# Malcolm Wiener Center for Social Policy

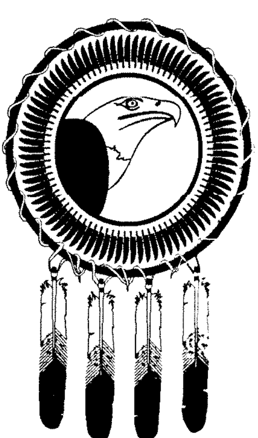
*The Partnership of Traditional Navajo Medicine and Biomedical Health Care Practices at the Chinle Comprehensive Care Facility*

by

Gina Cobin and Leslie Hsu

*PRS 98-24*

May 1998



Harvard Project on
American Indian Economic Development

John F. Kennedy School of Government
Harvard University

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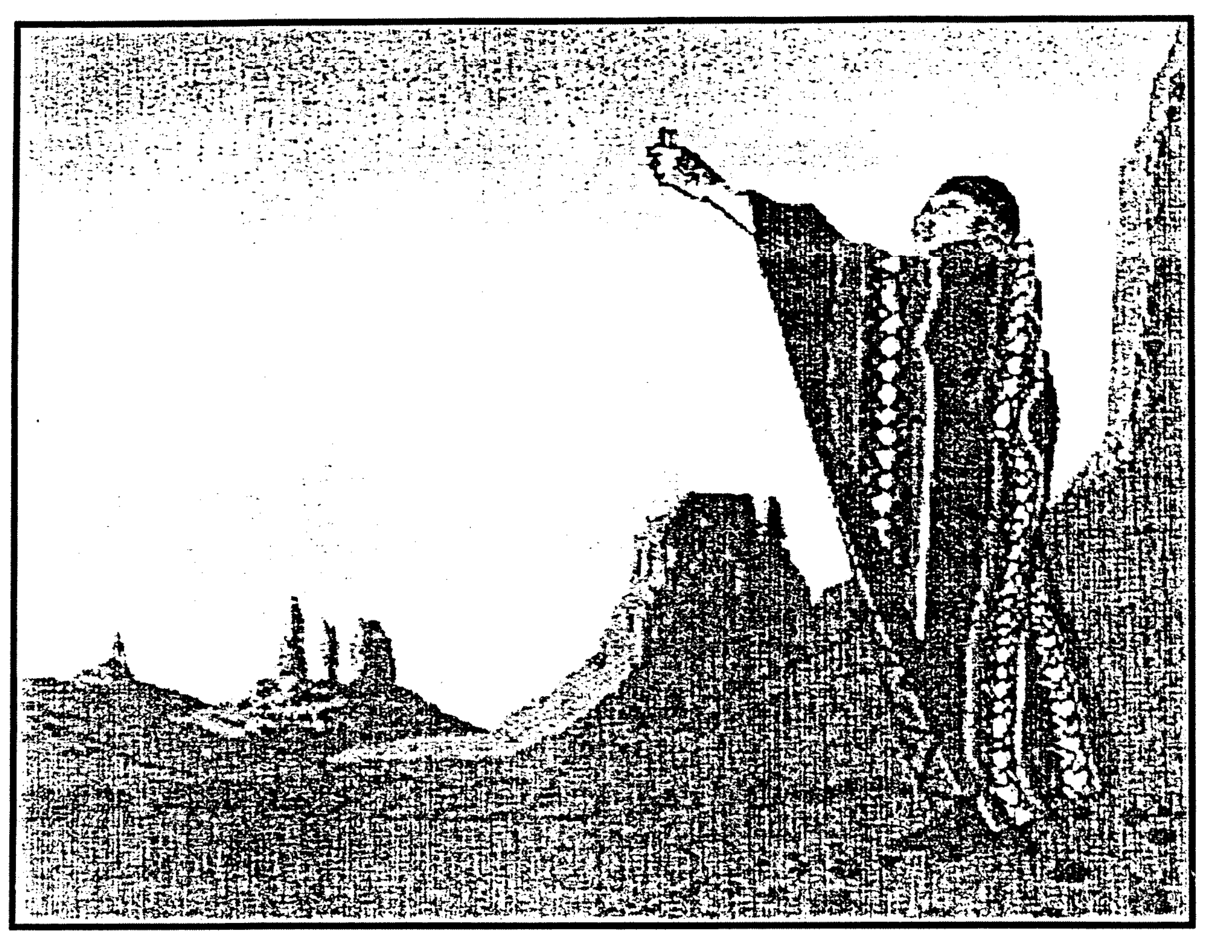
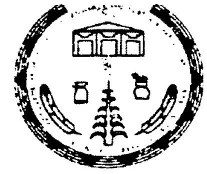


# The Partnership of Traditional Navajo Medicine and Biomedical Health Care Practices at the Chinle Comprehensive Care Facility

May 20, 1998



# Report on the Partnership of Traditional Navajo Medicine and Biomedical Health Care Practices at the Chinle Comprehensive Care Facility

Presented to

## The Role of Traditional Navajo Medicine Committee

by
Leslie Hsu and Gina Cobin
Harvard Native American Program
May 1998

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## Purpose of this report

This report is prepared for the "Role of Traditional Navajo Medicine" Committee at the Chinle Comprehensive Health Care Facility (CCHCF) in Chinle, Arizona. In January 1998, this committee was formed by the Chinle Service Unit (CSU) Advisory Health Board in order to develop a model of health care delivery that would facilitate the partnership (ahil na'anish) of traditional Navajo medicine (TNM) and biomedical health care practices (BHCP). Their short term goals are:

1) to define the role of TNM by developing a mission and vision for the initiative,
2) 2) to develop a design for implementation addressing the process of providing culturally appropriate care for all patients, and 3) to develop a strategic plan and a method for evaluating their success. Their long term goal is to provide a model of health care delivery that other tribes or nations can adopt into their health care systems.

We will begin this report in respect of Navajo traditions with a blessing followed by an expression of K'é. The blessing is intended to encourage happiness and well-being in the spirit of ahil na'anish. It encourages all participants to listen to one another, follow one another, and take care of one another. Traditional Navajo organizational planning and communication is based upon the expression of K'é. In this way, participants address one another through kinship terms, showing respect for Navajo traditions and helping to open channels of communication. Two key principles that must take place before ahil na'anish can succeed are: Naanish bá nitsáhákees (conceptualization) and Alk'i'diitiih (communication). In consideration of these factors, we have organized the report in the following manner:

- **BOOK ONE** will begin with the Role of Traditional Navajo Medicine (RTNM) Committee's conceptualization of ahil na'anish. Then we will present non-Native as well as Native conceptualizations of TNM and BHCP.

- **BOOK TWO** will present some of the forces that are driving and restraining this partnership of Traditional Navajo Medicine and Biomedical Health Care Practices. These forces were identified through opening channels of communication among key players at Chinle.

- **BOOK THREE** contains a strategic plan for the partnership of TNM and BHCP, preparing RTNM committee for their journey towards ahil na'anish.

This report was intentionally generated in a format that may be of use to all parties involved in the proposed partnership. The 3-ring binder organization of the material allows for sections to be rearranged, duplicated or removed. We have included a version on disk so that sections can be used or edited for reports or training materials. While the report is written specifically for the Chinle Comprehensive Health Care Facility, it is meant for all audiences who:

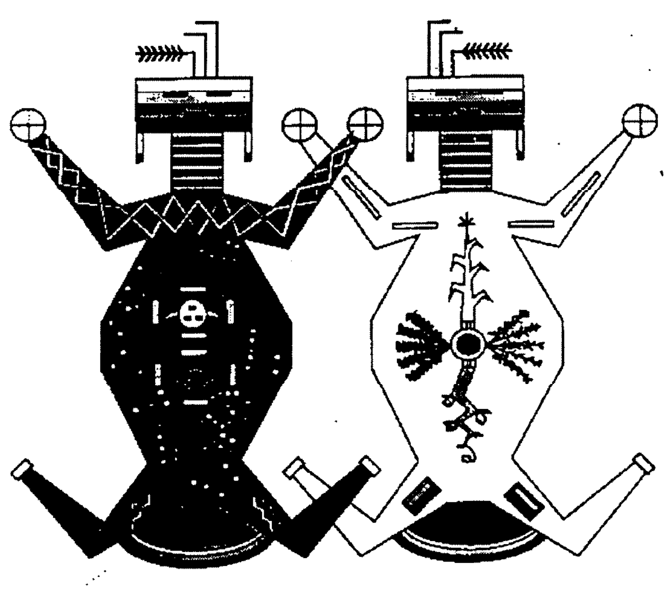
- appreciate the need to provide culturally appropriate care,
- want to integrate or form a partnership between alternative medicine and conventional Western medical practices, and/or
- seek to understand and respect diverse models of health care.

## Blessing

In Navajo tradition, a blessing is said before organizational meetings, in the spirit of anil na'anish. The blessing is intended to support happiness and well-being throughout the process of ahil na'anish. The blessing also encourages all partners to listen to one another, follow one another, and take care of one another.

*As the bluebird sings at dawn, I breathe in the cool, clean air to nourish my spirit. As I stand toward East to offer my corn pollen, I ask Mother Earth and Father Sky to rejuvenate my physical and mental health. Through the blessing of harmony and balance from the holy people, I shall always walk in beauty of Love and Happiness. This blessing shall always restore unity of my family and community. Hózhó Nahasdlii'*

*-Johnson Dennison, Dean of Diné College*



Source: "Mother Earth and Father Sky", Philmer Bluehouse, slide-handout.

## About the authors

In Navajo tradition, the expression of "K'é" is respected before members of an organization or institution begin working together. The expression of "K'é", addressing one another through kinship terms, establishes strong bonds of respect and appreciation[1] not only among the Navajo clans but non-Navajos as well.

**Leslie D. Hsu**

M.S. in Health and Social Behavior, Harvard School of Public Health

Born in North Carolina, I was raised by two loving parents (Hsu and Chow) who immigrated to the United States from China in their early 20's for college. When I was two, my mother gave me a little brother who loved me more than anything in the world. Together, we endured the social turmoil's of school in California. And together, we let our imagination run wild during the summers when our parents took us on our annual national park trips. On these trips, my family and I traveled extensively through Indian Country, where I felt most at home. My mother used to call me her "little Indian".

From 1991-1994, both my brother and mother were diagnosed with liver cancer. We tried several times to seek alternative therapies since biomedical treatments were not only invasive, dehumanizing, but they were not working. But every time, they were highly discouraged by their doctors and were labeled as "difficult" patients. Both of them felt very alone in their battle against cancer. They felt like they were just a "number," a "statistic."

I share this story with you because it explains why I would like to facilitate the partnership of TNM and BHCP. I understand the importance of honoring and respecting both health models since my undergraduate degree was in Biology. Accessing alternative medicine is a serious problem for a lot of Americans, and Native Americans are taking steps towards a model of health care that will be much desired by society. I have dedicated my studies towards empowering patients to be better managers of their own health and delivering health information that is culturally appropriate. I am honored that the RTNM committee trusts me to help facilitate this partnership and hope that Chinle's model will be useful for other hospitals, HMOs, and other health entities.

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[1]Dennison, Johnson. Personal Motivation and Navajo Perspective of Cooperation. Arizona: Office of Dine Educational Philosophy, Navajo Community College.

**Gina Cobin**

Ed.M. in Human Development and Psychology, Harvard Graduate School of Education

Born and raised in southern California, I am the descendent of Russian and Italian immigrants (Macarewich and Taglieri). My mother, who was a nursing educator and consultant for the World Health Organization, became my strongest role model. Having grown up around endless discussions about health issues and cultural traditions, I felt well suited to take on this project. Furthermore, as a health care consumer, I have experienced the success as well as the frustration that is brought about through the Western medical establishment. I have also been extremely satisfied in my experiences with various "alternative" approaches to healing.

Through my experiences as a parent and teacher, I have become especially interested in the ways people from different backgrounds think and behave. My current interests lie in the field of cultural psychology; how people come to make decisions about their lifestyle, health care, and their relationships is fascinating to me. I am a believer that the choices people make originate in their own unique histories, and therefore must be approached with respect and understanding. For this reason I am convinced of the necessity for health care professionals to be culturally sensitive to their clients.

I have had a longstanding interest in the issues facing Native Americans. I feel that it is my responsibility as an American, in my interactions with others and in raising my children, to learn about, to honor and respect native traditions and advocate a realistic view of native peoples as they live today.

## Executive Summary

This report was compiled at the request of Ursula Knoki-Wilson, the acting facilitator for the Role of Traditional Navajo Medicine (RTNM) Committee at the Chinle Comprehensive health Care Facility (CCHCF) in Chinle Arizona. The Committee is investigating the possibility of a partnership between traditional Navajo medicine (TNM) and biomedical health care practices (BHCP) while the Navajo Nation pursues the lengthy process of PL-638.

The report was funded by the Harvard Native American Program through a course entitled, "Nation Building II," and is an effort to support the committee leaders at CCHCF in accomplishing its goals. The authors of this report traveled to the Navajo Nation in order to gather the information contained in this report. Our task was to begin to synthesize the data collected in Chinle, Boston and in other parts of the country via internet. Data collection efforts centered on face to face interviews and focus groups. It was an honor and a pleasure to work with such capable leaders on this very important project.

The report is organized into three books and several resource appendices. **Book One** discusses the RTNM committee and its conceptualization of the partnership of TNM and BHCP. The Committee has outlined this through its mission and vision statements, which we have included in this report. It is our intention to make a clear differentiation between the methods of *partnership* versus *integration*. The Committee at Chinle is interested in a partnership. In the interest of gaining a sense of context, we have included a section dealing with the global conceptualizations of TNM and BHCP. In a world that is increasing turning to forms of non-biomedical therapies of health care, the promotion of the practice of Navajo medicine will find much support, even though at present most efforts are integrative rather than partnerships.

In **Book Two**, we make use of a problem-solving model to approach the challenges facing the RTNM Committee. According to this framework, there are forces at work in Chinle that have the potential both to support and impede the progress of the partnership initiative. We have identified several *driving forces* and *restraining forces* in an effort to identify areas for improvement and progress. In addition, we have offered ways in which to increase driving forces and decrease the restraining forces. In this way, the efforts of the Committee will achieve the balance required to make the initiative a success.

**Book Three** is a guidebook for action. It begins with a presentation of organizational planning that is based

on Navajo philosophy. Subsequently, we have identified specific action steps designed to address each of the forces we have identified. We conclude this section of the report with a timeline and checklists to assist in the implementation of the action steps.

It has been our intention that this report be seen as a tool, to be used and adapted as it becomes necessary and appropriate to those who are working on this project. It is our sincere hope that the information contained within will be useful in helping the Role of Traditional Navajo Medicine Committee at CCHCF achieve their goal of partnership.

## References


Adair, John. Deuschle, KW. Barnett, CR. *The People's Health*. Albuquerque: University of New Mexico Press, 1988.

Andrulis, Dennis P. *Toward a more Culturally Competent System of Care: Creating Opportunities for Managed Care Organizations, providers and Communities.* American Association of Health Plans Conference Notes. Washington DC: 1997.

Benson, Herbert. *Timeless Healing.* New York: Fireside Rockefeller Center. 1996 *Business Week.* 2 June 97, p.150-51.

Chang, Eunice. *The Power of Prayer.* Journal of Alternative Medicine. Harvard University, 1998.

Dennison, Johnson. Personal Motivation and Navajo Perspective of Cooperation. Arizona: Office of Dine Educational Philosophy, Navajo Community College.

Dubois, Christine. "Prayer: It's Just What the Doctor Ordered." *US Catholic.* Vol 62 (no.10) p.25.

Eisenberg, David. Advising Patients Who Seek Alternative Medical Therapies. *Annals of Internal Medicine*, 127(1):61-69, 1997.

Farella, John. *The MainStalk.* Tucson and London: The University of Arizona Press. 1996.

Griffin-Pierce, Trudy. *Earth is My Mother, Sky is My Father.* Albuquerque: University of New Mexico, 1992.

Jackson, Susan. Alternative Medicine: Not so Alternative Anymore.

Langone, John. Challenging the Mainstream. *Time.* Fall 1996, p.40-3.

Leighton, AH. Leighton DC. *The Navaho Door.* Massachusetts: Harvard University Press, 1944.

US Dept of Heath and Human Services. *Regional differences in Indian Health 1996,* IHS Office of Planning, Evaluation, and Legislation.

## Internet References

Alternative medicine - related legal pages. [http://www.viable-herbal.com/]

Alternative medicine - broad overview. [http://bw.medpateints.com/]

Alternative medicine resources - on-line searchable library. [http://www.gen.emory.edu/MEDWEB]

Holistic medicine. [http://www.hir.com/]

National Library of Medicine. [http://www.ncbi.nlm.nih.gov/PubMed/]

Office of Alternative Medicine - National Institutes of Health. [http://altmed.od.nih.gov/]

# CONTENTS OF BOOK ONE

## The Partnership: Traditional Navajo Medicine (TNM) and Biomedical Health Care Practices (BHCP)


Goals of Book One
Role of Traditional Navajo Medicine Committee's
Conceptualization of TNM and BHCP: A Partnership

- Vision
- Mission

Partnership vs. Integration
Non Native Conceptualization of TNM and BHCP: An Integration

- Global Trends

Native Conceptualization of TNM and BHCP: A Combination of

- Integration and Partnership

Strong Global Support for Traditional Indian Medicine

# BOOK ONE

## The Partnership: Traditional Navajo Medicine (TNM) and Biomedical Health Care Practices (BHCP)

### Goals of Book One:

A. To understand what the Role of Traditional Navajo Medicine committee hopes to achieve through the partnership of Traditional Navajo Medicine and Biomedical Health Care Practices at the Chinle Comprehensive Health Care Facility.

B. As "carriers of knowledge," it is important to learn how non-Natives and Natives conceptualize the role of traditional medicine within their health care systems.

## The Role of Traditional Navajo Medicine Committee
## Conceptualization of TNM And BHCP: A Partnership

*In April 1998, the Role of Traditional Navajo Medicine committee at Chile Service Unit (CSU) developed the following vision and mission statements:*

### Vision

The Chinle Service Unit acknowledges, honors, and respects traditional medicine as a discipline for the promotion of wellness and health and the prevention of illness and disease. We are the "carriers of knowledge", clinically and culturally competent to protect and nurture our patients' natural healing process. Thus, we empower the partnership of scientific, evidence-based biomedical practices and traditional Navajo medicine.

### Mission

The Chinle Service Unit facilitates the partnership (Ahil na'anish) between traditional Navajo medicine and biomedical health care practices as follows:

- To honor and respect our patients' cultural values, using a creative and positive approach when we provide health care.
- To teach our patients how to walk the journey of wellness when making lifestyle choices as symbolized in the Navajo concept of the "corn pollen path".
- To preserve the cultural sensitivity and competence of our staff and enhance the practice of holistic health care.
- To promote and use K'é (kinship relationships) in all we plan, do, check, and act upon.

The vision and mission statements outline the basic principles to a model of health care that will allow the patient to walk the journey of wellness between two parallel systems: TNM and BHCP. (See figure 1-Bluehouse model) The outer circle representing BHCP is characterized as the male form: the invasive, and reductionist form of medicine. The inner circle representing TNM is characterized as the female form: the gentler, and more holistic form of medicine. The opening at the bottom of this model is the way in and out of this journey towards wellness. As "carriers of knowledge", Chinle Service Unit staff will guide patients through both systems of health care depending upon their needs. Thus, in this model, there is a partnership, an ahil na'anish, between TNM and BHCP. Both systems run in parallel and are not at any point integrated. It is important to emphasize that what the RTNM committee wants to achieve is a partnership, not an integration.

## Partnership Versus Integration

Fundamentally, the RTNM committee desires a partnership because it retains the values and beliefs of both health care systems. Working together, side by side, with consensus at every step, a partnership instills mutual respect, mutual understanding, and cooperation. With this mutual co-existence, it is the patient's condition that determines which system they will use first. On the other hand, integration attempts to blend both health care systems into one, where a patient has only one point of entry. Instead of harmony, integration promotes a struggle for control in which each health paradigm feels threatened by the other and competes with the other for utilization of their services. As integration attempts to fit both paradigms into one, a loss of values and beliefs that are essential to each occurs. In the last decade, promotion of alternative medicine has mostly occurred through integration efforts.

***Partnership***

- keep both systems separate
- retain values and beliefs of both systems
- mutual respect
- mutual understanding
- cooperation
- 2 points of entry: entry into one system or the other depends on patient's condition

***Integration***

- blend both systems into one
- loss of values and beliefs of both systems
- defensive instead of understand
- struggle for control-competition
- interference in patient choice
- single point of entry

***The RTNM committee's initiative to partner TNM and BHCP falls within this global movement to bring "alternative medicine" into mainstream health care practice which is BHCP based. TNM is labeled as an "alternative medicine" by BHCP. It is important for the RTNM committee and "Carriers of Knowledge" to see how their initiative is conceptualized by non-Natives.***

Alternative medicine is becoming more accessible to consumers through integration efforts. Third-party payers are beginning to cover alternative medicine as an extra benefit package. Blue Shield of California began providing alternative health care coverage in January 1998. LifePath program will offer members access to more than 1,000 qualified alternative practitioners, including acupuncturists, chiropractors, massage therapists, and stress management experts.[3] Oxford Health Plan is offering chiropractic, acupuncture, and naturopathy as paid benefits to 1.5 million subscribers.[4] Both Blue Shield and Oxford realize that the population they need to attract, educated upper-income adults, is demanding alternative medicine.

Medical schools are starting to offer courses in alternative medicine. Only a few like Dr. Walt Hollow's "Indian Health Pathway Track" (Appendix R) at the University of Washington School of Medicine offer a certification which requires research, clerkships, preceptorships, and coursework in Indian Health issues. Dr. David Eisenberg[5] at Beth Israel Deaconess Medical Center proposes a step-by-step approach (Appendix D) whereby medical providers and patients can discuss available alternative therapies and identify a suitable licensed alternative health provider.

In order for BHCP systems to accept alternative medicine, many studies are being done to address the efficacy of alternative medicine in scientific biomedical terms (See Internet resources).

*Some argue that these studies may undermine the belief system itself, since the power of the belief system is to believe without scientific proof. They fear that legitimizing alternative medicine in biomedical terms may do violence to the nature of alternative medicine practice.*

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[3]Langone, John. Challenging the Mainstream. *Time.* Fall 1996, p.40-3.

[4]Eisenberg, David. Advising Patients Who Seek Alternative Medical Therapies. *Annals of Internal Medicine*, 127(1):61-69, 1997.

## GLOBAL TRENDS

### *Growing Consumer Demand for Alternative Medicine*

- 1 in 3 adults in the United States use some form of alternative medicine to prevent or relieve illness
- 60 million Americans use alternative medical therapies at an estimated cost of 13.7 billion on unconventional therapies and made an estimated 37 million more office visits to alternative practitioners than to US primary physicians in 1990[5]
- Profile of patients using alternative medicine were educated upper-income adults under the age of 40 seeking relief for a chronic condition[1]

### *The Integration of Alternative Medicine into Biomedical Health Care Systems*

- In the past 3 years, some third-party funders have started to provide limited coverage for "alternative health care,"
- One-third of US medical schools now offer courses in alternative or complimentary medicine,[2]
- Expansion of clinical trials demonstrating the efficacy of alternative medical therapies.

[1]Jackson, Susan. Alternative Medicine: Not so Alternative Anymore. *Business Week.* 2 June 97, p.150-51.
[2]Chang, Eunice. The Power of Prayer.

Many evidence-based studies have been done on meditative practices and belief systems, while recently there is a growth in studies on herbal medicines and other alternative treatments. Religious beliefs, the power of prayer, and spirituality have been found to affect a patient's health and wellness. Reduction in incidence of cancer, coronary artery disease, dementia and positive affects on communicable disease of childhood, pregnancy and family planning, affective disorders, mental health, alcoholism, and AIDS prove that belief systems improve health.

Prayer, for example, has been shown to work even in the case of a research study where bacteria is placed in two different test tubes. The researcher asked people 15 miles away to pray for one of the samples to grow faster. In 14 out of 15 trials, the group of bacteria that was prayed for showed an increased growth.[5] Some argue that these studies may undermine the belief system itself, since the power of the belief system is to believe without scientific proof. They fear that legitimizing alternative medicine in biomedical terms may do violence to the nature of alternative medicine practice.

[5]Dubois, Christine. "Prayer: It's Just What the Doctor Ordered." *US Catholic*. Vol 62 (no.10) p.25.

## Native Conceptualizations of TNM and BHCP: A Combination of Integration and Partnership

- Renewal of American Indian/Alaska Native Healing Practices
- 638 process
- Diversity in cultural beliefs, values, and traditional practices

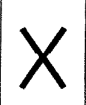
As compared to the overall health of US citizens, some AI/AN tribes are experiencing third world disease conditions. Comparing the top three causes of death in AI/AN populations from 1991-1993[6], alcoholism was 703% greater, tuberculosis was 525% greater, and accidents were 282% greater than US rates. Indian Health professionals have fought hard to bring back some of the traditional beliefs, values, and healing practices that have gone underground as a result of European oppression. The renewal of AI/AN traditional healing practices and its positive effects on Indian health demonstrate the urgency and need to respect cultural values in primary and preventative care.

There is a great variety in methods of renewing AI/AN traditions in health care. Most tribes have completed or are in the process of PL 638, utilizing the Indian Self-Determination Act and Education Assistance Act to contract IHS and Bureau of Indian Affairs programs and shape their own services. In 1995, the IHS also began a traditional medicine initiative. After 11 discussion groups representing all the geographic areas of IHS services, many needs were identified. No policies have resulted from these discussions as of yet. However, many reservation as well as urban based tribes have established their own clinics which provide both traditional medicine and BHCP through partnership as well as integrative methods. Because there are more than 500 Indian tribes, each with their own cultural beliefs, traditional healing practices, and governing system, this report does not claim to cover all of them, but will concentrate specifically on the Navajo Nation.

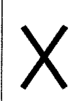
[6]US Dept of Heath and Human Services. *Regional differences in Indian Health 1996,* IHS Office of Planning, Evaluation, and Legislation.

## Strong Global Support for Traditional Indian Medicine

- Provide culturally appropriate care
- Shift from infectious to chronic illness
- Save millions of dollars through prevention



Advances in information technology and tremendous growth in health maintenance organizations has changed the patient-doctor relationship. Many patients complain of impersonal, and culturally insensitive care. And turn to alternative/traditional medicine for more intimacy between caregiver and patient.



There is a shift from infectious diseases to chronic illnesses. Patients suffering from chronic illness have tried every possible biomedical technology solution and are now turning to other treatments that are less invasive and less expensive.

The United States spends more than any other nation in the world on health care. These funds are spent mostly on drugs and treatment. There is little emphasis on preventive medicine and well-being. Alternative/traditional medicine is a model that improves the quality of life through promotion of wellness, self-care and discipline. Millions of dollars can be saved by teaching patients how to care for themselves and live a healthier lifestyle.

## CONTENTS OF BOOK TWO
**Achieving Balance in Partnership**

Goals of Book Two
Problem Definition
Methods
Forces Affecting the Partnership
- Driving Forces
- Restraining Forces

# BOOK TWO
# Achieving Balance in Partnership

## Goals of Book Two:

A. To analyze the problems facing the RTNM committee in achieving a partnership of Traditional Navajo Medicine and Biomedical Health Care Practices at CCHCF.

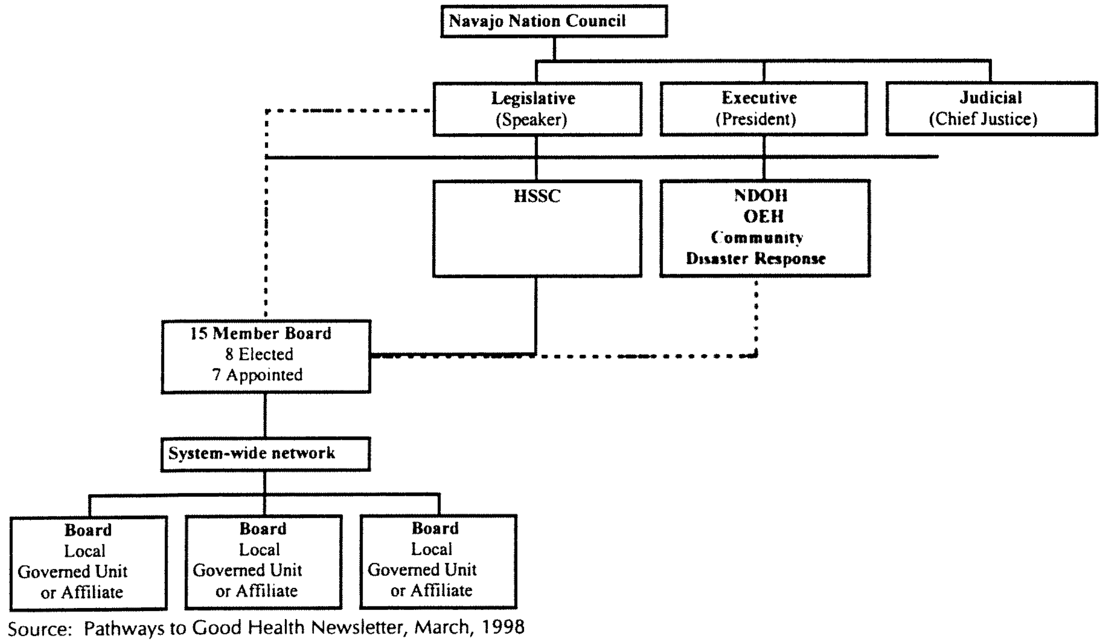
B. To describe the "driving forces" and the "restraining forces" affecting this partnership.

## Problem Definition

The Navajo Nation is in the process of redesigning their health care delivery system under the authority of Public Law 93-638, the Indian Self Determination Act and Education Assistance Act. This is the only IHS Area that has no tribally operated health facilities. They are currently in the pre-planning and conceptual design phase. There are three administrative organization options being discussed: corporate structure, 8 autonomous local operators, and area wide network with affiliates (Refer to diagram below). It may be several years before they complete the transition from federal control to tribal management. Only after stabilizing the transition will they initiate system-wide planning to restructure service delivery and incorporate traditional healing. Finally, the last stage will be to implement system-wide health services restructuring.

In the meantime, the RTNM committee at CSU wants to develop an action plan that would facilitate the partnership of TNM and BHCP. Their main goals are to provide culturally appropriate care and become "carriers of knowledge" so that patients can walk the journey of wellness through both TNM and BHCP paradigms.

**Proposed Navajo Nation Health Care System**
**(chartered under the auspices of the navajo Nation)**




Source: Pathways to Good Health Newsletter, March, 1998

## Methods

In order to develop an action plan for the RTNM committee, we used the following methods of gathering information:

1. We conducted on site interviews with IHS staff within the Chinle Service Unit, traditional healers, RTNM committee members, and tribal leaders to gain understanding of the situation and determine diverse concerns and needs.

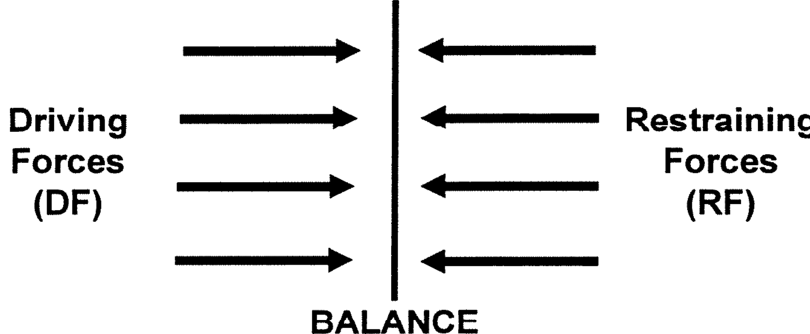
2. We phone-interviewed leaders within the health care systems of other tribes in order to learn about their efforts in providing access to traditional medicine, and to provide a context for Chinle's RTNM committee's planning process.

3. We spoke to leaders of reservation-based and urban-based tribes that have successfully completed the 638 process and those who have built their own clinics in order to gain a holistic view of the national effort.

4. Budget plans, proposals, and curriculum materials were collected as models for the RTNM committee.

## Forces Affecting Partnership

After sorting through this information, we have identified the various forces at work in Chinle that are both enabling and impeding the progress of the RTNM committee. To assist us in defining these forces, we have made use of the following problem-solving model. Most problem situations can be understood in terms of the forces which push toward progress and the forces which resist progress. We have called these respective forces *driving forces* and *restraining forces.*
The driving forces (DF) represent the positive energy that is pushing towards a successful partnership of TNM and BHCP. The restraining forces (RF) represent the negative energy that is resisting the partnership. An effective way to achieve balance, therefore, is to increase the influence of the driving forces while decreasing the influence of the restraining forces. We have formulated several proactive steps that will address each force we have identified, and enable the RTNM committee to move towards the balance required for a successful partnership of TNM and BCHP.



## DRIVING FORCES (DF)

- **Strong Cultural Foundation**
- **Existing Resources**
- **Common Goals**
- **Organizational Infrastructure**

### *1. Strong Cultural Foundation*

The Navajo Nation is home to the largest tribe of American Indians and with a landbase that stretches 25,000 square miles across four states. The Navajo people, due to their resilient nature and significant resources, have been able to retain much of their culture and language, despite the obstacles they have had to overcome. Fortunately, the People have preserved much of their traditions and healing practices. There is an abundance of anthropological literature available that records Navajo cultural values and spiritual practices from a Western perspective. Navajo medicine is an example of a traditional healing system that has remained intact despite the influence of BHCP. Traditionally, a Navajo who becomes ill will attempt self-medication with herbs first, then consult a diagnostician if needed who can determine what is the nature of the illness. The patient is then directed to a singer or other appropriate care provider.

The People have unique customs and traditions that are not found anywhere else. Truly, this is a matter of pride for the Navajo people, and their culture, traditions and language are important to maintain under all circumstances. The Navajo Nation is now in an unprecedented period of growth and cultural renewal. The effort to form this partnership at CCHCF is part of this trend, and it is of utmost importance that projects like this are supported for the future of Navajo culture.

## 2. Existing Resources

Fortunately, because of the strong cultural foundation that exists, there is an abundance of human and material resources readily available to the RTNM committee.

- Diné College and Northern Arizona University (NAU) offer courses in Navajo language, traditions, and Navajo perspectives on healing. For example, 1998 marks the 14th year that Diné College and NAU have co-sponsored a summer study tour entitled "Exploring Health Care in the Southwest, The Navajo Perspective" that features many of the topics which the RTNM committee may want to include in their orientation/training programs.

- There is a history of a dual system, a co-existence of TNM and BHCP on the Navajo Reservation. From 1955 to 1960, Cornell University and the Navajo Tribal Government established a cross-cultural clinic at Many Farms to introduce drugs for treatment of tuberculosis. Many important lessons were learned including the development of a culturally relevant format for medical records. [1] In 1979, Shiprock Hospital offered an internship where IHS staff and traditional healers worked together on a case-by-case basis.

- In the late 70's, the Navajo Medicine Man Association was formed to develop certification, reimbursement schedules, a code of ethics, and registration booklets. Insurance companies have approached the organization in an effort to develop a pricing system for traditional ceremonies. Although the association dissolved 8 or 9 years later, recently there has been a renewed demand for the services it provided.

- The IHS Traditional Medicine Initiative as well as other related tribal programs offer invaluable lessons which the RTNM can incorporate into their implementation plan. Some programs also offer sources of funding that may be of use to the work of the RTNM committee. Of special importance is the effort by the Indian Health Board (IHB) of Minneapolis to lobby Congress for traditional medicine appropriations. (Please refer to Appendix E)

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[1]Adair, John. Deuschle, KW. Barnett, CR. The People's Health. Albuquerque: University of New Mexico Press, 1988.

### *3. Common Goals*

Both traditional healers and Western-trained physicians desire the improvement of health among the Navajo peoples. Western trained physicians understand the importance of Navajo traditions and desire opportunities to learn more about the culture so that they can provide better care to their Navajo patients. Among all Western trained doctors interviewed, all emphasized that none of their colleagues would persuade a patient not to seek traditional healing. Traditional healers also welcome the opportunity of learning more about BHCP.

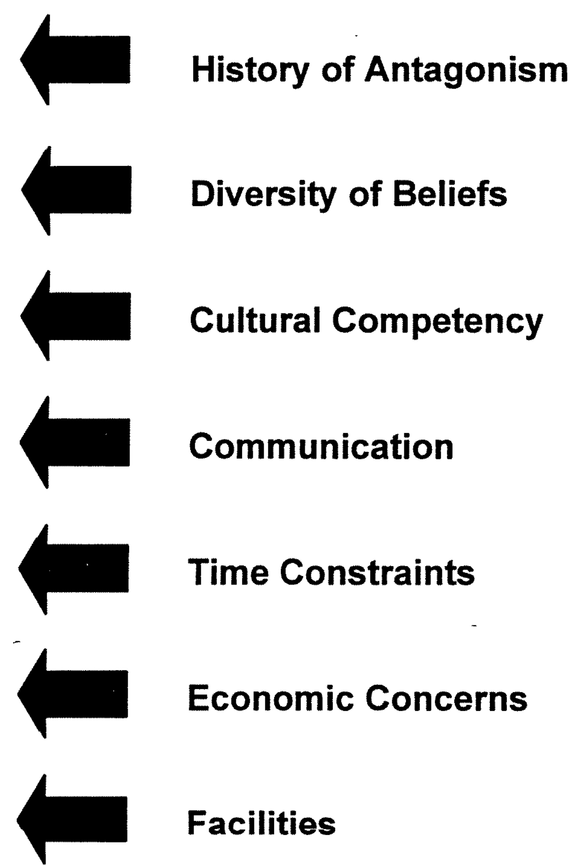
It is important for the leaders of this initiative to remind all participants of the common goals that exist in this effort. This will help to provide a positive outlook and positive focus throughout all working relationships.

### *4. Organizational Infrastructure*

The RTNM committee meets regularly to determine policy and future directions for this partnership. It serves as a forum for working group discussions. The committee has already held several focus groups in an effort to identify potential barriers to the partnership, kept its members informed of the progress of Navajo Nation 638 process, and operated within an effective organizational management framework. The committee is comprised of leaders in the community, heads of CSU departments, and influential individuals who will play a role in the success of the initiative. The committee further benefits from the advocacy and administrative competence of the committee facilitator and hospital CEO.

