

ON THE POSSIBILITY OF A SYNERGY BETWEEN INDIGENOUS KNOWLEDGES OF HEALTH AND HEALING AND WESTERN BIOMEDICINE: TOWARD A PHENOMENOLOGICAL UNDERSTANDING

ABSTRACT

In this paper, it is argued that the possibility for a formal synergy between Indigenous knowledges of health and healing and biomedicine—particularly in remote, Indigenous regions like the Canadian Arctic—at the clinical practice level may be difficult to sustain as a result of the major philosophical differences between the two systems. If a synergy of some form is to occur at all, it is more likely that it would not be at the level of formal services offered, but at the phenomenological level with respect to the help-seeking experiences and lived actualities of those in distress, crisis, or those labelled as “patients.” Building on the practice and experience of medical pluralism, it is claimed that it may be more likely for help seekers (in the capacity of nomadic bricoleurs) to form their own creative and strategic healing synergies. From the patients’ perspectives, the formation of synergies is achieved by availing themselves of practitioners of Indigenous healing, biomedicine, and any other types of healing services as resources to utilize in their quest for meaning and existential reconciliation in the face of illness and uncertainty. It follows, then, that my own theoretical position with respect to illness is that it is not only a subjective experience of pain or malady (and the physical manifestation thereof qua signs and symptoms), but also a crisis of interpretation: the introduction of illness into a help seeker’s life creates a sense of existential and interpretive volatility. It is argued that from a methodological standpoint, a phenomenologically-inspired approach is the most appropriate means through which to access patients’ experiences of the synergies of the help-seeking experience.

The issue of integrating Indigenous knowledges¹ of health and healing with biomedical approaches to disease has long been of interest to biotechnology and pharmaceutical companies, biomedical health professionals, researchers, practitioners of Indigenous healing techniques, and medical social scientists who work in Indigenous contexts the world over. Insofar as biomedicine occupies a

unique and prestigious position in Western and, in some cases, non-Western contexts, all non-biomedical systems of health and healing that are chosen as targets for research on the integration of biomedical and Indigenous medical systems are vetted according to the standards of verification and values of evidence-based biomedicine (Quah 2003; Rappaport and Rappaport 1981; Waldram et al.

2006). Because many Indigenous knowledges of health and healing are spiritual in origin or maintain a spiritual or symbolic component, the determination of their efficacies against empirically-derived scientific standards and values² is culturally and politically harmful inasmuch as the knowledges and practices associated therewith may be extricated from their proper social, cultural and existential contexts (Waldram et al. 2006).

While there are examples (albeit fairly rare) of public and privately funded healing programmes and initiatives based on the successful synergy between Indigenous knowledges of health and healing and Western biomedicine, there are marked differences in worldviews between the two approaches³. As such, these differences may, in some cases, hinder or even preclude the possibility for their successful and sustained integration.

In this paper, I will outline some of the major philosophical differences between Indigenous knowledge of health and healing and Western biomedicine, with particular attention paid to the concepts of health and disease. I will argue that the possibility for a formal synergy between Indigenous knowledges of health and healing and biomedicine—particularly in remote, Indigenous communities—at the clinical practice level may be difficult to sustain as a result of the major philosophical differences between the two systems⁴. And it is because of this philosophical incommensurability that I argue in

favour of re-conceptualising the semantic field in which the current use of the word “synergy” is oftentimes used.

If a synergy of some form is to occur at all in the health care contexts, it is more likely that it would not be at the level of formal health services offered, but at the conative⁵ (and, ultimately, apperceptive) level with respect to pathways to care and help-seeking behaviours of those in distress or experiencing an illness event. More specifically, building on the practice of medical pluralism, I will claim that it might be more plausible for help seekers—in the capacity of nomadic bricoleurs—to form their own creative and strategic synergies by availing themselves of practitioners of Indigenous healing, biomedicine, and any other types of healing services as *resources* to make use of in their quest for meaning and existential reconciliation in the face of illness and uncertainty.

