemologies that is geared toward decolonizing healthcare practices in Canada (cf. IWAMA *et al.* 2009; MARTIN 2012). Although *Two Eyed Seeing/Etuaptmumk* is meant as a unifying narrative, its limitation, in the way it tends to be utilized in health care research, is that it can end up reifying a false binary between “Western” and “Indigenous” (cf. DEI 2009). This binary negates the array of nuance among “Indigenous” Peoples (cf. SHIVA 2000), and does not account for the way health care reform in Canada is being shaped by neoliberal ideologies, such as the increasing privatization of health care services (cf. MCGREGOR 2001; NAVARRO & SHI 2001), including becoming increasingly privatized (cf. FLOOD & ARCHIBALD 2001; LEYS 2009). Furthermore, within each term, “Indigenous” and “Western,” there is nuance and complexity that must be explored, a need to understand and illuminate the external forces shaping each. OAKLEY’s *Mi’kmaq* great grandmother, who raised her, used to refer to herself as “granny spider” saying there are many ways to see the world and taught her that health and that healing can never be boiled down to one or two “siloe approaches” (cf. WALDRON 2010).

Nonetheless, *Two Eyed Seeing/Etuaptmumk* does help highlight a way of seeing health and health care that includes, for example incorporating elements of Indigenous practice into biomedical public health care settings such as hospitals, clinics and a recognition such as shake tents, sweats, smudges, drumming, incorporating Indigenous knowledges and so on. It includes a recognition that health and illness involve wider social, emotional, biographical and spiritual spheres, not just a fixation on the physical body. Further, *Two Eyed Seeing/Etuaptmumk* as a “way” of understanding biomedicine’s mind-body dichotomy is also helpful as it has the potential to draw attention to rather than obscure some of the tensions between differing perspectives and may protect Indigenous knowledges and healing ceremonies that are at risk of being assimilated, or contorted to fit within the boundaries of biomedicine. For example, in biomedicine a cancer diagnosis is placed into the biomedical assembly line of treat-

ment protocols, and its management is set in motion based on the cancer's cellular level characteristics. Instead of being seen as a whole person, the patient is viewed/treated more like a mechanical body, broken down into diseased parts such as healthy and unhealthy cells, diseased and healthy organs, that are alienated from one's whole "self" (cf. BROOM & TOVEY 2007; GRØSNETH 2014). Further, not only is our body, mind, and spirit not considered as part of a unified whole during the clinical encounter; we tend to also be stripped from our physical and social environment (cf. GRØSNETH 2014; HO 2011). Here is another quote from FOURNIER's cancer journal that highlights these separations:

"In the hospital everything is bright and cold, the lighting is stark and I feel like I am constantly under interrogation. There is nothing subtle or left to the imagination. On the way to surgery I am alone, my family is left to wait in a separate room. I am wheeled to the operating room lying down on a bed, it was so disorienting, I couldn't see where I was going and once I got to the surgery room everything was so cold, all shiny metal and more ultra-bright lights, the sounds in the room were echoey, and shrill, exaggerated by starkness of the room and the sterility of everything in there. Then I am transferred to a cold metal bed, and there are so many machines, monitoring machines that kept beeping. I was then pricked in the arm to get an IV and a mask was put over my mouth, I can no longer speak, or move...they tell me to start counting to 10 and the next thing I know I wake up groggy and confused in another room, a 'recovery' room by myself."

These are mundane experiences in the biomedical encounter, where disease is made to cohere through a range of alienating practices such as blood tests, surgery and CT scans, narratives, documents and files (cf. MOL 2003). To illustrate further, when FOURNIER told one of her biomedical practitioners that her mood was up and down after her cancer diagnosis (a common experience among cancer patients), they asked if she was crying a lot and handed her a paper with a depression scale questionnaire, with questions such as "in the past two weeks how often have you been bothered by the following: little or no interest in doing things; little interest or pleasure in doing things and feeling tired or having little energy?"

The possible responses range from not at all to several days, more than half the days and nearly everyday. This depression scale was created by a large pharmaceutical company and is a standard evaluation form given to patients to assess their degree of depression and to determine prescription of psycho-tropic medications.