One effective means by which the committee has tried to gather information relevant to its work is to invite local leaders to speak at each RTNM committee meeting. This program has at least two benefits: it brings information in and spreads the word of the partnership effort to the external community.

## RESTRAINING FORCES (RF)



### *1. History of antagonism*

This restraining force refers to the relationships that have often resulted between traditional Navajo healers and Western-trained physicians. Although each case is different, many relationships between the two groups have been decidedly strained. This has led to a polarization of the two forms of health care, one being seen as opposed to the other.

Several practitioners themselves cited a history of mistrust and misunderstanding between traditional healers and Western-trained health care providers. Back in the 50's, one prominent singer, Manuelito Begay, delegate to the Tribal Council from Crown Point, reported:

> I want to refer to what has gone on in the past relative to treatment of our people when they were ill–when the doctors and hospitals were first established among us, the doctors thought they were the only ones who knew how to apply medicine to the patients. The Navajo people were not recognized at all and, in that connection, we thought the same way, we could not agree as to whose treatment should be recognized, The doctors thought they were the ones, and we thought we were the ones.

Years of disrespect and antagonistic attitudes have caused medicine men to bring their practices underground. Many fear that this state of nondisclosure may inhibit this partnership especially since the very nature of traditional medicine is secretive, where ceremonies and prayers are passed by word of mouth from one healer to the next. It is our sincere hope that an earnest dialogue can occur between representatives of diverse health care systems at CCHCF. After all, there is much work for them to accomplish together as a group or committee, including the formulation of a certification process, the writing of the "Manual of Understanding," and the "buddy system."

### *2. Diversity of beliefs*

RTNM committee members along with other IHS staff and traditional healers have different ideas of what they want to see in this partnership. They are especially divided over issues of credentialing, certification, referral systems, and reimbursement schedules. Some believe these are tools created through Western belief systems that if enforced in this partnership would undermine traditional beliefs. Others argue that these standards are necessary for a successful partnership; that healers should not be afraid of these standards, but be proud of them, because traditionally medicine men had disciplines too. These issues create great controversy because some traditional healers say that the true medicine man does not need a certificate to prove his legitimacy while other traditional healers say that the true medicine man would not be afraid of getting a certificate. There needs to be someway for people to know who is a real traditional healer and who is a quack or charlatan.

Another form of diversity of opinion is along the lines of spirituality. At this time it is unclear what the religious makeup of the staff is at CCHCF. Many staff members are Navajos, and there is less cultural diversity among them than there is religious, spiritual and philosophical difference. There are staff members who are Navajo, European-American, Asian-American, Mexican-American, as well as Indians from other tribes. Moreover, there is a wide range of beliefs represented at CCHCF. The staff is made up of Protestants, Catholics, those who attend the Native American Church, Traditional Navajos, and those who are a mixture of several of these belief systems. It is important to get an idea about the extent to which the philosophies are represented , and give voice to dissenting viewpoints. After all, the initiative will not be a success without the support of each staff member. There is also much diversity of beliefs among patients. During FY 1997, Chinle served 35,195 Indian patients of which 34,811 were Navajo, 38 were Hopi, and 2 were Zuni.

### 3. Cultural Competency

Lack of awareness of Navajo traditions on the part of the practitioner during encounters with traditional Navajo patients has led to a certain degree of ethical and interpersonal tension at CCHCF. Many providers would like to learn more about Navajo traditions in order to provide better care to their patients. Familiarity with Navajo culture will help in designing a more culture appropriate treatment plan, changing certain health behaviors, and understanding compliance issues.

The Cultural Competency model is currently used among professionals in a variety of fields across the nation. This framework provides a means by which administrators can assess the degree to which employees are culturally sensitive to the clients they work with. It has been demonstrated to have a variety of positive effects on organizational health. It is in the best interest of the CSU to ensure that each member of the staff is culturally competent. It is our hope that a program for this purpose can be devised to promote greater cultural understanding among the staff and patients at CCHCF (See Appendices I and J).

### 4. Communication

At the time of our interviews, most community leaders who are partnering traditional Indian medicine and BHCP seem very isolated and unaware of what other groups are doing around the nation. Even individuals of the same tribe are not informed about current projects their colleagues are working on. In addition, among CSU staff, not all key players are aware of the RTNM committee. Since communication is the key to understanding and respect, it is important to open the channels of communication early in the game so that no one will be left out.

Communication is also a key part of the planning cycle based on traditional Navajo philosophy. It takes much time and effort to communicate effectively, but few projects are successful without this crucial element. We have included some suggestions for more effective communications internally as well as externally.

### 5. Time Constraints

All RTNM committee members have full-time job commitments and are working on this partnership initiative on their own time. Physicians have different schedules from other staff members and therefore meetings that accommodate all key players have been difficult to arrange. Also, there is a high turnover rate among staff. Public health nurses and physicians remain on staff for an average of 2 years.

Thus, the challenge of time constraints is truly key to the success of the partnership. Effective management of time and energy, and proper delegation of tasks will be required to work with ever present time issues. It is our recommendation that the committee consider the possibility of hiring a full time Coordinator to accomplish many committee tasks. We have identified funding sources that may be available for this purpose. If this step is not possible, the next option would be to break down tasks into manageable pieces and clearly delegate each task to members of the committee.

### 6. Economic concerns

The RTNM committee faces two immediate funding issues:

- First, they must find funding to support the initiative for new staff, training materials, and facilities, such as a detached hogan among other needs.

- Secondly, they must find funding for patients who do not have the ability to afford traditional medicine. Most Western-trained providers are concerned about who will bear the cost of traditional healing.

Priority should be given to financial issues at the earliest possible convenience. A person on the committee, preferably with some expertise, should be selected for this purpose alone, until a time when the job can be passed on to the full time Coordinator. This individual should develop a detailed budget proposal so that RTNM committee can demonstrate the efficient use of their resources and proper distribution of resources requested.

### *7. Facilities*

Certain aspects of the existing facility in Chinle are unaccommodating and disrespectful of certain Navajo traditions. Assessments should be made by each department, and funding secured for each department's needs. Some of the facility issues we identified during our time at CCHCF are the need for a detached hogan, the need for a more culturally appropriate atmosphere, and the need for Navajo language signs. It was recommended that it is important to promote the use of the Navajo language as a way to preserve culture.

## CONTENTS OF BOOK THREE
### Organizational Planning and Action Steps


Goals of Book Three
Organizational Planning: The Navajo Way
- ➢ East: Nitsáhákees
- ➢ South: Nahat'á
- ➢ West: Iiná
- ➢ North: Sih hasin

Action Steps
- ➢ To Increase Driving Forces (DF)
- ➢ To Reduce Restraining Forces (RF)

Timeline
Action Checklists

# BOOK THREE
## Organizational Planning and Action Steps

## Goals of Book Three

A. To outline the organizational planning process as prescribed by traditional Navajo philosophy, and incorporate this information with the model currently in use at CCHCF.

B. To recommend and prioritize a list of action step for each driving and restraining force we have identified. We have grouped these steps into phases for implementation.

C. To provide a timeline and checklists to make the recommendations easier to put into action.

Traditional Navajo teachings provide an effective method of organizational planning which forms the basis for this report. It is important to describe in detail the Navajo organizational planning process as a methodology for RTNM committee to apply towards each action step identified.

Along with the concept of anil na'anish, the Navajo planning cycle provides a solid basis from which the committee can accomplish its work. Moreover, it is important for all "carriers of knowledge" to understand the unique characteristics of a Navajo organizational planning model as well as to internalize the principles of anil na'anish. Together, these frameworks set a standard for the start of other committee work within CCHCF, the administration of the hospital as well as the work of individuals in partnering TNM and BHCP.

The following planning model was adapted from the work of Johnson Dennison and Philmer Bluehouse, and is centered on the four cardinal directions (See Appendices C and M). It may be described as a journey that begins in the East, the entry point, where ideas begin to germinate. It is the spring of the planning cycle, the color representing this stage is white, and it is symbolized by the dawn. The following description of the Navajo planning model is aligned with the four step planning model already in existence at CCHCF. The adaptation of a centered, traditional Navajo conception of organizational planning is thus made even easier to integrate into existing modes of strategic planning.

**East: Nitsahákees - PLAN - Conceptualization**

In Navajo philosophy, the dawn is symbolic of new life. Each morning when the sun rises from the east, the story of creation is re-enacted. It is appropriate for all new planning within an organization to begin in this way as well. N'tsahákees is the entry point of the cyclical planning process; it signifies a time to rethink and recreate the original creation and journey plan. It is to strategize, to create a blueprint for the plan to be implemented. This stage in the planning process is the naanish bá nitsáhákees, or conceptualization phase. It may also be corresponded to the PLAN stage of the existing hospital protocol.

**South: Nahat'á - DO - Communication**

Moving on through the process, we arrive at the stage involved in implementation of the plan for progress. This is the summer of the planning journey, and it is a time to build upon ideas formulated in the plan and/or revise the plan. Tactics are the focus of this stage of implemention, action and activity; it is the "daytime" phase of the project. It is also important to learn as much as possible at this stage. Effective communication among participants is critical to the success of the plan. This phase of the cycle corresponds to

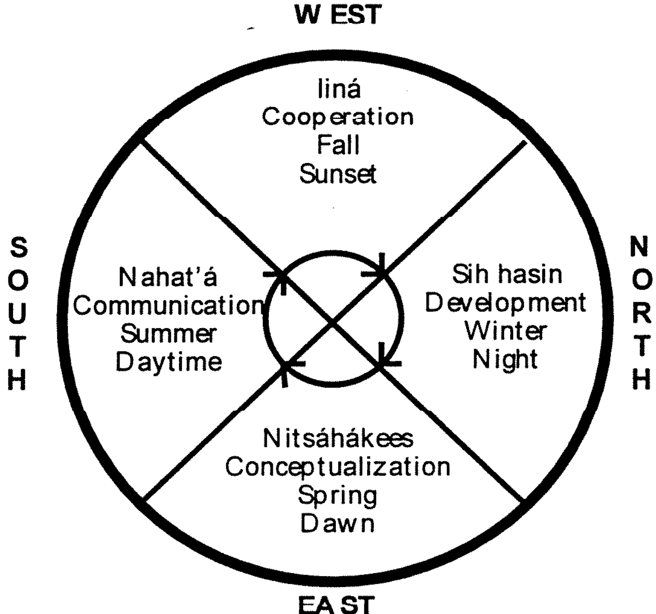
the DO stage of the existing hospital protocol.

**West: Iiná - ACT - Cooperation**

Arriving at Iiná, the process is well under way. Anil na'anish is an important descriptor of this stage, in the fall of the planning process. This is the phase of life experience, the continuation of life, using the combined strategies and tactics previously devised; the "sunset" stage of the project. At this stage of the process, wisdom is acquired. Those involved in the project are learning from difficulties they have encountered along the way. It is essentially a time to cooperate and work together. This phase of the cycle corresponds to the ACT stage of the existing hospital protocol.

**North: Sih hasin - CHECK - Development**

The fourth stage of the planning cycle corresponds to the cardinal direction north, and is described as the "night" time of the project. at this time is is necessary to reflect, evaluate and look back on the planning process. It is also a time to look ahead to repeating the cycle, to rise with new hope, to revitalize, to rejuvenate. It is the stage to re-create, modify and change plan, and look forward to the times ahead. This is truly the development stage, where participants reflect on what worked, what didn't and what will be changed to make their plan more effective next time. This phase of the cycle corresponds to the CHECK stage of the existing hospital protocol.




Source: "Organizational Management" from Dennison and Bluehouse.

# Action Steps

## To Increase Driving Forces (DF)

### *DF - Strong Cultural Foundation*

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Initiate Cultural Awareness Campaign | •Make hospital environment more comfortable for traditional clients<br>•Bi-lingual (Navajo and English) language signs (IHS)<br>•Staff culture and language program<br>•Design posters for distribution throughout hospital |
| 2 | •Develop "Manual of Understanding" | •Form a development committee with representatives of TNM and BHCP<br>•Purpose of Manual: Resource guide for traditional medicine as well as BHCP<br>•Proposed Topics for Manual:<br>-RTNM Vision/Mission Statement<br>-Code of Ethics for "Carriers of Knowledge"<br>-Basic concepts of TNM and BHCP<br>-Resource List<br>-Referral System/Careplan<br>-Guidelines<br>•Refer to other examples of curriculum (See Appendix B and R) |
| 3 | •Prepare resource list of appropriate reading materials/projects for "Carriers of Knowledge" certification | •Diné College library and bookstore<br>•Work closely with traditional healers and elders in the community to review and approve materials |
| 4 | •Help staff learn/reclaim Navajo traditions | •Sponsor staff retreats intended to encourage reconnection with traditional teachings |
| 5 | •Develop Patient Education/Community programs | •Promote awareness of TNM through health education, arts/crafts workshops, health fairs, community hogan project, etc.<br>•Refer to Appendix E for examples |

*DF - Existing Resources*

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Identify key players crucial to the success of initiative | •Locate individuals/institutions internally and externally who will play an influential role in the initiative |
| 2 | •Create Memorandum of Understanding (MOU) | •Clearly define the needs, roles, and accountability of key players |
| 3 | •Identify and collaborate with local potential partners | •Many individuals in Navajo Nation may be working on projects that overlap with initiative<br>•Collaborate with local medical school, dental school, nursing school, public health school to establish clerkships |
| 4 | •Provide forum for staff to share their knowledge and expertise about traditional practices | •Develop "hidden" resources, empower current staff, build trust and community in the workplace |
| 5 | •Develop summer internship/job training program for local youth (See Appendix L for names of programs already in place elsewhere) | •Expose high school students to careers in the health field<br>•Investment in local community<br>•Ensures greater number of trained Navajo professionals in long term |
| 6 | •Continue to invite community leaders for inservice presentations | •Established as part of RTNM committee meetings<br>•Exposes work of RTNM to outside |
| 7 | •Identify and collaborate with other leaders of traditional medicine initiatives | •Conference calls, e-mails, exchange of materials and resources<br>•Collaborate with other medical schools to send students to CSU for clerkships<br>•AAIP / Cross-cultural Workshops |

***DF - Common Goals***

| Priority Level | Action Step | Details |
| --- | --- | --- |
| 1 | •Institutionalize "common goals" into all committee business | •Reframe labels of "traditional healer" and "Western-trained provider" as "carriers of knowledge" |
| 2 | •Offer incentives to encourage full participation of key players | •Stipend, CMEs, mandatory certification, time off, etc... |
| 3 | Establish code of ethics for "Carriers of Knowledge" | •Promote mutual respect, mutual understanding, listening to one another<br>•Example of mental health "rules" (See Appendix N) |

***DF - Organizational Infrastructure***

| Priority Level | Action Step | Details |
| --- | --- | --- |
| 1 | •Hire full-time Coordinator of TNM and BHCP affairs | •Job Description<br>•Job Qualifications<br>-cultural competency<br>-grant/proposal writing experience<br>-knowledge of both models of health<br>-conflict negotiation/mediation skills |
| 2 | •Delegate responsibilities or form working committees within RTNM committee | •In lieu of full-time Coordinator |
| 3 | •Prioritize Action Steps | •Decide which steps are desirable and appropriate<br>•Put them in order of importance and need |

## To Reduce Restraining Forces (RF)

***RF - History of Antagonism***

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Create "Manual of Understanding" | •Booklet distributed to all staff that outlines the partnership and describes each approach to health care in some detail<br>•Process of creating booklet will begin dialog between diverse practitioners |
| 2 | •Develop "Buddy Program" | •Assign each BHCP practitioner to a TNM practitioner for sharing of information (Carriers of Knowledge partners)<br>•Provide opportunities for "shadowing" |
| 3 | •Sponsor workshops series | •To introduce beliefs/values of TNM and BHCP or CME-like course for Western-trained providers as well as traditional healers |
| 4 | •Institutionalize a certification process for "Carriers of Knowledge" | •Could function as legitimization for providers<br>•BHCP providers as well as TNM providers should play a role in the development of such a certification<br>•Should be valued by all parties<br>•Final certification does not necessarily have to be a document (i.e. ceremony) |

***RF - Diversity of Beliefs***

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Develop policies and procedures for:<br>-care plan/referral system<br>-credentialing<br>-certification<br>-compensation for traditional services | •Review IHB Minneapolis policies<br>•Discuss development of Navajo Medical Man Association with Eddie Tso<br>•Institutionalize "Carrier of Knowledge" certification<br>•Refer to Appendix Q |
| 2 | •Create task force on diversity | •Provide forum for expression of diverse opinions and ideas<br>•Should be facilitated by experienced professional mediator of mental health specialist<br>•Give voice to philosophical and religious diversity of staff at CCHCF |
| 3 | •Organize Focus groups/ Community Forums | •Perform needs assessment of traditional healers, community members and IHS staff |

***RF - Cultural Competency***

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Develop Orientation and Training programs for all staff | • Mandatory workshop on Navajo history and culture for all new hires<br>•Provide incentives for current staff to attend ( ie. Stipend, CME, Provide time-off)<br>•Training for administration of the TBBA |
| 2 | •Institutionalize Traditional Background and Behavior Assessment tool (TBBA) | •Training required to administer tool<br>•Use as part of patient intake process |
| 3 | •Develop staff awareness campaign | •Design culturally appealing posters<br>•Place policies and procedures in highly visible places throughout CSU ( ie. Washrooms, Lockers, etc...) |
| 4 | •Revise hiring process to give priority to candidates who have had exposure to traditional healing or are willing to learn | •Medical providers who have completed Indian Health Pathway Track<br>•Medical providers who have completed CME courses in TNM or BHCP |

### *RF - Communication Barriers*

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Develop Internal Communications | •RTNM Committee Newsletter<br>•E-mail all staff regularly<br>•Develop intranet web site |
| 2 | •Develop External Communications | Access technical facilities<br>-web site<br>-electronic bulletins<br>-telephone conference calls |
| 3 | •Develop School Wellness Program based on Navajo principles of wellness as well as BHCP models | •Initiate outreach to schools<br>•Promote understanding of and appreciation of TNM<br>•IHB Minneapolis (See Appendix E) |

### *RF - Time Constraints*

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Hire full-time RTNM Coordinator | •Job Description<br>•Job Qualifications<br>-cultural competency<br>-grant/proposal writing experience<br>-knowledge of both models of health<br>-conflict negotiation/mediation skills |
| 2 | •Offer incentives to ensure participation by all key players | •Provide time-off, stipend and/or CMEs for attending RTNM committee meetings and related activities |
| 3 | •Schedule meetings and other activities in such a way that they accommodate the majority of RTNM committee members | •Schedule meetings/activities well in advance<br>•Use scheduling software to coordinate activities with work schedules |

### *RF - Economic Concerns*

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Develop budget proposal | •Full-time Coordinator or Committee member delegate should be initiated immediately<br>•Reviewed by CFO |
| 2 | •Apply for internal and external grants and funding opportunities | •Internally - IHS Traditional Medicine Initiative<br>•IHB Minneapolis (Refer to Appendix E)<br>•Local/National Foundations - list of sources can be found in library or online |

### *RF - Facilities*

| Priority Level | Action Step | Details |
|---|---|---|
| 1 | •Construct detached hogan | •High school/community involvement<br>•Consult expert |
| 2 | •Install Bilingual (Navajo and English) language signs throughout hospital | •Possible IHS funding<br>•Promotes respect and interest in the language<br>•Every sign in Navajo and English |
| 3 | •Make hospital environment more comfortable for traditional clients | •Add to ambiance that is uniquely Navajo - display local artwork, make more homelike |
| 4 | •Assess facility needs of each department | •Rooms, decor, building may need to be altered to accommodate traditional Navajo healing practices<br>•Allocate financial needs into Budget proposal |

# Timeline

The following is a list of recommended action steps that address each of the driving and restraining forces we have identified. The action steps are prioritized beginning with the most important and simplest items to implement. You may, of course decide to reorder and/or delete items on this list based according to what is realistically possible for the committee to accomplish. The action steps are divided into four phases.

**PHASE ONE: Basic Needs**

1. Identify key players crucial to the success of initiative
2. Create Memorandum of Understanding (MOU)
3. Delegate responsibilities/form working committees within RTNM
4. Institutionalize "Common goals" into all committee business
5. Create "Manual of Understanding"
6. Enhance Internal Communications
7. Continue to invite community leaders for inservice presentations
8. Offer incentives to ensure participation by all key players
9. Schedule meetings and other activities in such a way that they accommodate the majority of RTNM committee members
10. Develop budget proposal
    establish funding for new Coordinator position
11. Make hospital environment more comfortable for traditional clients
12. Identify and collaborate with local potential partners
13. Provide forum for staff to share their knowledge and expertise about traditional practices

**PHASE TWO: Making Progress**

1. Hire full-time Coordinator of TNM and BHCP Affairs
2. Develop policies and procedures for:
    - care plan/referral system
    - credentialing/certification
    - compensation for traditional services
3. Initiate Cultural Awareness Campaign
4. Develop Orientation and Training programs for staff
5. Develop and initiate "Buddy Program"
6. Institutionalize Traditional Background and Behavior Assessment Tool (TBBA)

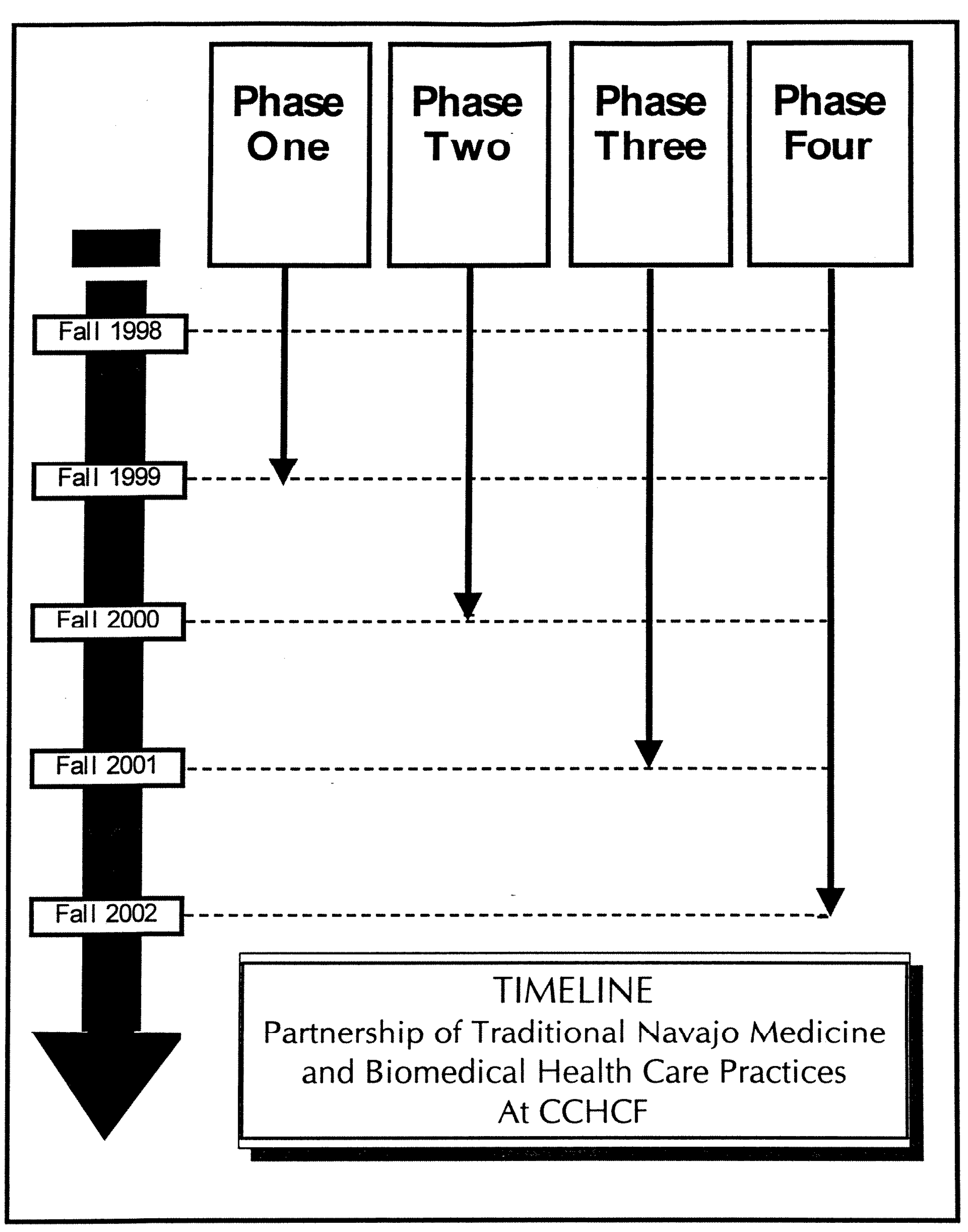
7. Identify internal and external grants and funding opportunities
8. Install Navajo language signs throughout hospital
9. Assess facility needs of each department
10. Develop staff awareness campaign (policies and procedures)

**PHASE THREE: Moving Towards Partnership**

1. Construct detached hogan
2. Develop summer internship/job training program for local youth (SeeAppendix L for examples of programs already in place)
3. Establish code of ethics for "Carriers of Knowledge"
4. Create task force on diversity
5. Revise hiring process to give priority to candidates who have had exposure to traditional healing or are willing to learn
6. Develop External Communications
6. Prepare resource list of appropriate reading materials/projects for proposed
"Carriers of Knowledge" certification
8. Help staff learn about/reclaim Navajo traditions (Retreats, workshops)
9. Organize Committee on Certification

**PHASE FOUR: Reaching Out**

1. Identify and collaborate with other leaders of traditional medicine initiatives
2. Sponsor workshop series for practitioners
3. Institutionalize certification process for "Carriers of Knowledge"
4. Develop School Wellness Program based on Navajo principles of wellness as well as BHCP models
5. Develop Patient Education/Community programs


Phase One
Phase Two
Phase Three
Phase Four
Fall 1998
Fall 1999
Fall 2000
Fall 2001
Fall 2002
TIMELINE
Partnership of Traditional Navajo Medicine
and Biomedical Health Care Practices
At CCHCF

## Action Checklists

**PHASE ONE**

| Action Step | Recommended Course of Action | Checklist |
|---|---|---|
| #1 | Identify key players crucial to the success of initiative | ❑Locate local influential leaders of TNM and BHCP<br><br>❑Invite them to a brainstorming session to identify their needs and concerns, elicit their support<br><br>❑Consult IHS and Navajo Nation officials<br><br>❑ Maintain a record of all transactions and discussions among key players |
| #2 | Create Memorandum of Understanding (MOU) | ❑Get format from Administration Office<br><br>❑Delegate sections to committee members<br><br>❑Discuss sections during meeting<br><br>❑Delegate the task of writing it up and having it signed by all key players |
| #3 | Delegate responsibilities/form working committees within RTNM | ❑ Prioritize work to be done<br><br>❑ Break into manageable chunks<br><br>❑ Elect chairman of working committees<br><br>❑Delegate work to individuals and groups<br>of individuals |

| | | |
|---|---|---|
| #4 | Institutionalize "Common goals" into all committee business | ❑Use positive words like "carriers of knowledge" in all business<br><br>❑Make all key players, committee members aware of common goals<br><br>❑Use positive words in all written communications to promote a positive outlook on project |
| #5 | Create "Manual of Understanding" | ❑Identify influential and highly respected, "open-minded" TNM and BCHP<br>providers<br><br>❑Form committee for purpose of creating<br>manual and to serve as a editorial review board<br><br>❑Publish<br><br>❑Distribute to current staff and new hires |
| #6 | Enhance Internal Communications | ❑Assess technical facilities<br><br>❑Create Intranet website<br><br>❑Delegate task to update staff regularly by email<br><br>❑Delegate responsibility to publish monthly newsletter |
| #7 | Continue to invite community leaders for inservice presentations | ❑Identify experts in the community<br><br>❑Send out invitations to local schools, Navajo Nation council members, traditional healers, etc.. to excite them about partnership |

| | | |
|---|---|---|
| #8 | Offer incentives to ensure participation by all key players at committee meetings and activities | ❑Send out survey or perform focus group to see which of the following incentives are most well received<br>-Offer time off<br>-Offer CMEs for workshops<br>-Offer paid time to attend |
| #9 | Schedule meetings and other activities in such a way that they accommodate the majority of RTNM committee members | ❑Schedule well in advance<br><br>❑Use scheduling software to coordinate timing<br><br>❑Use additional staff on meeting/activity dates to reduce workload |
| #10 | Develop budget proposal | ❑Schedule appointment with financial officer<br><br>❑Decide on action plan for Phase I<br><br>❑Review IHB Minneapolis' budget proposal for similar expenditures<br><br>❑Include proposed cost of full-time Coordinator<br><br>❑Approach IHS for funds<br><br>❑Consider outside sources of funding |
| #11 | Make hospital environment more comfortable for traditional clients | ❑Delegate this responsibility to working committee<br><br>❑Include costs in proposed budget<br><br>❑Survey clients about what they would like to see in the hospital<br><br>❑Solicit donations and identify cost-effective projects that could be implemented in a short-time |

| | | |
|---|---|---|
| **#12** | Identify and collaborate with local potential partners | ❑Identify local individuals with interests and/or expertise in TNM<br><br>❑Invite them to speak at RTNM meetings<br><br>❑Put them on your email list<br><br>❑Communicate with them regularly |
| **#13** | Provide forum for staff to share their knowledge and expertise about traditional Navajo practices | ❑Allow one staff member to share story or expertise at each RTNM meeting<br><br>❑Send inquiry to staff members about this forum |

**PHASE TWO**

| Action Step | Recommended Course of Action | Checklist |
|---|---|---|
| #1 | Hire full time Coordinator of BCHP and TNM Affairs | ❑Develop job description<br>❑Develop job qualifications<br>❑Obtain budget and other approvals<br>❑Conduct search |
| #2 | Develop Policies and Procedures<br>•care plan/referral system<br>•credentialing/certification compensation for TNM procedures | ❑Set aside meeting time for each task<br>❑Brainstorm policies and procedures<br>❑Review current examples<br>❑Delegate tasks, one each to a "point person" who is to be responsible for preparation of information |
| #3 | Initiate Cultural Awareness Campaign | ❑Identify individual who is proficient at graphic arts or desktop publishing<br>❑Have person head up task force to increase cultural awareness at CCHCF<br>❑Create attractive posters<br>❑Put in locations that are highly visible to staff |

| | | |
|---|---|---|
| #4 | Develop Orientation and Training program for all staff and traditional healers | ❑Form long term working committee<br><br>❑Obtain materials from similar programs<br><br>❑Ask Philmer Bluehouse to provide training for assessment tool (TBBA)<br><br>❑Provide orientation for all programs initiated by the committee, including the<br>Manual for understanding |
| #5 | Develop and initiate "Buddy Program" | ❑Make a list of willing practitioners, TNM and BHCP<br><br>❑Arrange them in teams of two, one TNM and one BHCP<br><br>❑Ask them to "shadow" each other once a<br>month during a normal work day<br><br>❑Promote close relationships between "buddies" (sponsor dinners, family activities, etc.) |
| #6 | Institutionalize Traditional Background and Behavior Assessment tool (TBBA) | ❑Provide training for staff by Phil Bluehouse<br><br>❑Duplicate assessment tool<br><br>❑Place them with other intake forms in each department |

| | | |
|---|---|---|
| **#7** | Identify internal and external grants and funding opportunities | ❑Elect financial officer for committee<br><br>❑Locate resources at HIS<br><br>❑Locate resources through other organizations with traditional medicine Initiatives and over internet<br><br>❑Write grant proposals as often as possible |
| **#8** | Install bilingual signs throughout hospital | ❑Contact IHS for funding<br><br>❑Include in budget proposal<br><br>❑Delegate responsibility of writing out Navajo words to go on signs<br><br>❑Order signs (Navajo - English)<br><br>❑Write work order for hanging of signs |
| **#9** | Assess facility needs of each department | ❑Orient head of department to vision and mission of this initiative<br><br>❑If necessary, allow traditional Navajo to assess facility needs<br><br>❑Develop facility needs surveys and distribute to each department<br><br>❑Evaluate their needs and include in budget proposal |

| #10 | Develop staff awareness campaign (Procedures and Policies) | ❑Identify policies and procedures that all staff should be aware of<br><br>❑ ❑Identify individual who is proficient at graphic arts or desktop publishing<br><br>❑Have person head up task force to increase staff awareness of these policies<br><br>❑Create attractive posters<br><br>❑Put in locations that are highly visible to staff |
|---|---|---|

**PHASE THREE**

| Action Step | Recommended Course of Action | Checklist |
|---|---|---|
| #1 | Construct detached hogan | ❑Identify expert who can assist with planning of construction<br><br>❑Put up fliers or postings in community, local schools to excite volunteers in this project<br><br>❑Assess budget needs and put in proposal |
| #2 | Develop summer internship/job training program for local youth<br>(See Appendix L) | ❑Get information about Beth Israel Deaconness Medical Center youth programs and others<br><br>❑Identify leaders of this program and form planning committee<br><br>❑Involve community and local schools<br><br>❑Assist with planning stages and implementation |
| #3 | Establish code of ethics for "Carriers of Knowledge" | ❑Review Code of Ethics of IHB Minneapolis and Mental Health<br><br>❑Form a committee to decide on rules<br><br>❑Review rules by RTNM committee<br><br>❑Include in Manual of Understanding<br><br>❑Include in Training/Orientation |
| #4 | Create task force on diversity | ❑Identify interested staff<br><br>❑Create committee and have them provide feedback to RTNM committee |

| #5 | Revise hiring process to give priority to candidates who have had exposure to traditional healing or are willing to learn | ❑Contact CME programs and medical student training programs |
|---|---|---|
| #6 | Develop External Communications | ❑Assess technical facilities<br><br>❑Develop e-mail, electronic bulletin, web site |
| #7 | Prepare resource list of appropriate reading materials/projects for proposed "Carriers of Knowledge" certification | ❑Set up review board with traditional healers and elders<br><br>❑Select quality resources<br><br>❑Include in Manual of Understanding |
| #8 | Help staff learn about/reclaim Navajo traditions (Retreats, workshops) | ❑Organize retreats, after-work dinners, etc... |
| #9 | Organize Committee on Certification | ❑Review what other tribes are doing<br><br>❑Solicit ideas from opposing parties<br><br>❑Make a decision<br><br>❑Include in Manual of Understanding |

**PHASE FOUR**

| Action Step | Recommended Course of Action | Checklist |
|---|---|---|
| #1 | Identify and collaborate with other leaders of traditional medicine initiatives | ❑Review appendix<br>❑Contact any whom may be able to collaborate and share resources |
| #2 | Sponsor workshop series for practitioners | ❑Assess subjects that TNM and BHCP individuals may not understand<br>❑Organize workshops that accommodate schedules |
| #3 | Institutionalize certification process for "Carriers of Knowledge" | ❑Ensure that all key players and all staff are happy with certification process<br>❑Work with Eddie Tso to implement credentialing process Nation wide |
| #4 | Develop School Wellness Program based on Navajo principles of wellness as well as BHCP models | ❑Work with local schools and identify a leader that will adopt this idea<br>❑Assist with the development of this program |
| #5 | Develop Patient Education/Community programs | ❑Review IHB Minneapolis Training Program<br>❑Develop program plan<br>❑Involve patients, community in planning stage through focus groups<br>❑Implement plan |

## Glossary

**Alternative Medicine** – *umbrella word for numerous therapies not taught in mainstream medical schools.*

**Anil na'anish** – *a Navajo concept for cooperation among a group of people—family, clan group, extended relatives, or community. In this case, it is the partnership of traditional healers, IHS staff, other health care practitioners, and the community. Literally, it means "working together" towards a positive outcome.*

**Biomedicine** – *approach to health care based upon the Cartesian model whereby mind-body are completely separate and scientifically derived physical evidence is paramount.*

**Carriers of Knowledge** – *hospital staff, traditional healer, community leader that volunteer to gain an understanding and respect for TNM and BHCP.*

**Corn Pollen Path** – *symbol of life; form of addressing Holy ones to thank them for life, to remember them, to cleanse the mind and body.*

**Culture** – *symbolic meaning system which consists of customs, traditions, and language that is shared among members of a population. The phenomenon is supraindividual, that is to say, it exists only in the interrelated nature of human beings.*

**Disease** – *for BHCP, the main causes of illness are due to pathogens like bacteria or viruses, and biochemical imbalances. For Navajos, disease results from disrupting hózhó. Illness can be caused by failure to respect nature, improper contact with animals, mistreatment of others, etc.*

**Disease Prevention** – *preventing disease through counseling, screening, immunization, health education, etc.*

**Health** – *for BHCP, health is an absence of disease. For Navajos, health is a result of living life spiritually and in harmony. Spirituality, health, harmony, and beauty are inseparable. All forces in the universe (good and evil, natural and supernatural, male and female) are integrated into a state of balance and harmony known as hozho. All humans, animals, plants, and nature make up this balance. It is our responsibility as humans to honor and maintain this balance.*

**Health Promotion** – *improving an individual's health through influencing an individual's lifestyle choices like physical activity and fitness, nutrition, use of drugs, alcohol, tobacco, etc...*

**Holistic Care** – *understanding that the whole is greater than the sum of the parts in the context of health care delivery.*

**Integration** – *to blend into a functioning or unified whole; unite.*

**K'é** – *expression of respect and honor by addressing one another through kinship terms. K'é is to have reverence for all things in the universe, and to maintain balance and harmony by acknowledging and respecting clan and kinship.*

**Tradition** – *a practice that is passed on through generations, generally accepted by a population as an important expression of their culture.*

**Traditional Medicine** – *in this report, this term is a label for medicine that is not mainstream, not part of the biomedical health care system.*

**Wellness** – *a culturally determined state of being, involving body and mind. Sometimes associated with the absence of disease and a positive mental outlook.*

## Appendices


**Appendix A:** The Adapted Bluehouse Traditional Background and Behavior Assessment tool (TBBA)

**Appendix B:** Role of Traditional Medicine Resource Database

**Appendix C:** *Personal Motivation* and *Navajo Perspective of Cooperation* Dean Johnson Dennison, Diné College

**Appendix D:** *Advising Patients Who Seek Alternative Medical Therapies*

**Appendix E:** Indian Health Board of Minneapolis - Report & Program Plan

**Appendix F:** *Navaho Ways and White Man's Medicine - in the Hospital*

**Appendix G:** American SPIRITual History

**Appendix H:** Association of American Indian Physicians Bibliography

**Appendix I:** *Toward a more Culturally Competent System of Care: Creating Opportunities for Managed Care organizations, Providers and Communities* - Conference presentation notes

**Appendix J:** Spectrum of Cultural Competence

**Appendix K:** AAIP website - Traditional Medicine

**Appendix L:** Beth Israel Deaconess Medical Center Community Report (excerpts)

**Appendix M:** *The Association between Western and Navajo Medicine* Philmer Bluehouse

**Appendix N:** *Combining Traditional Healing with Psychotherapy* Presentation Handouts

**Appendix O:** CCHCF Counseling Services Philosophy & Pledge

**Appendix P:** IHS Mission, Goal & CCHCF Vision Statement

**Appendix Q:** Sample Practice Policy: Acupuncture Brigham and Women's Hospital

**Traditional Background and Behavior Assessment (TBBA)**

The Traditional Background and Behavior Assessment was created in order to assess the degree to which patients might benefit from traditional Navajo health care practices. Results of this questionnaire will be used to determine an appropriate health care plan for each patient.

