

# Alberta Doctors' Digest

## The medicine chest

Late May, in Edmonton, I emceed the 25th anniversary celebrations of the U of A Department of Oncology at the Cross Cancer Institute. It was fun to meet old friends and colleagues – some had aged over the 28 years since last seeing them – amiable Dorian Grays (the portrait, of course) and ghosts of Christmas Past – while others were still remarkably trim. It's a challenge meeting someone you know you should know but can't quite place them ... a senior's version of that infant's game of fitting shaped blocks into the proper cut-out spaces.

The main job of emceeding is salting program gaps with stories from the past and peppering introductions with a few quotes and jokes, but it also involves re-jigging the "short biographies" the department's administrator had sent me.

"Short bios" (especially my own) are a niche branch of fake news. Never are they biographies. They are autobiographies thrust into the third person – dispassionate, factual reportage written by a friendly biographer (and they're not that short either) usually accompanied by an over-the-shoulder-view, best-side-of-the-face photograph taken five-to-15 years earlier. Never are struggles, disappointments or failures mentioned ... no, all of us selfie biographers are respected, have international reputations, have published in the leading journals of the day and have received a multitude of prizes and rewards. All is happiness and achievement, and why not?

A speaker's response on being thus introduced should really be: "Thank you for the kind words of introduction that I sent you last week."

But I had been sent a required slide to open the celebration (since the meeting was under U of A auspices). It was the first time I've had to do this. The slide read:

"The University of Alberta acknowledges that we are located on Treaty 6 Territory, and respects the histories, languages, and cultures of First Nations, Metis, Inuit, and all First Peoples of Canada, whose presence continues to enrich our vibrant community."

My first reaction on receiving this was an upward roll of the eyes ... oh no ... can I get out of this? What does this political correctness achieve? This land was sold legally 145 years ago. I suspect introducers mentally shrug their shoulders and pass on to the first speaker having done their duty.

But then, I realized this recognition deserves a second thought because as doctors (especially us oncologists) practicing in what was Treaty 6, 7 and 8 territory in the 1870s, we've tried to honor the obligations of the "Medicine Chest" – that codicil to Treaty 6 from 1876 whereby the Indian agent should keep a supply of medicines in his house for use by the tribes – though in 1876 there can't have been much in the medicine cabinet.

Key figures, representing the Crown in the negotiations were [Alexander Morris](#), Lieutenant Governor of the Northwest Territories; [James McKay](#), Minister of Agriculture for Manitoba; and [W.J. Christie](#), Chief Factor of the Hudson's Bay Company.

Treaty Six states:

“whereas the said Indians have been ... informed by Her Majesty's Commissioners that it is the desire of Her Majesty to open up for settlement, immigration and such other purposes ... a tract of country ... and to obtain the consent of Her Indian subjects inhabiting the said tract, and to make a treaty ... so that there may be peace and good will between them and Her Majesty, and that they may know ... what allowance they are to ... receive from Her Majesty's bounty and benevolence ... and that a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians ...

The Plain and Wood Cree Tribes of Indians, and all other Indians ... do hereby cede, release, surrender and yield up to the Government of the Dominion of Canada, for Her Majesty the Queen and Her successors forever, all their rights, titles and privileges, whatsoever, to the lands included within the following limits ...”

We call upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

Many of the Crown's negotiators were Scots and there's an old one-liner in Scotland: “The New York Mafia will make you an offer you can't refuse, but the Glasgow Mafia will make you an offer you can't understand.” Indigenous concepts of land “property” were rudimentary at the time and the signing of the Treaties with an “X” and their complex legal language was a formula for future misunderstanding.

When Treaty 6 was signed (1876), the famous “Medicine Chest” clause was inserted at First Nations insistence (though Treaties 7 and 8 make no mention of this). Today we have a broad range of medical care and the Medicine Chest clause is symbolic for that. Today's Medicine Chest is a health and wellness centre.

My good friend, Bob, MLA Edmonton-Whitemud, then followed up, emphasizing that the Notley government believes that now is the time to effect real change in Indigenous communities starting bottom-up. Fresh thinking is needed. He's right.

We've all had difficulties fulfilling the Medicine Chest deal, and the reasons have not been clear – often leading to rolling of the eyes and a shake of the head: missed appointments, non-adherence to protocols, seeming disregard for extra efforts on Indigenous patients' behalf – this all in the face of the high regard and appreciation by immigrants from poorer, disadvantaged countries, of the privilege of participating in Canadian health care. What is going on here?

Surely no harm can come of linking up with traditional healers and rather than creating an us-and-them culture ... to work together. They'll have some useful therapies that we're unaware of.