This depression questionnaire, an idiosyncratic cultural artefact endorsed by the pharmaceutical company who developed it, both objectifies and individualizes the illness experience in a peculiar manner, and also reifies any emotional experience into a tightly controlled and reductionist classification system to be measured. For FOURNIER, this scale did not fit – the questions were too generic and vague. The "solution" if one scores high on this scale is quite peculiar, but not surprising: pharmaceuticals, in this instance anti-depressants. Additionally, her family doctor suggested she take a vacation, to go somewhere and relax in order to recover psychologically from having cancer. This type of biomedical encounter leaves it up to the individual to navigate their way through this process and rely on pharmaceuticals for support, or having the privilege to take a vacation.

On the other hand, when FOURNIER talked about her low mood and sadness with the *Elder* and the healer, they both spoke about the need to cry to let the sadness out, and that not only her tears, but the cancer itself was medicine, a way of healing from intergenerational trauma, and the impact colonization and assimilation had on her family. She was not asked about the frequency of her crying, instead she was encouraged to express her emotions and to engage with ceremony with community to help heal. During this time, she received a spirit name, to help provide a sense of belonging, and community, a spiritual home. She also received a pipe: a sacred spiritual tool that is used to connect to the spirit realm. She was told that going through cancer and other deep personal struggles to help heal herself and her family earned her this honour. It is this connection to community and ceremony that grew out of her cancer experience that has had a major impact on FOURNIER's healing experience: It took a cancer diagnosis to help connect her to community and ceremony, as well as helping her reconnect to her family's Indigenous roots. For many Indigenous Peoples, particularly those who did not grow up

on reserve, grew up in urban settings, or whose families hid their identities to survive, it can be very difficult to find a sense of belonging to community.

Additionally, as mentioned earlier there is little recognition in the biomedical clinical encounter that the root of many cancers lies in the toxic activities from unregulated corporate industrial practices (cf. KRESS & STINE 2017; SINGER & BAER 2009; TSING 2015), and a flagrant disregard of subaltern communities who bear a heavy cost from these activities, sometimes referred to as forms of environmental racism (cf. WALDRON 2018). In short, as BRIAN MCKENNA (2012b) states “biomedicine focuses on diseased bodies, not the body politic” (*ibid.* 96; cf. HOLMES 2013), yet as argued by LEVIN (1985) the body and the body politic have become one existential unit. Indeed, having cancer forces one to pay attention in ways one may not have before and commands our “bewildered attention” (cf. LITTLE *et al.* 1998) and here, we purposefully place the “self” and its link to a wider collective at the fore (cf. GRØNSETH 2010; HOLMES 2013). An Indigenous healing approach, as told here, enhances our interconnection with other people, the earth, animals, plants and the spirit realm, and helps one carve out space for a “healing journey.” In this instance illness was transformed into powerful “medicine,” and cancer a catalyst for intergenerational healing, resisting assimilation and strengthening Indigenous roots and traditions as well as developing a sense of community (cf. COTE-MEEK 2014; WANE *et al.* 2011). Carving out spaces like this and navigating health care in a way that is meaningful, transformative and also effective is challenging, yet crucial, particularly when one is dealing with a serious diagnosis such as cancer (cf. MCCABE 2008; STRUTHERS & ESCHITI 2005).

Carving a Space for the Sacred

We started writing this paper during a really hopeful moment in Canadian health care when Indigenous approaches were just on the cusp on being shaped and incorporated across the provinces. The meaning of this could include things like shake tents, smudges, or perhaps drumming in the forest and ways of strengthening people’s connection to nature and to each other. For OAKLEY,

picking an array of summer berries is a cherished link to her great grandmother and the extended family, for whom collectively gathering and processing these summer fruits was the main way to access fruit in the winter. It was part of a seasonal mainstay including fishing, hunting and getting together with relatives to also share stories and songs. The seasonal gathering of wild foods is as much a part of maintaining bodily health as a sacred way to build social health through getting together and processing the food as for example outlined by TURNER and CLIFTON (2006) for the *Gitga’at*, a First Nations peoples from British Columbia:

“[T]he harvesting processing, and use of this seaweed, undertaken for many centuries by the *Gitga’at* and their ancestors and still practiced today, is infused within all facets of *Gitga’at* culture and life ways, and is vital to their identity, health and well-being as a people [...] continued use in the face of economic restructuring and accelerating cultural change since the time of European contact is remarkable. In a sense, the use of seaweed represents the resiliency of a people [...] provides important opportunities for knowledge acquisition and communication, and promotes health and well-being through providing a nutritious food, requiring a healthy outdoor lifestyle, and promoting cultural values.” (*ibid.* 160)