CCHCF Staff: This TBBA may be administered orally or in writing. Before administering this assessment, you must have completed a TBBA procedure orientation. Inform the patient about the nature of the TBBA and advise them of your intention to ask the questions verbally and record their responses. The patient may elect to record his or her answers independently.

Patient: Please answer each of the following questions to the best of your ability. The questions are designed to help us to ensure that you are receiving the best possible care that we can provide for your individual needs. Thank you.

Name:________________________________ Date:__________________

1. Does your family participate in traditional Navajo practices?

2. If you are a parent, do you teach your children traditional Navajo practices?

3. When you introduce yourself, do you include the names of your clans?

4. Do you know the Navajo Creation story?

5. Do you offer prayers and/or run at dawn?

6. Do you follow the teachings of your elders?

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This tool was adapted from the original Traditional Background and Behavior Assessment Tool developed by Philmer Bluehouse, Peacemaker Division, Window Rock, AZ.

# Role of Traditional Medicine Resource Database

| Contact | Associated Organization | Details/ Description | Training/ Curricula | Assessment Model | Credentialing Procedure | Funding | Facilities/ Staff | Advice |
|---|---|---|---|---|---|---|---|---|
| Dr. Linda Barnes Northeastern University, Boston, MA. | Professor Northeastern University, MA. | Anthropologist with focus on cultural approaches to illness. | -Teaches courses on Culture, Illness, Healing -Has some material about cooperation of MDs and traditional healers. | | | | | Traditional Healing must be practiced on its own terms. It must be an equal, not a subsidiary of biomedical model in clinic. |
| Hoskie Benally Four Corners Regional Adol. Treatment Center/ PO Box 567/ Shiprock, NM. 87420 505-368-5457 (fax) | Four Corners Regional Adolescent Treatment Center. (Shiprock NM) | -nonprofit juvenile residential substance abuse treatment center -Combines Western therapy w/ Native 'therapies.' | | Use cultural/ spiritual assessment tool along with ASI and MALON/ All traditional treatments are observed and documented on patients' charts. | JCAHO Accredited./ Traditional counselors require documentation from their teacher or community. | IHS funded through 4970 (Subcontracted by Navajo Nation) All follow-up ceremonies must be funded by patient families. | Staff majority Navajo. All staff interviewed about their attitude towards Native healing techniques. | There must be full support from staff. Be up front about mission. |
| Dan Old Elk PO Box 549 Garryowen, MT. 59031 406-638-2804 | Native Healer/ IHS Crow Hospital, MT | Based in hospital. Conducts healing in other area hospitals. | Did initial training for hospital staff when facility opened. No ongoing training./ Healers work with patients to explain biomedical treatment | Evaluation is difficult. Traditional healing does not aim always for immediate results. | Healing is a gift from the Creator. Who would give license? | Patient funded. | Sacred room in hospital for healing./ Issue of who can observe ceremony. | Doctors are trying to understand but they're skeptical. |

| Contact | Associated Organization | Details/ Description | Training/ Curricula | Assessment Model | Credentialing Procedure | Funding | Facilities/ Staff | Advice |
|---|---|---|---|---|---|---|---|---|
| Dr. James Gordon<br>5225 Connecticut Ave, NW, Suite 414<br>Washington, DC 20015<br>202-966-7338<br>cmbm@idsonline.com | Director of Center for Mind-BodyMedicine | Non-profit educational organization dedicatedto reviving the spirit and transforming the practice of medicine. | -Professional Training Program<br>-Public Workshop Series<br>-Quarterly Newsletter<br>-School Wellness Program<br>-Community Education Program<br>-Medical student programs at UCSF, Harvard, Johns Hopkins, Columbia, Georgetown Univ School of Medicine | | | | | |
| Walter Hollow, MD. | University of Washington Office of Multicultural Affairs | -Medical School Professor<br>-Program offers Indian Health Pathway Track which includes research, clerkships, preceptorships | Hasdeveloped curricula for training medical students. (e.g students trained to take spiritual history) | | | | | |

| Contact | Associated Organization | Details/ Description | Training/ Curricula | Assessment Model | Credentialing Procedure | Funding | Facilities/ Staff | Advice |
|---|---|---|---|---|---|---|---|---|
| Connie McCloud | Puyallup Tribal Health Authority (WA) | IHS subsidiary/ 638 clinic/ urban and reservation based. | Committed to intensive education/ Established protocols for providers. | | Stressed need to establish professionalism of healers | IHS funding/ 3rd party payments. Funds all aspects of traditional healing | Cultural Coordinator helps clients negotiate services. | Need to change attitude that traditional medicine is an add-on, not a priority./ Need for education. |
| Dr. Gregory Plotnikoff 6-101 Weaver-Densford Hall/ 308 Harvard St. SE/ Minneapolis, MN, 55455 612-626-3817 | Center for Spirituality and Healing/ Academic Health Center/ University of Minnesota. | Conducts courses for health care workers dealing with Native American and immigrant populations. | Has developed ongoing workshops for health care providers already working. | | | | | |
| Dr. Yvette Roubideaux | Association of American Indian Physicians | Active in medical education, cross cultural training, assisting Indian communities | -Cross Cultural Workshops -Traditional Medicine Clerkship | | | | | |
| Mary Schaeffer Cultural Services/ Zotzebue Senior Center/ PO Box 1073 Kotzebue, AL, 99752 1-907-442-3590 | Tribal Doctor's Program. Kotzebue,Al | Trains traditional healers to work in villages. Maintains exam room at Kotzebue Medical Center. | Tribal Doctors and MDs consult with each other on particular cases. | Conducts regular client surveys. Established avenue for patient complaints. | Belief that traditional tribal doctors have a 'gift,' but tribal doctors also train for 2 years with established healer. | IHS funded. | Work in villages and medical center. Tribal doctors work autonomously from MDs. | The tribal doctors program and Western medicine are established as 2 independent systems. However, they complement each other when they work side by side. |

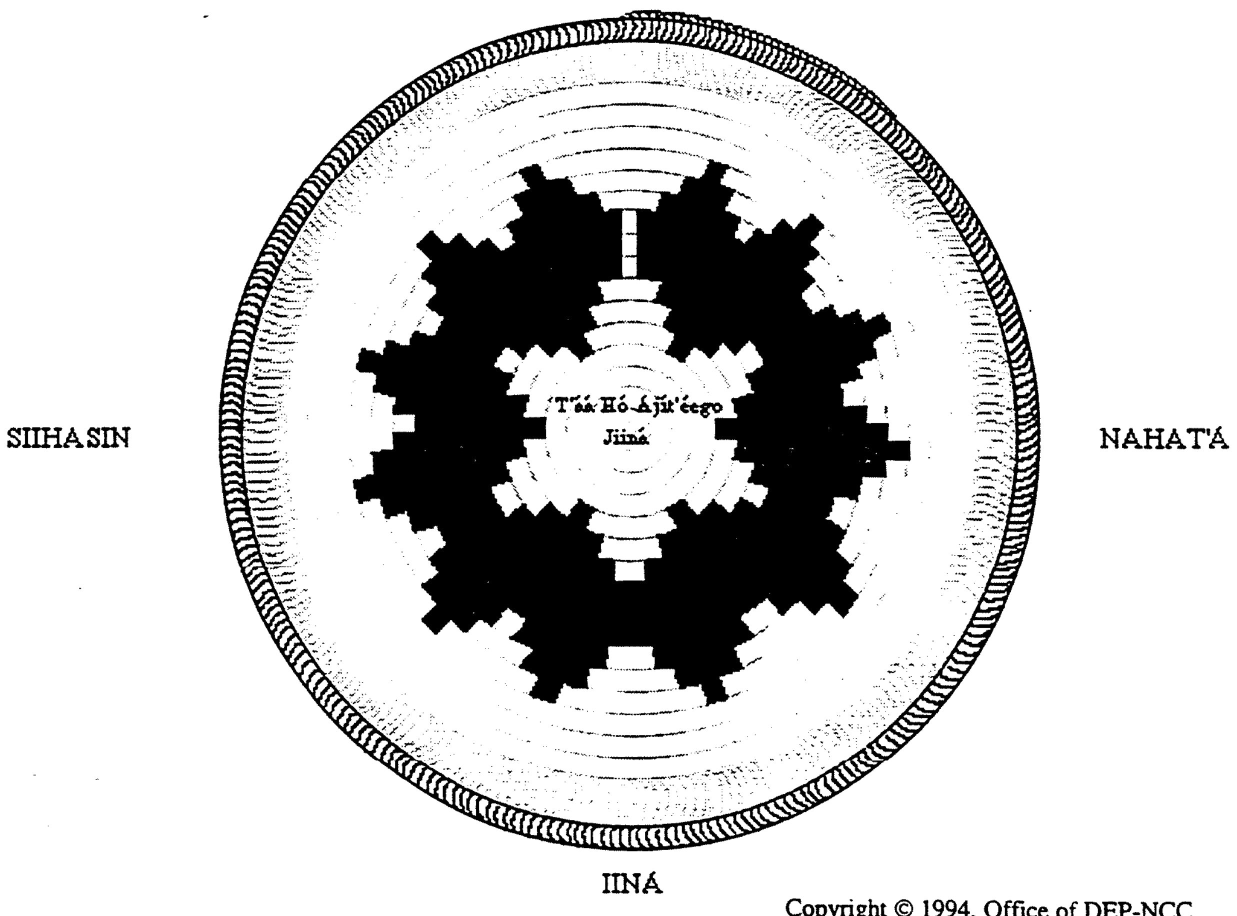
| Contact | Associated Organization | Details/ Description | Training/ Curricula | Assessment Model | Credentialing Procedure | Funding | Facilities/ Staff | Advice |
|---|---|---|---|---|---|---|---|---|
| Dr. Kermit Smith 301-443-1083 | Director of IHS Traditional Medicine Initiative | 1995-IHS Traditional Medicine Initiative held 11 discussion circles to review Agency policy and protocols on traditional healing practices | | | | Local issue to be determined by family or tribe, however IHS should accommodate the payment of expenses for healers | | Status of initiative uncertain |
| Noreen Smith | -Indian Health Board of Minneapolis -Red-Tailed Hawk Healing and Training Center | nonprofit corporation/ urban-based/ serves 70 tribes | -Is developing a curriculum -Training programs for improving cultural awareness of patients/family | | Code of Ethics and Credentialing- assuring patients that ethical standards will be followed | -Pays for all aspects of traditional healing -compensation to healers -lobbying for funding for all tribes | -Traditional healers included on staff -Built own healing and training center | First step is getting together a board of directors. Include healers in all aspects of development. |
| Lynwood TallBull PO Box 376 Lame Dear, MT 59043 406-477-8801 | Community Health Outreach Educator. | Runs training sessions for hospital staff working with Native Peoples. | Worked with IHS hospitals and Private Hospitals./ Produced video about culturally sensitive care | | | | | Requires lots of planning. Make real effort to involve healers in process. |
| Linda Ward (marketing director) 4527 N 27th Avenue/ Phoenix, AZ. 85017 | Prime Medical Centers/ Phoenix. | Non-native franchise/ center for biomedicine and holistic treatment | | Follows model of National Committee for Quality Assurance | | 3rd party insurance payments | MDs, DOs, Chiropractors, Physical Therapists/ Patient care overseen by MD. | |

# "Personal Motivation"

# and

# "Navajo Perspective of Cooperation"

Office of Diné Educational Philosophy
Navajo Community College
Tsaile, Arizona

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# Ts'aa' biyi'gi tádídíín bee ahéé' átiingo éí ałníí'dóó t'áá hó ájít'éego jiiná.

Díí éí na'nitin t'áá áłtsojį' bee oodáałii át'é. Éí Diné t'áá áłtso bá át'é háálá t'áá áłtso yee hadít'éego bee hoogááł. Hazhó'ó dílzin dóó baa nitsáhákeesgo binahjį' ak'i diitįįh dóó éé'deetįįh át'éego bee ádá hodílzin. Díí bee joogáałgo éí bine' oodáałii dóó bee hózhǫǫgo oodáałii éí as'ahgóó ádee ní'jíldįįh dooleeł.

Díí bik'izhdiitįįhgo éí ółta'í jílį́įgo óhoo'aah bidziilgo béézh di'dootį́įł; éí doodago

Díí bik'ehgo naalnishí jílį́įgo éí hanaanish nilíinii bidziilgo náás jiyoołdił dooleeł; éí doodago

Díí bik'ehgo naat'áanii jílį́įgo éí bidziilgo dóó índa hózhǫǫgo nazhnit'áa dooleeł; áádóó

Díí bik'ehgo azhé'é dóó amá jílį́įgo hółdzilee hoł haz'ą́ą dooleeł.

"T'áá Hwó Ájít'éego Yá'át'éehgo Jiinàa Łeh"
"Only By Means of Strong Personal Motivation One Will Attain Admirable Living"
*By Johnson Dennison*

T'áá Hwó Ájít'éego is the Navajo teaching that used to be taught by the elders to every Navajo youth to prepare them to succeed in life. However, the contemporary Navajo families are lacking this teaching since most of their teaching, learning, and training are from the Western educational setting. This is not to say that Western education does not prepare you for a better life, the Western education teaches you the values of academic professional preparation, but the ethical and moral standards should be taught at home as a preparation for challenges in life. What is the teaching of "T'áá Hwó Ájít'éego" and how does it prepare you for challenges in life? T'áá Hwó Ájít'éego yá'át'éehgo jiinàa łeh is translated as "Be yourself and to live a good life."

To be successful in your life is based on your mental, social, emotional, physical, and spiritual strengths. Your mental growth allows you to develop intellectual ability and maturity to perceive and understand yourself and the way you relate yourself to your natural environment. Your social and emotional ability allows you to develop your skills in interpersonal relationships such as being able to withstand pressures and at the same time earning social respect. Your physical fitness not only provides you with good health but there is a variety of physical and practical skills you can learn to develop a trade in your life such as being a weaver, artist, welder, etc. Finally, the spirituality of a person is the cohesion of all areas mentioned above. The human spirit is the greatest natural force in the universe. It is the finest thing that we are born with and it is only a matter of the manner in which a person discovers it. We can nurture and cultivate that human spirit within ourselves to bring about both a happy and successful journey through life.

Life is a journey with a beginning and an ending, the path of this wonderful journey is called the road of Są'ah Naaghái Bik'eh Hózhóón in Navajo philosophy. How you travel this path is T'áá Hwó Ájít'éego yá'át'éehgo jiinàa łeh. To travel on your journey, it is important that you have a map as a guide to reach your destination, which is old age. The map is a plan you will establish for yourself of how you want to live in the future. Along the way in your journey, you will experience happiness, success and failure. Success and happiness does not just happen: you

first develop an idea or a dream as part of your plan on what you want to accomplish in your life.

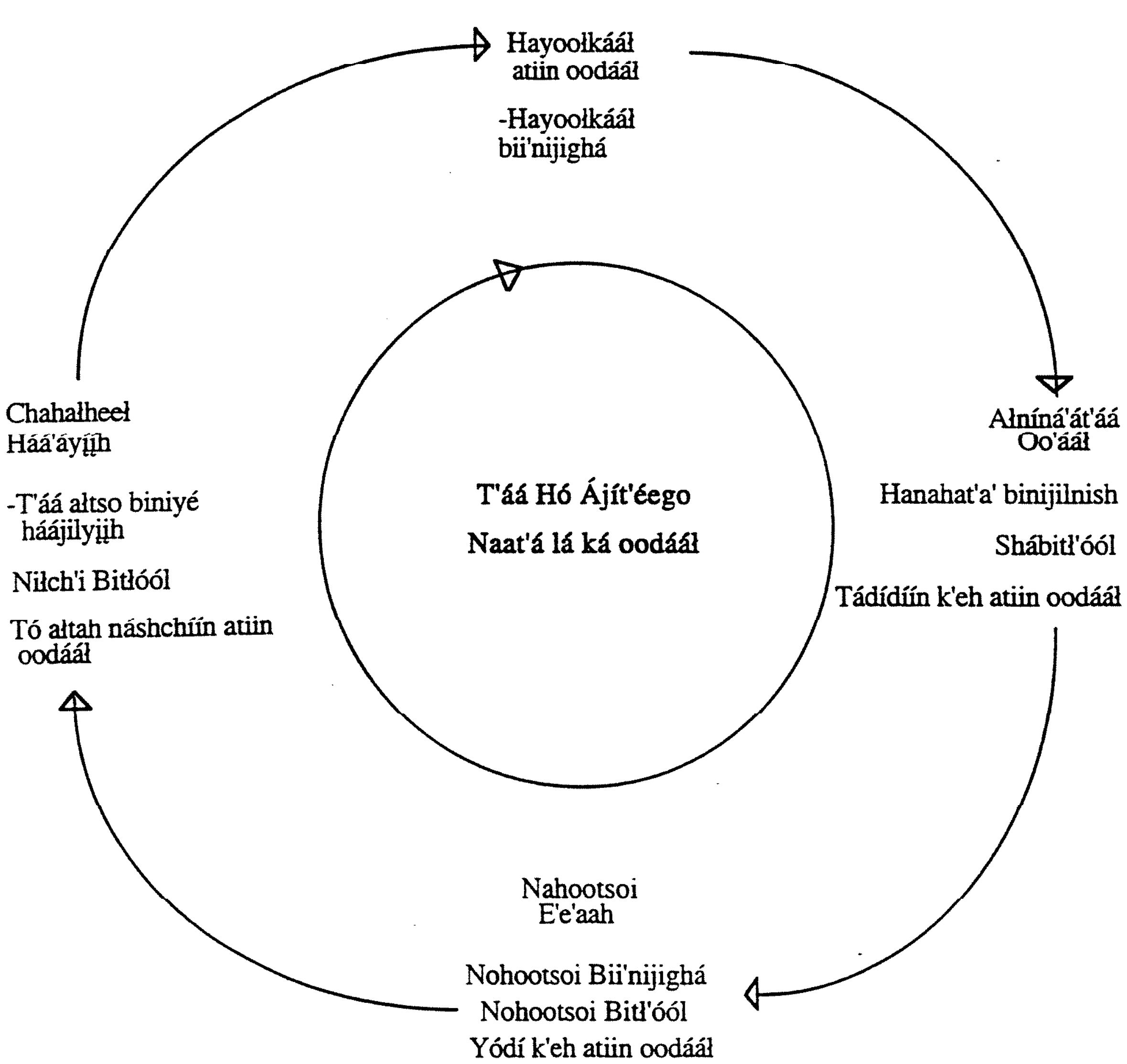
You could have a dream in becoming an outstanding athlete, an artist, an educated person, a good parent, or having a good home, etc. Your dream becomes your goal to accomplish in your life. Your dream can become reality if you strongly believe in yourself. Believing in yourself will grow when you develop your mental, physical, social/emotional, and spiritual strength by proper teaching and training from your elders. To believe in yourself means that you will firmly establish a positive mental attitude in a future outlook for yourself. To reach your goals through positive mental attitude, you must be prepared to meet any obstacle. Anyone with a negative mental attitude will say "I quit" , "I can't do it", or "it's impossible" when he or she meets the first obstacle. Eventually, it will become a failure. A failure is always a test of your perseverance. You could stop with your efforts and feel sorry for yourself or you could start all over again. On other hand, a person with positive mental attitude will make an opportunity for the self to challenge the first obstacle he or she meets. Therefore, it is important for an individual to be properly prepared for challenges in life.

As a preparation for challenges in life, you will be trained to wake up every morning before sun rise, at dawn, to run toward east. While you are running, your thought is clear and your body is nourishing from breathing in clean fresh air. It is said that you will be recognized and acknowledged by the morning spirit, which is Talking God. Talking God is dwelling in the dawn light in the east and he will be your guidance throughout the day as you are performing your daily tasks. If you should sleep late in the morning, the laziness will be in your system throughout the day. This is why the Navajo youth is always taught not to be lazy. The Navajo boys and girls used to be taught and trained to have courage by running in the morning and taking a bath in the ice water during the winter and run in the heat at mid day in the summer. Having courage means being ready to meet challenges and being able to handle difficult situations: this is called the protection-way teaching.

There are two categories of Navajo teachings, they are protection-way teachings and blessing-way teachings The protection way teachings are teaching concepts of protecting yourself from harm and dangers which will disrupt and hurt your life. The harmful elements surround us every day in the world in which we live. The harmful elements could be laziness, disease, mishaps, illness, crime, verbal and physical abuse, alcohol, weather, nature, animal, and the most dangerous is human being. The protection way teaching principles are considered as the male teachings in

Navajo. This does not mean only males could be taught the protection way teachings, the females are taught as well Along with the protection way teachings, there are blessing way teaching principles to balance and harmonize life. The blessing way teachings are such teachings as being kind, generous, respectful, appreciative, and etc. to instill the positive mental attitude as a self-fulfillment. Both teaching categories will empower an individual to protect himself from harms and enjoy living in the harmony of life called the "Sa̜'ah Naaghái Bik'eh Hózhóón" and the way to live it is T'áá Hwó Ájít'éego Yá'át'éehgo Jiináa Leh.

**T'áá Hó Ájít'éego Hanahat'a'**
**Hayoolkáál Bítł'óól**



## Empowering Values of the Diné Individual (English Version)

1. Naayée'eek'ehgo Nanitin
(Protection Way Teachings)

**Doo hwiił hóyéeda**
Never be fearful.

**Doo ádahozhdeeláa da**
Never be impatient.

**Doo t'áadoole'é bich'į' ni' jiłįį da**
Do not be hesitant.

**Doo háni jizh'ą́ą da**
Never be easily hurt

**Doo ák'e' jidlíí da**
Never be overly emotional.

**Doo ni' na'áhozhdiiltée da**
Do not be overly reluctant.

**Doo adááh yájiiłti' da**
Never be overly argumentative.

**Dadilzinii jidisin**
Respect the sacred.

**Doo t'áadoole'é áde' ájiłnééh da**
Do not overburden the self.

**Ázhdiiłti'is**
Have self discipline and be prepared for challenges.

2. Hózhǫ́ǫ́jik'ehgo Nanitin
(Blessing Way Teachings)

**Há áhwiinít'į́'í**
Be generous and kind.

**K'ézhnidzin**
Acknowledging and respecting kinship and clanship.

**Hane'zhdindzin**
Seek traditional knowledge and traditions.

**Hwii (hol) ílį́**
Respecting values.

**ádá hozhdilzin**
Respecting the sacred nature of the self.

**Hazaad baa áhojilyą́**
Having reverence and care of speech.

**Hazhó'ó ajiists'ą́ą́'**
Being a careful listener.

**Ahééh jinizin**
Being appreciative and thankful.

**Hanitsékees k'ézdongo ájósin**
Having a balance perspective and mind.

**Há hózhǫ́**
Showing positive feelings toward others.

**Na'ádizhnitaah**
Asserting the potential.

**Doo yázhnízin da**
Do not be shy.

**Doo nįichxǫ' da**
Do not get mad.

**Doo ách'į' ní'jódlíí da**
Do not carry around expectations of negative circumstances.

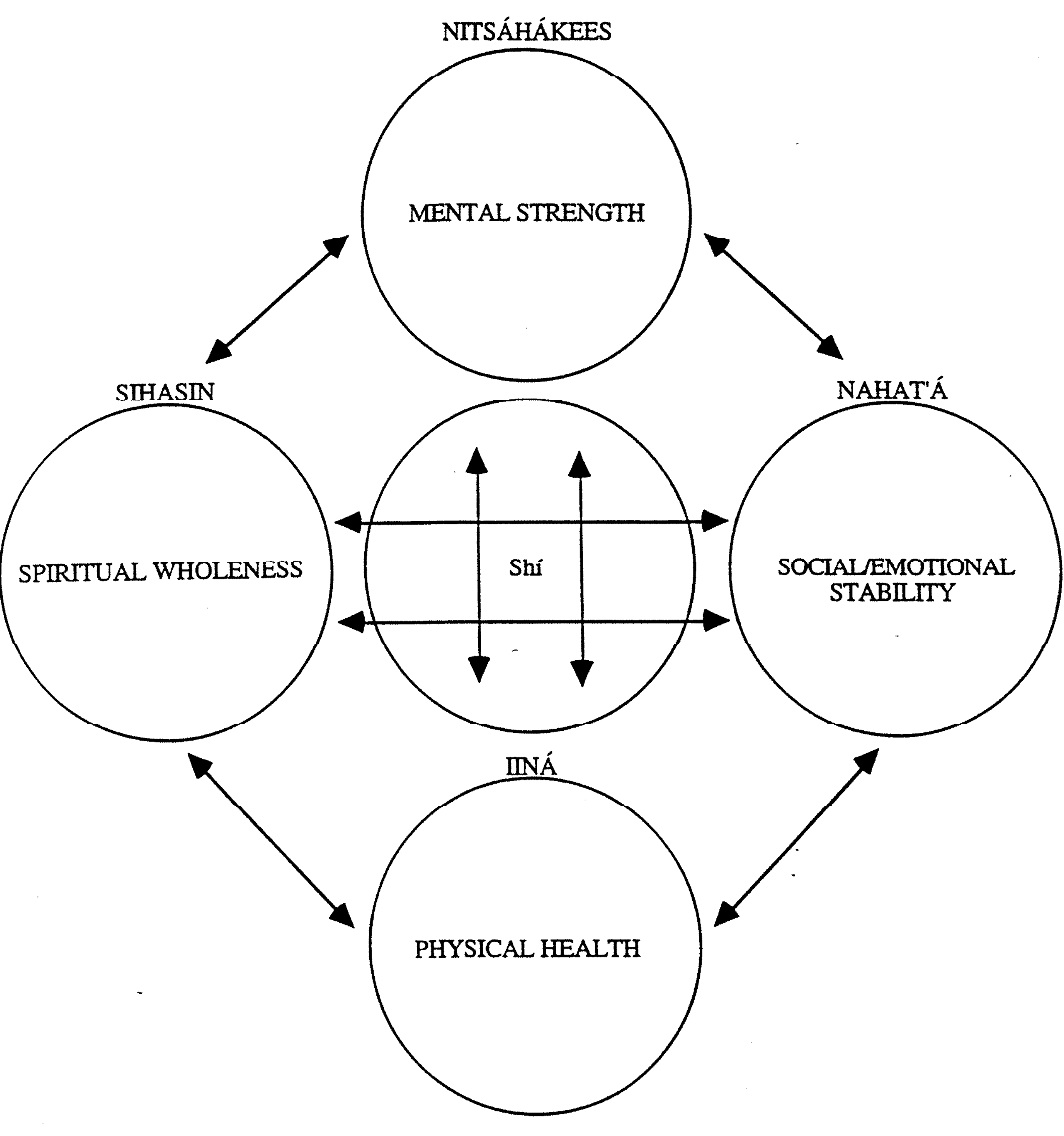
**Dloh hodichí yá'át'ééhígíí hazhó'ó bee yájiłti'**
Expression of appropriate and proper sense of humor.

**ádil jidlį**
Maintaining strong reverence of the self.

**Hanaanish ájił'íinii bizhneedlį**
Maintaining enthusiasm and motivation for one's work.

**Hanaanish baa hááh jinízin**
Protect and care for one's work.

**SA'AH NAAGHÁÍ BIK'EH HÓZHÓÓN**
**IINÁ BEE OODAAL BINIDII'A'**
**SNBH Principles of Well Balanced Life and Harmony**




Revised 2/24/95 by JD/at

I. Nitsáhákees Nilłdzil - Mental Strength

A. Hózhǫ́ǫgo ádaanitsáhákees - positive self image
Ádiłjídlįįgo éí ádá hozdílzin dóó yá'át'éehgo ádá tsídzookos. Ádá tsozdilzin éí bik'ehgo hoł ílį́ dóó t'áá altso baa ahééh dzinízin. Ayóí'óóní hwii' hólǫ́ǫgo éí bik'ehgo jijooba dóó aheełt'éego diné baa nitsídzíkees. Díígi' át'éego tsídzookosgo éí hanitsékees k'ézdongo éí binahjį' hanaanish bízhneedlį́į́ dóó ałkéé' dzisnil.

B. Naayée'eek'ehgo ádaanitsáhákees - thought of protection from harm
Ádaahasti' dóó diné baa hasti' dóó hanaanish baa hasti'. Ha'át'íida hodínóołtł'ah dóó atihodoolíilii bits'ąą tsídzookosgo bee ách'ááh adóta'. T'áá altso bich'į' ha'jólníi dooleeł biniiyé abíínídą́ą́' nijighá. Díí bik'ehgo éí áłąąjį' tsídzookosgo hasht'e'ázhdolzin.

II. Diné Bił Nahat'á Bee Ha'ahóní - Social/Emotional Stability

A. Hozhǫ́ǫ́jík'ehgo ádá nahodit'á
Ajooba' hwii' si'ánígíí bik'ehgo diné bił kééhojit'ínígíí dóó bił nidajilnishígíí bił ałk'izh diitįįh dóó ałk'eh hojíl'į́. Díí éí binahjį' k'é ahizhdiní dóó éí bee ha'jólní. Kót'éego éí ayóí'í'ahijóní dóó ałhaa áko hwiinidzinígíí há díníséehgo ahíłká'aníjíilwo' yileeh. Kodóó éí Diné bił na'ahijidlo' yileeh dóó nitsaago Diné bił ahizhdóta' yileeh. Kót'éego índa éí hanahat'a' k'íhineezláago náshoodił.

B. Naayée'eek'ehgo ádá nahodit'á
Hanahat'a' doo naaki nilį́įgóó ádzósingo t'áá' altsoji' bee ááhoo'níįl. Nahat'a' yéego yídéeltǫ', éí biniinaa baa áhojilyą́ą́ dóó bee dzizíinii ániidí áníjoodlíiłgo éí doo hanahat'a' nídínídáah da. Ha'jólnínígíí íiyisíí bóhólníih, éí biniinaa yikáííhdą́ą́' nijigháago bee hadziil.

III. Hwe'iina' Ditłée'go - Physical Health

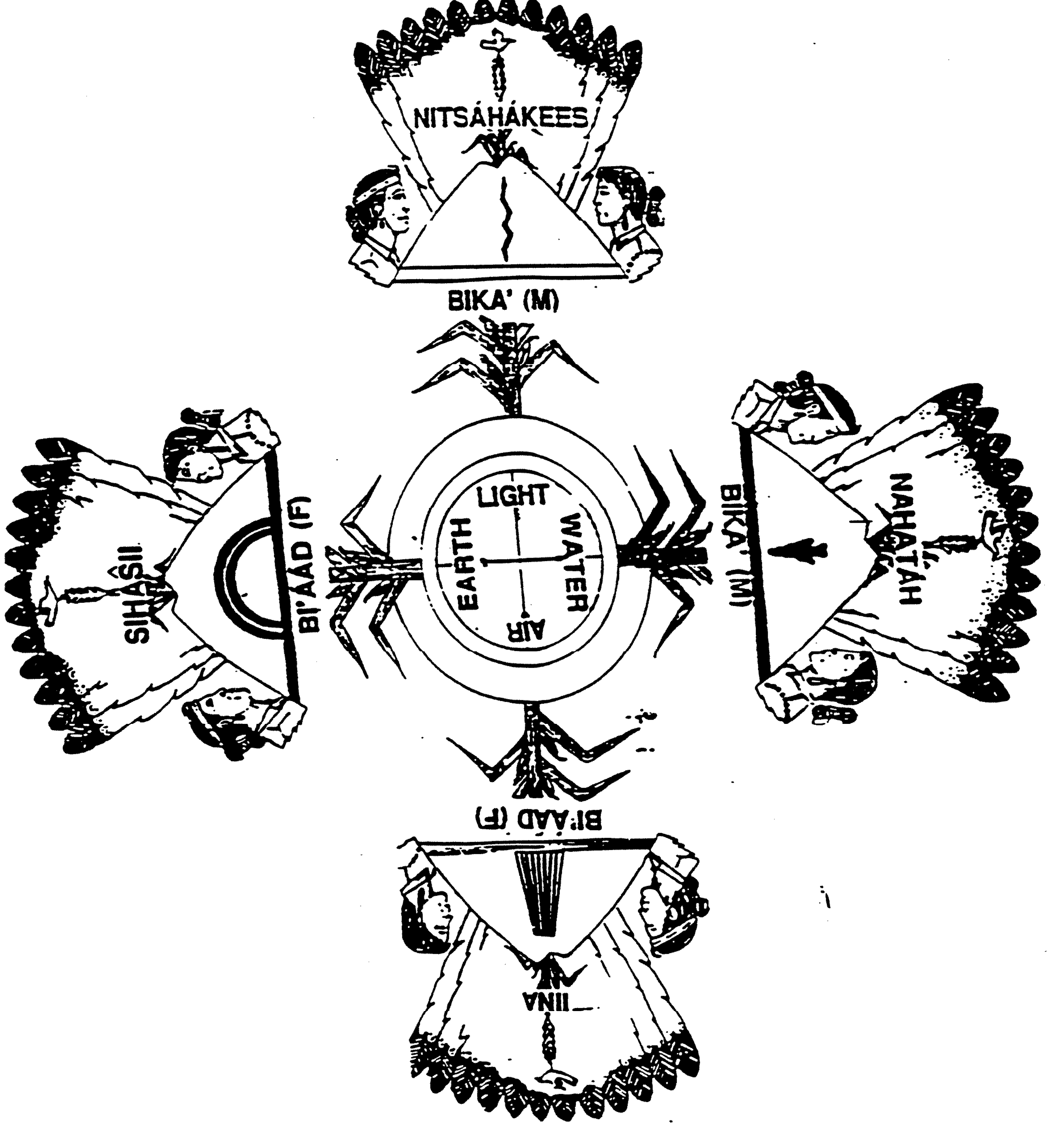
A. Hózhǫ́ǫ́jík'ehgo hats'íís baa áhojilyą́ - Blessing way teaching for physical health
Yikáííhtah nijigháago nílch'i ániidígíí bee náhizhdidziihgo bee ádiłha'iidzooł. Tó yá'át'éhígíí jidlą́ dóó ch'iiyáán yá'át'éhígíí jiyą́ągo bee hats'íístah yá'áhoot'ééh. Ázhdíltł'is dóó na'ádízhnítaahgo as'ah na'adá. Hats'íís chin bąąh ádingo ádzósin, hááijiilyį́įh dóó hak'ééhwiitaa'go hatah áhooszólí.

B. Naayéé' atah nidashigizhii bich'į' hwe'iina' jiyoołnaał - Stress Management
Ch'ééh'adidááh ił yaa nináhwiildóóh, dóó ádenitsehadá éí biniiyé ádił háá'iidzooł. Bee ádiłha'doodzołii éí tsodizin, íishjání ízhdólzin, ch'aa na'adá, dóó ch'ízhdíłdlohgo hatah yá'áhoot'ééh yileeh. Yéego nitsáhákees hade'át'įįhgo éí hózhǫ́ǫjí nahaghá bideełní.

IV. Siihasin - Spiritual Wholeness

A. Hózhǫ́ǫgo hwidiyį́į́' dóó hwii'sizíinii bee nijighá

B. Tsodizin dóó sin éí bee ádił háá'iidzooł. Hwidiyį́į́' éí tsodizin yee hoo'náałgo yee nahwiilná.



NITSÁHÁKEES
BIKA' (M)
NAHAT'ÁH
BIKA' (M)
IINA
BI'ÁÁD (F)
SIHASIIN
BI'ÁÁD (F)
LIGHT
WATER
AIR
EARTH

# AHIŁ NA'ANISH

Working together well doesn't come naturally. It's something we learn to do by establishing positive relationships with other family members and through participation in family and community events. The Navajo concept of "Ahił na'anish" captures this idea. The term describes cooperation among a group of people--family, clan group, extended relatives, or community. It can be applied to members of an organization or institution.

Literally, "Ahił na'anish" means "working together." A couple of people or a group of people can work together harmoniously to accomplish a task at home or in a community without any conflicts. The results of their accomplishment are visible to the people. The positive response from the general public proves the positive outcome. A family, clan group, or community that achieves such positive outcomes eventually earns a positive reputation.

In a family or clan group, an elder is usually looked upon as a wise person for advisement and decision making. The elder as a decision maker does not come to any conclusion without discussing the matter with the family or the clan group. In this way, the major decision made is in agreement with most or all of the members so it will not be a surprise to anyone. The purpose for consultation is to consider the members' input so that the decision can be precise and effective. Taking the members' input into consideration establishes harmony among the group, and this creates a strong bond between them with respect for each other and strong feelings of security. The family and clan members with confidence and respect are thus strongly motivated to participate in the event with a positive outlook and focus. In the Navajo language, one says, "Ayóo bóhoneedlį́," which means, "I'm positively motivated to participate."

After a decision is made, a request for participation and resources often is in order. This is called, "Ahíłká'e'elyeed." All extended family and clan members are notified about the upcoming event. It might be a ceremony to be sponsored, a wedding, or anything similarly important. The successful communication and planning of the event is based on the expression of K'é among the clan group. Members address one another by a proper kinship term. Addressing one another through kinship terms establishes mutual respect among the clan group. If a person is not using

the K'é concept while asking relatives for assistance, that person is considered impolite, and the request for help may not be taken seriously into consideration. Therefore, Navajo youth and adults are always encouraged by their elders to use K'é in social and working relations.