It follows that illness is not only a subjective experience of pain or malady and the physical manifestation thereof *qua* signs and symptoms, but also a *crisis of interpretation*: the introduction of illness into a help seeker’s life creates a sense of existential and interpretive volatility. For, simply stated, “illness” is life shot through the jagged prism of ambiguity and uncertainty. Understood as such, the imperative is not only to maintain one’s health or re-establish it through various means such as dialogue, relationships, rituals, pharmaceuticals, food, etc., but also to *learn* from and gain valuable insight

from the illness experience, however contradictory and jury-rigged the available information may be. Ultimately, the goal is to answer the perennial question regarding illness and its seemingly aleatory nature—*why me?* To approach illness, then, as a crisis of interpretation wherein patients marshal the knowledge(s) (resources) furnished by various healing services, might better equip health practitioners with more nuanced repertoires of social, cultural, psychological and existential knowledge with which to better understand and treat patients living in remote Indigenous communities.

INDIGENOUS KNOWLEDGES OF HEALTH AND HEALING: PHILOSOPHICAL FOUNDATIONS

Indigenous knowledges of health and healing and biomedicine, to me, are based on two entirely different philosophical systems of understanding and acting upon the world and reality. As I see it, Indigenous knowledge of health and healing, particularly as it is practiced in remote, primarily Indigenous regions stands as a “meta-medical system,”⁶ and is based upon a syncretism between old animistic system of seeing and experiencing the world and aspects of Christian theology (Adelson 2001, 2009; Turner 1996). In practice, the worldview that results from such a syncretism is an ever-shifting but ordered dynamic of equilibrium between the Creator (oftentimes God), human beings, animals, natural phenomena, and the surrounding environment (both physical and non-physical) which

subtends them. All of these beings, phenomena, and processes are thought to be imbued with the capacity to engage in dialogue with human beings, what Hallowell (1960, 1992) referred to as “other-than-human persons.”

Pervading the relations between human beings, God, natural phenomena, other-than-human persons, and the environment, are temporal, moral, personal, political, social, ancestral, economic, and interpersonal forces (Bennet and Rowley 2004; Laugrand et al. 2000; Laugrand and Therrien 2001). The confluence of these forces not only suffuses the world, but is responsible for its continuity. The nature of these aforesaid forces may be characterised as synergistic and protean: their products and effects are not reducible to the outcome of any one force in interaction with another, but are the outcome of their mutable but no less ordered flux and flow.

That those adhering to this philosophical approach view God, humans, angels, other than human persons, the environment, and beings of the spirit world with the ability to communicate, is evidence of a relational orientation to the world—a version of what Leenhardt (1979) called “participation.”⁷ As such, this relational orientation to the world can be understood as a totalising interweaving of nature, society, myth and technology. Such an experiential interweaving is predicated upon a mythico-ecological landscape wherein all natural phenomena are phenomenologically continuous,

particularly with respect to their ability to engage in dialogue with one another. Taken as such, the notion of “the individual” is nothing more than an abstraction predicated on the idea that the self can be rent from its *a priori* relational moorings.

Health, then, as it is conceptualised by this philosophical system is not perforce a state or possession that one has or attains, but a dynamic *process* that results from constant negotiations and transactions with fellow humans and other-than-human persons of the physical and spirit world (Adelson 2001, 2009; Tanner 1979; Turner 1996). For instance, writing of the Cree of northern Quebec, Adelson (2001, 2009) explains that health is not a state of being free from illness and disease that resides in the individual, but is better characterised by a *pervasive quality of life*, which transcends the individual. As such, health (*miyupimaatisiün* in Cree) is a way of being which results from the constant movement, engagement, and negotiation with broader social (interpersonal, including other-than-human persons), cultural, political, economic, religious, spiritual, and moral processes (Adelson 2001, 2009; Culhane 2009; Kirmayer et al. 2009; Kirmayer et al. 2009; Kirmayer et al. 2009; Niezen 1997). These broader social processes are set within shifting and differential fields of power (which inhere in the interpersonal and cosmic orders). Ill health, then, may be conceptualised as the outcome of specific power relations at the interpersonal, social, political, and cosmological levels.

Similarly, Turner (1996) writing of the Iñupiat of Alaska, states that health is not something possessed by an individual, but is rooted in spirit and linked to the greater cosmos. For the Iñupiat, all beings, such as humans, animals, and geographic features, have a *ĩñua* (spirit). The *ĩñua* transcends individual beings for it is also manifest in the *processes of existence*—birth, death, re-birth, food, and hunting. Health to the Iñupiat is a communicative and connective practice; it requires dialogue between persons, non-human persons, and the landscape so that connections can be maintained between one’s ancestors, history, and one’s kin (Turner 1996).