A recent case. In a darkened clinic room at Calgary's Holy Cross Hospital (where we see new oncology patients) sits a lovely young woman in her early 30s, and beside her an older woman, probably in her 60s. I thought it was her mother but no, it was her auntie, the local healer. The younger woman had two young children and was from an Indigenous community.

So I now examine the woman: she has a five centimeter mass in her right breast.

"We can help here ... You'll need chemotherapy for a few months and Herceptin for a year."

The older woman glared – "Why not the hormone therapy? No chemo," she said.

"That won't work. The biomarker tests tell us it's not hormone sensitive."

The older woman said no chemo, hormones only. We sat hoping something would change. It didn't. We set up a time to start chemo. The patient looked as though she might go along with our advice. But no, the appointment for daycare was missed and Kelsey, the nurse, spent the next three months trying to contact her.

We phoned and phoned. Always excuses not to come until one day, she turned up with her husband and kids. The patient had been treated with local herbs and ointments. The old woman was not with her. Pulling down the exam gown, in place of a discrete barely visible mass was a thick, infiltrating red rash over both breasts with glands in the supraclavicular and axillary regions.

"I was using a special cream, but I think I reacted to it," she said.

We got her in and started her on a tolerable dose of chemo with the wonder drug Trastuzumab ... and she responded with clearing of the skin. The patient became confident in us. She told me that a distant grandfather had been a signatory to Treaty 7. She had a good summer, but as happens with this sub-type of cancer which has presented late and been allowed to metastasize, the next year she developed brain metastases – and it was all over.

And I got to thinking. What went wrong here? I called the patient's family doctor. "They go their own way," she said, with a sigh.

"Perhaps we can have a Sacred Space in the new Cancer Centre?" she said. "That may be a start," I said.

Many local healers have a huge influence on Indigenous patients on reserves and there is social pressure to listen to them. Should we have included the old woman healer in discussing the management? Perhaps we should include local healers in efforts at education bringing them in as part of the team when dealing with Indigenous patients? I suspect this is being done in some clinics, but usually it isn't.

Can we learn from others' experiences where there's a gulf between conventional medical practice and traditional practices? Well, we've seen this in the U of C Global Health Project in Zamboanga in the southern Philippines, an area covering a multitude

of small islands, where the infant mortality rate was high – around 80/1,000 live births in 1995.

In thinking how to improve this dismal figure, the Ateneo de Zamboanga became aware that most deliveries were attended by local “hilots” (traditional birth attendants). Educational programs and a controlled trial were set up (randomized by location and the presence or absence of a trained midwife). The hilots were funded to come in for education and to meet trained midwives (*on an equal level.*) The results have been extraordinary – an improvement in the status and attitudes of the hilots and a fall in infant mortality rates from 80 in 1995 to 7-8/1,000 live births in 2014.

Could taking an example from a developing world setting to a country like Canada lead to health improvements? Surely no harm can come of linking up with traditional healers and rather than creating an us-and-them culture, it may be possible to accept the reality of life on the reserves and work on educating these medicine men and women – and ourselves – to work together. They’ll have some useful therapies that we’re unaware of.

I talked about that to Eileen, the Foothills Hospital Indigenous liaison, an Ojibwe woman born in Selkirk, Manitoba, who’s been liaising for 21 years and before that was an LPN for 19 years:

“Well, what you’re talking about is what Justice Murray Sinclair’s Commission on Truth and Reconciliation has been recommending. See here, item 22 (she had the report on her desk).

“We call upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.”

Respect and acknowledgement is what it’s all about – that was Eileen’s position anyway. She talked about her pride participating in Indigenous ceremonies like smudging, a purification ceremony using smoke – often sage or sweetgrass, but she also openly talked about bad times in Selkirk and elsewhere: the drugs, alcohol and suicides – her “short bio” would be listened to with respect in silence – a real “short autobio.”

I said: “I’m really talking about mutual education, Eileen. Most medical-school-educated clinicians have limited regard for traditional nostrums and cures, regarding them as harmless at best. In oncology we’re charging ahead with ever more complex diagnostics and therapeutics but not making much headway in trust with the Indigenous populations.”

Eileen then talked about residential schools and we were getting into deep water. I said that as a nine-year-old, I’d been to a “residential school” in Edinburgh, Scotland – not a great experience, quite lonely, with a fair bit of physical abuse (sticks on the knuckles, strapping) and mental abuse (though we didn’t call it that – those bitter, nightly demeaning harangues from the matron). It was the way in those harsh post-war days when every family had lost a son, husband or lover, so I had a glimmer of what Eileen was talking about – though in my case there was no attempt at cultural denigration that Indigenous children experienced – at least I emerged with a tiny kernel of self-esteem preserved. But I backed off this complex subject, perhaps to be discussed on another day.

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“That may be a start,” I said.

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