The expression of K'é establishes strong bonds of respect and appreciation not only within one's clan group, but also across different clan groups. This notion is called "K'éznídzin." The people readily know who is "K'é nídzin" and who is not. When a family is sponsoring an event like a ceremony, the people say, "Let's help this family since they always greet you with respect through the expression of K'é," or they might say, "We're not going to help them, they are very rude and impolite."

A clan group can earn a respectful reputation from the general public by setting the positive example of harmoniously working together in sponsoring a ceremony or event. The family members working together attract the public who, in turn, volunteer to help and contribute resources to the family that sponsors the ceremony or event. In this way, one could say that "working together" is contagious.

During a ceremony, a family constantly expresses its appreciation of "K'é" to everyone while serving food. In this way, everyone feels satisfied with their contributions at the end of the ceremony. If someone is not treated with the expressions of appreciation and "K'é," that person may feel humiliated. He or she may not consider helping the family again when they sponsor another ceremony.

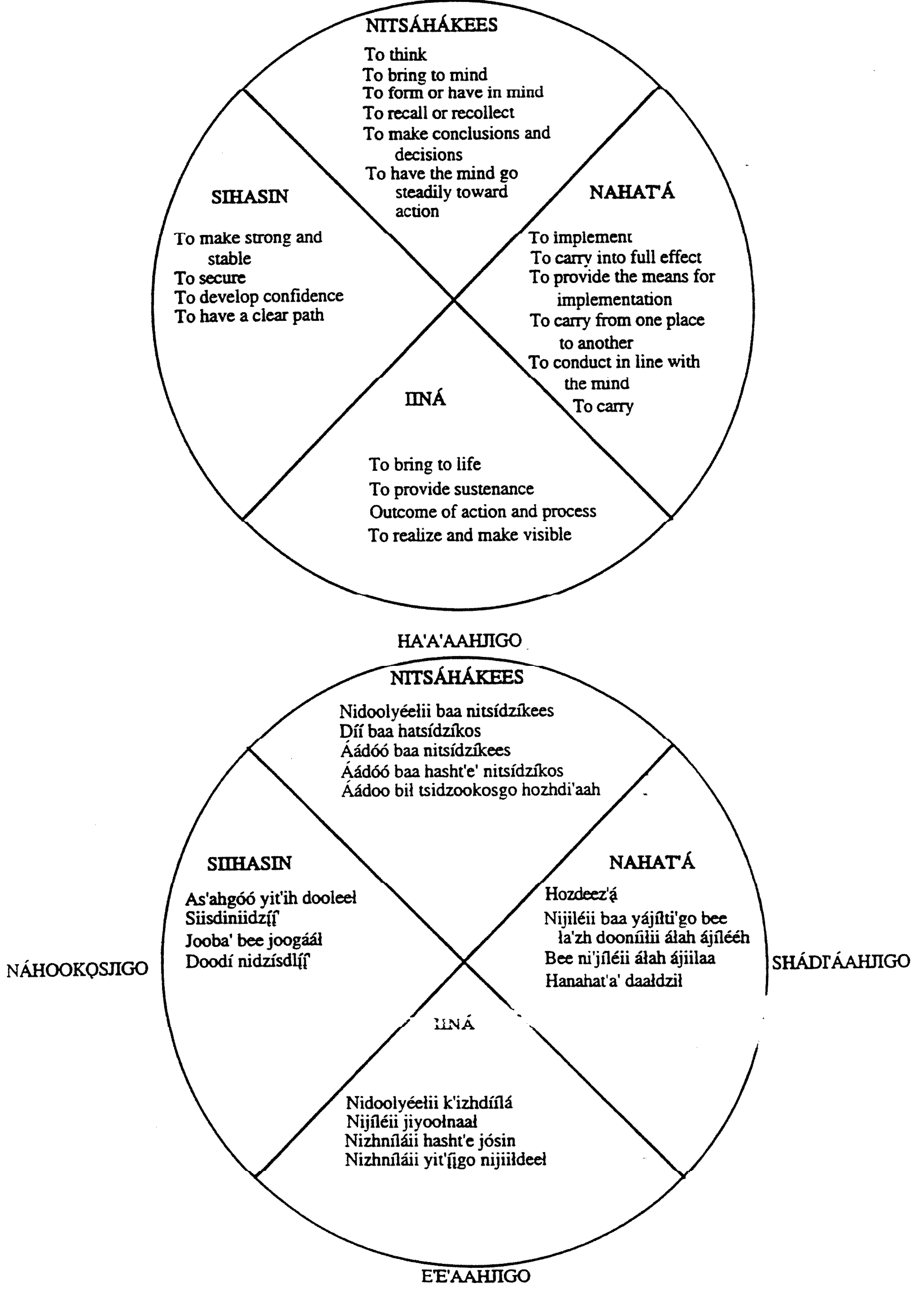
The concept of "Ahił na'anish" can be applied to other endeavors, including organizational life. An organization is a group of people working together with a purpose. It should be working toward positive outcomes. The typical structure of an organization is hierarchical, with bottom levels filled by workers and higher levels staffed by executives who are vested with certain kinds of authority. Communication within this scheme may also be hierarchical in structure, such that important information only trickles down from higher to lower levels, causing much misunderstanding. The lack of effective communication among employees can thus create distrust

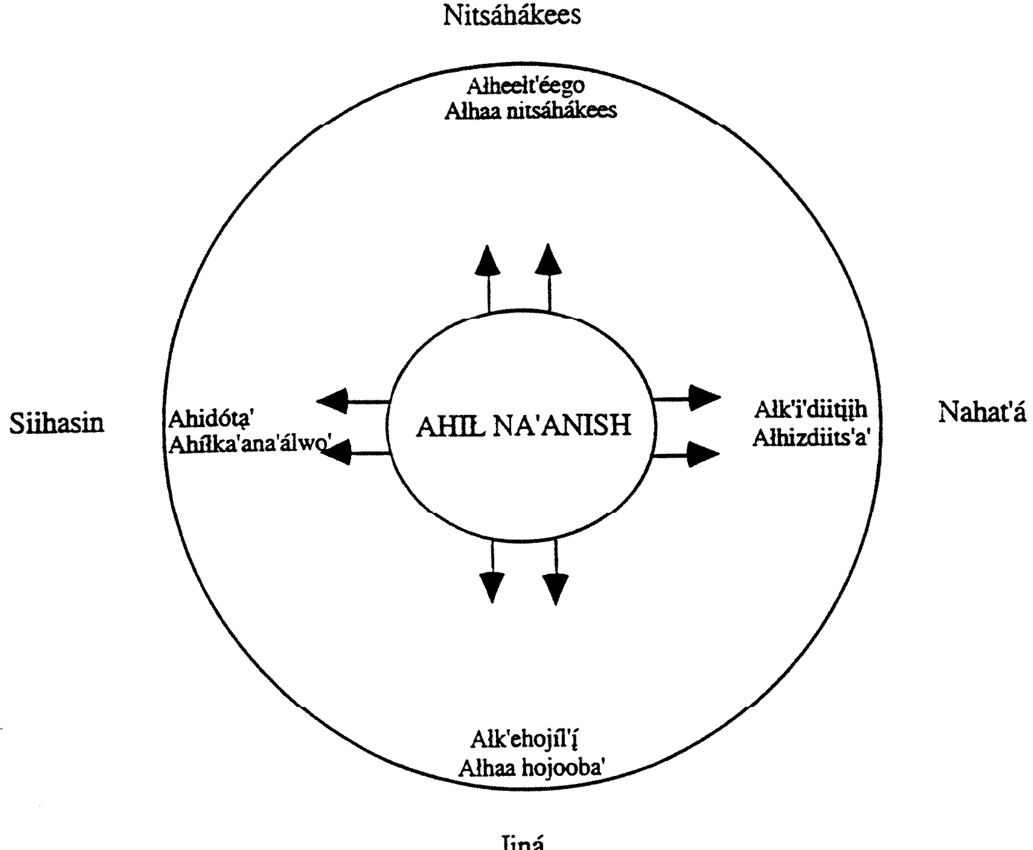
and low morale, impeding the development of organizational strength that derives from the concept of "Ahił na'anish".

Following "Ahił na'anish," every member of an organization should feel a sense of community within, and responsibility to, other organizational participants. To nurture these ties, input from everyone should be taken into the consideration before making major plans and decisions. When this happens, members feel important to the organization. For example, all employees of a school can develop positive attitudes toward their school and be motivated if they are asked for their input. All input does not have to directly shape a major decision, but it can be taken into consideration since it represents the expression of members' concerns. Regardless of the level of hierarchy, each member should be considered important with their input. The oral or written input can establish a better understanding among all members of the organization. Eventually, the members who understand each other bond together and better appreciate one another.

In an organization where there are significant numbers of Navajos, the expression of "K'é" should be encouraged and practiced. However, it should be noted that some people can abuse the notions of "K'é" concept to get their requests approved in direct contradiction to organizational policy. At the same time, the expression of "K'é" can also be applied to disapprove any requests for the sake of the organization. The exprssion of "K'é" is the same as the expression of respect and appreciation for a person.

In organizational life, a worker or a supervisor can ask for help in a very polite way so people can be motivated to contribute their time and begin to start working together. As the people are working, appreciation should constantly be expressed so everyone knows that he or she is appreciated. If the supervisor only expresses appreciation to one or two selected individuals, the others may not feel appreciated. They could stop contributing, causing low staff moral. It is best for all employees to be equally appreciated.


NITSÁHÁKEES
To think
To bring to mind
To form or have in mind
To recall or recollect
To make conclusions and decisions
To have the mind go steadily toward action
SIHASIN
To make strong and stable
To secure
To develop confidence
To have a clear path
NAHAT'Á
To implement
To carry into full effect
To provide the means for implementation
To carry from one place to another
To conduct in line with the mind
To carry
IINÁ
To bring to life
To provide sustenance
Outcome of action and process
To realize and make visible
HA'A'AAHJIGO
NITSÁHÁKEES
Nidoolyéełii baa nitsídzíkees
Díí baa hatsídzíkos
Áádóó baa nitsídzíkees
Áádóó baa hasht'e' nitsídzíkos
Áádoo bił tsidzookosgo hozhdi'aah
SIIHASIN
As'ahgóó yit'ih dooleeł
Siisdiniidzį́į́'
Jooba' bee joogááł
Doodí nidzísdlį́į́'
NÁHOOKǪSJIGO
NAHAT'Á
Hozdeez'ą́
Nijiléii baa yájíłti'go bee ła'zh dooníiłii áłah ájíléeh
Bee ni'jíléii áłah ájiilaa
Hanahat'a' daałdził
SHÁDI'ÁAHJIGO
IINÁ
Nidoolyéełii k'izhdíílá
Nijíléii jiyoołnaał
Nizhníláii hasht'e jósin
Nizhníláii yit'įįgo nijiiłdeeł
E'E'AAHJIGO

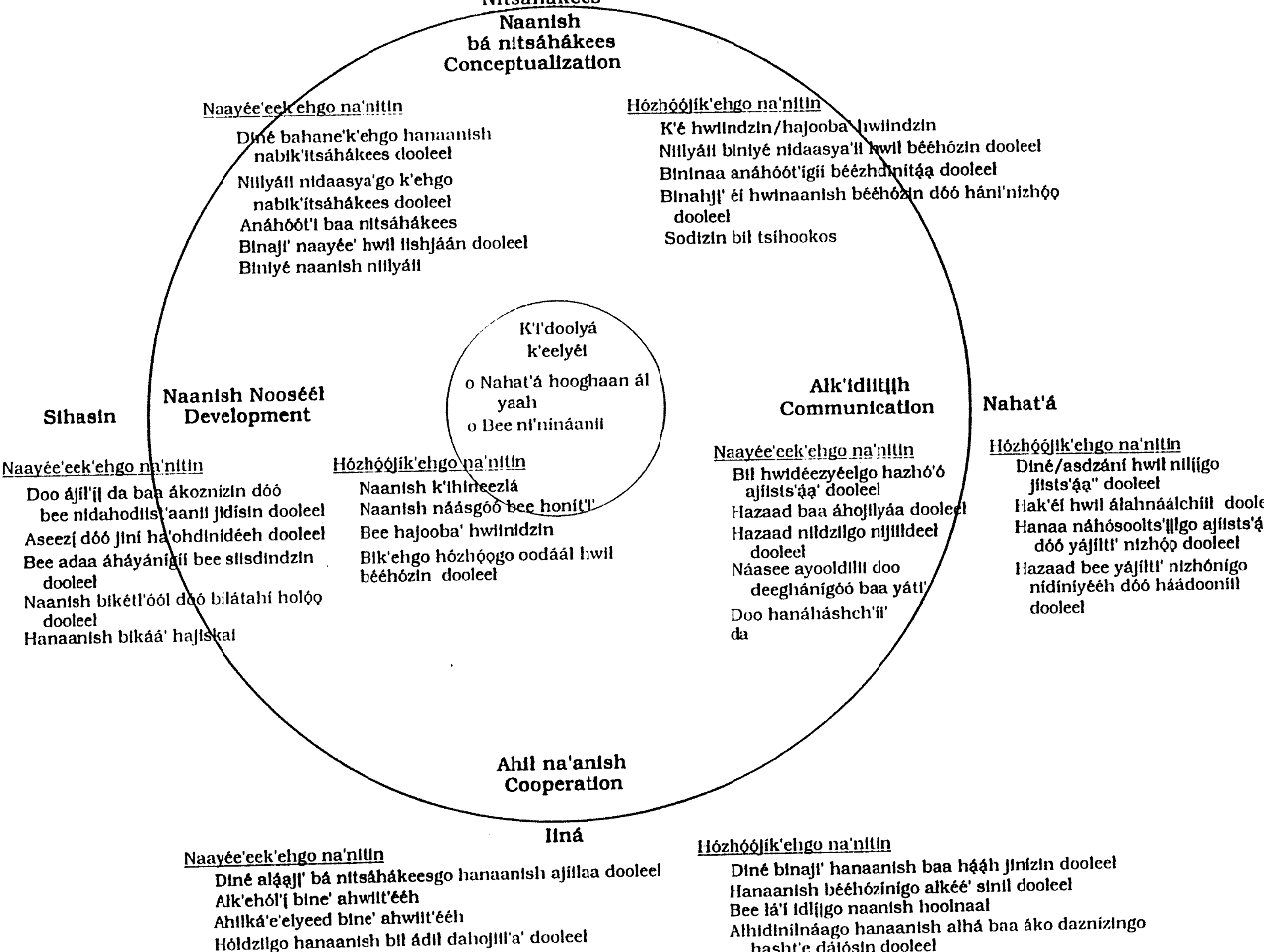



Ałheełt'éego ałhaa nitsáhákees bik'ehgo ałch'į' yájíłti'go bee ahidzíists'ą́ą' dóó ałk'izhdiitįįh. Díí binahjį' ałk'ehojíł'į dóó ałhaa jijooba' dóó t'áá éí bee ahijótą'go ahiłká'aníjíłwo'go bee naanish hooldił.

Ałheełt'éego ałhaa nitsídzíkees ha'nínígíí éí ha'át'íí shíí bee ał'ąą ájít'éhígíí éí ałhidiníłnáago ałhá baa ákoznízin dooleeł. Naanish béédahodzísinígíí éí bee ahíłká'aníjíjahgo binahjį' nizhónígo ahił nijilnish dooleeł.

Ałk'i'diitįįh éí ałhidzíists'ą́ą'. Diné yaa yáłti'ígíí hazhó'ó dzíists'ą́ą'go ałtsoh yaa yáłtihgo índa hwí yánáájíłti' łeh.

# ORGANIZATIONAL MANAGEMENT



NAVAJO COMMUNITY COLLEGE
OFFICE OF DINÉ EDUCATIONAL PHILOSOPHY
*Workshop Cuniculum*

**Bik'eh Hózhóón Oodáál Na'nitin Bee Ahił Na'anish**
*Working together according to the teachings of Ethical and Balanced living*

Bik'eh Hózhóón = harmonious; balanced; according to Blessing Way teachings.
Oodáál = walking there; living; behavior
Na'nitin = the teachings
Bee = by means of that
Ahił = together; cooperatively; side by side; with concensus
Na'anish = working; performance

**Goals, Concepts and Content to understand.**

- Bee hoł dahózhǫ́ǫgo nidajilnish dooleełii
By means of the Blessing Way practices which will provide happiness and well-being in working relationships.

- Bee naanish bóhoneedlįįgo nahat'á ászóólígo náás yit'ááł dooleełii. By means of the Blessing Way practices which will make all work interesting so that the plans and objectives are moved forward with great ease.

- Bee ahíists'ą́ą' dóó ałk'ehól'į dóó ałhaa áháyą́ą dooleełii.
By means of the Blessing Way practices that provide listening to one another, following one another, and taking care of each other.

Organizational atmosphere/climate must be developed according to the purpose of the organization, plan, objectives, response to the need and demand which created the organization, and the organizational philosophy that serves as the foundation and operational methods. These create the necessary conditions and environment in which there is teamwork, communication, understanding, and interpersonal relations. Thus, principles of working together, i.e. procedures, attitudes, values, are established. After these are established Nitsáhákees, Nahat'á, Iiná, and Siihasin develop and proceed smoothly among the workers.

## PRINCIPLES OF AHIŁ NA'ANISH
Principles of Working Together; Teamwork; Organized Working Relationships

Essential characteristics of Ahił Na'anish OR behavioral objectives to be attained through self analysis and application in daily work.

## Ahizhdiits'a'

Listening to and understanding one another.

• There must be conditions conducive to listening to and understanding one another. Da'ahijíísts'ą́ą́' haleehgo éí nizhónígo ałk'idazhdiitįįh.

Conditions for understanding have to do with clear communication and clear instruction or statements of intent. There must be no shą'shin(assumptions), daats'í(perhaps, maybe), t'áá ni níhólnííh(it is up to you however you think or prefer) in directions and instructions with one another. When these confusing elements in communication is eliminated then there is good understanding.

• To enable others to listen to one another there must be respectful relationships. Ahił dajídlíįgo éí binahjį' hazhó'ó ahizhdiits'a'.

Respect for each other and have good reputation is very important in listening to one another. Sometimes people say "Eii t'óó ání. Doo bił bééhózin da. Ákót'éego haadzih nidi bí éí doo yik'ehgóó át'ée da!" - "He is just saying those things. He does not know very much about it. He does not follow what he says!" When directions come from a person who is perceived to have low reputation it is put off; not followed; ignored and forgotten.

• When people have been truthful there is respect. Doo da'ahizhnót'ááhgóó éí ahił dajídlį́.

Planned responsibilities and duties must be carried out as stated. If not, those who fail to do their part lose integrity and he or she cannot be relied on in the future. Prioritize and take on the proper amount of tasks.

• When people have been consistent there is respect. Doo háá-hizhnoolwołgóó éí binahjį' ahił dajídlį́.

Consistency in a worker's performance is essential in earning respect from others. Being organized and effective in all work and in interpersonal relations earn respect.

• When people or persons have taken responsibilities and performed their part there is respect and listening. Doo t'óó ahada'jódlíígóó éí ahił dajídlį́ dóó da'ahizhdiits'a'.

In order to have respect and ability to influence others the worker must not shirk responsibilities or wait for some one to take on the tasks and responsibilities.

• When people are not working against each other there is mutual respect and cooperation.
Doo ałk'ijį' nidajilnish dago éí ahił dajídlį́ dóó da'ahizhdiits'a'.

Some times individuals are considered to be overly assertive with intentions to gain his or her way. It is difficult to go along with this person.

## Ałk'edahojíl'į́

People obey one another/follow each other.

• When people understand each other then they follow each other's directions and arrive at concensus. Ałk'idazhdiitįįh yileehgo éí ałk'edahojíl'į́ dóó nahat'á bee t'áá-łá'á dajileeh.

• When people express their intentions clearly and positively then they understand each other.
Hazaad yá'át'éehgo bee ałch'į' yádajiłti'go dóó hanahat'a' biyéest'įįgo ádajósingo éí ałk'idazhdiitįįh dóó ałk'edahojíl'į́.

• When people perform their equal share of responsibilities and tasks necessary to achieve the objectives then it is easy to follow each other's directions cooperatively. T'áá ájíłtso nahat'á bina'anish aheełt'éego dajótą'go éí bóhoneedlįįgo ahił nidajilnish.

• When people refer to each other with kinship terms and spirit then all group actions upon objectives and plans are lively and enthusiastic. Kinship spirit enables workers to effectively carry out each other's instructions.
K'é bee ahaa nitsídajikeesgo dóó bee ałch'į' yádajiłti'go éí hanahat'a' ditłéé' dóó bóhoneedlįįgo t'áadoole'é doo ch'ééh da'ahizhdi'níígóó ałk'edahojíl'į́.

## Ałhaa Áhá'yą́

Taking care of each other.

• When people have learned to listen to one another and developed cooperative working environment people will perceive and speak of each other in equal terms.
Ahíists'ą́ą́' dóó ałk'ehól'į́ éí bee aheełt'éego ahaa nitsáhákees dóó ałch'į' yáti'.

• When people have learned to work together in equal terms then they will help each other with enthusiasm.
Aheełt'éego ahaa nitsáhákees haleehgo éí ahíłká' aná'alwo' bee ałk'i adéest'įį' bóhoneedlį́.

# "Ahił na'anish"

A. **Są́'ah Naagháí Bik'eh Hózhǫ́ǫ́n k'ehgo Ahił na'anish**

B. **Ahił na'anish bee nanitł'aaígíí - Organizational issues - creating uncooperative setting**

ORGANIZATIONAL ISSUES

1. T'áá ákwíí́jį́ naanish danilínígíí doo nahat'á nilínígíí bidadiit'i' da - The reality of our everyday task is not in compliance with the overall plan of the organization.

2. Bee nihinahat'a' bineilnishii doo hazhó'ó bee nihíhólnííh da - Employees not being involved for their input in major decision making, which effects their performance within the organization.

3. Nahat'á doo hazhó'ó ałkéé' yi'nił da. - The organizational plans are not properly organized

4. Nidiilyéełii doo hazhó'ó nihił bééhózin dago doo hazhó'ó bee ałkéé' siidzį́į́ da. - When the employees don't know the purpose of the organization, they will be inconsistent in supporting the goals.

5. Naat'áanii bił anáhóót'i'. - The lack of organizational leadership.

6. Naat'áanii nahat'á yee ałdádaastxa'go doo nizhónígo bee da'íníísh da - When the organizational leaders are not willing to work together to achieve a goal, their employees will follow their action and begin to work against one another.

7. Naat'áanii t'áłá'í aghá ádool'áago, bá nidaalnishígíí dóó yił nidaalnishígíí doo yá has'ą́ą́góó naanish doo bóhoneedlį́įgóó áyósin - When one leader only wants things done his way, he doesn't allow for employee creativity in achieving personal motivation on the job.

8. Naat'áanii naanish doo yee ásizį́įgóó, naanish doo bóhoneedlį́į da (t'óó "shá" t'éí aghá ha'níigo) - When the leader is not committed to the goals of the organization. the employees are not motivated and get frustrated and waste time and energy.

9. Naanish haashį́į́ yit'éé shį́į́ ałts'ąą nanil'in - Workers not properly informed by supervisor or co-workers.

10. Doo aheełt'éego ałhaa nitsáhákees da. - Employees of the organization are not treated equally.

11. Doo hazho'ó ahił hane' da. - Lack of organizational communication.

12. Naanish biyi'jį' ahijoolch'į́įd - Organizational jealousy

13. Naanish t'óó bee ałha'ódlí - Unequal share of work

14. Ałk'ihodiit'aah - Blaming one another

15. T'áadoo át'éégóó ałhaa yáti' - Talking about each other inappropriately

16. T'áá na'níle'dii ałch'į' yáti' - Using inappropirate language in communication

17. Ałhaa oodloh dóó ałhá nahat'i' - Making fun of each other

18. Aseezį́ bee ałhíhoneedlį́ - When gossip controls the organization.

19. Na'ahíhodinidle' - Sexual harassment

20. Yooch'ííd nijiiłdeeł - Lying at work

21. K'é ha'nínígíí doo bee yáti' da - We're not addressing each other by k'é

22. Doo ahéhee' da'ahizhdi'níígóó - When the employees don't appreciate each other.

## C. Naanish bee nizhóní dooleełii

1.a. Ádaa ákozhnidzin, hazaad baa áhojilyą́ - Self awareness, be aware of your language
1.b. Ádaa atíjít'į́ - To exercise spiritual value, well-being, organized in work place and home, professional development

2.a. K'é dzindzin - To honor/respect and practice clanship
2.b. K'é bee yájíłti', hwił íłį́ - To value addressing one another using Navajo clanship

3.a. Doo t'óó ałha'jódlíída - Don't be overly dependent on one another
3.b. Ahiłká aná'alwo' - To cooperate and help one another

4.a. Doo ahizhdidláash da - Do not develop negative thoughts about each other at work
4.b. Ałheełtéego ahaa nitsáhákees - To respect one another on equal terms

5.a. Aseezį́ baa hojíyą́ - To be fully aware of what is rumor/gossip
5.b. Diné baa yáti'go hazhó'ó baa nitsidzíkeesgo baa yájíłti' - To think and speak of fellow co-workers with high regard and respect

6.a. Doo ałk'íhojit'áah da - Don't deliberately blame one another
6.b. Saad yá'át'éehii bee ałch'į' yájíłti' - Use proper and appropriate language for communication

7.a. Doo naanish ałts'ąą nazhnil'inda - Do not keep work task as a secret
7.b. Naanish ahił ííshjáán ádzólzin - To keep all workers well informed

## D. Naanish bee bóhoneedlíinii - Organization motivation

1. Naanish bee haa héé' hwinidzin - Being appreciative

2. Naanish baa jé'jólná - Being careful of your work performance

3. Naanish hwił nilį́ - To value your work performance

4. Naanish bił haz'ą́ągi jidísin - To render respect and reverance for institution

5. Biniiyé áhát'ínígíí hanahat'a' - Include the purpose of the institution in your planning

6. Ahíłká'ana'álwo' - Helping each other

7. Ałhidzíists'ą́ą́' - Communication

8. Naat'áanii haa ákonízin - Supervisor's awareness

9. Ha'jólní naanishgi - Being able to withstand pressure

10. Naanish ałkéé'dzisnil - Being organized

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# Advising Patients Who Seek Alternative Medical Therapies

[Perspective]

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**Alternative medical therapies, such as chiropractic, acupuncture, homeopathy, and herbal remedies, are in great public demand. Some managed care organizations now offer these therapies as an "expanded benefit." Because the safety and efficacy of these practices remain largely unknown, advising patients who use or seek alternative treatments presents a professional challenge. A step-by-step strategy is proposed whereby conventionally trained medical providers and their patients can proactively discuss the use or avoidance of alternative therapies. This strategy involves a formal discussion of patients' preferences and expectations, the maintenance of symptom diaries, and follow-up visits to monitor for potentially harmful situations. In the absence of professional medical and legal guidelines, the proposed management plan emphasizes patient safety, the need for documentation in the patient record, and the**

**importance of shared decision making.**

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Alternative therapies can be defined as medical interventions that are neither taught widely in U.S. medical schools nor generally available in U.S. hospitals (1). Examples include chiropractic, acupuncture, massage, and homeopathy. In 1993, my colleagues and I reported that an estimated 60 million Americans used alternative medical therapies in 1990 at an estimated cost of $13.7 billion, that the estimated number of annual visits to providers of alternative medicine (425 million) exceeded the number of visits to all U.S. primary care physicians (388 million), and that more than 70% of patients who acknowledged using alternative therapy never mentioned it to their physicians (1). These data generated considerable attention and debate and suggest that an "invisible mainstream" exists within the U.S. health care system (2). Little is known, however, about the safety, efficacy, mechanism of action, and cost-effectiveness of individual alternative treatments.

In the past 3 years, the lay press has reported a national trend: third-party payers who provide alternative therapies in the form of "expanded benefits" (3-11). Most recently, the Oxford Health Plan began a program whereby chiropractic, acupuncture, and naturopathy became available to the Plan's 1.5 million subscribers as paid benefits (12,13). This trend poses a predicament for physicians: how to responsibly advise patients who use or seek alternative therapies in the face of inconclusive evidence about the safety and effectiveness of these therapies.

This unavoidable challenge is not without risk. Questions of professional liability are valid. The reality is that no case law directly answers the question, "Will I be sued if I knowingly comanage a patient who sees an alternative therapy practitioner and experiences a bad outcome from that therapy?" Although physicians have been prosecuted for malpractice when they have personally delivered alternative treatments, no cases have involved conventionally trained physicians who have advised patients about alternative medical therapies.

The other extreme involves the risk of not asking about alternative therapies known to be dangerous. In 1996, the media reported deaths from overdoses of Herba ephedra (herbal ephedrine), known in Chinese herbal medicine as ma huang (14,15). A death attributed to pennyroyal, an herb commonly available in health food stores, was recently reported in the medical literature (16). As more patients use over-the-counter herbs, botanicals, and supplements, physicians should discuss such practices with their patients, if only to safeguard their health.

Undoubtedly, talking with patients about alternative therapies requires additional skills and time. Yet, is this responsibility significantly different from exploring patients' use of alcohol or drugs, exposure to abuse, or preferences for cardiopulmonary resuscitation? Each is critically important to maintaining health and respecting patient values, and each takes time.

I propose a step-by-step approach whereby medical providers and patients can proactively discuss alternative medical treatments. These suggestions emphasize patient safety, the need for documentation in the patient record, and the importance of shared decision making.

# Asking the Unasked Question

I suggest that after completing routine questioning to identify patients' chief symptoms, medical providers begin a conversation about alternative therapies with some version of the following question: "Patients with (chief symptom) frequently use other kinds of therapy to find relief. For example, some patients use chiropractic, massage, herbs, vitamins, etc. Have you used or thought about using any of these or other therapies for your chief symptom, or for other reasons?"

Because one third of all alternative therapy use seems to be associated with health promotion and disease prevention (1), providers should also ask about a patient's use of alternative therapy in this context. This inquiry can be assimilated into questions about lifestyle and health risks.

The physician and patient must feel comfortable with how the question is asked. Two caveats are worth considering: 1) The neutrality with which this question is asked influences the honesty of the answer, and 2) there is no need to refer to the "other therapies" as "alternative," "complementary," or "unorthodox." Such labels may be perceived as judgmental, thereby inhibiting disclosure and discussion.

Patients who are interested in exploring alternative therapies do so for diverse reasons: 1) They seek health promotion and disease prevention; 2) conventional therapies have been exhausted; 3) conventional therapies are of indeterminate effectiveness or are commonly associated with side effects or significant risk; 4) no conventional therapy is known to relieve the patient's condition; and 5) the conventional approach is perceived to be emotionally or spiritually without benefit. Whether or not patients use or seek advice about an alternative therapy, they are likely to be pleased when their physician cares enough to ask.

## Prerequisites

Detailed discussion about alternative therapy should not occur until the patient 1) has undergone a complete conventional medical evaluation, including diagnostic assessment and, where indicated, referral to consultants; 2) has been advised of conventional therapeutic options; and 3) has tried or exhausted conventional therapeutic options or refused these options for reasons documented in their record. Professional advice on the adjunctive or exclusive use of alternative therapy without a complete diagnostic evaluation is irresponsible and does not serve the patient's best interest.

## A Step-by-Step Strategy

Consider a patient with intermittent low back pain for whom nonsteroidal anti-inflammatory medications, physical therapy, regular exercise, and avoidance of heavy or improper lifting have not adequately reduced chronic or recurrent pain. The following approach (* Figure 1*), guided by the principle "do no harm" and its corollary, "monitor for unintentional side effects," can be considered:

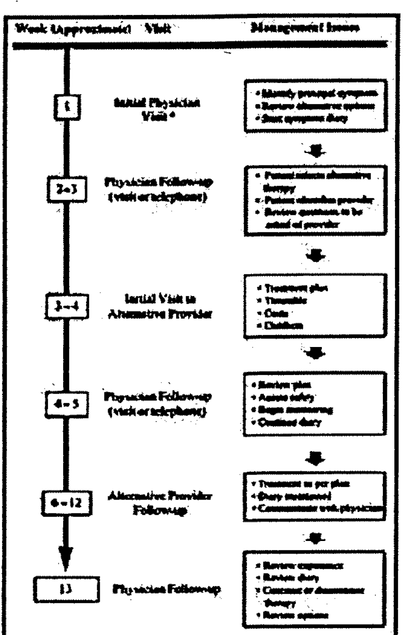


*Figure 1. Proposed process for managing alternative therapy. * = assumes that medical evaluation has been completed and conventional options have been offered.*

1. Ask the patient to identify the principal symptom.

Back pain is the principal symptom.

2. Maintain a symptom diary.

Assist the patient with a daily symptom diary to be used for baseline assessment and evaluation of subsequent alternative (or conventional) therapeutic interventions. A scale from 0 ("no back pain") to 10 ("the worst pain imaginable") is recommended. Patients should be reminded that because accurate recall of discomfort, fatigue, and other symptoms is difficult, daily logs are essential.

3. Discuss the patient's preferences and expectations.

Many patients come prepared to discuss opinions or powerful anecdotes from friends or family members. The discussion often focuses on the reasons patients seek alternative treatment or their desire to avoid conventional therapies. Patients with low back pain, for example, may incorrectly assume that surgery is their only conventional option.

If patients wish to pursue alternative therapy but lack strong preferences for specific therapies, encourage shared responsibility for investigating options further. Various texts are available to both patients and conventional medical providers. These offer information on multiple alternative therapies (17-32) or focus on single treatments (33-43). Conventional practitioners might consider attending continuing medical education courses on this topic (44-46). In our hypothetical example, the patient opts to pursue acupuncture.

4. Review issues of safety and efficacy.

It is the conventional provider's professional obligation to monitor therapies with potential or documented toxicity, including herbal preparations (47-73), dietary regimens (74,75) and supplements (76-79), medicinal agents delivered by injection (80), intravenous infusion (such as chelation therapy (81)), and certain forms of spinal manipulation (82-89). Advise patients that the absence of documented toxicity for herbs, supplements, or chemical preparations does not equal safety. Notions that "natural" substances are inherently safe are false (90). Snake venom is "natural" but deadly (91); poison oak and ivy contain "natural" urushiols that cause severe contact dermatitis (92). Examples of potentially toxic herbs include sassafras (55), chaparral (69), and germander (73). Reference books (93-95) and online resources (96) (Appendix 1) are available to investigate the relative safety of individual herbs and supplements.

Reviewing the current medical literature fails to provide unequivocal documentation of the safety or efficacy of the overwhelming majority of alternative therapies (85,87,89,97-102). Notable exceptions include spinal manipulation for acute low back pain (103), acupuncture for nausea (104), and behavioral and relaxation techniques for chronic pain and insomnia (105). Adverse events attributable to acupuncture have been reported (106,107) but are rare (108-112). The risk for transmission of infectious organisms can be reduced to almost zero by using disposable needles.

Risk is also associated with manipulation of the cervical spine (82,83,87-89). Other treatments with potential significant risks include some single herbs; some Chinese "patent" remedies manufactured overseas that routinely include various herbs and are occasionally adulterated with steroids or lead (68); high-dose vitamins and minerals, radical diets, certain deep-tissue massage; and any substance administered intravenously.

Relatively low-risk therapies include homeopathy, most forms of massage, prayer, guided imagery, spiritual healing, hypnosis, and relaxation techniques. Two caveats are worth noting: 1) Any therapy can cause "indirect toxicity" if it results in a delay of a proven treatment, and 2) there is a risk for perceived blame and failure among patients who, expecting a "cure" as a result of mental or spiritual exercises, do not experience the desired result (113). Thus, thinking of alternative therapies in terms of relative risk or benefit is reasonable.

Indirect toxicity is exemplified by documented drug-drug interactions. Examples include the potentiation of calcium channel blockers by grapefruit juice (63) and decrease in the bioavailability of digoxin in the presence of guar gum consumption (48). Given the potential for unintended drug-drug interactions, patients who take prescription medications, especially drugs with known toxicity to the liver or kidneys (such as chemotherapeutic agents), should be cautioned about, if not dissuaded from,

simultaneously using herbs, supplements, and other substances with poorly studied pharmacologic activities. Perhaps the most common, vexing example involves the patient who is receiving chemotherapy or radiation therapy and considers the consumption of herbs, high-dose vitamins, or supplements before or during treatment. These substances may, hypothetically, inhibit or potentiate the activity of conventional therapeutic agents. Physicians must warn patients about unintended drug-drug interactions and the prospect of not knowing which substance is responsible. In general, a strategy that uses one therapeutic intervention at a time, at least until a therapeutic plateau is reached or a reasonable period of monitoring elapses, should be discussed and documented in the record.

5. Identify a suitable licensed provider.

Patients may have already identified a provider by word of mouth or informal referral. Physicians should emphasize that alternative therapy providers are licensed by state governments and commonly maintain professional malpractice insurance. Licensure laws and the scope of practice guidelines regulating individual practices vary by state (114) (* Figure 2*) and are subject to frequent change. Patients should review the professional credentials of any prospective alternative provider. Ideally, this information should be documented in the patient's record.

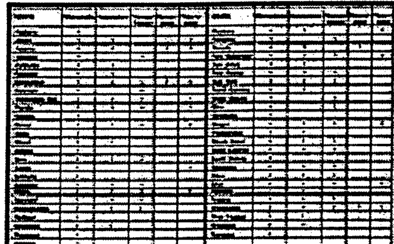

*Figure 2. State licensure of alternative medicine practitioners. Asterisks indicate state licensure. The absence of state licensure does not necessarily imply the absence of state or local regulatory authority. For additional information, contact Federation of State Medical Licensing, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039; phone 817-868-4000; e-mail http://FSMB.org. See Appendix 2 for information on organizations for each individual therapy.*

6. Provide key questions for the alternative therapy provider during initial consultation.

When patients are being counseled about use of alternative therapy, providing the following questions to ask the alternative medical provider is helpful: 1) Is the provider's belief in the effectiveness of the therapy (for example, acupuncture) based on clinical experience with similar patients? If so, is it possible to speak to such a patient? 2) Of what will the therapy consist? What is the recommended frequency of therapy? 3) How many weeks will pass before the patient and provider can decide that the therapy is or is not beneficial? 4) What is the cost per session, with or without medication, and the anticipated total cost for the specified time period? Is third-party reimbursement available? 5) Are there potential side effects? 6) Is the provider willing to communicate diagnostic findings, therapeutic plans, and follow-up with the patient's primary care provider or subspecialist? Are there any limitations to this communication?