That health may be approached as a relational, transactional process for many northern Canadian Indigenous peoples means that, in some cases, it may signify a multitude of different, sometimes, counter-intuitive values. For instance, the experience of illness may foster the process of insight in a person, and thus may be of extraordinary benefit to those wanting to re-evaluate their lives (Waldram et al. 2006). To this end, illness may be approached as a positive or helpful experience, such as an essential step in righting one’s existential valence to the cosmos and all that is subtended by its broad and inclusive processes.

Building on the physician and philosopher George Canguilhem’s notion of health, that being simply “...the margin of tolerance for the inconsistencies of the environment” (1991:197), one could say that for many northern Indigenous peoples

of Canada, the notion of “environment” could be deepened and augmented so as to include not only the physical landscape and its various ecosystems but also the greater cosmological milieu, including the interconnectedness of all its inhabitants. These might include spirit, human, other-than-human persons, land, and the processes of all existence; not only spiritual processes, but social, moral, political and economic. One falls into ill health, then, when some form of existential or political turbulence, such as a lack of respect for other beings, or emasculation of political agency and autonomy, disrupts communication and interconnectivity.

THE BIOMEDICAL MODEL OF DISEASE: PHILOSOPHICAL FOUNDATIONS

Biomedicine, in sharp contrast to any form of Indigenous knowledge of health and healing, does not recognise any form of relational philosophy, and thus, neglects this interconnectivity of worlds. On the contrary, in its most simple and vulgar form, it is based on the complementarity between the philosophies of naturalism, reductionism, and individualism. I will briefly describe each in turn, starting with naturalism. Proponents of naturalism, a somewhat static and rigid philosophy, mandate that in order to be known, the causes and physical products or effects of natural and physical forces⁸ must be cleaved apart conceptually⁹, partitioned according to different assumptions about how they may be systematised and known, and

approached as autonomous essences or entities (Comaroff 1982; Gordon 1988). This philosophical approach is based on the mutual exclusivity and autonomy of material entities and essences, which maintain fixed and stable identities (Gordon 1988). Reality, then, according to this view, is determined by the sum of its exclusive and autonomous parts (read: observable, material parts); and, given that the identity of reality’s respective “parts” is self-determined, the parts may be freely moved, interchanged and extricated from their contexts without any compromise to the integrity of their identity (Gordon 1988). Limited to purely visible, material phenomena, supporters of naturalism see the investigation of such immaterial phenomena¹⁰ as spirit, soul, value, or the fundamental question and meaning of “Being” itself (Heidegger 1962) as matters of theology, philosophy or the social sciences.

Insofar as biomedicine is based in part on the philosophy of naturalism and reductionism, its proponents see the ultimate cause and process of disease as following purely chemical and biological pathways. By dint of this philosophical and scientific purview, proponents of the biomedical model oftentimes eschew social, cultural, psychological, political and, at a much broader level, moral and existential *noxae* as potential agents in the aetiology of disease (Comaroff 1982; Engel 1989; Kleinman 1995; Kleinman et al. 1997). In favour of decontextualization, the biomedical model almost always espouses a reductionist approach by reducing a

complex suite of phenomena, such as illness, to a single, primary biological principle (Engel 1989; Worsley 1982) for the explanation of anomalous bio-physical signs and processes in the human body. Accordingly, supporters of the biomedical model conceive of disease as a reduced and ontologically separate entity which resides within the confines of the physiological and anatomical body—much to the exclusion of broader social, cultural and existential processes.

Aligned philosophically with biological reductionism is the notion of individualism¹¹, a socially reductionist philosophy. This is the view that the individual, particularly in North American contexts, is understood to exist *a priori* to society and culture. To the extent that the individual, as a *solus ipse*, exists prior to society and culture is to view the relationship between the individual and society as essentially antagonistic. Society and culture serve as nothing more than an illusory veneer that can be pried back (as a feat of nothing more than reflection) in order to expose the “true,” pre-given individual. Thus, all relationships are seen as being contingent upon the free agency and decision of the individual, while society is understood to be merely derivative (Gordon 1988).