Without knowing the salience of a thing, the meaning and sacredness to individual and community health could be missed entirely as LYONS (2010) pointed out with regard to sleeping sickness in the *Belgian Congo* and the clearing and burning of bushes where the *Tsetse* fly lived but was disregarded by Europeans and instead harmful medicines with debilitating side effects were seen as the “pseudo” solution. There is also the more recent case in *Northern Ghana* where international health and aid agencies, informed by *Christian* concepts of death and disease, thought it important to eradicate *Guinea worms*, whereas for the local people the presence of the disease was an important part of their cosmology related to health and illness (cf. MORAN THOMAS 2013). We raise these cases because they highlight issues at play now, in the midst of the COVID19 crisis and the dominance of the germ theory approach to health and illness, a moment significantly different than where we began the paper. Much like the narrow,

invasive and depersonalised approach to “treating” cancer outlined by FOURNIER, the COVID-19 crisis has once again affirmed the idea that there is only one acceptable “scientific” body of knowledge and all others are dangerous, suspect and risky. Funding is being prioritized toward the virus, as we can already see in Canada with increased wait-times overall let alone for incorporating elements that might bridge the mind-body dichotomy of biomedicine as Indigenous approaches could do. With the ending of the TRC undertaking, the rise of COVID-19 and associated funding, it is difficult to say where the current interest in Indigenous approaches to health care will lead in Canada. We hope that this paper might provide a modest example of how incorporating Indigenous approaches has a great deal of value to bridge the mind-body divide of biomedicine.

Concluding Thoughts

What does this mean for health care in general? While spaces are being carved out for Indigenous medicines/knowledges, we suggest a move to “multi-eyed seeing,” maybe more like a “granny spider” to allow for the rich diverse approaches of Canada’s Indigenous Peoples to be incorporated and valued, one that accounts for the impact of colonialism, and capitalism on how knowledges are shaped and enacted in the realm of health care. By maximizing our inter-relatedness to spirit, community, people, the environment and all other forms of life, we are actively decolonizing health care spaces and embracing Indigenous ceremony as profound acts of healing (WARD GAILEY 2003).

There are sensory/aesthetic implications of healing raised by our analysis as well. FOURNIER’s sensory experience of biomedical practices contrasts markedly with her experience of Indigenous healing practices. While the former tends to isolate individuals and separate the body from its social and spiritual context, the latter grounds healing in community and spirituality. As such, the shortcomings of biomedicine may be felt and experienced more profoundly by those for whom ceremony is integral to their way of life. Further, our exploratory analysis suggests rather than striving for a way to combine the strengths of both approaches, what is needed instead is to understand the tensions between them, where they originate,

the implications for health and well-being, and for whom. This kind of approach challenges the dichotomies that were established during colonization, representing a first step in opening up space for the sacred in health care.

Both authors see in stark detail, the enhanced urgency to continue to create spaces for sacred Indigenous forms of healing that reunite the mind and body and recognize the intimate link between individuals and a wider social and natural environment. We hope that this paper will contribute to helping to see why it is important to continue to insist on incorporation of these elements into health care, perhaps now more than ever, as public health and biomedicine become increasingly technologized, and more comprehensive concepts of health and illness swept aside for universalised notions of public health and safety.

Notes

- 1 The Métis in Canada are specific cultural communities who trace their descent to First Nations and European settlers, primarily the French.
- 2 Indigenous medicines in this instance refers to healing ceremonies, plant medicines, teachings and life lessons.
- 3 During the colonial period Indigenous women who married non-Indigenous men lost their Indian status, as did their children as per the laws of the Indian Act prior to 1985; Indian status prior to 1985 was determined by paternal lineage only and as a result many women and children lost status.
- 4 A shake tent is referred to in *Ojibwe* as “jiisakaan.” This ceremony was widespread amongst many Indigenous Peoples in Canada prior to colonization.
- 5 However this practice has been modified in some urban contexts and is held indoors.

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ROBIN OAKLEY PhD is an Anthropologist interested in the relationship between economic constraints and cultural values in relation to health and policy. She analyzed caregiving strategies for the elderly in Namaqualand, South Africa, among a community who enjoyed communal land tenure until the late 1990s. She is currently comparing the Namaqualand reserves that pre-dated the Canadian reserve system by examining the migration routes of Mi'kmaq who were forced off reserves recognized by Joseph Howe in St Margaret's Bay, Nova Scotia in the 1800s. She is interested in exploring common sense approaches to health such as guaranteed income, food, shelter, caregiving, public curative systems when people fall ill and the salience of socio-cultural nuances of these elements in practice.

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