Ideally, the physician should obtain patients' permission to release relevant information (including information on the use of prescription medications) to the alternative therapy provider in order to offer accurate historical information and avoid conflicting recommendations.

7. Schedule a follow-up visit (or telephone call) to review treatment plan.

Topics to be addressed during this session include 1) the alternative practitioner's responses to the questions outlined above; 2) potential risks or toxicity, particularly those involving therapies taken orally, intramuscularly, or intravenously; and 3) recommendations that directly conflict with those of the conventional provider. An extreme example is the recommendation that a patient delay or forego surgery, chemotherapy, or radiation therapy for a potentially treatable malignant condition.

8. Follow up to review the response to treatment.

This should occur after a "reasonable" period (usually 4 to 8 weeks). By the time this follow-up session takes place, patients usually have decided whether or not to continue the alternative therapy. If the therapy was effective, the patient's positive experience constitutes a beneficial clinical outcome and

provides anecdotal evidence that this therapy (or, one might argue, the provider of this therapy) may be helpful to others with similar problems. If the therapy was ineffective, the patient and physician together can review other alternative and conventional therapeutic options. Regardless of the perceived efficacy or lack thereof, patients who pursue an alternative therapy while being monitored by their physician tend to feel "listened to" and enjoy a degree of perceived safety that they might otherwise be denied.

9. Provide documentation.

Conventional providers are encouraged to build a record of the clinical encounters, conversations, and advice that lead to all treatment decisions.

## Patients Who Already Use Alternative Therapies

Such patients may not wish to discuss these alternative practices; this should be recorded in their medical records. For patients who welcome this conversation, the physician's challenge is to explore whether the patient and alternative provider are willing to follow the steps discussed above. Refusal on the part of either party should be documented in the patient's record.

## Patients Who Reject Conventional Diagnosis or Therapy

A more challenging situation involves the new patient who currently uses an alternative therapy (or wants a referral) but refuses conventional evaluation. Patients have the right to forego conventional treatment, but this choice does not constitute a right to obtain a referral or tacit medical approval for alternative therapy in the absence of a diagnosis.

Physicians might convince such patients that an "integrated" approach is in their best interest. If patients refuse this advice, they are best served by the unequivocal message that requests for referral to an alternative provider are unreasonable and cannot be met. Physicians facing this predicament should follow accepted professional guidelines for referring patients to another physician. Under no circumstances should a conventional medical provider feel professionally obligated to make or support referrals to alternative therapy providers in the absence of a thorough medical evaluation.

## Discussion

Discussions about the use of alternative medicine are primarily influenced by patient preference, perceived need for alternative interventions, and anecdotal evidence that the therapy may provide relief and long-term benefit or be toxic. Together, patients and providers must acknowledge that as long as information on the efficacy and toxicity of alternative therapies remains inadequate, advice will remain imperfect and a matter of judgment.

As with all good care, the patient's wishes should not override a physician's professional judgment. If the physician believes that an alternative therapy is unsafe or inappropriate, patient requests for it should not be endorsed. Perhaps the question each clinician must ask is, "Would I let a family member follow this course of action?" Patients, I believe, want their physician's opinion, even if it is a blunt "I wouldn't be comfortable watching a family member do this...." If, however, little evidence suggests that risks outweigh potential benefits and the physician is willing to monitor the patient, it is often appropriate to pursue alternative treatment.

By implementing the proposed strategy, physicians and patients may disagree about which alternative therapy is safe and potentially effective. I believe that this kind of disagreement is extremely valuable. Kassirer (115) commented that

"the patient should be given the benefit of the doubt when important decisions are contemplated. The physician initially should assume that the patient is capable of becoming a full partner in the decision-making process and encourage active participation. This means the patient will have to assume more responsibility for outcomes of medical decisions and the physician will have to relinquish some....'

Kassirer concludes that

"when discussing details with the patient, physicians should disclose whatever uncertainties exist. Most patients are not horrified to learn that a considerable body of medical information is fuzzy and uncertain. Neither do they fail to comprehend that some tests and treatments are risky, that some treatments are not always efficacious, and that on occasion the treatment may turn out to be worse than the disease."

Physicians and patients should dare to disagree, especially about therapies for which scientific support is anecdotal, equivocal, or preliminary. Often, the most sensitive barometer of a relationship is the ability to resolve disagreement. A rabbi commented that when providing premarital counseling, she always asks the couple, "Tell me how you disagree. I'm not interested in what you disagree about, but rather how you work through your disagreement." The manner in which the patient and physician wrestle with disagreements about therapeutic choices helps define their relationship and its value to each party.

We as a profession must address the challenge of discussing alternative therapies with our patients and put an end to the "don't ask, don't tell" approach that characterizes communication in this area. These discussions are opportunities for shared decision making and "relationship-centered care" (116). No patient should feel that their medical journey is to be taken alone or according to some stealth trajectory, invisible to their conventional providers. The delivery of medical care, like the experience of illness, is best viewed as a journey shared.

## Appendix 1. Selected Information Resources on Herbs and Supplements

### Research Databases

U.S. Department of Agriculture

Agricultural Genome Information System

http://probe.nalusda.gov

Free access to 80 000 records on herb taxonomy and the use of herbs worldwide, developed by Dr. James Duke. Other available databases include a WAIS (wide-area information server)-based subset of Agricola.

NAPRALERT

College of Pharmacy

The University of Illinois at Chicago

Contact: Mary Lou Quinn

Phone: 312-996-2246

Fax: 312-996-7107

www.pmmp.uic.edu

Contains 124 000 scientific articles on the chemical constituents and pharmacology of plants (75% were published after 1975). Requires annual subscription fee for mediated searching plus a fee for each record retrieved.

### Research Journals

Journal of Natural Products

American Society of Pharmacognosy

555 31st Street

Downers Grove, IL 60515

Phone: 708-971-6417

Journal of Ethnopharmacy

Elsevier Science Ireland, Ltd.

Madison Square Station, Box 882

New York, NY 10159

Phone: 212-989-5800

International Journal of Pharmacognosy

Swets & Zeilinger

400 Creamery Way, Suite A

Exton, PA 19341

Phone: 800-447-9387

HerbalGram, HerbClip

American Botanical Council

PO Box 201660

Austin, TX 78720

Fax: 512-331-1924

www.herbalgram.org/abcmission.html

## Mediated Searching

Herb Research Foundation

1007 Pearl Street, Suite 200

Boulder, CO 80302

Phone: 303-449-2265

Fax: 303-449-7849

www.herbs.org

Hand searching of private library composed of 125 000 papers that cover a full range of botanical issues. Hourly fee for searching plus a per-page charge.

U.S. Department of Agriculture National Agricultural Library

Food and Nutrition Information Center

Phone: 301-504-5719

www.nal.usda.gov/fnic

National Institutes of Health Office of Dietary Supplements' public information service. No charge for telephone requests. Reference service hours are Monday through Friday, 12:30 to 4:30 p.m. Eastern Standard Time.

Lloyd Library

917 Plum Street

Cincinnati, OH 45202

Phone: 513-721-3707

www.libraries.uc.edu/lloyd

One of the largest comprehensive collections of books and serials on natural pharmaceuticals in North America. Searches are free, but a copy fee is charged for materials retrieved.

### List of Associations

Herbnet

www.herbnet.com/associations.html

Extensive annotated listing of commercial, nonprofit, national, and regional organizations dedicated to the support of herbal medicine. Other resources available through Herbnet include recent news and publications.

## Appendix 2. Information Resources for State Licensing

### Chiropractic

Federation of Chiropractic Licensing Boards

901 54th Avenue, Suite 101

Greeley, CO 80634

Phone: 970-356-3500

www.fclb.org/fclb

### Homeopathy

National Center for Homeopathy

801 North Fairfax Street, Suite 306

Alexandria, VA 22314

Phone: 703-548-7790

www.homeopathic.org

Homeopathy is licensed in three states. Contact state licensing boards for general information.

## Massage Therapy

National Certification Board for Therapeutic Massage and Bodywork

8201 Greensboro Drive, Suite 300

McLean, VA 22102

Phone: 800-296-0664

www.ncbtmb.com

Provides detailed information on state licensing and regulatory requirements and on individual certified practitioners. Certification is not consistently required for licensure. Not all massage therapists are nationally certified.

## Acupuncture

No single acupuncture organization can provide information by telephone on a state-by-state basis. State boards of registration in medicine should be contacted for further information.

National Certification Commission for Acupuncture and Oriental Medicine (NCCA)

1424 16th Street NW

Suite 501

Washington, DC 20036

Phone: 202-232-1404

Book (cost, $7.00) available that provides each state's licensing and regulatory requirements.

American Academy of Medical Acupuncture

5820 Wilshire Boulevard, Suite 500

Los Angeles, CA 90036

Phone: 213-937-5514

www.medicalacupuncture.org

Membership limited to allopathic and osteopathic physicians who have had 200 hours of acupuncture training.

## Naturopathy

American Association of Naturopathic Physicians (AANP)

601 Valley Street, Suite 105

Seattle, WA 98109

Phone: 206-328-8510

www.infinite.org/Naturopathic.Physician

Naturopathy is licensed in 12 states and the District of Columbia (* Figure 2*). The AANP provides contacts for local licensing and regulatory boards and general information on naturopathy.

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# REFERENCES

1. Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco TL. Unconventional medicine in the United States. Prevalence, costs, and patterns of use. N Engl J Med. 1993;328:246-52. [Medline Link] [Context Link]

2. Eisenberg DM. The invisible mainstream. Harvard Medical Alumni Bulletin. 1996;70:20-5. [Context Link]

3. Phalon R. New support for old therapies. Forbes. 20 December 1993:254-55. [Context Link]

4. Neff R. They fly through the air with the greatest of... ki? Business Week. 23 January 1995:60. [Context Link]

5. Carton B. Health insurers embrace eye-of-newt therapy. Wall Street Journal. 30 January 1995:B1. [Context Link]

6. Scheck A. Alternative medicine is next health trend. Investor's Business Daily. 20 June 1995. [Context Link]

7. Dunkin A. "Complementary" medicine: is it good for what ails you? Business Week. 27 November 1995:134. [Context Link]

8. Hilts PJ. Health maintenance organizations turn to spiritual healing. The New York Times. 27 December 1995:B10. [Context Link]

9. Egan T. Seattle officials seeking to establish a subsidized natural medicine clinic. The New York Times. 3 January 1996:A6. [Context Link]

10. Jackson C. Alternative medicine goes mainstream. The Tampa Tribune. 8 January 1996:8. [Context Link]

11. Russell S. HMOs try dose of alternative medicine. San Francisco Chronicle. 22 January 1996:A1. [Context Link]

12. Bloomberg Business News. Oxford Health plans to cover alternative care. The New York Times. 9 October 1996:A11. [Context Link]

13. Lagnado L. Oxford to create alternative-medicine network. Wall Street Journal. 7 October 1996:B9. [Context Link]

14. Krauss C. Pataki outlaws herbal stimulant linked to deaths. The New York Times. 24 May 1996:B1. [Context Link]

15. Cowley G. Herbal warning. Newsweek. 6 May 1996:60. [Context Link]

16. Anderson IB, Mullen WH, Meeker JE, Khojasteh-Bakht SC, Oishi S, Nelson SD, et al. Pennyroyal toxicity: measurement of toxic metabolite levels in two cases and review of the literature. Ann Intern Med. 1996;124:726-34. [Fulltext Link] [Medline Link] [Context Link]

17. National Institutes of Health. Office of Alternative Medicine. Alternative Medicine: Expanding Medical Horizons. Washington, DC: US Gov Pr Office; 1994. [Context Link]

18. Zwicky JF. American Medical Association. Reader's Guide to Alternative Health Methods. Chicago: American Med Assoc; 1993. [Context Link]

19. Collinge W. Complete Guide to Alternative Medicine. New York: Warner Books; 1996. [Context Link]

20. Micozzi MS, ed. Fundamentals of Complementary and Alternative Medicine. New York: Churchill Livingstone; 1996.

[Context Link]

21. Fugh-Berman A. Alternative Medicine: What Works. Tucson, AZ: Odonian Pr; 1996. [Context Link]

22. Burton Goldberg Group. Alternative Medicine: The Definitive Guide. Puyallup, WA: Future Medicine; 1993. [Context Link]

23. Marti JE, Hines A. The Alternative Health and Medicine Encyclopedia. New York: Gale Research; 1995. [Context Link]

24. Lerner M. Choices in Healing: Integrating the Best of Conventional and Complementary Approaches to Cancer. Cambridge, MA: MIT Pr; 1994. [Context Link]

25. U.S. Congress Office of Technology Assessment. Unconventional Cancer Treatments. OTA-H-405. Washington, DC: US Gov Pr Office; 1990. [Context Link]

26. Goleman D, Gurin J. Mind/Body Medicine: How to Use Your Mind for Better Health. Yonkers, NY: Consumer Reports Books; 1993. [Context Link]

27. Stalker D, Glymour C, eds. Examining Holistic Medicine. Buffalo, NY: Prometheus Books; 1989. [Context Link]

28. Butler K, Barrett S. A Consumer's Guide to Alternative Medicine: A Close Look at Homeopathy, Acupuncture, Faith-Healing, and Other Unconventional Treatments. Buffalo, NY: Prometheus Books; 1992. [Context Link]

29. Barrett S. Health Schemes, Scams, and Frauds. Mt. Vernon, NY: Consumers Union; 1990. [Context Link]

30. Raso J, Barrett S, eds. Mystical Diets: Paranormal, Spiritual, and Occult Nutrition Practices. Buffalo, NY: Prometheus Books; 1993. [Context Link]

31. Gevitz N. Other Healers: Unorthodox Medicine in America Baltimore: Johns Hopkins Univ Pr; 1988. [Context Link]

32. O'Connor BB. Healing Traditions: Alternative Medicine and the Health Professions. Philadelphia: Univ of Pennsylvania Pr; 1995. [Context Link]

33. Kaptchuk T. The Web That Has No Weaver: Understanding Chinese Medicine. New York: Congdon & Weed; 1983. [Context Link]

34. Pizzorno JE, Murray MT. A Textbook of Natural Medicine. Seattle, WA: John Bastyr College Publications; 1993. [Context Link]

35. Bellavite P, Signorini A. Homeopathy: A Frontier in Medical Science. Berkeley, CA: North Atlantic Books; 1995. [Context Link]

36. Vithoulkas G. The Science of Homeopathy. New York: Grove Pr; 1980. [Context Link]

37. Weiner M, Goss K. The Complete Book of Homeopathy. New York: Bantam Books; 1982. [Context Link]

38. Wardwell WI. Chiropractic: History and Evolution of a New Profession. St. Louis: Mosby-Year Book; 1992. [Context Link]

39. Moore JS. Chiropractic in America. The History of a Medical Alternative. Baltimore: Johns Hopkins Univ Pr; 1993. [Context Link]

40. Tyler VE. Herbs of Choice: The Therapeutic Use of Phytomedicinals. Binghamton, NY: Haworth Pr; 1994. [Context Link]

41. Tyler VE. The Honest Herbal: A Sensible Guide to the Use of Herbs and Related Remedies. 3d ed. Binghamton, NY: Haworth Pr; 1993. [Context Link]

42. Weiss RF. Herbal Medicine. Beaconsfield, United Kingdom: Beaconsfield Publishers; 1988. [Context Link]

43. Werbach MR, Murray MT. Botanical Influences on Illness: A Sourcebook of Clinical Research. Tarzana, CA: Third Line Pr; 1994. [Context Link]

44. Conference calendar. Alternative Therapies in Health and Medicine. Aliso Viejo, CA: Innovision Communications. 1997;3:125. [Context Link]

45. Upcoming conferences and training seminars. Alternative & Complementary Therapies. Larchmont, NY: Mary Ann Liebert. 1997;3:72. [Context Link]

46. Forthcoming meetings of interest. Advances: The Journal of Mind-Body Health. Kalamazoo, MI: John E. Fetzer Institute. 1997;13:79. [Context Link]

47. Huxtable RJ. The harmful potential of herbal and other plant products. Drug Saf. 1990;5(Suppl 1):126-36. [Medline Link] [Context Link]

48. de Smet PA. Health risks of herbal remedies. Drug Saf. 1995;13:81-93. [Medline Link] [Context Link]

49. de Smet PA, Dukes MN, eds. Drugs used in non-orthodox medicine. In: Dukes MN, ed. Meyler's Side Effects of Drugs. 12th ed. Amsterdam: Elsevier; 1992:1209-32. [Context Link]

50. de Smet PA, Keller K, Hansel R, Chander RF, eds. Toxicological Outlook on the Quality Assurance of Herbal Remedies: Adverse Effects of Herbal Drugs. Berlin: Springer-Verlag; 1992:1-72. [Context Link]

51. de Smet PA. Is there any danger in using traditional remedies? J Ethnopharmacol. 1991;32:43-50. [Medline Link] [Context Link]

52. D'Arcy PF. Adverse reactions and interactions with herbal medicines. Part 1. Adverse reactions. Adverse Drug React Toxicol Rev. 1991;10:189-208. [Medline Link] [Context Link]

53. D'Arcy PF. Adverse reactions and interactions with herbal medicines. Part 2-Drug interactions. Adverse Drug React Toxicol Rev. 1993;12:147-62. [Medline Link] [Context Link]

54. Woolf GM, Petrovic LM, Rojter SE, Wainwright S, Villamil FG, Katkov WN, et al. Acute hepatitis associated with the Chinese herbal product jin bu huan. Ann Intern Med. 1994;121:729-35. [Fulltext Link] [Medline Link] [Context Link]

55. Segelman AB, Segelman FP, Karliner J, Sofia RD. Sassafras and herb tea. Potential health hazards. JAMA. 1976;236:477 [Medline Link] [Context Link]

56. Ridker PM, McDermott WV. Comfrey herb tea and hepatic veno-occlusive disease. Lancet. 1989;1:657-8. [Medline Link] [Context Link]

57. Tai YT, But PP, Young K, Lau CP. Cardiotoxicity after accidental herbinduced aconite poisoning. Lancet. 1992;340:1254-6. [Medline Link] [Context Link]

58. Vanherweghem JL, Depierreux M, Tielemans C, Abramowicz D, Dratwa M, Jadoul M, et al. Rapidly progressive interstitial renal fibrosis in young women: association with slimming regimen including Chinese herbs. Lancet. 1993;341:387-91. [Medline Link] [Context Link]

59. World Health Organization. Herbal Medicines Containing Germander Withdrawn. PHA Information Exchange Service. Geneva: World Health Organization; 1992. [Context Link]

60. Jimson weed poisoning-Texas, New York, and California, 1994. MMWR Morb Mortal Wkly Rep. 1995;44:41-4. [Medline Link] [Context Link]

61. Lead poisoning associated with use of traditional ethnic remedies-California, 1991-1992. MMWR Morb Mortal Wkly Rep. 1993;42:521-4. [Medline Link] [Context Link]

62. Smith GW, Chalmers TM, Nuki G. Vasculitis associated with herbal preparation containing Passiflora extract [Letter]. Br J Rheumatol. 1993;32:87-8. [Medline Link] [Context Link]

63. Bailey DG, Arnold JM, Spence JD. Grapefruit juice and drugs. How significant is the interaction? Clin Pharmacokinet. 1994;26:91-8. [Medline Link] [Context Link]

64. Chan TY, Chan JC, Tomlinson B, Critchley JA. Chinese herbal medicines revisited: a Hong Kong perspective. Lancet. 1993;342:1532-4. [Fulltext Link] [Medline Link] [Context Link]

65. Conn JW, Rovner DR, Cohen EL. Licorice-induced pseudoaldosteronism. Hypertension, hypokalemia, aldosteronopenia, and suppressed plasma renin activity. JAMA. 1968;205:492-6. [Medline Link] [Context Link]

66. Dandekar UP, Chandra RS, Dalvi SS, Joshi MV, Gokhale PC, Sharma AV, et al. Analysis of a clinically important interaction between phenytoin and Shankhapushpi, an Ayurvedic preparation. J Ethnopharmacol. 1992;35:285-8. [Medline Link] [Context Link]

67. Fushimi R, Tachi J, Amino N, Miyai K. Chinese medicine interfering with digoxin immunoassays [Letter]. Lancet. 1989;1:339. [Medline Link] [Context Link]

68. Goldman JA, Myerson G. Chinese herbal medicine: camouflaged prescription antiinflammatory drugs, corticosteroids, and lead. Arthritis Rheum. 1991;34:1207. [Context Link]

69. Gordon DW, Rosenthal G, Hart J, Sirota R, Baker AL. Chaparral ingestion. The broadening spectrum of liver injury caused by herbal medications. JAMA. 1995;273:489-90. [Fulltext Link] [Medline Link] [Context Link]

70. Hogan RP 3d. Hemorrhagic diathesis caused by drinking an herbal tea. JAMA. 1983;249:2679-80. [Medline Link] [Context Link]

71. Kane JA, Kane SP, Jain S. Hepatitis induced by traditional Chinese herbs: possible toxic components. Gut. 1995;36:146-7. [Fulltext Link] [Medline Link] [Context Link]

72. Kempin SJ. Warfarin resistance caused by broccoli [Letter]. N Engl J Med. 1983;308:1229-30. [Medline Link] [Context Link]

73. Larrey D, Vial T, Pauwels A, Castot A, Biour M, David M, et al. Hepatitis after germander (Teucrium chamaedrys) administration: another instance of herbal medicine hepatotoxicity. Ann Intern Med. 1992;117:129-32. [Medline Link] [Context Link]

74. Roberts IF, West RJ, Ogilvie D, Dillon MJ. Malnutrition in infants receiving cult diets: a form of child abuse. Br Med J. 1979;1:296-8. [Context Link]

75. Sherlock P, Rothschild EO. Scurvy produced by a Zen macrobiotic diet. JAMA. 1967;199:794-8. [Medline Link] [Context Link]

76. Kamb ML, Murphy JJ, Jones JL, Caston JC, Nederlof K, Horney LF, et al. Eosinophilia-myalgia syndrome in L-tryptophan-exposed patients. JAMA. 1992;267:77-82. [Medline Link] [Context Link]

77. Hertzman PA, Blevins WL, Mayer J, Greenfield B, Ting M, Gleich GJ. Association of the eosinophilia-myalgia syndrome with the ingestion of tryptophan. N Engl J Med. 1990;322:869-73. [Medline Link] [Context Link]

78. Vitamin preparations as dietary supplements and as therapeutic agents. Council on Scientific Affairs. JAMA. 1987;257:1929-36. [Medline Link] [Context Link]

79. Megavitamin and megamineral therapy in childhood. Nutrition Committee. Canadian Paediatric Society. Can Med Assoc J. 1990;143:1009-13. [Medline Link] [Context Link]

80. Taylor GD, Turner AR. Cutaneous abscess due to Nocardia after "alternative" therapy for lymphoma. Can Med Assoc J. 1985;133:767. [Medline Link] [Context Link]

81. Oliver LD, Mehta R, Sarles HE. Acute renal failure following administration of ethylenediamine-tetraacetic acid (EDTA). Tex Med. 1984;80:40-2. [Medline Link] [Context Link]

82. Powell FC, Hanigan WC, Olivero WC. A risk/benefit analysis of spinal manipulation therapy for relief of lumbar or cervical pain. Neurosurgery. 1993;33:73-9. [Medline Link] [Context Link]

83. Fast A, Zinicola DF, Marin EL. Vertebral artery damage complicating cervical manipulation. Spine. 1987;12:840-2. [Medline Link] [Context Link]

84. Lee KP, Carlini WG, McCormick GF, Albers GW. Neurologic complications following chiropractic manipulation: a survey of California neurologists. Neurology. 1995;45:1213-5. [Medline Link] [Context Link]

85. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Brook RH. Spinal manipulation for low-back pain. Ann Intern Med. 1992;117:590-8. [Medline Link] [Context Link]

86. Haldeman S, Rubinstein SM. Cauda equina syndrome in patients under-going manipulation of the lumbar spine. Spine. 1992;17:1469-73. [Medline Link] [Context Link]

87. Assendelft WJ, Koes BW, van der Heijden GJ, Bouter LM. The efficacy of chiropractic manipulation for back pain: blinded review of relevant randomized clinical trials. J Manipulative Physiol Ther. 1992;15:487-94. [Medline Link] [Context Link]

88. Hurwitz EL, Aker PD, Adams AH, Meeker WC, Shekelle PG. Manipulation and mobilization of the cervical spine. A systematic review of the literature. Spine. 1996;21:1746-59. [Medline Link] [Context Link]

89. Coulter I, Hurwitz E, Adams A, Meeker W. The Appropriateness of Spinal Manipulation and Mobilization of the Cervical Spine: Literature Review, Indications and Ratings by a Multidisciplinary Expert Panel. Santa Monica, CA: RAND; 1995. [Context Link]

90. Friedman RA. "Natural" doesn't mean safe [Editorial]. The New York Times. 19 April 1996:A29. [Context Link]

91. Russell FE, Carlson RW, Wainschel J, Osborne AH. Snake venom poisoning in the United States. Experiences with 550 cases. JAMA. 1975;233:341-4. [Medline Link] [Context Link]

92. Epstein WL. Plant-induced dermatitis. Ann Emerg Med. 1987;16:950-5. [Medline Link] [Context Link]

93. de Smet PA, Keller K, Hansel R, Chander RF, eds. Adverse Effects of Herbal Drugs. Berlin: Springer-Verlag; 1993. [Context Link]

94. Newall CA, Anderson LA, Phillipson JD. Herbal Medicines: A Guide for Health-Care Professionals. London: Pharmaceutical Pr; 1996. [Context Link]

95. Blumenthal M, Hall T, Rister R, Gruenwald J, Riggins C, eds. Klein S, Gruenwald J, Rister R, translators. Commission E Monographs. Austin, TX: American Botanical Council; 1996. [Context Link]

96. Wilkinson JA. The internet as a research and information tool for herbal medicine. British Journal of Phytotherapy. 1995;4:34-45. [Context Link]

97. ter Riet G, Kleijnen J, Knipschild P. Acupuncture and chronic pain: a criteria-based meta-analysis. J Clin Epidemiol. 1990;43:1191-9. [Medline Link] [Context Link]

98. Patel M, Gutzwiller F, Paccaud F, Marazzi A. A meta-analysis of acupuncture for chronic pain. Int J Epidemiol. 1989;18:900-6. [Medline Link] [Context Link]

99. Kleijnen J, ter Riet G, Knipschild P. Acupuncture and asthma: a review of controlled trials. Thorax. 1991;46:799-802. [Medline Link] [Context Link]

100. ter Riet G, Kleijnen J, Knipschild P. A meta-analysis of studies into the effect of acupuncture on addiction. Br J Gen Pract. 1990;40:379-82. [Medline Link] [Context Link]

101. Kleijnen J, Knipschild P, ter Riet G. Trials of homoeopathy [Letter]. BMJ. 1991;302:316-23. [Medline Link] [Context Link]

102. Reilly D, Taylor MA, Beattie NG, Campbell JH, McSharry C, Aitchison TC, et al. Is evidence for homoeopathy reproducible? Lancet. 1994;344:1601-6. [Fulltext Link] [Medline Link] [Context Link]

103. Bigos SJ, Bowyer OR, Braen RG, et al. Clinical Practice Guideline. Number 14. Rockville, MD: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services; 1994. [Context Link]

104. Vickers AJ. Can acupuncture have specific effects on health? A systematic review of acupuncture antiemesis trials. J R Soc Med. 1996;89:303-11. [Context Link]

105. Glock M, Friedman R, Myers P. National Institutes of Health Technology Assessment Statement. Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia. Bethesda, MD: National Institutes of Health; 1995; NIH publication no. PB96113964. [Context Link]

106. Carron H, Epstein BS, Grand B. Complications of acupuncture. JAMA. 1974;228:1552-4. [Medline Link] [Context Link]

107. Rampes H, James R. Complications of acupuncture. Acupuncture in Medicine. 1995;13:26-33. [Context Link]

108. Cheng TO. Acupuncture and acquired immunodeficiency syndrome [Letter]. Am J Med. 1989;87:489. [Medline Link] [Context Link]

109. Kent GP, Brondum J, Keenlyside RA, LaFazia LM, Scott HD. A large outbreak of acupuncture-associated hepatitis B. Am J Epidemiol. 1988;127:591-8. [Medline Link] [Context Link]

110. Slater PE. Ben-Ishai P, Leventhal A, Zahger D, Bashary A, Moses A, et al. An acupuncture-associated outbreak of hepatitis B in Jerusalem. Eur J Epidemiol. 1988;4:322-5. [Medline Link] [Context Link]

111. Stryker WS, Gunn RA, Francis DP. Outbreak of hepatitis B associated with acupuncture. J Fam Pract. 1986;22:155-8. [Medline Link] [Context Link]

112. Vittecoq D, Mettetal JF, Rouzioux C, Bach JF, Bouchon JP. Acute HIV infection after acupuncture treatments [Letter]. N Engl J Med. 1989;320:250-1. [Medline Link] [Context Link]

113. Angell M. Disease as a reflection of the psyche [Editorial]. N Engl J Med. 1985;312:1570-2. [Medline Link] [Context Link]

114. Sale JD. Overview of Legislative Developments Concerning Alternative Health Care in the United States. Kalamazoo,

MI: John E. Fetzer Institute; 1994. [Context Link]

115. Kassirer JP. Adding insult to injury. Usurping patients' prerogatives. N Engl J Med. 1983;308:898-901. [Medline Link] [Context Link]

116. Tresolini CP. Health Education and Relationship-Centered Care. San Francisco: Pew Health Professions Committee; 1994. [Context Link]

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## INTRODUCTION

The Indian Health Board, Board of Directors developed the following mission statement for the Red-Tailed Hawk Healing and Training Center.

> *"The mission statement of the Red-Tailed Hawk Healing and Training Center is to administer a health and charitable organization providing opportunities through the Medicine Wheel approach to promote physical, mental, spiritual and environmental well-being of people by offering traditional American Indian, Allopathic, and North American healing practices."*

The medicine wheel model uses the four directions of wellness; Physical, Mental, Spiritual and Environmental. No direction is any more or any less important than another. It encourages positive growth and change in all areas of life, and therefore, has the potential of being a powerful mechanism for those who seek inner peace, spiritual strength and a healthier body and mind. It incorporates the four sacred colors of all races; white, yellow, red and black. The medicine wheel model emphasizes a circular as opposed to a linear path to healing. The North, the physical sector or component, gives wise counsel to and encourages care of the physical self; the East, the environmental sector, guides you to face your greatest challenges of knowledge and self enlightenment about your connection to the web of life; the South, the spiritual sector, reminds you to trust in a higher power; the West, the mental sector, leads you to face your personal truth through honest self examination. When all four directions are in harmony, one experiences wellness, self acceptance, and love of the self, and when one or more directions are in disharmony, there is lack of wellness or illness. It is our spiritual direction that keeps us connected with all the threads of

the web; the Creator, the land, one another, and with all living things. This connection is formed through prayer, faith, work, love, and unselfish behavior.

## HEALTH CARE COST & DISEASE PATTERNS

The United States spends more for health services than any other nation in the world. The miracles brought by medical research have never been more plentiful - yet less accessible to the population at large. Partly because of high costs and poor access, the health of Americans - measured in infant mortality rates, the prevalence of addiction, and our mortality and morbidity rates for many diseases - is worse than that of citizens of many other industrialized nations.

Our health care system does a terrible job of preventing illness. A large portion of the population is out of shape, overweight, and suffering from addictions to drugs, alcohol, and cigarettes. A huge segment of the population is bored, lonely, afraid, and in need of help for emotional problems. Sexually transmitted diseases have yet to be brought under control. One reason we have such a costly health care system is, it offers little if any emphasis on preventive medicine. Relatively little money is spent on preventive medical services. Health insurers give limited counseling or health education services to promote patient self care and discipline.

The American Indian traditional health model is a system that improves the quality of life. It represents an alternative approach to daily living, and stresses the teaching of the values that will improve the future for the community. The American Indian traditional model includes promotion of wellness, self care and discipline. These practices if implemented in Indian

country and adopted by Indian people could save millions of dollars spent on health care. These savings would then in turn help to stop the rationing of health care to Indian people. This comprehensive approach of combining allopathic and complimentary medicine can create a beneficial cycle in which both lives and dollars are saved.

## RENEWAL OF AMERICAN INDIAN/ALASKA NATIVE HEALING PRACTICES

When Europeans arrived in North America, they encountered an estimated 10 million native inhabitants who enjoyed excellent health. Exposure to disease and ecological changes introduced by European explorers took a heavy toll on the native inhabitants -- now known as American Indian/Alaskan Natives (AI/AN). Today there are approximately two million AI/AN that live on reservations, rural areas, cities, and villages, throughout the United States. Although, there are more than 500 Indian tribes; each has its own cultural beliefs, values, and traditional practices.

The AI/AN traditional values, beliefs and healing practices have long been respected by many Indian Health professionals as major influences on the health of the AI/AN. As stated in the Indian Health Service, Comprehensive Health Care Program for American Indian and Alaska Natives,

> *"The traditional beliefs of American Indian/Alaska Native people regarding wellness, sickness and treatment are very different from the medical model or public health approach used in training health care providers today. The beliefs, traditions and customs handed down through many generations played the principal role in the establishment of individual and collective AI/AN identity. The effectiveness of any health care approach is greatly affected by the inherent beliefs of the patient."*

Health seems interwoven with an individual's perception of their quality of life. Often dissatisfaction with self, family and work prevents a "cure" or improvement in health from ever happening. It is this disharmony, or being "out of balance" that often results in poor health. Many individuals are unhappy about their lives and need a huge amount of psychological and spiritual nourishment before a lasting medical cure can be hoped for.

People need more in their lives than medication. Health is based on happiness, finding joy in self, family and friends, satisfaction in work and ecstasy in nature. Health of an individual can not be separated from the family, community or society. The Traditional Health program helps people rebuild their lives, and re-establish love of self and others.

Traditional AI/AN healing practices start with an individual willing to face and address their own issues by "cleaning their own house". These practices help people to learn methods and techniques to discard any negative attitudes, fears and imposed limitations that hold an individual back. The learned techniques and adopted philosophy help people to appreciate the miracles of life and to enjoy the world's many treasures and be thankful for them. One begins to sense the belonging and relationship to humanity and all living creatures.

## THE TRADITIONAL HEALTH PROGRAM

The traditional health center will be much more then a simple medical center, the center will be a microcosm of life. The center will integrate AI/AN healing practices with allopathic medicine that include; healing ceremonies, direct medical care, chiropractic and acupuncture, dental care, and counseling

services. Other components will emphasize self care, health education, family well being, counseling, friendship, community health, arts and crafts, performing arts, recreation, farming and nature.

The staff in the traditional health center are identified professionals that already ascribe to this holistic way of life. They will teach others to participate in the following ceremonies, which will serve as the pivotal activities of the healing center.

**CLEANSING CEREMONY**; As we burn sage, sweetgrass, or cedar, we draw the smoke to ourselves for the purification and blessing of our spirit, mind, heart and body. Breath is a sign of the Spirit of Life within us. Taking the smoke towards our breath, we ask the Creator to purify and bless our spirit, our life. Taking the smoke towards our mind we ask that we might think good thoughts and use our intelligence for the good of the community. Taking the smoke over our hearts we purify and bless ourselves, so that we might work to develop such positive feelings as generosity, love, kindness, and forgiveness, rather than negative destructive feelings. Finally, we wash our whole being in the smoke so that we might be saturated in blessing to live fully as the Creator meant us to live.

**SACRED PIPE CEREMONY**; The sacred pipe was given for the life and health of the people. With the sacred pipe, we give thanks to the Creator for having made us in a fourfold relationship - to the Creator, to ourselves, to one another and to all creation. The sacred pipe is made of

pipestone representing the Earth. The stem, made of wood, represents all plant life and is often decorated with hide, feathers or beadwork to represent all other created beings. The ceremony interweaves all elements of which we are made; earth (bowl), fire (lighted tobacco), air (as we draw it through the stem) and water (moisture forming in the stem when the hot air condenses as it cools). Tobacco and prayers are offered in seven directions - upward towards our Creator/Sky, downward toward the Earth, then in the four directions and finally inward to the spirit who dwells within us. The Sacred Pipe binds us to all our relations, our Creator, our ancestors, our family, all people of the Earth and all creation. We treat the Sacred Pipe in a sacred manner because of what it is intended to do for us.

**SWEAT LODGE CEREMONY**; The sweat lodge ceremony cleanses our spirit, mind, heart, and body to make us perceptive and pure for Spirit/healing ceremonies, vision quests and the rigors of everyday life. Sweat lodge ceremonies are held for various reasons; healing, purification, blessing or preparation for some other sacred ceremony. The ritual itself prepares us to be open to deeper realities of life and the mystical aspects of contemplative prayer. The term "sweat lodge" seems self explanatory; one literally sweats inside a lodge specifically constructed for that purpose. The dome shaped structure, made of bent white willow tied together with twine, represents the womb of "Mother Earth". The frame is covered with canvas tarps or blankets, and a pit is

dug in the center. Outside the lodge is a firepit in which rocks are heated prior to the sweat. These heated rocks represent the spirits who will enter the lodge to hear the supplicant's prayers. A keeper of the lodge, who conducts the ceremony, gathers the participants within the darkened interior to experience spiritual and physical purification, and healing generated by pouring water over the heated rocks that have been placed in the center pit during the ceremony. The darkness and the intense heat of the steam opens the participants to a deep sense of relatedness with our Creator, with the others in the lodge, with Mother Earth and with all of creation. In a way, the whole universe opens up to us in a form of contemplative prayers. The Sacred Pipe Ceremony is included with the sweat. When the sweat lodge ceremony is completed the participants return with renewed vigor to a feast and the continued experience of life.