The outcome of the aforementioned philosophical stances (naturalism, reductionism, and individualism) has important implications for how proponents¹² of the biomedical view conceptualise health. According to *Stedman's Concise Medical Diction-*

ary for the Health Professions (1997), the entry for *health* is: “the state of the organism when it functions optimally without evidence of disease or abnormality” (382); or, “a state characterized by anatomical, physiological, and psychological integrity, ability to perform personally valued family, work and community roles” (382-383). One need not parse the aforesaid definitions long before it becomes apparent that health is a state that an individual has or possesses, and, therefore, becomes something that one can lose¹³. The former definition clearly bespeaks an individualistic philosophic orientation in that the focus of health as a state is on the *organism*; it says nothing of the broader social, cultural political processes in which all organisms are in a constant state of negotiation. And, so, too, the latter definition intimates a reductionist and individualist perspective in that it centres on the “anatomical, physiological, and psychological integrity” of an individual, and the ability of he or she to perform “personally valued” roles. Such an approach rends the individual from his or her social and existential moorings, and ultimately effaces the notion of disease or illness as an ongoing and uneven process of negotiation between personal, social and biological factors.

WEAVING TOGETHER RESOURCES IN THE QUEST FOR MEANING: THE PRACTICE OF MEDICAL PLURALISM

Even a *prima facie* glance at the differences discussed above between Indigenous knowledge of health and

healing and biomedical approaches to disease indicates that these respective approaches are quite incommensurate on a cosmological, spiritual, practical, theoretical, or experiential¹⁴ level. Owing to this incommensurability, the synergy between the two approaches might be tremendously difficult to effect on many levels, particularly with respect to the systematisation of clinical programmes, training, and the actual delivery of services. However, this incommensurability need not preclude the possibility of synergy if we re-conceptualise synergy. As such, we can re-conceptualise the idea of “synergy” not as the incorporation of two systems that lead to a combined effect that is greater than the sum of its constituent parts, but as a conative and, ultimately, symbolically apprehensive function based on the *choice of resources* available and the use and navigation thereof. Conceived as such, the Indigenous help seeker, in the capacity of a nomadic bricoleur¹⁵, might attempt to create an interpretive synergy out of the tools and resources available through the practice of *medical pluralism*.

If we use Kleinman’s (1980) somewhat basic model of various health care sectors available to help seekers, particularly in North America, we can define medical pluralism loosely as the navigation and use of various available medical “sectors.” These sectors may include the following: (1) the *popular sector*: health care conducted by the ill person him or her self, conducted through use of the internet, family members and other social networks; (2) the *folk*

sector: “traditional” healers such as shamans, mediums, or sorcerers; and, lastly, (3) the *professional sector*: regulated and professionalized medical systems such as biomedicine, Ayurvedic and Chinese medicines. To this end, one who engages in medical pluralism may be said to avail (but not necessarily fully abide) the aforementioned health care sectors for the sole purpose of piecing together a comprehensive understanding of the illness event.

My argument rests on the premise that when stricken with ill-health, Indigenous help seekers in remote regions, such as the Canadian north¹⁶ may very well consult family, friends, and quite possibly other media sources, too, along with Indigenous healers and biomedical practitioners in the quest for healing, existential restitution, and the reconciliation of meaning, therefore attempting to create an interpretive synergy based on the tools and resources provided by disparate approaches to health, healing and disease. The practice of medical pluralism among some Canadian Indigenous peoples has been illuminated by Niezen (1997), Smylie et al. (2009) and Waldram et al. (2006). Their respective studies found that given the choice between non-Indigenous and Indigenous treatment knowledges, many help seekers oftentimes chose to make use of both in a fluid manner, regardless of whether or not they had approval from the practitioners of the respective systems; however, in the movement between resources, help seekers may or may not have had a detailed understanding of the resp-

ective knowledges of health and healing. Thus, to the help seeker working in the capacity of a nomadic bricoleur, the widely contrasting premises of Indigenous knowledge of health and healing and biomedical approaches to disease might be used to broaden and augment the range of healing and interpretive resources to avail, rather than as contradictory systems between which one must choose either beliefs or availability (Niezen 1997).