**HEALING CEREMONY**; The healing ceremony is a ceremony of faith. The medicine people are an added dimension of faith wherein they share with the patient the belief that the patient can and will be healed. Medicine people/interpreters are channels that have been selected by the Spiritual Beings to interpret information from the spirit world to those participating in healing ceremonies. Often the Interpreter may not understand the significance of the message but the patient will understand the message. This knowledge helps those trained in the traditional ways of healing. The patients increase their faith and believe that through this ceremony they will be healed. The fear and anxiety the

patient may experience can be incapacitating and can make it very difficult for the patient to help clear and have a positive mind. The healer is not so burdened and is able to supply clarity, calmness and hope. As the healer works on the patient, the power flows through him or her to the patient. The patients fear and anxiety subsides. The patients attention turns away from pain and fear toward optimism and motivation. The healer helps the patient understand that as soon as an illness invades the body, the mind, body, and spirit join together to fight it and overcome it. The patient is turned away from negative thoughts and gradually, but firmly turned toward a state of mind wherein the patient is assured that healing is going on. Supplemental treatment with herbs, roots, therapeutic touch, and prayer may continue for weeks or months. As far as the healer and patient are concerned the main job is done through the ceremony process.

It is vital to recognize that the balance of mind, body and spirit are an integral part of healing, as well as part of the general welfare of the person. When each of the three aspects of the person receives the care it deserves, the three work in concert to root out and disperse the causes and complications of the illness. Proper care of the mind, body, and spirit includes such interrelated elements as proper nutrition, exercise, personal dignity, honor, shared responsibility, participation in ceremonies and abstinence from drugs and alcohol.

Balance is a truly comprehensive term in the healing practices of Native Americans. There is a need to achieve balance between mind and body; balance between the spiritual and physical aspects; balance in the scope and of pace secular activities; as well as in ritual performance. The healing ceremony is interdependent on the cleansing ceremony, sacred pipe ceremony, and sweat lodge ceremony. The interrelationship of these ceremonies is an example of the inter connection and balance of the individual and all creation.

**THE VISION QUEST**; The Vision Quest is an extremely important ritual. It is a time to look at yourself and get to know yourself. In ancient times young men underwent this experience, in some instances at an age as young as eleven. Adult males quested when they were in need of spirit helpers to assure their success in war, raiding and leadership. Some women vision quested too, but not as many as men. Medicine persons depend heavily upon the quests and frequently accompany and guide other questors.

Many places are used for the vision quest, but Bear Butte seems to be the most frequently used in the northern plains. In ancient times, any isolated and rugged site that would stimulate spiritual thoughts served as an acceptable questing place. After counseling by the medicine person and undergoing purification in a sweat lodge, the questor goes with a medicine person and his helpers to a questing place. There he/she will

spend as many as four days and nights fasting and praying as they seek a vision from the Above Beings and the spirits.

The questor is placed in a natural alter, an area four to six feet wide by seven to eight feet long. This cleared rectangle is surrounded by the trees or brush. The six cloth flags are placed in the representative directions, around the altar, and the 606 tobacco ties are laid around the outside perimeter to lock the person in his/her altar. The 606 tobacco (prayer) ties are made from colored fabric representing the six directions, these colors are black, red, yellow, white, green = grandmother earth, and blue = grandfather sky. One hundred and one prayer ties for each color are then tied to a continuous length of string. Inside the altar, tobacco is placed in the center and at each of the four corners. A bed of sage is then laid over the tobacco within the altar area.

The questor then sets up the interior of the alter as prescribed by their personal interpreter. Questors are allowed to take blankets, a star quilt and a pendleton, to protect against the cold possibly stormy nights. The wood bowl containing the food offerings is placed at the pipe rack, this rack is made of choke cherry sticks. A waluta, is a special prayer flag, made out of red felt, filled with tobacco, that has an eagle feather, abalony shell, and medicine wheel attached to it. This is hung on the pipe rack, along with 75 red tobacco ties, while 3 black ties are kept by the individual for protection. During the waking hours, the questor either stands and follows the path of the Sun as he/she prays, or they sit facing

east and meditate. Visions do not always come, but once one has been received, the questor returns to camp and consults with the medicine person. If a questor receives an object, such as a rock, it would be obtained and placed in his/her medicine bundle. This act assures the person that the power of vision would enter into them, and there after remain with them to remind, protect and guide them.

The questor must prepare for one year prior to their questing. Attending the sweat lodge on a weekly basis, making prayer ties and fasting are all the ways one must prepare for a vision quest. If the questor is not prepared there are signs, like the tobacco ties tangling or a snake appearing on the path as the questor is taken to their vision quest site.

The questor is instructed to watch for signs to stay or when to come down from the mountain. If the questor sees an eagle in the morning the questor stays another day and night. If the questor sees a four legged then it is time to come down and return to a feast. Vision Quest is a time to reflect on your life and who you are as a person.

**FEAST:** Food plays a major role in all of the ceremonies. Food is part of the ritual, its a signal of completion of the ceremony. Each ceremony has a feast that is prepared by the women. Women prepare the food because they are the givers of life and provide the nourishment for life to continue. This is an opportunity to teach proper nutrition and the

importance of a proper diet. Food is important in all the American Indian rituals.

## ALLOPATHIC MEDICINE

The type of allopathic medical care provided at the Red-Tailed Hawk Healing and Training Center is based upon the acceptance of Traditional Health practices. Patients of the center will frequently seek a traditional healer for healing services after they have been diagnosed with a serious illness or a life threatening disease.

The patient will participate in an extended two to four hour interview as part of a complete medical and social history and physical exam. This interview will lay a foundation for openness and an all important friendship with the provider. The patient and provider will fully explore the patients reasons for coming to the Red-Tailed Hawk Healing and Training Center and what they hope to gain from the visit. The patient will be asked about all areas of stress in their life: family, work, and personal. The provider will discuss which tests and studies need to be done and will outline a treatment plan.

There will be three entry points into the system of health care plans available to patients. The first scenario involves the referral of a patient to a RTHHTC provider. The provider will receive a copy of the patients medical record to review past care and to assess the health care the individual is to receive. The provider would then make a recommendation on the types of health care services available to the patient at the RTHHTC. The patient would then be returned to their primary care provider. The second entry point would

involve the provider, providing care to the seriously ill patient and developing a comprehensive treatment plan, and working with the individual to manage their illness. The third point would involve the provider serving as a primary care provider. The second and third points would involve the provider, providing in patient hospital care.

The clinic will develop a prevention program that will focus on the leading causes of mortality; alcohol/drugs, diabetes, cancer, heart/hypertension, violence, and kidney failure etc.. This will be done through delivery of comprehensive primary health care services including Radiological services.

## DENTAL CARE

Dental Care is essential for good health care and plays a vital role in keeping individuals healthy. The Red-Tailed Hawk Healing and Training Center will offer dental services that include examination, diagnosis, and treatment planning; nutritional counseling to control carries, instruction in plaque control methods; periodontal scaling and mechanical polishing; operative dentistry; endodontics; fixed and removable prosthodontics. Preventive dental health care will a the Red-Tailed Hawk Healing and Training Center focus.

Due to the promotion of personal growth and self-care, there will also be a commitment to restoration services as noted in the provision of endodontic services and prosthodontics. Currently, poor dental health is common among children and adults throughout "Indian Country". This is due primarily to limited access to dental services and the lack of financial resources. Poor dental health

can lead to many other health problems through poor nutrition and the lowering of self - esteem.

It will be a positive indicator of both increasing health and rising self-esteem to see an increase in the request for dental services.

## CHIROPRACTIC AND ACUPUNCTURE SERVICES

Chiropractic and Acupuncture providers normally do not practice with an allopathic practice. People are so unique, and diseases so multi-factoral that we need hundreds of approaches in order to find the right ones and to keep the patient's hope alive. Since there are miracles in all healing techniques we are proposing to have a facility in which all providers can work together.

Chiropractic services will consist of an orthopedic test, a neurological test, a blood pressure test, a spinal alignment check, an examination for restricted or excess motion in the spine, a test for muscle strength and a private consultation with the doctor to discuss the results. Gentle effective relief will be provided for lower back pain, headaches, shoulder pain, arm pain, arthritis, dizziness, sore elbows, neck pain, indigestion, numb hands, joint pain, bursitis, pain down the legs, muscle spasms, numb fingers, hip pain, tight muscles, aching feet, and tension. Herbs and acupuncture will also be offered for healing as an alternative to prescription drugs.

## COUNSELING SERVICES

The Counseling and Support part of the clinic will use the medicine wheel approach to guide individuals who seek spiritual, emotional, psychological, and

physical growth or improvement. The following description of the Medicine Wheel is based upon the Ojibway cosmology.

The Western quadrant represents the sunset. This is the direction from which storms come, and is represented by the color black. The west has elements of both completion and transformation within its realm. The realm within which we must begin to look inside ourselves and be honest with what we see or find.

The Northern quadrant represents the physical realm of the world (white). In the north, snow falls heavy each year. The earth sleeps under a blanket of snow, but when spring comes the earth is reborn. The north will be a time of rebirth for an individual. A time for an individual to invest in self care and stop abusing their body. It is the point where they start to put balance in their life.

The Eastern quadrant represents the morning direction (yellow). It is the beginning of a new day, new light and new thought. The east is the realm where we expand our views, learn new ways, and rediscover forgotten yesterdays in living.

The Southern quadrant is thought of as visions of warmth, comfort, and closeness to the earth (red). The south is the realm of existence where we make a connection with a spiritual power greater then ourselves. It represents the direction of the spirit world to which one day all of us will return. It is our eternal home. Chaos is the genesis of this personal transformation which is the spiral of life. The cycle does not end until we go home.

To walk the steps of the medicine wheel is to follow a path that will lead us in the direction of becoming fully human. Within the positive way of living provided by the medicine wheel we can, and will come to understand the many facets of our existence. Our emotions, need for humor, desires, sexuality, prejudices, preferences, spiritual selves, limitations and potential, all can be experiences processed and understood within the balances of living the entire human path.

The medicine wheel approach to counseling will provide the tools and necessary steps to keep people on the whole human path. With its strong emphasis on balance, harmony, centeredness, and freedom, the medicine wheel becomes a road to self discovery. It is a model for the maintenance of mind, body, and spirit in a state of wellness. It is in seeking this state of well being that we will be able to begin the process of setting aside our unsubstantiated fears, abandoning our rigid judgmental attitudes and opening ourselves to total learning.

## CREDENTIALING AND CODE OF ETHICS

The Red-Tailed Hawk Healing and Training Center will develop a program to credential healers and individuals that possess an intelligence property on the knowledge of the medicine wheel approach to healing, or individuals that have knowledge about the traditional ways to heal oneself.

The credentialing of the healers will be a means of assuring patients and organizations using the services that ethical standards will be followed. The credentialing serves as a means of identifying "peer-recognized" healers

accepted by their teachers and colleagues. Furthermore, many traditional healers have been tarnished by the activities of a few who have exploited their gifts for money, or power, or sexual favors. In preliminary discussions with recognized healers, two concerns keep coming up, they are, monetary payment to healers and ethics.

We, as Indian people and those that practice the traditional ways, must recognize and accept that healers are no longer taken care of by their tribal communities. These practitioners do not usually hold regular full-time employment due to the demands on their time to perform healing ceremonies for the sick and troubled. This does not lessen the needs of the healer and his/her entire family. They still need to meet the demands of every day life such as food, clothing, and shelter. The RTHHTC will provide uniform and standard compensation deemed appropriate by a cadre of recognized healers/interpreters. Another facet of these meetings with the healers is the development of a Code of Ethics.

Similar to the professional standards and ethics which govern the professional behavior of others associated with the RTHHTC, a code of ethics will be developed in tandem with the healers, for the healers themselves. Documents which serve counselors and other religious workers will form the basis for this Code of Ethics. Like other healing professions the ethical foundation will address the need to "do no harm" to the patient or their family. Financial or sexual exploitation will also be addressed in this document. Once accepted by the interpreters, this document will serve as part of the written

agreement/contract all Traditional Health consultants will sign when working with the RTHHTC. These documents will be developed and presented to the medicine people/healers/interpreters at regional conferences.

## RESERVATION CONNECTIONS

On the Red Lake Indian Reservation and other Indian reservations across this country, violence, alcohol and drugs are killing American Indian people. The young people have taken Indian communities hostage through their violent behavior and acts of terror while under the influence of alcohol and drugs. Alcohol and drugs have had a major impact on Indian people for generations. In some Indian communities, the alcoholic culture dominates communities, and Indian people fear their own American Indian culture and rituals.

The land, religion, language, and culture were taken from Indian people. Indian people have lost so much that one wonders if the population is grieving or if the grieving process has stopped in the denial state. Denial is what prevents people from feeling pain or looking at a difficult situation. Denial fosters the growth of illnesses and problems. Grief and loss are also issues for individual Indian people; loss of childhood, loss of parent or parents, loss of identity, loss of self-worth, and loss of physical and mental health. If Indian people are still grieving, personally or as a nation, this will interfere with their growth, development and recovery process. To recover, Indian people must admit the losses have taken place, accept the loss, and realize they are powerless to change anyone else except themselves. They must remove the blocks to the natural grieving process. This is an extremely painful process, but if done

correctly can empower an individual and help them move forward in the growth process.

American Indians must be taught as youths to grieve their losses and replace the losses with high self esteem. To accomplish this Indian people need to be taught to be proud of their heritage and themselves as individuals. They need to look at their own values and accept them as a way of life. Indian people must regain their identity to heal.

Where did Chippewa Indian people get their values? Through the Midewiwin Society, which is a secret society that requires an invitation to attend the ceremonies.

The ethics of the Midewiwin are simple yet sound. They teach that rectitude "integrity and morals" of conduct produces long and happy life, and that evil inevitably reacts on the offender. Simply put "what goes around comes back around." Membership in the Midewiwin does not exempt a man from the consequences of his sins. Respect toward the Midewiwin is emphasized, and respect toward women is enjoined upon the men. (Densmore, pg. 60) Lying, stealing, and the use of liquor/drugs are strictly forbidden. The Midewiwin is not without its means of punishing offenders. Those holding high degrees in the Midewiwin are familiar with the use of subtle poisons which may be used if necessary. The men were taught to be moderate in speech and quiet in manner, and not hasty in action. The right of initiation is supposed to inject a certain "spirit power" into the candidate who is expected to "renew his spirit power" by attending the annual ceremony of the society.

The Midewiwin society teachings are sound and ethical but they are not available to all people. The Red-Tailed Hawk Healing and Training Center will teach individuals on the Red Lake Reservation the universal Indian rituals.

The rituals of the cleansing ceremony, sacred pipe ceremony, sweat lodge ceremony, and the healing ceremony along with feasts and give-a-ways will be part of the activities re-introduced on the reservation. The language will be part of a curriculum that is developed to enhance this project.

In addition to cultural activities the program will be designed to help the participants understand the personal impact of living with addiction and dysfunctional behavior. Understanding leads to feelings. Expression of these feelings leads to healing, forgiveness and behavioral change. Children of alcoholics are resilient people and can become the most productive and balanced individuals. If children of alcoholics are left untreated, they will continue the cycles of alcoholism, eating disorders, workaholism, marriage to alcoholics, divorce, debt, drug misuse, gambling, parenting problems, battering, incest, frequent sickness and depression. In the workplace, their performance symptoms include poor output, lower quality, difficulty following instructions, memory difficulties and lateness. In each of these cases an addictive approach to life and living is in place. Therefore, the focus in treatment and recovery needs to be on growing beyond addictive life patterns. If this is not accomplished, the addicted person runs the risk of simply moving from one addiction to another with very little real change in his or her approach to living.

The medicine wheel model will encourage positive growth and change in all areas of life. To accomplish these things, and to better serve both the reservation and urban communities, the Red-Tailed Hawk Healing and Training Center will focus on maintaining and strengthening the networks between these communities. Beginning with these outreach programs and initiating and facilitating patient healer contracts, and hopefully culminating with the establishment of branch clinics on any reservation that requests one. The link of communities and resources will be greatly strengthened and the quality of life for both the reservation and urban communities will increase. The branch proposed for the Red Lake reservation will act as a trailblazer for these programs.

## OTHER RESERVATION CONNECTIONS

The Red-Tailed Hawk Healing and Training Center will provide support to the Veterans Sun Dance located on the Pine Ridge Reservation. This Sun Dance involves American Indian Veterans from all the tribes that have been involved with armed forces defending this country. By supporting this Sun Dance, not only are many Veterans and their families helped, but again, the connections between the urban community and the reservation community of Pine Ridge are strengthened. Hopefully, as these connections are fostered and grown, a branch clinic similar to the one on the Red Lake reservation will develop. At the least, the maintenance of the links between communities and resources will continue to raise the standard of living in both communities.

**THE SUN DANCE**; The Sun Dance is a rite of rebirth, renewal, procreation and thanksgiving. While it is held in the summer, plans for

each year's event are begun in the spring - at the same time Mother Earth is preparing to give birth and nourishment to the new growth and to life as a whole.

The Sun Dance is held in a large open circle whose perimeter is marked by a shaded arbor for spectators. At the center of this circle there is a tall, sacred, cottonwood Sun Dance Tree set up. While, the site is selected early in the year, the feeding and blessing of the grounds takes place in the spring. The actual ceremony is held for four days in the summer, with another four days of concentrated preparation preceding it.

On the third or fourth day of the Sun Dance each of the men called "pledgers" is pierced by having two wooden pegs (or sometimes eagle claws) inserted under their skin. These pegs are then attached to a strong rope and the other end is tied to the Sun Dance Tree. Then the men form a circle around the tree and after going forward four times to place their hands on the tree to pray, they pull back as hard as they are able until the pegs are at last torn free. An alternate method is to have two of the pegs inserted under the skin of the back at shoulder blade height. Heavy buffalo skulls are then hung by throngs until their weight tears the pegs loose as the Sun dancer pulls the skulls around the interior of the Sun Dance arena.

The entire dance is made up of requests, acknowledgments and thanksgivings. Each segment of the dance addresses itself to one or another of these.

Rebirth is considered and treated as the dancers, dance barefooted to unite with Mother Earth as she gave new birth to all nature: soil, vegetation, rivers, streams, fish, the bird and animal worlds. Since the dancers are barefooted, there is no barrier to keep Mother Earth from imparting rebirth power to them. The dancer's wear ankle bracelets and a crown of sage, a sacred plant, that keeps evil spirits from entering them and affecting the power of the dance. The drumming and singing that is performed at the dance is Mother Earth's voice, sending to the people her words of encouragement, approval and love through the singers. The tree having been ritually cut down for the occasion, represents a transition period. Since, the tree died it signifies death of the old, and after the four days of the Sun Dance ritual are completed, it is time for rebirth and renewal - a new year.

Power and assistance are also called in from the four cardinal directions. The position of each direction for the Sun Dance are marked by pairs of flags placed at the perimeter of the arena: red for the north, yellow for the east, white for the south and black for the west, the arrangement of colors differ from the Ojibway, because they are based on Lakota Cosmology. The sun also imparts a healing power to the dancers and at least one day during the dance, healings are performed for all of the spectators who request it.

Individual and group prayers during the dance take place in several ways. The first is through songs sung by the singers who

accompany the dancers. The second is the blowing of whistles made from the wing bone of the golden eagle. The third is by the use of each dancer's sacred pipe. The fourth means is through the person who leads the dance to offer up prayers at specified intervals. The fifth means is by individuals attaching pray flags, long strips of cloth filled with tobacco, to the tree.

Procreation is considered and acknowledged by attaching two symbols to the leafed boughs of the tree top. Not always, but in most instances, these symbols have large phallic appendages to represent procreation. One is of a man and it is painted red or black. The other is of a buffalo or bird, representing thunder and is painted black.

As the dancers and the accompanying musicians center their minds and prayers upon symbols, they think through and sing about matters associated with the continuation of life, especially about how the Above Beings blessed humankind and how they provide everything in season that is needed. In addition to the symbols, an alter is placed at the west end of the dancing circle. This alter includes a painted buffalo skull placed on a bed of sacred sage, two black flags and a pipe rack to hold the dancers sacred pipes when they are not in use.

In preparation for the Sun Dance, the medicine man, his assistants, and the pledges, gather in sweat lodges to purify themselves and to pray for the Creator's blessings. Once the dance is underway, a pre-sunrise

purification ritual is held each day in the sweat lodge that is set up to the west of the Sun Dance circle.

Food is prepared for the elders, children and helpers at the Sun Dance by the women.

The Lakota people view the Sun Dance as the Universe. It represents change, birth, life, learning, and death. It is a way of life for the people and the ultimate healing ceremony so the Indian people will survive.

## TRAINING

The first thing patients and students will be taught is to have a genuine, compassionate, loving and joyous feeling for themselves. The greatest gift a patient/student can take to a healing interaction is their own progress toward a multifaceted, healthy lifestyle. As early as possible, the patient/student will be advised to choose wellness; celebrate the miracle of life every single day, search within for what they believe unconditionally, develop as many deep friendships as possible, cultivate their sense of play and creativity, exercise regularly and eat the healthiest food they can. Often, switching to and maintaining healthy living practices will be enough to prevent many illnesses and mitigate those that do occur. Through the resurrection of cultural principles and practices of living, the Red-Tailed Hawk Healing and Training Center will create a wellness program model which can be adopted by all Indian communities and nations. **Adoption of the model will also accomplish preservation of American Indian culture as interpreted at the tribal and urban community**

**level to pass onto future generations.** The model will include healers in all phases of health care as well as the following activities;

I. Self-Care/Health Education:
- Patient will receive education to promote awareness of self-care and self-importance;
- Patient will be treated as a human being, not a disease or body part;
- Patient will receive training on traditional rituals for men, women, and children;
- Patient will receive nutritional counseling appropriate for prevention or management of chronic illness risks.

II. Family:
- Teach the importance of family;
- Teach that health and well-being are linked to family, family is first circle of support;
- Teach how to find joy in family, how to work through periods of family disruption, and correct patterns of family dysfunction;
- Support retreats on family health issues.

III. Friendship:
- Address feelings of loneliness and isolation in society; both urban and reservation settings;
- Participating in Traditional Health ceremonies helps identify and develop social support network. Sweat lodge, ceremonies, and feasts
- Create a social support network through participation in rituals as the starting point for other activities needed by the community.

IV. Community Health Issues:
- Provide positive social interaction, traditional practices as methods for resolution of social problems;
- Hold 4 season community feasts - a way to say thank-you
- Sponsor Pow-Wows ~ Indian community marketing; exercise program.

V. Arts/Crafts:
- Teach Drum-making/Drum sticks
- Teach the Tanning Hides
- Teach how to do Bead Work
- Teach how to do Quillwork
- Teach how to make Pow-Wow Dance Outfits
- Teach how to make Ritual Outfits e.g. Sun dance skirts
- Teach how to make Moccasins
- Teach how to make Pipes (carving stems and bowls)
- Teach how to make Pipebags

VI. Performing Arts:

- Teach Songs; Ceremonial and Pow-Wow;
- Teach the Role of singers and songs in ceremonies;
- Teach the Role of drummers and proper drum beat in ceremonies;
- Teach all forms of Native American dancing;
- Teach story telling techniques as a way to teach values and consequences to all.

VII. Recreation and Exercise:

The goal of this section is to teach others of all ages how to have fun and enjoy life through the adoption of activities which promote balance and harmony in one's life by making time for recreation and exercise on an individual and family/group basis.

- Pow-Wows;
- All forms of sports and opportunities to exercise while enjoying nature. i.e.; walks in the forest, along the river or the ocean;
- Increase opportunities for joy and laughter in our daily lives - daily laughter is viewed as a life affirming activity which improves health and recuperation from illness;
- Group recreation/exercise increases opportunities for development of social support network and decreases personal isolation.

VIII. Farming/Resource Conservation:

This section addresses the need to restore or renew traditional healing or sacred plants/animals that are close to extinction because people have not replenished the supply, teach appropriate harvesting techniques:

- Red Willow - principle component of traditional "tobacco"
- Sage
- Sweetgrass
- Choke Cherry Trees
- Ginseng (indigenous) - other healing herbs
- Cottonwood Trees
- Flat Cedar
- Buffalo Ranching

IX. Nature:

- Develop Respect for nature - learning the beauty in all aspects of life among plants and animals;
- Teach how to observe life lessons in nature;
- Learn healing properties of spending time in nature - of each element of nature;
- Teach means of survival in nature through harvesting traditional foods, such as ;
    - Berries
    - Wild Rice

- Hunting wild game
  - Wild game preparation
  - Fishing
  - Trapping
  - Maple syrup preparation
- Teach individuals how to harvest sage, sweet grass, etc. so they do not become extinct.

X. Indian Library/Museum
- Document Indian History
- Resource of Indian Culture
- Teach individuals to read/write (studies show that violence can be the result of an individual not being able to read or write)
- Assess level of adolescent and adult literacy then sponsor activities which will promote and enhance literacy.

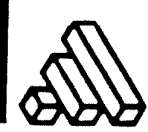
The concept of treating the whole person, and of perceiving people as more than their disease, implies a huge amount of psychological and spiritual work. That is why the Red-Tailed Hawk Healing and Training Center integrates healing with nature, agriculture, recreation, performing arts, arts and crafts, friendships, self care/health education, and believes in strengthening, the individual, and the family to bring about a better community.

For this model to work in Indian communities, the staff will need to be trained using this philosophy. The individuals employed by these projects will ascribe to this way of life. There already is a core group of professionals that follow this path and wish to join the RTHHTC. Each organization will have to build their internal community first before they reach out to the larger community. This has to be more than a pay check, it has to be a way of life. Employees will serve as role models.

These Traditional Health practices in use today are considered by western medicine to be new and innovative alternative or complimentary

treatments. As Indians, we know that traditional methods are time proven, successful, and come with centuries of practice. Traditional Indian healing has always been recognized by the tribes. Recently, Indian Health Service leadership is exploring the role of Traditional Health practices within the IHS service units, Tribal "638" clinics and urban Indian health settings. However, Traditional Health is a way of life that can improve the quality of life through the prevention and delayed onset of many serious diseases and behavior patterns which result in the leading causes of Indian mortality, and the high cost of health care.

**The Associated Architects**



241 South Cleveland Avenue
Saint Paul, Minnesota 55105
Telephone 612/698-0808

## Memorandum

Re: RTHHTC - Project Scope, Budget Estimate

Project No: 1606.00

Date: January 3, 1997

From: Jim Cox, The Associated Architects

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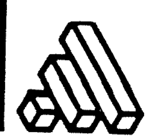
| | | | |
|---|---|---|---|
| A. | Project Summary | | |
| | 1. Main Building (25190 s.f. @ $100) | | $ 2,519,000 |
| | 2. Garage/Storage Facility (2000 s.f. @ $50) | | $ 100,000 |
| | 3. Short Term Living (3580 s.f. @ $70) | | $ 250,600 |
| | 4. Changing House | | $ 5,000 |
| | 5. Boat House | | $ 5,000 |
| | 6. Garden Shed | | $ 5,000 |
| | 7. Pow-Wow Area (site development) | | $ 20,000 |
| | | Budget Estimate | $ 2,904,600 |
| B. | Additional Budget Items | | |
| | 1. Land Cost | | $ 200,000 |
| | 2. Site Development Costs<br>• Sewer<br>• Water<br>• Road System<br>• Selective Clearing | | $ 100,000 |
| | 3. Furniture & Equipment | | $ 250,000 |
| | | | $ 550,000 |
| C. | Architectural/Engineering Fee | | |
| | 1. Site Analysis | | $ 10,000 |
| | 2. Programming (space plan layouts) | | $ 10,000 |
| | 3. Initial Building Design (concept) | | $ 21,800 |
| | 4. Current Building Design 8% | | $ 201,520 |
| | 5. Garage/Storage Facility | | $ 4,000 |
| | 6. Indirect Costs<br>printing, xerox, courier, mileage... | | $ 26,000 |
| | 7. Furniture & Equipment<br>assume $250,000 x 6% | | $ 15,000 |
| | | Total | $ 288,320 |
| | | **Total Project Budget Estimate** | $ 3,742,920 |
| | | **Project Contingency 10%** | $ 374,292 |
| | | | $ 4,117,212 |

Attachments: Preliminary Program (17 December 1996)

**The Associated Architects**



241 South Cleveland Avenue
Saint Paul, Minnesota 55105
Telephone 612/698-0808

## Memorandum

Re: RTHHTC - North
Red Lake, MN

Project No: 1606.01

Date: January 3, 1997

From: Jim Cox, The Associated Architects

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A. Project Summary

| | | | |
|---|---|---|---|
| 1. | Quonset Hut Structure (50x100 = 5,000 s.f. @ $30)<br>Remodel add entry | $ | 150,000 |
| 2. | Changing House | $ | 5,000 |
| 3. | Site Costs:<br>• Sewer<br>• Water | $ | 20,000 |
| | Budget Estimate | $ | 175,000 |
| | Estimate A/E Fees | $ | 14,000 |
| | Indirect Costs | $ | 1,500 |
| | Total | $ | 15,500 |
| | **Total Budget** | **$** | **190,500** |

17 December 1996

# RED-TAILED HAWK HEALING & TRAINING CENTER
# THE VERNON WECKWORTH BUILDING

## The Associated Architects
## St. Paul, MN
## Project No. 1606.00

## PRELIMINARY PROGRAM

Area Needs:

| | sq. ft. |
|---|---|
| **Administration (13 FTE)** | |
| • Entry | 70 |
| • Waiting | 100 |
| • Reception | 70 |
| • Executive Director | 180 |
| • Offices (8) @ 120 sq. ft. | 960 |
| • Marketing/Editor | 120 |
| • Toilets - Men, Women | 120 |
| • Training/Workshop/Meeting Room (30-60 people) | 900 |
| • Copy Center/Storage | 170 |
| • General Use Offices (3) @ 120 sq. ft. | 360 |
| • Wall/Circulation | 350 |
| | 3,400 |
| **Ceremony (Soundproof, Dual Use as Workshop Facility)** | |
| • Dining (30-60 People) & Exterior Balcony/Lobby | 2,600 |
| • Ceremony (30-60 People) | 1,260 |
| • General Storage | 300 |
| • Meeting 1 (Soundproof) | 90 |
| • Meeting 2 (Soundproof) | 90 |
| • Kitchen (Commercial NSF)/Pantry | 350 |
| • Storage | 150 |
| • Men's Restroom | 200 |
| • Women's Restroom | 200 |
| • Mechanical/Electrical | 250 |
| • Walls/Circulation | 500 |
| | 5,990 |
| **Group Counseling (10 FTE)** | |
| • Classroom 1 (10-15 People) | 320 |
| • Classroom 2 (10-15 People) | 300 |
| • Classroom 3 (3-4 People) | 180 |
| • Classroom 4 (3-4 People) | 140 |
| • Classroom 5 (2-3 People) | 80 |
| • Classroom 6 (2-3 People) | 90 |
| • Office | 190 |
| • Counselor Offices (4) @ 150 sq. ft. | 600 |

| Group Counseling Cont. | sq. ft. |
|---|---|
| • General Offices (5) @ 120 sq. ft. (arts and crafts) | 600 |
| • Men's Restroom | 120 |
| • Women's Restroom | 120 |
| • Electrical/Equipment | 100 |
| • Mechanical | 360 |
| • Storage | 150 |
| • Reception/Office | 100 |
| • Coffee (Lounge) | 200 |
| • Walls/Circulation | 950 |
| | **4,600** |

| Arts and Crafts (6 FTE) | |
|---|---|
| • Library | 400 |
| • Museum | 400 |
| • Workroom | 600 |
| • Display | 200 |
| • Storage | 200 |
| • Walls/Circulation | 450 |
| | **2,250** |

| Allopathic Medicine (15 FTE) | |
|---|---|
| • Reception/Waiting | 280 |
| • Interview Rooms (2) | 200 |
| • Exam Rooms (9) | 650 |
| • Office (2) | 290 |
| • Workroom (staff) | 150 |
| • File Room/Records | 150 |
| • X-Ray Room/Lab | 200 |
| • Dark Room | 40 |
| • Storage | 100 |
| • Toilet (patient/Staff) | 120 |
| • Walls/Circulation | 420 |
| | **2,600** |

| Dental Care (5 FTE) | |
|---|---|
| • Reception/Waiting | 200 |
| • Office (shared) | 150 |
| • Operatories (4) | 400 |
| • Workroom (lab) | 50 |
| • Sterilization/Supplies | 50 |
| • Radiology - Panoramic X-Ray | 20 |
| • Dark Room | 100 |
| • Toilet | 80 |
| • Scrubbing Area | 50 |
| • Conference | 100 |
| • Storage/Compressor | 100 |
| • Walls/Circulation | 350 |
| | **1,650** |

| Chiropractic and Acupuncture Services (3 FTE) | sq. ft. |
|---|---|
| • Reception/Waiting | 200 |
| • Office | 120 |
| • Adjustment Rooms (2) @ 10x12 | 360 |
| • Acupuncture | 150 |
| • Exam, X-Ray (shared with Allopathic) | |
| • Dark Room | 100 |
| • Massage Therapy | 150 |
| • Toilets - Men, Women | 120 |
| • Walls/Circulation | 300 |
| | **1,500** |

| Joint Staff Facilities | |
|---|---|
| • Locker Room | 150 |
| • Shower | 200 |
| • Toilets | 200 |
| • Lunch Area | 200 |
| • Vending | 100 |
| • Walls/Circulation | 100 |
| | **950** |

| Exercise | |
|---|---|
| • Nautilus Area | 500 |
| • Office | 120 |
| • Locker Areas - Men, Women | 400 |
| • Shower Facilities | 200 |
| • Steam Room | 100 |
| • Storage | 100 |
| • Walls/Circulation | 330 |
| | **1,750** |

| Receiving/Mechanical/Electrical | **500** |
|---|---|

| **TOTAL AREA (Sq. Ft.)** | **25,190** |
|---|---|

| Garage/Storage Facility (Separate Building) | |
|---|---|
| • 4 Vehicles | 800 |
| • Shop | 200 |
| • Snow Plow Equipment | 300 |
| • Lawn Equipment | 200 |
| • Storage | 500 |
| | **2,000** |

**BOARD MEMBERS**

| | |
|---|---|
| Douglas Fairbanks | Signature |
| Allen Autrey | Signature |
| Lisa Bellanger | Signature |
| Erroll Brown Eyes | Signature |
| Ted Harrison | Signature |
| Sophia Monroe | Signature |
| Myrtle Monroe | Signature |
| Arif Altaf | Signature |
| Andrea Fairbanks | Signature |
| Jonas Wounded Foot | Signature |

| Additional Requirements: | sq. ft. |
|---|---|
| • Sweat Lodge | 200 |
| • Changing House | 200 |
| • Storage | |
| • Dock Structure | |
| • Boat House | |
| • Parking 126 stalls; 5 accessible stalls plus 1 van accessible stall (plus overflow parking) | |
| • Garden (Herbs) | |
| • Tool Shed | 100 |
| • Pow-wow Area | |

| Short Term Living Quarters | |
|---|---|
| • 12 Rooms with Bath 240 sq. ft. | 2,880 |
| • Common Meeting Eating Area | 400 |
| • Office/Storage/Laundry | 200 |
| • Furnace Room | 100 |
| | 3,580 |
| • Parking (15 stalls); 1 van accessible stall | |

17 December 1996

# RED-TAILED HAWK HEALING & TRAINING CENTER - NORTH

The Associated Architects
St. Paul, MN
Project No. 1606.01

## PRELIMINARY PROGRAM

Satellite Site - Red Lake, MN

sq. ft.

Existing Structure

- Entry/Reception
- Office
- Ceremony Room, Multi-Use
- Kitchen (commercial)
- Dining
- Locker/Shower Room
- Storage

New Structure

- Changing House

Form ST 17
(Rev. 8-1-74)

State of Minnesota
Department of Revenue – Sales and Use Tax Division
Centennial Office Building – St. Paul, Minnesota 55145

## CERTIFICATE OF EXEMPT STATUS – EXEMPT ORGANIZATION

Under the provisions of Section 25, Subdivision 1 (p) of the Minnesota Sales and Use Tax Law, the organization whose name appears below is certified to be exempt from sales and use taxes applicable to purchases, rentals and leases of tangible personal property to be used solely and exclusively in the performance of charitable, religious or educational functions by that organization.

Indian Health Board of Minneapolis, Inc.
1315 E. 24th Street
Minneapolis, Minnesota 55404

Certificate No.
ES 26074

Date Issued May 16, 1975

Date Reissued: November 4, 1976

ARTHUR C. ROEMER, Commissioner of Revenue

By [signature]
D. S. MUNDAHL, Director
Sales and Use Tax Division

This certificate is valid until revoked by the Minnesota Department of Revenue.

The exemption does not apply to purchases of meals, lodging or tickets of admission

To: IHB Board of Directors
From: Dr. Allen Autrey
RE: Resolution to Restrict Proceeds from the Lindstrom Land Sale
Date: September 30, 1996

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In 1995, the Indian Health Board developed a vision for the future operations of the clinic including a new organization to integrate traditional American Indian, allopathic, and complimentary health care services within one organization which would encompass the Medicine Wheel approach to services. One component of the vision was to obtain land for the development of a healing and training center in which traditional healing ceremonies and training seminars could be held. In July 1995, 4.5 acres of lakeshore property near Lindstrom, Minnesota was donated to Norine Smith for the Indian Health Board by Dr. Vern Weckworth. Dr. Weckworth indicated that he wanted the land to be used to support a traditional American Indian health enterprise because he recognized the merit of traditional health and the growth of spirituality in health sciences..

In the initial development of the property site, neighborhood opposition to commercial development and barriers from the Departments of Transportation and Natural Resources were discovered. In July 1996, an offer was made to purchase the land by Mr. James Swanberg, Lindstrom land developer and neighbor of the site. On September 11, 1996, Mr. Paul Smith and Lisa Bellanger, IHB board member, on behalf of the Indian Health Board of Minneapolis sold the Lindstrom land to Mr. James Swanberg for the amount of $48,300. To continue movement towards the projected vision of the board and management staff and in keeping with the wishes of the land donor, Dr. Vern Weckworth, the proceeds from the sale should be restricted to the purchase of new land to build the Redtail Hawk Healing and Training Center.

WHEREAS, the Indian Health Board was established over 25 years to improve the health of American Indians living in the Twin Cities metropolitan area; and

WHEREAS, it is now recognized that allopathic medical services are not the only approach to improve the health of American Indians; and

WHEREAS, the board and management staff of the organization created a vision of a healing and training center dedicated to the purpose of providing traditional American Indian, allopathic, and complimentary healthcare services within the Medicine Wheel approach to balanced lifestyles; and

WHEREAS, many of the leading causes of American Indian mortality and morbidity arise from behavioral practices and lifestyle; and

WHEREAS, adoption of traditional American Indian values, health practices and spirituality have been shown to improve the health of those suffering from chronic illness and other behaviorally related illnesses; and

WHEREAS, recognition and support is growing in the private sector to explore the use of traditional health practices and spirituality as a cornerstone of healing , and

WHEREAS, the land donation was made to Ms. Smith to build a traditional healing and training center for American Indian and all people of the four directions, and

WHEREAS, IHB board of directors passed a previous motion on 4/22/96 to transfer any proceeds from the sale of the Lindstrom land to be given to the new corporation for the development of the healing and training center, now

BE IT RESOLVED, that IHB will reserve the proceeds from the Lindstrom land sale of $48,300.00 for the purchase of new lands on which to build the Redtail Hawk Healing & Training Center.

BE IT FURTHER RESOLVED, that once the Redtail Hawk Healing and Training Center is incorporated as a non-profit corporation in the state of Minnesota, these assets will be transferred from IHB/COPE to the new corporation.

INDIAN HEALTH BOARD OF MINNEAPOLIS
1315 East 24th Street Minneapolis, MN 55404-3959

## RESOLUTION

**TITLE:** The need to use the Indian Health Board's 501-c-3 to start the fund raising process for the Red-Tailed Hawk Healing and Training Center.

**WHEREAS:** The Red-Tailed Hawk Healing and Training Center is a new organization that is being created by the Indian Health Board.

**WHEREAS:** The program for the Red-Tailed Hawk Healing and Training Center is developed and ready for the fund raising process.

**WHEREAS:** The legal work of incorporating the new organization has just started and will take a couple of months before the I.R.S. and State governments assign numbers. Once the organization is incorporated funds raised will be transferred to the Red-Tailed Hawk Healing and Training Center.

**WHEREAS:** The funds raised for the Red-Tailed Hawk Healing and Training Center will be used to further develop this program and the current traditional health program at the Indian Health Board.

**NOW THEREFORE BE IT RESOLVED:** that, the Red-Tailed Hawk Healing and Training Center is an expansion of a current program, Traditional Health, funded under the umbrella of the Indian Health Board.

**NOW THEREFORE BE IT RESOLVED:** that, the Indian Health Board, Board of Directors authorizes the Red-Tailed Hawk Healing and Training Center to use their 501-C-3 status to start the fund raising for the Red-Tailed Hawk Healing and Training Center.

An Equal Opportunity Employer

formation/Administration • (612) 721-9800 • Admin. Fax (612) 721-7870 • Medical (612) 721-9898 • Medical Fax (612) 721-2904

## RED-TAILED HAWK HEALING & TRAINING CENTER
## PROPOSED PROGRAM PLAN

Overarching Goal: To establish the Red-Tailed Hawk Healing & Training Center (RTHHTC) as a integrated holistic health center that promoted the health and well-being of its patients through the provision of traditional American Indian, Allopathic, and Complimentary healthcare services within the medicine wheel approach to health.

| Objectives: | Action Steps: | Progress Measures: | Comments: |
| --- | --- | --- | --- |
| 1.1 Establish new corporate infrastructure to allow RTHHTC to function as an agency independent of IHB. | 1.1a Submit draft bylaws and articles of incorporation for IHB board to review and approve by 10/30/96.<br>1.1b. Approved documents will besubmitted as part of the application for incorporation to MN atty. generals office by 1/30/97. | 1.1a Copy of approved RTHHTC bylaws and articles of incorporation will be in BOD files by 11/15/96.<br>1.1b Copy of RTHHTC proposed board roster will be listed in the articles of incorporation by 11/30/96.<br>1.1c. Receipt of provisional incorporation will be available at IHB office no later than 2/28/97. | 1.1b IHB BOD requested review by attorneys. |
| 1.2 Submit operating program plans and budget for FY97 to IHB board for review and approval. | 1.2a. Draft program plans-proposal and activity objectives will be submitted to the planning committee for review prior to submission for BOD approval by 10/30/96.<br>1.2b. Submit revised proposal budget for main activities by 11/30/96.<br>1.2c. Submit program proposal to IHS and foundations to secure program opertaing funds for RTHHTC by 1/30/97. | 1.2a. Copy of draft proposal and approved budget will be available in committee and BOD files by 11/30/96.<br>1.2b. Approved revised draft proposal with budget will be available in RTHHTC files by 12/30/96.<br>1.2c. Copies of transmittal letters will be on file to document submission of proposal by 1/30/97. | |

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| Objectives: | Action Steps: | Progress Measures: | Comments: |
|---|---|---|---|
| 2.1 Purchase new land with proceeds from Lindstrom land sale by 2/28/97. | 2.1a Identify land sites for RTHHTC by 2/28/97.<br>2.1b Obtain BOD approval to purchase site by 3/30/97.<br>2.1c Complete title search and qualifying for land purchase by 4/30/97.<br>2.1d Closing date for purchase of land will be set for 6/30/97. | 2.1a Submit to BOD a description of the proposed RTHHTC site-include tur of the land by 4/30/97.<br>2.1b RTHHTC BOD approval of site selection for purchase by 4/30/97.<br>2.1c RTHHTC BOD staff will purchase land site by 6/30/97. | |
| 2.2 Revise architectural plans to new RTHHTC site by 6/30/97. | 2.2a Revise architectural plans to meet new land specifications by 5/30/97.<br>2.2b Submit revised architectural plans to RTHHTC BOD by 6/30/97. | 2.2a Maintain copies of revised architect plans in RTHHTC files including budget projections by 6/30/97.<br>2.2b Submit plans to capital campaing committee of BOD by 5/30/97.<br>2.2c Copy of BOD approved drawings will be on file 6/30/97. | |
| 2.3 Begin capital campaign to fund development, construction, and furnishing of RTHHTC facility. | 2.3a Complete capital campaign proposal for board committee review by 11/15/96.<br>2.3b Submit proposal to IHB BOD for approval prior to submission to foundations by 11/30/96.<br>2.3c Submit proposal to several foundations by 1/30/97. | 2.3a Submit draft capital capital campaign proposal to BOD by 11/15/97.<br>2.3b IHB BOD approval to submit capital proposal to foundations noted in BOD minutes on file by 11/30/96.<br>2.3c Copies of transmittal letters to foundations on file by 1/30/97. | |

*RED-TAILED HAWK HEALING & TRAINING CENTER*
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| Objectives: | Action Steps: | Progress Measures: | Comments |
|---|---|---|---|
| 2.4 Begin RTTHC facility construction by 10/97. | 2.4a Obtain all necessary building permits by 9/30/97.<br>2.4b General building contractor hired by 9/15/97.<br>2.4c RTHHTC construction groundbreaking by 10/10/97. | 2.4a Copies of building permirs will be in RTHHTC files by 4/1/97.<br>2.4b Copies of contracts on file by 9/30/97.<br>2.4c Site construction begun according to contract workplans by 10/10/97. | |
| 2.5 Complete construction of the RTHHTC facility by 3/30/98. | 2.5a Sign-off on contractor's punch list by 3/30/98.<br>2.5b Sign-off on lein waivers by 3/30/98. | 2.5a Copy of completed punch list in RTHHTC files by 4/1/98.<br>2.5b Copy of the signed lein waivers in RTHHTC files by 4/1/98. | |

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| ***CONTINGENCY PLAN* Objectives: | Action Steps: | Progress Measures: | Comments: |
|---|---|---|---|
| 2.6 Identification of temporary site to house RTHHTC services until permanent facility completed by 9/97. | 2.6a Select possible sites to temporarily house RTHHTC site with possible clinic services offered at another site by 7/1/97<br>2.6b BOD review and approval of site and projected length of lease agreement by 8/1/97.<br>2.6c Signed lease agreement for the RTHHTC temporary site program until move to the permanent facility by 8/15/97. | 2.6a Site descriptions of the those sites which meeet the needs of RTHHTC on file by 7/15/97.<br>2.6b BOD approval of site selected for lease on temp. basis noted in RTHHTC files by 8/15/97.<br>2.6c Copy of lease agreement on file in RTHHTC files by 8/15/97. | This section of the facility development plan is for temporary space to provide services until the new facility can be constructed and may be subject to change. |
| 2.7 Site development to enable provision of initial program services to begin by 9/1/97. | 2.7a All renovations to the site will be made as part of the lease agreement will be completed by 9/1/97.<br>2.7b Equipment and furnishings to accomodate phase I program needs will be moved to the new site no later than 10/97.<br>2.7c Utility and communication services will be connected to temp site by 9/1/97. | 2.7a Any renovations agreed upon in lease agreement will be completed no later than and noted in files by 9/1/97.<br>2.7 b Inventory of all equipment and furnishings for RTHHTC will be documented in RTHHTC files by 9/30/97.<br>27.c Utilities and communication agreements will either be included in lease or established in independent contracts by 9/1/97. | |
| 2.8 RTHHTC service delivery to begin at temporary site by 9/30/97. | 2.8a Phase I programs will be available at the new site by 11/97. | 2.8 a Notices and brochures documenting the services and program schedules will be distributed to target audience as documented in program files by 10/30/97. | |

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| Objectives: | Action Steps: | Progress Measures | Comments: |
|---|---|---|---|
| 3.1 Development of Code of Ethics for all RTHHTC providers including Traditional American Indian healers and interpreters. | 3.1a Research legislated codes and ethics mandated for psychologists, therapists, and ministerial counselors by 11/15/97.<br>3.1b Submit draft Code of Ethics for Tradtional American Indian healers to RTHHTC to be included with regional conference proposals to BOD by 11/30/97.<br>3.1c Submit "Interpreters & Tradtional Healers" Conference to IHS/foundations by 12/15/97.<br>3.1d. Hold 4 regional conferences by 6/30/98. | 3.1a Copies of various MN Codes of Ethics will be on file with planner by 10/30/97.<br>3.1b Copy of draft code of ethics on file under planning committee & BOD minutes of RTHHTC by 11/30/97.<br>3.1c Copies of draft "TAI&H" conference propsal along with transmittal letters will be on file by 12/30/97.<br>3.1d Copy of funal version of TAI&H code of Ethics will distributed to all participants and in files along with conference proceedings by 8/15/97. | |
| 3.2 Development of clinical services component which promotes the "Medicine Wheel" approach to healthcare delivery. | 3.2a Development of operating policies by 10/30/97.<br>3.2b Development of staff orientation curriculum based on RTHHTC mission by 10/30/97.<br>3.2c Recruit and hire traditional health staff by 11/30/97.<br>3.2d Development of clinical program technical proposal that integrates tradtional health and complimentary clinics with allopathic services by 12/15/97******. | 32a Copies of BOD approved operating polcies will be ina dminsstrative files by 11/30/97.<br>3.2b Copy of staff orientation curriculum will be on file by 11/30/97.<br>3.2c Recruitment notices/ads/ job descriptions along with all responses received in RTHHTC files by 12/30/97 an ongoing effort.<br>3.2d Technical proposal will be approved by BOD and copies in minutes and RTHHTC files 1/98 | |

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| Objectives: | Action Steps: | Progress Measures: | Comments: |
|---|---|---|---|
| 3.3 Development of program services and operating policies &procedures for RTHHTC . | 3.3a Provide a schedule of traditional health services through the RTHHTC such as: 1) sage smudge; 2) sacred pipe ceremonies; 3) sweatlodge healing & purification ceremony; 4) Preparation for vision quest; 5) Sponsor the Veteran's Sundance ceremony held at Slim Buttes, SD by 6/30/97. | 3.3a Notice of Phase I services will be disseminated to target community by 6/30/97.<br>3.3b Records of patient services and participation logs will be established by 10/30/97. | |
| 3.4 Development of formal affiliation ties with two reservations to connect with RTHHTC traditional health programs. | 3.4a RTHHTC will develop formal affilation with Red Lake and establish a satelite site on the reservation by 12/30/97.<br>3.4b RTHHTC will continue its support of Pine Ridge efforts through support of the Veterans' Sundance by 6/30/97. | 3.4a IHB will establish a field satelite site on the Red LAke reservtion by 12/30/97<br>.3.4b RTHHTC will establish agreements between Veteran's Sundance leaders to takeover support of the Sundance program in the future from IHB by 12/30/97. ????? | |

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| Objectives: | Action Steps: | Progress Measures: | Comments: |
|---|---|---|---|
| 4.1 Development of allopathic clinical services component of the RTHHTC that promote healthy behaviors to combat the leading causes of American Indian mortality. | 4.1a Recruit and hire PC providers for all clincs and requisite support staff for all patients referred from the Traditional Health program by 11/30/97.<br>4.1b Credentialing of clinic providers completed by 12/31/97.<br>4.1c Establishment of hospital and specialty referral networks for RTHHTC clinic providers by 1/30/98.<br>4.1d. Allopathic services will begin by 6/30/98. | 4.1a Copies of provider resumes and results of selection panel in RTHHTC files by 12/15/97.<br>4.1b RTHHTC staff will document inquiries to appropriate provider databases to verify credentials of clinical provider applicants in RTHHTC files by 12/31/97.<br>4.1c Date of onset of allopathic services will be disseminated to target communties via brochures, as well as, patient chart documents onset of service delivery by 7/30/98. | |
| 4.2 Development of health promotion/education services for those suffering from complications of diabetes, kidney failure, hypertension, CHD, and chemical dependency. | 4.2 a Medical clinic will expand health promotion/education services to compliment on-going therapies for those patients suffering from chronic illness by 6/30/98. | 4.2a Records of health education class agendas and participants rosters will serve as documentation in RTHHTC files by 7/30/98.<br>4.2b Chart audits performed on a quarterly basis will review and note the progress of participants in the RTHHTC program by 8/30/98. | |

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| Phase II<br>Objectives: | Action Steps: | Progress Measures: | Comments: |
| --- | --- | --- | --- |
| 5.1 RTHHTC will affiliate with UM Medical School program targeted to the recruit of AI medical students to serve as a site which will provide them with exposure to traditional American Indian health practices. The clerkship will include time in workshop training and actual participation in traditional healing ceremonies. | 5.1 a Establish formal agreement between the RTHHTC and UM School of Medicine by 8/1/98.<br>5.1b Develop pilot training curriculum for medical students to partic ipate in a traditional health clerkship in coordination with UM & AAIPmembers by 6/30/98.<br>5.1c Develop P.L. 102-537 mandated orientation training for health providers assigned to IHS/Tribal Health facilities by 9/30/98. | 5.1a Copy of affiliation agreement between RTHHTC & UM School of Medicine to refer interested students for training or services by 7/30/98.<br>5.1b Draft curriculum and revision willbe noted in the RTHHTC project files by 7/31/98.<br>5.1c RTHHTC traaditional health staff will meet with local members of AAIP and MN tribal health diretors to gain input into the orientsion needs of health providers placed in IHS/Tribal health clinics, copies of the orientation curriculum will be in files by 8/98. | 5.1a Current letter of support from Dr. Gerald Hill, Director of AI/Minority recruitment at UM SM. Also letter of support for RTHHTC by the Association of American Indian Physicians on file. These will be updated to met program objectives. |

| | | |
|---|---|---|
| <u>LOCAL TRAVEL</u> | | 4,500 |
| <u>OUT-OF-TOWN TRAVEL</u> | | |
| STAFF AIRFARE & PER DIEM TO ATTEND NATIONAL/REGIONAL MEETINGS | | |
| 8 TRIPS X $1,200/TRIP | | 9,600 |
| <u>PROFESSIONAL SUPPLIES</u> | | |
| MEDICAL | 10,100 | |
| LAB | 24,800 | |
| PHARMACY | 3,400 | |
| DENTAL | 27,800 | |
| CHIROPRACTIC | 6,000 | |
| TRADITIONAL | 3,000 | |
| | | 75,100 |
| <u>PROFESSIONAL SERVICES</u> | | |
| MEDICAL | 4,000 | |
| LAB | 2,200 | |
| DENTAL | 4,400 | |
| | | 10,600 |
| <u>INSURANCE</u> | | |
| PROFESSIONAL OFFICE PACKAGE | 9,900 | |
| PROFESSIONAL LIABILITY | 10,000 | |
| OFFICERS & DIRECTORS | 5,000 | |
| | | 24,900 |
| <u>TRAINING</u> | | 7,100 |
| <u>TELEPHONE</u> | | 13,900 |
| <u>PRINT/COPY</u> | | 5,800 |
| <u>OFFICE SUPPLIES/EXPENSES</u> | | 42,900 |
| <u>POSTAGE</u> | | 6,000 |
| <u>DATA PROCESSING</u> | | 3,100 |
| <u>BOARD EXPENSE</u> | | 9,200 |
| <u>RENT</u> | | 186,500 |
| <u>EQUIPMENT REPAIR</u> | | 16,500 |
| <u>EQUIPMENT RENTAL</u> | | 15,700 |
| <u>MEETING EXPENSES</u> | | 4,200 |
| <u>TOTAL COSTS</u> | | 2,180,369 |

## RED-TAILED HAWK HEALING AND TRAINING CENTER ~ BUDGET

| POSITION | HOURLY RATE | ANNUAL SALARY | FTE | NO MOS IN BGT | AMOUNT REQUIRED | |
|---|---|---|---|---|---|---|
| EXECUTIVE DIRECTOR | 44.50 | 92,560 | 1.00 | 12 | 92,560 | |
| ADMINISTRATIVE ASSISTANT | 20.00 | 41,600 | 1.00 | 12 | 41,600 | |
| TRADITIONAL HEALTH DIRECTOR | 27.50 | 57,200 | 1.00 | 12 | 57,200 | |
| PLANNER | 27.50 | 57,200 | 1.00 | 12 | 57,200 | |
| COMPTROLLER | 34.00 | 70,720 | 1.00 | 12 | 70,720 | |
| PATIENT ACCOUNTS | 14.00 | 29,120 | 1.00 | 12 | 29,120 | |
| PHYSICIAN | 67.30 | 139,984 | 1.00 | 12 | 139,984 | |
| PHYSICIAN | 67.30 | 139,984 | 1.00 | 12 | 139,984 | |
| R N SUPERVISOR | 18.20 | 37,856 | 1.00 | 12 | 37,856 | |
| MEDICAL ASSISTANT | 12.75 | 26,520 | 1.00 | 12 | 26,520 | |
| MEDICAL ASSISTANT | 12.75 | 26,520 | 1.00 | 12 | 26,520 | |
| MEDICAL ASSISTANT | 12.75 | 26,520 | 1.00 | 12 | 26,520 | |
| LAB/X-RAY TECH | 15.80 | 32,864 | 1.00 | 12 | 32,864 | |
| MEDICAL RECORDS | 12.75 | 26,520 | 1.00 | 12 | 26,520 | |
| MEDICAL ADMIT | 12.75 | 26,520 | 1.00 | 12 | 26,520 | |
| MEDICAL CLERK | 12.75 | 26,520 | 1.00 | 12 | 26,520 | |
| DENTIST | 32.50 | 67,600 | 1.00 | 12 | 67,600 | |
| DENTAL ASSISTANT | 12.75 | 26,520 | 1.00 | 12 | 26,520 | |
| CHIROPRACTIC | 41.85 | 87,048 | 1.00 | 12 | 87,048 | |
| CHIROPRACTIC ASSISTANT | 12.75 | 26,520 | 1.00 | 12 | 26,520 | |
| MASTERS IN SOCIAL WORK | 26.00 | 54,080 | 1.00 | 12 | 54,080 | |
| TRADITIONAL HLTH COUNSELOR | 20.00 | 41,600 | 1.00 | 12 | 41,600 | |
| TRADITIONAL HLTH COUNSELOR | 20.00 | 41,600 | 1.00 | 12 | 41,600 | |
| TRADITIONAL HLTH COUNSELOR | 20.00 | 41,600 | 1.00 | 12 | 41,600 | |
| TRADITIONAL HLTH COUNSELOR | 20.00 | 41,600 | 1.00 | 12 | 41,600 | |
| MARKETING/EDITOR | 20.00 | 41,600 | 1.00 | 12 | 41,600 | |
| | 638.45 | 1,327,976 | 26.00 | | 1,327,976 | |
| SALARY ADJUSTMENTS 04% | | | 53,119 | | | |
| PERSONAL LEAVE | | | 51,076 | | | |
| | | | | | 104,195 | |
| | | | | | | 1,432,171 |
| **FRINGE BENEFITS** | | | | | | |
| SOCIAL SECURITY TAXES | 6.2% LIMIT 65,400 | | | | 69,594 | |
| MEDICARE TAXES | 1.45% | | | | 20,766 | |
| HEALTH INSURANCE | 4,200/YR X 26 FTE | | | | 109,200 | |
| STATE UNEMPLOYMENT TAXES | 2.2%, LIMIT 15,800 | | | | 9,038 | |
| WORKERS COMPENSATION INSURANCE | | | | | 12,600 | |
| | | | | | | 221,198 |
| **CONSULTANTS/CONTRACTS/TEMPORARIES** | | | | | | |
| AUDIT | | | | | 15,200 | |
| LEGAL SERVICES | | | | | 10,000 | |
| COMPUTER CONSULTANT | | | | | 2,400 | |
| TRADITIONAL HEALTH CONSULTANTS | | | | | 63,800 | |
| | | | | | | 91,400 |

# NAVAHO WAYS AND WHITE MAN'S MEDICINE — IN THE HOSPITAL

IN THE PRECEDING CHAPTERS an attempt has been made to supply general information about Navahos and the Navaho Service. The present chapter is an effort to show by specific instances how this material can be used in working with the Navahos in a practical way.

Because the authors are physicians and because the health problem among the Navahos seems to be one of the most important problems, the next pages are devoted to discussion that will be most useful to doctors and nurses and other medical workers. Many teachers, range riders, and even construction men will be called at times to render medical assistance, or to try to persuade some sick Indian to go to the hospital, and so they, too, may find the suggestions helpful.

It is true that the type of ceremonial described in the chapter on religion will not heal tuberculosis, remove an appendix, or set a broken bone. However, the greatest single aid to recovery from illness is rest, and things which occupy the mind and keep up hope enable one to accept affliction more easily. Few people will doubt that the attitude of a patient is one of the most important factors in his recovery. Even when good medical attention is available, time,



rest, and a hopeful attitude play leading roles, and they are all the more important to the many cases of sickness among the Navahos that never come to the attention of doctors, since there are not enough hospital beds to care for all.

Because of their beliefs, the Indians have a strong tendency to try their own ceremonials before calling in a white doctor, regardless of the type of sickness. As we have suggested, the Navaho theory of illness is not that illness is caused by germs, wrong food, or improper functioning of the body, as we believe, but rather that by some means the patient fell out of harmony with the forces of nature, and this discord makes him susceptible to catching a sickness from another person, breaking his leg, or developing any of the symptoms that can plague a human being. The natural consequence of this belief is that, when a person falls ill, the most important thing is to restore through ritual the harmony which has been disrupted so the body can heal itself.

Belief

The primary concern of the Navaho is with the illness, and getting rid of it, and he does not demand consistency of theory and treatment so long as the illness is dispelled. He is remarkably experimental and practical in his attitude and often tries medical preparations dispensed by Government workers or bought at the traders' before arranging a ceremonial, to see if the medicine is as good as the white people tell him. Similarly, if he tries a ceremonial first and it is not effective he is likely to come to the hospital.

The Navahos know from experience that it is possible to catch diseases from people who have them. The time of the following incident, cited as an example, must have been about 1870-1880.

"One day a man and a woman came to our place. The man was pretty sick. He was my brother. His wife went home and he stayed there. Next day when they were looking at this man, the people says he has something all over his body. What he has over his body is all red. We had stayed all night with him, all of us. In the morning my father took us to another place. Father says it was pretty bad to stay near that man, we might get it from him. What he had on his body was getting heavier every day. They found out it was smallpox. My father got afraid to go over to him, but my mother wasn't afraid.

She went over and took care of him. After she stayed with him two days, we heard she got it, too. The sick man and my mother and my father was the only ones talked together. When my mother came over she just walked behind the doorway here and talked to us. My father told her not to come in. Some of our folks fixed some food up and carried it outside for them. The man got better but my mother got worse. She got too worse, had sores all over her body and died, didn't live long. Everybody got afraid to go near there, so they didn't bury her but just left her inside the brush hogan. They cut a lot of pinyon limbs and cover her up good with it and close up the brush hogan. We move away from there right away.

"One of my oldest brothers, he was a Singer, too, came in there just about the time my mother died, and he got it right away. But he didn't have it very bad and got better. The two men used some kind of medicine, and was drinking it and rubbing it on their bodies, and they got well. But they don't come in on us. They keep their camp on one side. They do that for quite a while till they think they are sure well."

One could hardly improve on the precautions that the Navahos took in this situation.

When it comes to the hospitalization of Navahos, one sometimes meets with a surprising amount of resistance. It is well to bear in mind that the Indians' experience with hospitals extends over a period of less than one lifetime. Only recently have they brought in a patient before he was moribund; they commonly hold the opinion that a hospital is a place to go to die. A generation ago this was the view of most people in our culture and it still is the view of many people today. Moreover, it is hard for most of us to picture the extent of personal adjustment that a Navaho must make when he becomes a bed patient in a hospital. When we go to a hospital we may have to get used to eating our meals at a different hour from our usual one, or to having our faces washed for us, or taking medicine we do not like, or the various medical and surgical procedures that one goes to the hospital to get, but the Navaho has these adjustments and many more to make. He is unaccustomed to a bed, to living by the clock, to staying in one place continuously instead of



wandering around as he pleases, and to efficient impersonal attention by people whose language he cannot speak. He cannot see why he must be content with gruel and milk when, if he were home, he would be fed as much as he could eat of the best food the family could get for him. He feels uneasy about doing intimate personal things before other people, especially people who are not related or familiar. It seems as if the doctors and nurses could not be very much interested in him because they come to see him only at long intervals instead of staying with him constantly as his family would. He cannot understand why if medicine is going to cure him, they do not give it to him all the time instead of only a little three or four times a day. When he has been sick at home before and has had a ceremonial, the medicine man has given him his undivided attention constantly for as much as nine days and nights. There were numbers of other people there, too, all laboring to get him well. Here it seems as if no one cares whether he gets well or not, and all he has to do is to lie there and wonder what his family is doing, and feel homesick for them and for his hogan and mutton.

The patient would think it silly and out of place for a white doctor to put on a dance for him or pray over him or construct religious paraphernalia, but he would be much easier in his mind if the doctor would explain a little about the kind of sickness he has and what white people believe to be the best way of treating it. This is a wonderful opportunity for health education, for if the doctor is able to convince the patient that rest is the principal thing his body needs to get well, for instance, or that soft foods are easier for his stomach to digest when he is sick than mutton, he is likely to follow such a regimen next time he gets sick whether he comes to the hospital or not. That is, he will follow it if it works. Otherwise, he will probably conclude that this time the white doctor guessed wrongly as to what was the matter with him and how it should be treated, just as the native diagnosticians sometimes do, and he will go to another doctor, either white or Indian. Each patient must be thought of as an educational problem as well as a therapeutic one.

Explanations cannot be simply a list of technical terms which even the interpreter cannot understand or translate. They must be

in simple, graphic words with as much reference as possible to things familiar to the Indians. They have a fair knowledge of human anatomy and even better of sheep and goat anatomy. As can be seen from the description of the smallpox epidemic quoted above, they also have a good idea of contagiousness, although they do not always act on it.

Medical workers should be aware of Navaho customs and attitudes that have a direct bearing on hospitalization: When a man or woman gets sick, the family takes over the direction of treatment. Sometimes the patient has a voice in the matter, but not always. The family decides whether to call a Singer or a diagnostician or take the patient to the hospital. If the Singer comes they tell him just what they want him to do. A few medicine men take it on themselves to advise the family, but most conform to the pattern of doing as they are told with all the skill they possess. In dealing with the hospitalization of a patient it is important to keep this in mind, as persuading the patient may be only the first step in securing your result, and when the family is considering a matter, it may take several hours of talking to reach a decision.

The patient and his family are principally interested in the present illness, especially the present complaint. In their thinking, they recognize clearly enough the possibility of connection between past and present illness, but, because of the customs of their own diagnosticians and Singers, they look on it as weakness on the part of the doctor to ask questions. They think he should know what is wrong and get to work fixing it. This raises an obstacle to getting an adequate past history. The Indian patient will usually respond to the doctor if he devotes enough time and interest to the description of his present illness. Even if the chief complaint has little to do with the fundamental pathology, it is worth while to give some symptomatic treatment, such as liniment or cough medicine, to indicate that you take it seriously. By making this concession one can often carry out procedures that would be resisted otherwise, and the patient will be much more contented, for he will see that what bothered him is being treated.



Most Navahos like to make speeches. "Yes" and "No" answers are not customary with them. A busy doctor or nurse is often irritated when, on asking a patient how long he has been sick, he starts a detailed account of how he has passed the last two days. Although this may sound irrelevant at the start, if one listens, the patient usually ends up with a point which has considerable bearing on his previous account and gives it meaning. If one does not listen, the patient will not talk and the medical worker will not learn anything.

The Navahos are accused of being unresponsive. It is true that they do not often say thank you, nor show much enthusiasm when something is done that they like. Such behavior is not good formal manners in the Navaho way. In unfamiliar surroundings one must maintain an outward dignity and composure. A part of this behavior is often dictated by shyness. Even with each other, children returning to school in the fall act like strangers until they get re-acquainted. It is unlikely that the outward appearance is a true indication of the inward feeling.

If you have occasion to drive up to a Navaho hogan, you might be surprised that your friends do not rush up to shake your hands. They may not even act as if they knew you were there, or they may retire into the hogan. After a little some of them will probably approach you to see what you want or to ask you inside. You get a different picture if you are living with the family and in the hogan when another car is approaching. Every one quits what he is doing so as to be able to hear better. There are excited whisperings. The children are sent to peek out the cracks to see who it is, and when that is not good enough, one may be sent out to throw some trash on the ash pile so he can get a better view. Even if this report discloses that it is some favorite relative, calm has descended by the time he comes in, hands are shaken gravely, and some minutes are spent in silent smoking before a word beyond that of greeting is said.

Your tone of voice and attitude will tell the Navahos a great deal, no matter what words you use, even if they understand no English. They are very keen judges of whether or not you are friendly, patient, interested. They may misunderstand if you talk too loudly or too

rapidly, as they may take that to indicate irritation whether or not you feel it. You will get far with them if you are friendly and patient, and nowhere if you are not.

The patient in the hospital is likely to feel lonesome away from his family surroundings and may want to leave on that account. If he is too sick to do this safely, a compromise that has been used successfully is to put him in a private room and get a member of his family to come and stay with him. This gives the doctor an added opportunity for educating Navahos in medical matters.

Navahos like to eat heartily and to feel satisfied after eating. They think this is more important if they are sick than when they are well, and sometimes will want to leave the hospital because they dislike a liquid diet. If you find out about this and feel the patient still needs hospitalization, you may be able to keep him by compromising and putting him on semi-solid food. It is very easy for the patients to misunderstand special diets and assume them to be mere slop and evidence of neglect.

Navaho women are very modest. They are trained from the time they begin to walk that they must keep their skirts down and their bodies covered below the waist. The upper part of the body does not seem to matter so much. Nurses should be even more careful with them than with white patients not to expose them unnecessarily when bathing, giving douches, or enemas.

Like most people, the Navahos do not want to be laughed at unless they are trying to be funny. Among nearly all American Indians, ridicule and public opinion were extremely potent forces in producing smoothly running community life. These forces worked so well that little was needed in the way of policing or formal regulations for punishment. Even today, most Indians, especially those who live largely according to their own customs, are more sensitive to ridicule than the average white man. They care most about the opinions of other Indians, but next to this they want to be well regarded by those white people they look upon as their friends. On the other hand, the Navahos have an excellent sense of humor and love to make jokes, especially puns, in their own language. Much of their humor is quite subtle and based on the vagaries of human nature.



In general Navahos have an uneasy feeling about people who show some physical deformity. This may be related to their fear of witchcraft and result in their thinking that since such a person cannot do very much because of the deformity, he may try to exert power or gain riches in an abnormal way. Their fear is probably in part due to feeling that since the deformed are out of harmony with the forces of nature, contact with them may bring disharmony to one's own life, according to the general principles of contagious magic. Occasionally a deformed infant will be abandoned to die, or will be brought to the hospital and never taken home again. Their uneasiness is doubtless also linked with their admiration of physical perfection, a point of view said to have been dictated by the Holy Beings. In the ceremonials where Navahos take the part of the various gods, there is a strict injunction against the parts being played by any but the physically perfect. Probably this ruling prevented transmission of disease through the leather masks used in certain ceremonials, in spite of the prevalence a few years ago of trachoma. People with sore eyes were not allowed to wear the masks.

Many Navahos do not like to speak about their past illnesses, or to mention relatives who have died, for fear that such talk will start trouble again. Often at a Blessing Way ceremonial, for instance, the Singer will put a stop to bad news or tales of hardship, saying they must speak of success with crops, lots of rain, and things recognized by all as good. This is sometimes an added difficulty in getting a good past history or family history, but the passage of time and the growth of confidence in the hospital will frequently overcome the feeling. At other times a long-term acquaintance with the person and his family is the only way of knowing what his health history has been.

Navaho babies usually continue to nurse until the next baby is born. This is contrary to our idea of what is desirable, but it must be remembered that the child probably has no other source of milk and there is little opportunity for gradation between infant food and the adult diet of fried bread and meat. With white people it is more consideration for the mother than the child that puts an end to nursing at six to nine months. Thus, when either the mother or the infant is sick, both may have to be accepted by the hospital,

perhaps a sick baby and his source of food, or a not too sick mother and her hungry child.

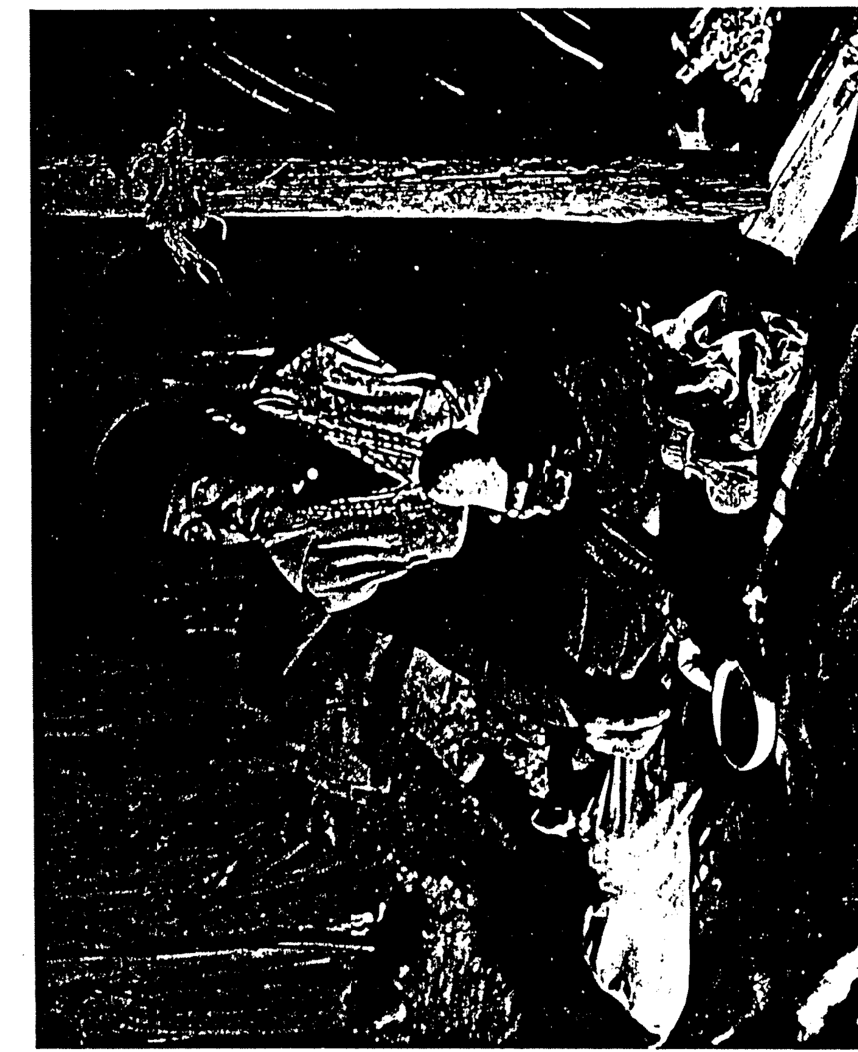
In their native medicine, Navahos use herbal concoctions by first rubbing them on their bodies, beginning at the feet and working up to the head in a ceremonial sequence, and then by drinking what is left over. Consequently, at some of the hospitals it has been found helpful to provide liniment for use on the outside of the body when giving internal medication.

The Navahos are accustomed to ointments. In the windy spring months they often smear their faces with sheep tallow and red clay to prevent chapping. Skin diseases are treated with various greases. In the ceremonials, ointments from such animals as the mountain lion are often used. Skunk grease has been recommended as a smallpox preventive. Thus, they will accept readily any sort of ointment if it is explained to them, and will use it as directed if directions are sufficiently specific.