METHODOLOGICAL MODES OF ACCESS: MEDICAL PLURALISM AND THE ILLNESS EXPERIENCE

Regarding my approach to the illness event as an interpretive crisis, help seekers, insofar as they are on an interpretive quest for meaning and healing, may, when given the choice, avail themselves of multiple, sometimes contradictory, healing resources. To this end, the imperative is for the help seeker to piece together—using the tools and resources provided by Indigenous knowledge of health and healing and biomedicine¹⁷—a series of provisional understandings, and ultimately, the *raison d'être* (“why me,” “why now”) of the illness event. The processes involved in this interpretive quest are as much conative as they are epistemic, and, therefore, symbolic.

The help seeker may be oriented toward or drawn to particular resources owing to a desire and a striving to know and create subjective meaning wrought from intersubjective processes. As such, the most appropri-

ate methodological approach to take in the investigation of the aforementioned processes is to use tools borrowed from existential or phenomenological anthropology¹⁸ (see Jackson 1989, 1996, 2005, 2009) and, European and American phenomenology and phenomenological psychiatry, upon which existential anthropology, in part, is based (see Binswanger 1963; Blankenburg 1982, 1980; Foucault 1954; Merleau-Ponty 1962; Minkowski 1970; Natanson 1974). The aforesaid approaches equip the investigator with the requisite tools for both conducting and analysing illness narratives and help seekers’ oral histories regarding the cause, course, and meaning(s) of distress—however provisional, fragmented or disjointed narratives may be.

Specifically, the phenomenological method may be used in the analysis of narrative, literature, oral history, or even artwork, to investigate the lifeworld as the site of struggle for existence and the meaning of being and well-being (Jackson 2005). In general, proponents of the phenomenological method are particularly concerned with re-establishing a pre-theoretical, pre-reflective relationship with the world in order to plumb the depths of its most inchoate, oneiric and ineffable qualities, and endowing it with philosophical status (Merleau-Ponty 1962; Natanson 1974). That the phenomenological method is concerned with one’s pre-theoretical, pre-reflective experience—and, by extension, interpretation—of the world means that its philosophical imperative is *descriptive* and not analytical (Merleau-Ponty 1962;

Natanson 1974). A phenomenological stance perforce requires one to effect a poetic orientation to the world. As such, the objective of the phenomenological method is to attempt to describe the world, its processes, and the multiform relationships which inhere in it, from a stance of wonder and amazement. To modify Merleau-Ponty's (1962) metaphor, it is to watch closely the flames of transcendence and experience, focussing on the initial sparks that fly as they lead to the ignition of greater, broader flames. The phenomenological method attempts to catch these sparks before they dissipate into the ether as irretrievable idolum or trace.

Writing on the application of the phenomenological method to the study of mental illness, Foucault explains:

[inasmuch as the morbid world remains penetrable] it is a question of restoring, through this understanding, both the experience that the patient has of his illness (the way in which he experiences himself as a sick or abnormal individual) and the morbid world on which his consciousness of illness opens, the world at which this consciousness is directed and which it constitutes. *The understanding of the sick consciousness and the reconstitution of its pathological world*, these are the two tasks of a phenomenology of mental illness (1987:46, emphasis added).

Making use of the conceptual tools offered by existential anthropology and the European and American schools of phenomenology may afford one greater insight into investigating the processes and dynamics involved in the help seeker's subjective orientation to his or her self,

others, and the world regarding the ontology or ultimate nature of the illness experience. So, too, the aforementioned approaches may assist one in understanding illness from a more conative, cognitive and symbolic perspective. This might afford interested researchers a more humanistic or existential perspective when formulating questions about the dynamics of meaning making during the illness event.

In this paper I argued that in order to better understand the possibility of a "synergy" between Indigenous knowledges of health and healing and biomedicine, we need to re-conceptualise and reframe our very understanding of the term. This re-conceptualisation may be achieved by moving away from the more common understanding of the term as it is oftentimes used in terms of service provision—referring to the integration of biological and Indigenous medical systems—to a more *phenomenological* one. Synergy, then, as I re-conceptualised it in this paper, occurs at the subjective, phenomenological level during a patient's interpretative quest for meaning in the face of illness. This is achieved when individual patients avail themselves of practitioners of Indigenous healing, biomedicine, and any other types of healing services as *resources* to make use of in their quest for meaning and existential reconciliation in the face of illness, uncertainty, and existential volatility.

The clarion call of this paper is that there should be a renewed interest in research on the phenomenology of

patients' subjective illness experiences in order to better understand the social, cultural, psychological and existential bases of the various pathways and barriers to care—especially in remote Indigenous communities (such as in the Canadian Arctic) where there may be very limited health services. More specifically, in terms of future research, a focus on phenomenologically-grounded patient case studies might shed better light on the various interpretive strategies patients employ when first experiencing an illness event, as well as the various dynamics and processes involved in prioritizing one interpretation over another.

At a very broad level, the outcome of the knowledge yielded from such case studies could lead to the following: (1) the creation and implementation of more inclusive, culturally sensitive, and efficient treatment regimens (whether for physical or mental health problems); and, (2) better equipping health professionals (Indigenous and biomedical) in remote regions with a more nuanced and sophisticated repertoire of social, cultural and psychological knowledge. This knowledge could then be marshalled alongside established clinical guidelines (or other protocols that may be used in Indigenous systems) in those cases where a patient might resist a certain treatment regimen, disregard follow up treatment, contest a given diagnosis, or even fail to seek adequate treatment at the onset of illness.

NOTES

¹ They are performed more like ways of seeing the world, or an "optics," than knowledge as such, but we will use this term for its ease of use throughout this paper.

² In cross-cultural contexts, this is usually achieved through randomised placebo controlled trials (RPCT) (see Fabrega 2002).

³ A prime example being Poundmaker's Lodge for addictions counselling in Edmonton, Alberta (see www.poundmaker.org).

⁴ Not to mention the low population densities, the high turnover rates for health care professionals, and the fact that most remote communities in the north have only one nursing station, usually staffed with a maximum of two to four full time nurses—all of which affect the sustainability of potential integration at the clinical practice level.

⁵ Regarding behaviour directed toward action, striving, and volition.

⁶ According to Worsley (1982), conceptions of illness and cure are always embedded within wider frameworks which supply cognitive, normative, and conative (purpose, desire, and will) ideals—simply put, metamedical systems attempt to provide answers, sometimes grounded in metaphysical assumptions of the ultimate nature of the world and reality, as to why people fall sick.

⁷ This term was originally coined by the social philosopher Lévy-Bruhl (1910); however, Maurice Leenhardt, a student of his, (1979) whose research was based on some 40 years of fieldwork in New Caledonia, significantly modified the term.

⁸ Other forces such as social or spiritual, are merely seen as epiphenomenal to material or physical forces and are therefore of little concern.

⁹ Separating natural from supernatural, individual from society, and the social world, including culture, from nature (Gordon 1988; Worsley 1982).

¹⁰ Such things usually fall within the purview of cosmology, *meta*-physics—literally beyond the reach of physics and its sister sciences, chemistry and biology—and therefore

fall out of the practical reach and range of the scientific method.

¹¹ Oftentimes referred to as methodological individualism or rational individualism.

¹² This should include lay persons as well, as biomedicine is so pervasive that is may be considered to be not only an official scientific model, but a folk-model as well (Engel 1989).

¹³ Much like Virchow's approach to disease, it is something ontologically distinct and separate from one's situatedness in broader existential processes.

¹⁴ Whereas Indigenous medicine, for the most part, takes effect via the dynamics of faith and belief, biomedicine seeks to cure through faith and belief, too, but more so through the innovations of technical efficiency (Niezen 1997).

¹⁵ Meaning that a help seeker may move from resource to resource in the quest to build a sense of meaning out of the disruptive experience of illness.

¹⁶ This goes for almost any other help seeker as well in different geographical contexts, depending on the resources available.

¹⁷ And, quite possibly, other resources, too, such as chiropractic medicine, new age medicine, or other available resources.

¹⁸ What Jackson (2009:6) has most recently referred to as a "phenomenology of liminality:" an approach which places emphasis on the multiplex ways in which temporal, spatial, personal, and cultural "in-betweenness" is experienced in human life.

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