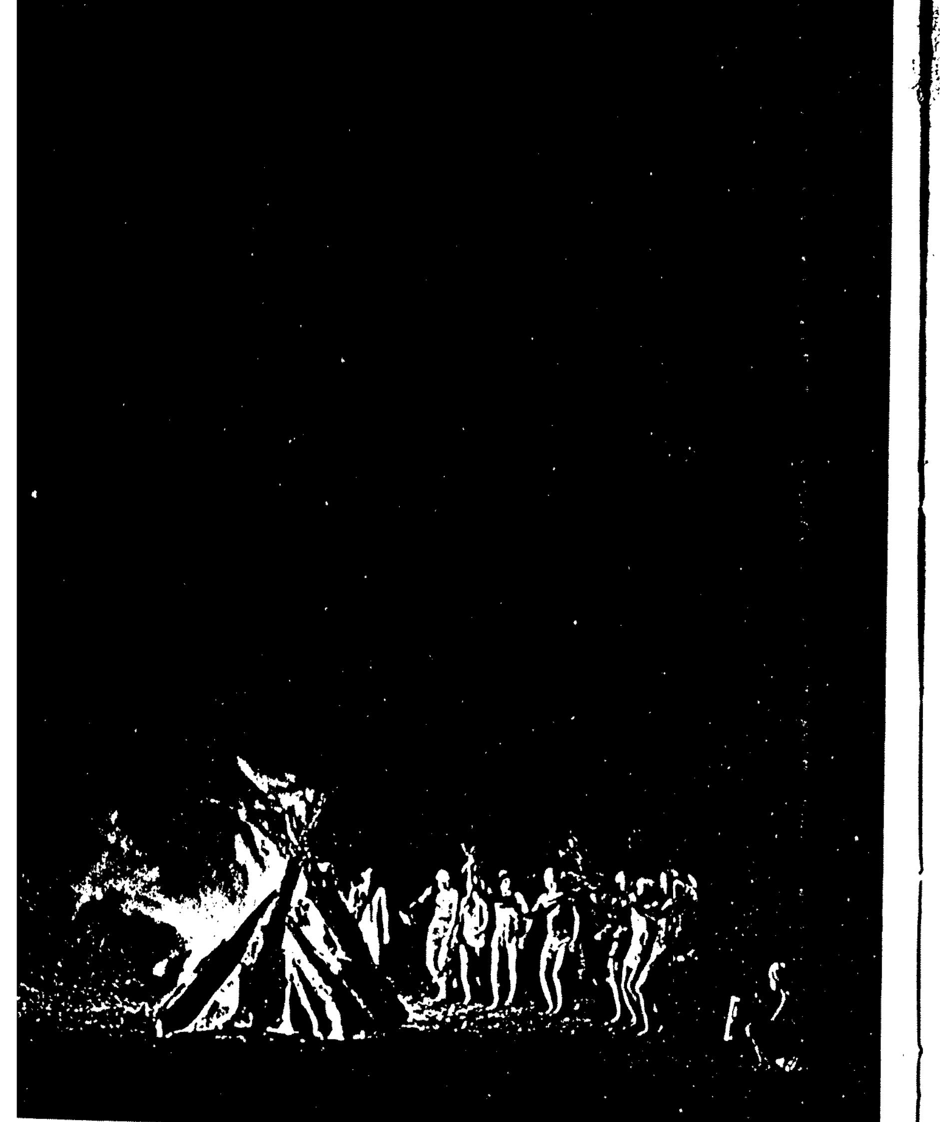
Doctors have reported seeing cases brought to the hospital in which chest pain had already been treated with applications of various kinds of pitch, probably as a counterirritant or poultice. Emetics and cathartics are used often in ceremonials "to clean out the body." Astringents such as juniper tea are used after childbirth to "clean the blood." Medicines are also employed as inhalants, usually by sprinkling a pinch on a red coal while the patient leans over and breathes the fumes. This practice paves the way for using inhalations in such conditions as croup and bronchitis, and may be carried out quite easily in hogans.

The Navahos are accustomed to doing things connected with treating the sick in a precise way, as prescribed by the medicine man, and with certain items always following certain other items. This gives the doctor a basis for having treatments carried out exactly as he wishes, provided he makes that wish very clear and definite and avoids all vague and generalized recommendations.

With their own medicines the Navahos are always interested in what sort of plant, animal or mineral mixture they are using, and how the components were collected and prepared. They would take white medicine more seriously if the doctor were to describe a little



*U. S. Indian Service photograph*



*Photograph by Helen M. Post*

The Fire Dance



the source of the various elements in his doses, making the picture vivid but nontechnical.

To the Navahos the number four is charged with great significance. This may be related to the four points of the compass, or the four seasons of the year, but in any event carries emotional tones which are possibly similar to those felt in Europe during the middle ages for the number three and its association with the Trinity. The doctor treating Navahos can use four in a number of ways to fortify treatment, such as prescribing medicine four times a day, courses of treatment in groups of four days, and bed rest for four days, or four weeks, or twice four days.

Bathing by means of the sweatbath or the yucca-root-and-water bath is part of both ceremonial and everyday treatment. Sweatbaths are taken to tone up the system, as well as for purposes of cleanliness, and after a doctor has seen or participated in one, so that he understands what it involves, he might find it very helpful to advise it in certain cases where he feels a general tonic is needed. Nurses and day school teachers report that if you provide a Navaho with soap and water there is no trouble in keeping him clean. When given the facilities, Navahos love to bathe, and at home it seems that only the lack of water and privacy keeps them from it. As with the use of liniment, the ceremonial bathing order begins with the feet and works up toward the head.

All through the hospitalization, and even after the doctor tells the patient he may go home, the Navaho may have been feeling that he should not have come to the hospital without at least trying out the medicine man first. He may believe that the cure will only be temporary without the religious sanctions procured through the ceremonial. In many cases such feelings get too strong for him and he will leave the hospital in spite of the doctor's pleading. If the doctor could find this out before the patient makes this decision, it would often be possible to persuade him to wait until the doctor is finished with him. One might tell him, for instance, that he now has a white man's sickness and needs white man's medicine, or suggest that he have a Sing after the doctor at the hospital has treated him.

Nothing will be gained by treating his feelings lightly, any more

than if you tried to tell a good Christian or Jew in a hospital that seeing the minister will have no effect on his recovery. The Christian, the Jew, and the Navaho have a deeply rooted conviction that unless their religious needs are taken care of as well as their physical needs, they are not truly cured. One difference between the Christian and the Navaho is that the minister and priest have modified their procedures so that they can be used in the hospital to the comfort of the patient's soul, while the Navaho medicine man has not yet done this and has received no encouragement to do so from the white doctors or administrators.

It is impossible to say what might be gained by according to the medicine men the same privileges and respect that we give priests and ministers. Perhaps no use would be made of them, because the whole hospital atmosphere would seem inimical to Navaho religious concepts. Certainly it would be impractical in most cases to attempt to have ceremonials performed in the hospital building. It seems, however, as if a great deal could be done in the way of improving relations with the medicine men and thereby with Navaho patients if the medicine men were treated as colleagues to some extent, shown how a hospital operates, allowed to witness operations so as to see for themselves that much training is necessary. They have already given evidence of their interest in such things by their attendance at first-aid classes, and their eagerness to take and use a clinical thermometer when it is permitted. It would be better to teach them our medical theories and some of our practices than to have them pick them up in a distorted form from uncontrolled sources.

One way in which the medicine man could be of definite help to a doctor would be to persuade a patient who wanted to go home to stay until the hospital was through with him before having a ceremonial. If medicine men were used much in this way the hospitals or patients would have to pay them something for their time, because they are often busy men with families to support. They would do this sort of talking only if a good relationship could be established between them and the hospital or the doctor. Perhaps they could be asked to perform some of the very short curing rites that are taken from longer ceremonials, or to suggest to the patient that he have a



Blessing Way ceremonial after leaving. As far as the lay Navaho is concerned, the white doctor or nurse is just another sort of medicine man, who uses different but not necessarily better techniques to attain the same end, namely, the healing of the sick.

The good medicine man is usually very intelligent, but a difficulty will lie in distinguishing between the good ones and those less gifted and less admirable. It is altogether likely that there are some who would try to use a relationship with the hospital for their personal aggrandizement rather than as a means of helping their people. Men of this sort would become obvious in time, but in any case the harm they might do would be greatly outweighed by the good to be expected from a gradual infiltration of improved hygienic ideals and practices.

It is not just the medicine men who should be educated; perhaps because of their intelligence they could be taught more than the others, but all Navahos need health education, and will get it from everything they see a doctor or nurse do or refrain from doing. Each explanation you take pains to make will spread like a ripple in a pool, for the Navahos love to tell a "story," and they are all keenly interested in health. It is well to remember that they will tell it as they understand it, so that it is worth some pains to see that their understanding is the same as yours.

Having said this much about the importance of explanation, a few samples will be given below to serve as a guide in developing such techniques. These are not intended to be memorized and repeated verbatim, but only to show some of the possibilities.

The first thing to make sure of is your interpreters, since you are dependent on them for knowing what Navahos say to you and for speaking to Navahos. It is worth a good deal of your time to train the interpreters so that they know your ways of expressing things, and understand what you are talking about. Good interpretation requires considerable intelligence, depends on knowing the person for whom one is interpreting and knowing the subject under discussion. Several of the medical interpreters who attended the school held for them at Fort Defiance considered that they got the greatest help from the detailed discussions they had in trying to find the right

word to express an idea. In doing this they learned a great deal about medical concepts that had previously been unknown to them.

Interpreting is hard enough between any two languages, and is far more than just finding equivalent words; you have to find ways of expressing the idea and the feeling that goes with it. With Navaho and English the problem is further complicated by the fact that the words are used in a different order so that a sentence has to be turned around before being translated; and in telling a story, the Navaho is likely to start with the point and then explain what led up to it, whereas in English the point comes at the end.

The doctor, teacher, or other worker speaking through an interpreter should first have clearly in mind what he wants to say, and then he should reduce it to the simplest possible English. If he works customarily with the same interpreter, he should listen to the interpreter's English and use the same expressions as much as possible, because that will make it more understandable to the interpreter and thus the translation will be more accurate. Too much cannot be said in favor of workers among the Navahos trying to learn some Navaho words so that they can follow the general drift of the discussion.*

In the examples following, the English used is similar to that employed by the interpreter with whom the writers were most familiar.

Pneumonia. "This patient has a sickness in his lungs. Some pus is in his lungs and it is filling them up. That is why he has to breathe so fast. It is harder for him to get his breath because there is pus in his lungs. This kind of sickness goes pretty fast and is pretty bad unless he gets just the right kind of treatment. I am glad that you brought him in so soon after he got sick, because we have some good medicine that helps a man with his sickness a whole lot. If he comes into the hospital right away he will probably be much better in four days and all right in twice four days. If you take him home he will probably get sicker all the time, and he will die pretty soon. See, here are some X-rays. This one shows you a man with good lungs, nothing wrong with them. Here is the X-ray of the patient. You can see his picture has a big white place in it. That is where the pus is. If we treat him in the hospital, that place will get smaller and smaller until his lungs get to look just like these good ones. You ought to leave him in the hospital until they look good again.

"Would you like to listen to the sick place through this rubber that I use? (stethoscope). First listen to this other man's lungs. Can you hear what it sounds like when he takes a big breath? Now put the rubber right here (over consolidation). That sounds different, doesn't it? The pus that is in there, that makes the white place in the X-ray, makes it sound like that. When he gets well that place will sound just like that other man's lung. You ought to leave him in the hospital until it sounds good again."

Tuberculosis. "This boy has tuberculosis. I guess you know about tuberculosis? Has he been coughing for a long time? Has he been getting poor (thin) for a long time? Did he ever spit any blood? Did he ever have any fever? I think he has had it quite a while, and I will show you why. See, here are some X-rays. This one is from a boy who has good lungs, nothing the matter with them. You can see they look all the same. Here is the X-ray of this patient. It looks like he has a cloud in his chest. And here you can see a round mark. That is the edge of a hole. There is a hole there where his lung has rotted away. He has it pretty bad in one lung, but the other one looks pretty good still.

"Was he living in the same hogan with you? How many other people were in that hogan? Did he ever go any place else? Do other people sometimes use his bedding and his dishes? The reason I am asking you all these questions is, when a boy has holes in his lungs from tuberculosis he can give it to another person pretty easy. Another person can catch it from him. You see, the lung that rotted and left that hole, he coughed that up in his spit, little at a time. That rot-

* The Medical Dictionary, that was worked out by the medical interpreters, the medical staff, and Mr. Adolf Bitanny, is worth study so that you can familiarize yourself with medical terminology in Navaho. A copy can be obtained from the medical office at Window Rock.

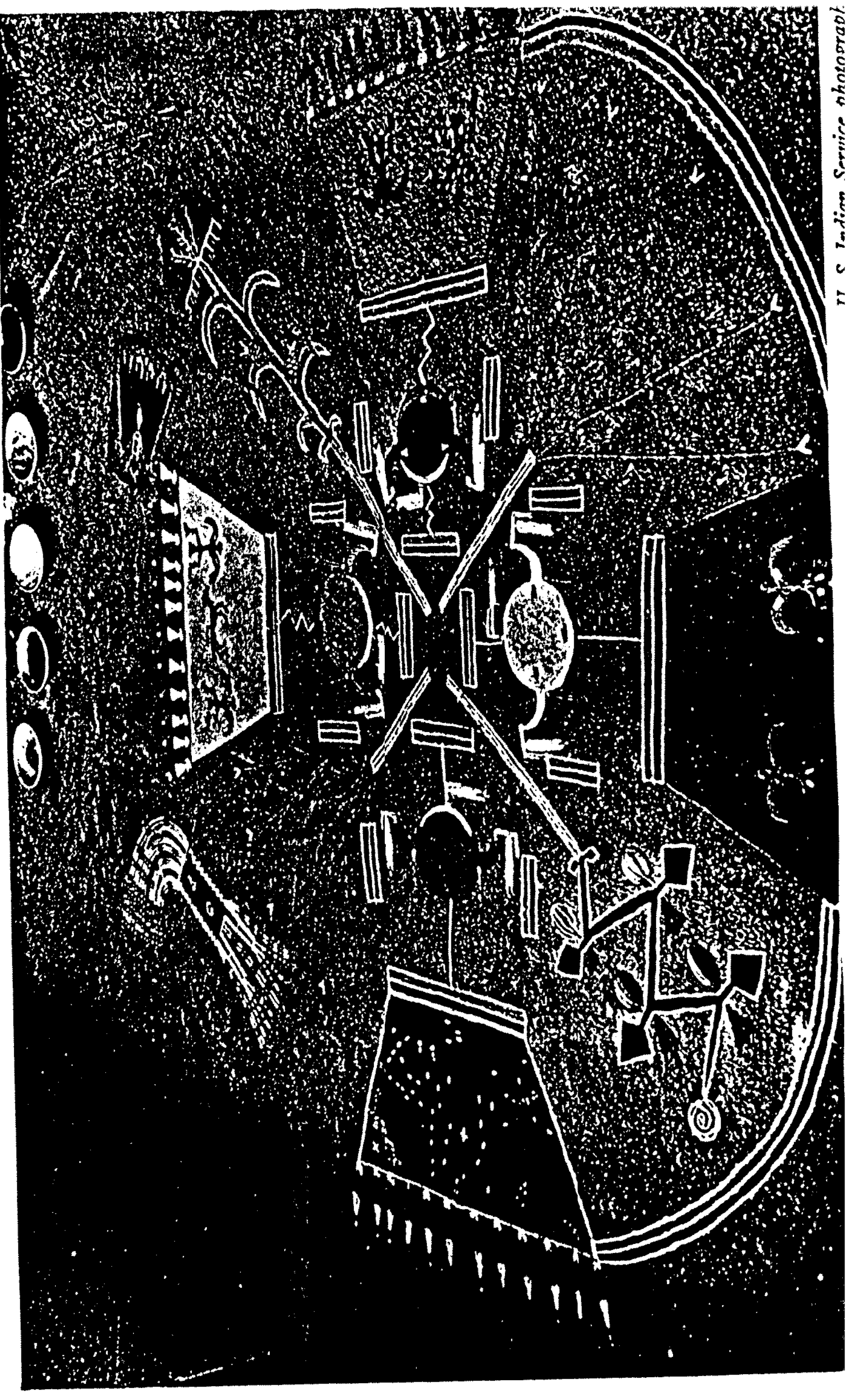
*Learning Navaho,* by Father Berard Haile, St. Michaels 1941, is also a good text for a beginner.

ten lung has a lot of little tiny bugs or worms in it, so small that you can't see them. Maybe his spit got on his bedding or on his dishes. If somebody used the bedding or the dishes, maybe they got some of that spit into their lungs. That is the way a person can catch tuberculosis from a man who has it.

"Tuberculosis is a pretty bad disease. White people used to get it all the time, too, just like the Navahos, and they used to die from it all the time. Then they found out that to get well from tuberculosis a person has to take a long rest. He has to rest so much that he doesn't even sit up, he doesn't do any walking, he just lies there and helps his body to close up that hole by taking it easy. Besides resting he needs a lot of the right kind of food. He needs a lot of milk and eggs and meat and fruit. You know a person gets very poor (thin) when he has tuberculosis, and so we have to make him get fat again. White people found that if a person did all that resting and ate all that food, after a good many months he could begin to sit up, a few weeks more he could begin to walk a little, in a few months he could do a little easy work. Maybe in about two years he could go home and go back to work again. They found out if he didn't do all this resting, those holes in his lungs would get bigger and bigger, pretty soon no lungs left, can't breathe any more and he is dead.

"They found out that a hospital is the best place for a person with tuberculosis. It is hard to do all that resting at home, and it is hard to buy milk and fruit, and the other people there might catch his sickness. After he does all that resting and gets nice and fat there is not much chance that they will catch it.

"They found out that if you can start a person with tuberculosis to resting before he gets any holes in his lungs, he will get well quicker than if he already has some holes. If he only has a little bit of tuberculosis he will get well very soon if he takes a rest. You ought to bring to this hospital every person who has been in the hogan with this boy so we can take X-rays and see if any of them have caught tuberculosis from him. Then if they have we can get them well quicker than we can this boy. Maybe they can get well pretty soon."



U. S. Indian Service photograph

*U. S. Indian Service photograph*

Both Navaho and White Religious Leaders Took Part in the Dedication of the Fort Defiance Hospital



HYPODERMOCLYSIS. "You have seen that this child can't drink anything. Every time she drinks she vomits it right up again. See how wrinkled her skin is getting? And see how dry her mouth is? Doctors have found out how to give a child like this a drink of water and the medicine she needs without her having to swallow it. It hurts the child a little bit, but if we don't do it she will probably get too dry and die because she can't drink. You don't want that to happen, do you? She is very sick, but I think she will be better and will feel better if we give her some water and some medicine. We have to put some hollow needles under her skin and let the water and medicine run in a little at a time. It will make a little swelling and will hurt a little, but that is not so bad as dying."

APPENDICITIS. "This woman has some pus in her guts one place. That is what makes it hurt in her side there. You know how it hurts when you get a boil on your skin? Well, this is like a boil, only it is in her guts. If we leave her alone, don't do anything, that pus will get more and more, maybe fill her whole belly, and she will get more and more sick until she dies. The best thing to do for that kind of sickness is to let her smell ether till it puts her to sleep. Then we make a little cut right where that pain is and find the place in her guts where there is some pus. We cut out that pus and sew up her guts and her side and then let her wake up. It doesn't hurt her at all because she is asleep all the time. After that she has to stay in the hospital ten days, and then you people can come and take her home. You see it isn't a very bad sickness if we operate on her right now, but if you put it off, don't let us operate for a few days, maybe by that time she will have too much pus in her belly, hard to cure, keep her sick a long time, maybe four weeks instead of only ten days. Maybe even the pus will get so much that it will be too strong. It will kill her even if we try to take it out if you let her wait too long."

TONSILLECTOMY. "I asked you people to come to see me because I want to talk to you about your little boy here. He has been in school here all winter, and all winter I have been taking care of him

because he was sick so much. Most all the time he had a cold, and then lots of times he had a bad sore throat. Your little girl here, who was in school, too, I didn't hardly see her at all. She was pretty healthy all winter. I want you to look at her throat. See, it looks nice and even, no big lumps anywhere, no bright red anywhere. Now look at this boy's throat. Do you see those two big lumps back there? We call those lumps his tonsils. Last winter when he had those colds and those sore throats those two lumps swelled way up. They got real red, and there were some white places on them where there was some pus. Those two lumps hurt him a whole lot when they swelled up. Some times it looks as if he had a hard time to breathe with those two lumps there.

"White doctors have found out that when a boy's tonsils get like that, swell up pretty easy, get red, lots of colds and sore throats, that means there is a lot of sickness in those tonsils. They found out the best thing to do is to take out those tonsils. If they do that the boy won't have any sore throats, not so many colds. If they didn't do that, maybe after a while that sickness gets all through the boy's body, makes him very sick.

"We don't like to take them out when the boy's throat is sore or he has a cold. That makes it too hard on the boy. We like to wait till it gets warm weather like now and he doesn't have any cold or sore throat, and then take them out. We put him to sleep so that he doesn't feel it when we take those tonsils out. When he wakes up it will be a little sore in his throat. But in a few days' time, maybe four days, his throat will feel a whole lot better. Four more days, he will forget he had his tonsils out, and next winter he won't have any more sore throats and not so many colds.

"So I want to talk to you people about that because I know you like to have your boy nice and strong, and not have sore throats like he did this winter, and I hope you will ask me to take out his tonsils. If you make up your mind you want me to do that, you can leave the boy in the hospital right now and I will do it pretty soon. In that way you won't have to make another trip to bring the boy back to the hospital, and we can do it before he catches another cold."



OTITIS MEDIA. "The reason this little baby is crying all the time and holding onto her ear is that she has a lot of pus in her ear, and it hurts her a whole lot. It is like a boil, only it is way inside her ear. You can't even see it unless you look with something like this thing. I don't think I will show you what it looks like because it hurts the baby too much. You know, when you get a boil, the boil gets bigger and bigger, and pretty soon it breaks and a lot of pus comes out. Well, that is what will happen with this little baby if we don't help her. Only in the ear it is kind of small, and sometimes that pus breaks into the bone instead of outside, and then the bone here back of her ear would get all rotten and she would be very, very sick. The best thing to do for this baby is to open that place where the pus is with a little tiny knife so that the pus will run outside and not into the bone. In that way she will be all right in a few days.

"Do you nurse this baby? Well then, I think you and the baby had better stay in the hospital. That way the nurses can take care of the baby so her ear will get well pretty fast, and you can see how they do it and see that the baby is all right, too. It will be better for the baby if you come with her so that she will get the same food that she is used to. In that way I don't think you will have to stay very long, maybe twice four days."

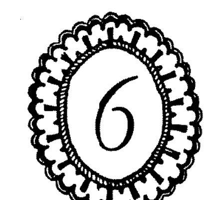
SYPHILIS. The patient was a forty-five-year-old woman who came into the hospital for a broken wrist, suffered when she fell off a horse. Routine Wassermann found to be positive. No symptoms or other findings of syphilis.

"You remember we took some blood out of your arm the other day? We tested that blood and we found out you have a sickness you didn't know about. There is something wrong with your blood. Did you ever hear about anything like that in the Navaho way?

"I have heard that in the Navaho way if your father or mother does something like kill a snake or go to a ceremonial before you are born, maybe after many years you will get sick from that. Is that true? Is there any way you can keep from getting sick if you know about that? (Right ceremonial.) Well, this disease you have in your blood is a little bit like that. Maybe you got it many years

ago, but you didn't know anything about it. So far, it didn't make you sick. But maybe in a few more years it will make you very sick, maybe it will make your heart too big, or it will make your mind not work right.

"In the white way we can give you some medicine so you will never get sick from this thing, just like in the Navaho way you would have a ceremonial if your father had killed a snake. It is strong medicine and you can only take a little at a time, and you have to take it for one year. We have to put it in your arm or in your meat (muscle), and you will have to come to —— hospital every week for one year. If you do this you will never have any trouble with it, but if you don't keep coming every week for one year, maybe in a few years' time your heart will be too big or your mind will not work right. If you wait till you are sick in this way, it will be too late, this medicine will not cure you then, but if you take this medicine now, as I have been telling you, you will never get sick from this disease."



## NAVAHO WAYS AND WHITE MAN'S MEDICINE—IN OUT-PATIENT WORK

As WITH OURSELVES, so with the Navaho, the time will probably never come when everybody who gets ill is immediately hospitalized. There is little point in working toward such an end, but there are great possibilities for improving the way in which the sick are handled at home, both for their benefit and for the good of others.

In addition to using the suggestions for getting hygienic ideas across in a way familiar to the Navahos, any doctor, nurse or teacher working with the health problems has to realize the limitations imposed by the living conditions. Many things which we think of as simple necessities, like running water, beds and bedding, and screens, are either nonexistent for the Navahos or are in the luxury class. For instance their only running water would be that in the irrigation ditches or rivers. Some families live within a mile of a good spring or well; most of them have to go several miles to get a few gallons of water that may be full of silt. Gargling or using hot compresses under these circumstances can be recommended only with discretion. Again, the real necessity of bed rest should be carefully weighed. A man lying down in the daytime is a lazy man in the opinion of the Navahos; he has only a couple of sheepskins on the

dusty, draughty floor for a bed; he is in the way of the others; and some one else is having to do his work. In some families, on the other hand, a sick man can have a hogan to himself, which would make staying on his back more feasible.

Patient, painstaking, and vivid explanations pay dividends in hospital work, in the out-patient clinic at the hospital, and in the day school. The same attitudes and customs have to be taken into account, and the same pre-existing Navaho medical concepts can be used to build upon. It is here, perhaps, that their custom of observing very precise and unvarying rules for their ceremonial treatment of the sick will be of the greatest help, and it is here that you can expect to do the most in diffusing modern ideas of hygiene and public health.

In using any of these ideas, you will not succeed if you say to your patient, "You believe you have to gather your plant medicine just right and use it just the way the medicine man tells you, don't you? Well, you ought to do the same thing with this medicine I am giving you." This will sound to the Navaho as if some one had been telling tales out of school, and he will resent the white man ordering him to do something he knows much more about himself. It is more likely to be successful if used as questions, somewhat as follows: "I hear in the Navaho way you have some good medicine. Is that true?" "Do you have some strong ones?" "How do you get the strong ones?" Here you will probably be told that the medicine man tells one of the men to go get them during a ceremonial, and you may even be told the exact way in which it is done. "How do you use them?" "Well, in the American way we have some strong medicines, too. This one (if it is digitalis, for instance) comes from a plant that grows in some parts of this country. We pick the leaves and dry them and grind them up and then press the powder very hard into these little pills. It makes a very strong medicine, and too much of it will hurt a person. You have to take it just the way I tell you, and then it will do your body lots of good and make you strong again." The thing to keep in mind is that the Navaho knows something as well as the doctor, and if the doctor pays him the compliment of inquiring about it in an

*Photograph by the authors*

Pine-clad Navaho Mountain

Photograph by the authors

Pinyon and Cedar Country



interested way, he will not only learn a good deal about Navahos and their point of view, but he will enlist the loyalty and confidence of his patient, who will then do his utmost to follow instructions. If the doctor contents himself with handing an anemic patient a box of iron pills and telling him to take eight a day, he is less likely to be obeyed than if he makes it a point to explain that the tests he has made show that the patient's blood is not so red as it ought to be, it is a little weak, and it will be stronger if he can make it more red again. "These pills have some good medicine in them that will do that. Part of it is iron, but of course you can't eat iron, like the blade of your knife, just by itself. It wouldn't stay in your body but would go right through you. It is the same as when a woman wants to dye some wool: she uses one plant for the color, and another plant or some ashes or some ground-up rock to make the color stick to the wool. So this medicine has something else mixed with the iron to make it stay in your body. In the white way we believe that iron will make a man's body strong, but it will take four months to make your blood just right. You must take these pills just the way I tell you and then you will start to feel a little better pretty soon. You must take two of them in the morning when you can first see the sun; two more when the sun stands here (indicate position for ten o'clock in the morning); two more when the sun is here (indicate position for two o'clock in the afternoon); and two more at sundown. That makes four times every day. If you take it in that way and don't do too much hard work, you will get strong pretty fast. If you have to go away from your hogan you should carry some pills with you, so that you can take them at the right time. The pills I have given you will last for four weeks, one month. When they are almost gone you should come back and I will make another test to see how red your blood is getting and give you some more pills."

Even white patients would follow instructions better if they were more specific, but with the Navahos it is a matter of having respect for the medicine or not having it according to the importance the doctor seems to attach to it as judged by the care of his prescription.

Way) special food is cooked for the patient. What he does not eat must be destroyed, as it will cause sickness in any one else who eats it. This principle might be spread to all food a patient eats.

These remarks about contagion are suggestions about where to begin. The ultimate goal, of course, is to have Navahos thoroughly understand the nature of bacteria and other infecting organisms, and their control. To grasp this, however, a Navaho must have a high general level of education and acculturation, while any Navaho of normal intelligence can understand contagion as a spreading of evil influences and will be interested in hearing some new rules about it. A start could be made by preparing stained slides and showing them to the patient and his family whenever the case warranted it, as from tuberculous sputum or gonorrhoeal pus.

To show possible ways of giving directions for home treatment, the following descriptions are added:

MEASLES. A child of eight is brought to the doctor at the day school. He has a rash and Koplik spots, but shows no evidence of complications in ears, lungs, or kidneys. The doctor says:

"Has your little boy been around where there were some sick children? Well, I think he has caught the measles from some of them. Have you heard about measles? A lot of people are catching measles now. Do you have some other children? Are any of them sick? Have any of them had measles already?

"This boy is not very sick now, and if you do what I tell you he will probably get along all right. If you don't he might get pus in his ears, or in his lungs, or his kidneys might start to bleed.

"The first thing you have to do is to make him lie down all the time. That might be hard to do, but you must do it if you do not want him to get more sick. Keep him warm, but not so hot that he sweats. Four times a day he has to drink four cups of water—at sunup, and here (ten o'clock in the morning) and here (two in the afternoon) and at sundown, he must drink four cups of water. He can eat some of the food you eat if you cook it nice and soft for him. Make him some soup, and cook him some rice and potatoes in the soup.

*U. S. Indian Service photograph*

Although the Navahos do not have many clocks and watches, the sun is a very reliable timekeeper and is used by them to estimate midmorning, noon, and midafternoon. First brightness in the east, sunup, and sunset are other well established points. To indicate time, one faces south, so that he faces the sun's path. With the right forefinger curled in a semicircle he will indicate the sun's position at the hour he is talking about.

Here follow some beliefs and customs that will appear more in dispensary practice than with patients in hospital and some concepts which are more useful in this connection than when nurses and hospital attendants have charge of cleanliness and decontamination techniques.

The Navahos have a deep-rooted fear of the dead. This is in part a fear of the ghost and in part a fear that by being near the dead they will come under the same evil supernatural influences that caused the death. This idea is very close to being afraid of the illness that caused the death. After a death Navahos usually get a white man to bury the corpse, but if they do it themselves a few persons are delegated for the purpose and they take off most of their clothing, avoid handling the body more than necessary, and fix up the hogan in which the death took place in such a way that no one will use it again. After the rites are over, they go through a long series of purification ceremonies, including bathing, and they avoid contact with others for four days. A hogan is often abandoned after serious illness even if death does not occur in it. A little understanding of their burial customs tends to make one more sympathetic with their habit of asking the nearest white man to bury their dead, or taking the patients to the hospital instead of letting them die at home. It is so much easier for a white man than for a Navaho.

Contagious illness could be described to Navahos as a state which is partly under the evil influences that cause death, and should be treated with similar isolation, including delegating certain members of the family to care for the patient, keeping the dishes separate, washing carefully, and maintaining a period of quarantine after the symptoms subside. One must be careful not to seem too cautious, however, or it may lead to desertion of the patient.



Portions of the body, such as hair-combings, nail parings, feces, urine, and saliva, are thought to be strongly associated with the life of the person of whom they were a part. Witches are able to bring harm to people by collecting such intimate castoffs of the body and doing evil things to them which soon affect the person from whom they came. Medicine men, endowed with the power of the gods, frequently use their saliva to help the patient by chewing and spitting concoctions on him. We would call most of these ideas magical, but it is a contagious magic and here we meet on common ground with the Navaho. We and they agree that saliva and excreta are important and powerful in some instances. Starting on such a basis, a doctor or nurse could draw parallels to show that the saliva and excreta of the sick are dangerous because they carry with them some of the evil that affects the sick person.

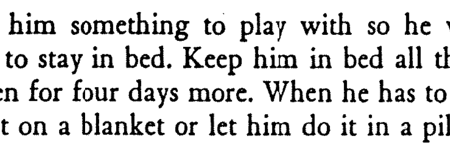
In making recommendations, one must remember that the less he interferes with the established way of life, the more successful he will be. One of the day school teachers was offended by the Navaho custom of spitting freely and forbade it inside her school. However, it was impossible to suppress the habit entirely, so she allowed spitting into tin cans partly filled with sand. During a subsequent measles epidemic she was pleased to find that in nearly every hogan where there were sick people, the patient was doing all his spitting into such a can or into a pile of soft sand which could be carried out on a shovel.

Fire is powerful. As lightning it may be full of danger or, if properly handled, will protect a person from other danger. As the means of heating the hogan and cooking food it is revered, and ceremonially it is one of the means taken to get rid of evil. From this start it is possible to recommend fire as a means of sterilizing things used by a sick person—burning the contents of sputum container, burning cloths used where there is pus, boiling or heating in the flame eating utensils the patient has used, and boiling his clothes and bedding when he recovers. When Navahos come to the hospital they may be shown the way the hospital sterilizes all contaminated objects and how the dishes are washed.

In some ceremonials (for example, the Chiricahua Apache Wind

*Photograph by the authors*

A Bridge Built by Wind and Rain





"Get him something to play with so he won't mind so much having to stay in bed. Keep him in bed all the time for four days, and then for four days more. When he has to go to the toilet, carry him out on a blanket or let him do it in a pile of sand on a shovel that you can take outside. If he spits, make him do it in a can with some sand in it. After eight days he can begin to sit up, and in four days more you can let him walk outside a little.

"You must keep the other children away from him as much as you can, but if they begin to get sick, you can put them to bed alongside this boy and take care of them the same way I have been telling you.

"Don't let any other children come to play with your children because if they do they will get the measles, too. Don't let them go to Sings or to the traders. Just keep them at home, but if they get the measles, take good care of them and they won't get too sick either."

IMPETIGO. A child of two is brought in with a good many crusts on his face, which is smeared with red clay and grease. He has had the crusts for one week and his mother has one on her breast. The doctor says:

"This child has some skin disease, and you have caught it from him a little, on your breast. We have some ointment here that is good for that kind of skin disease. This ointment is made with the grease from sheep's wool and some special kind of white rock that they grind up real fine. When they put the ground-up rock in the grease, that makes it all soft and it helps this kind of skin disease a whole lot. You will have to use it just the way I tell you or it won't do much good.

"The baby is not going to like what you have to do to cure this skin trouble, but you will have to let him cry a little. There are some very, very small bugs underneath these crusts. This ointment here will kill those bugs, but the crusts make it too safe for them. You have to take off the crusts first, and then the ointment will kill the bugs.

"I will let you do it because the baby knows you and you can

do it kind of easy. First let's wash off this grease and clay with this liquid soap. Now let's pull off these crusts, kind of gently, but quick, and then it won't hurt the baby so much. Now take some of this ointment and rub it into his face pretty good. Don't let him scratch his face any because that will just make it more sore. Now do the same thing to that place on your breast. That is very good. You are almost like a nurse.

"I will give you some of this ointment and a bottle of this liquid soap to take home with you, and some of this cloth to use to wash his face. I want you to use it this way: In the morning at sunup do just like you did now, wash his face, take off the crusts, rub in the ointment. When the sun is here (ten o'clock) rub in some more ointment. When the sun is here (two o'clock) rub in some more ointment. At sundown wash his face, take off the crusts, rub in some more ointment. Can you remember everything that I told you?

"Do you have some other children? Don't let them touch the baby till his face is all cured, or they may get some sores, too. And don't let them use this cloth. Keep the cloth just to wash his face and your breast. Every morning after you have washed his face with it you ought to put it in an old pot with some water and let it boil in the fire quite a while. Then hang it out in the sunshine. The boiling water and the sunshine will kill any of the bugs that get on the cloth from under the crusts. Don't use the pot for anything else, and when his face is all well, throw the pot and the cloth away. Do all these things just like I have told you and his face will get better pretty quick."

MALNUTRITION. A mother brings in a baby of nine months with complaint that he is not very fat and he cries all the time. The doctor says:

"What do you feed this baby? He just sucks? Do you give him anything else to eat? Not anything? Well, I think maybe you do not have enough milk for this baby. Did you ever hear about mothers who don't have enough milk? I have seen some mothers who don't have any milk at all, and I have seen lots of them who don't have enough for their babies when they get as old as this boy.



Is he your first baby? I guess that is why you didn't hear about that yet. I think this baby is not getting enough to eat, he is hungry. Does he cry a lot? Well, that is because he is hungry. What kind of food do you eat? Bread, coffee and mutton? I think that is too strong for this baby yet. He doesn't have many teeth to chew that mutton or that bread with, does he? He can't swallow that kind of food very well if he doesn't chew it up first.

"Maybe you can do this: Maybe you can get some milk for him. Do you know anybody who has some goats? You have some goats? Well, that is fine. Do you milk them? No? Do they look like they had some milk? Well, I think this boy needs two cups of goat's milk every day, two full cups. Do you think you can get that much? He doesn't want it all at one time. He can have half a cup of goat's milk four times every day. Does he drink water out of a cup? Oh, he never drinks any water? Well, you can see if he will drink the goat's milk out of a cup. If he doesn't like that, you can buy him a bottle and a nipple at the traders. If you buy him a bottle and nipple, you have to keep them nice and clean. Every time he has a drink of goat's milk, right after that you have to wash the bottle and the nipple with hot water and put it where the flies won't walk on it. Every morning you have to put that bottle and nipple into some water in a pot and put it in the fire until it boils hard. That way you can keep it nice and clean.

"I want you to give this baby one-half cup of goat's milk when you can just see the sun; then one-half cup more when the sun is right here (ten o'clock); then one-half cup more when the sun is here (two o'clock); and then one-half cup at sundown. Can you remember what I told you?

"Do you eat any mutton in your home? You have it every week? Well, if you make some soup for this baby, he can eat that. You can put it in his mouth with a spoon. Don't let it be too hot. And do you have some potatoes? He can have some potatoes if you cook them nice and soft and mash them up for him.

"If you give him all that to eat, I think he will get nice and fat, and I don't think he will be crying much. Bring him back here in four weeks and we will see how fat he is getting."

Bugs in hair. The complaint is that a little girl of seven has sores in her hair. Her hair is matted and full of nits. The sores are excoriations from scratching bug bites. The doctor says:

"It looks to me like this little girl has lots of bugs in her hair. They make her head itch, and when she scratches she pulls the skin right off and makes a sore place. When did you wash her hair last time? Long time ago? I am sorry you didn't wash it every week. If you wash it every week with yucca and lots of water, it wouldn't have so many bugs in it.

"Now she has so many bugs it is kind of hard to get rid of them. Shall we cut all her hair off? It will grow again pretty soon. You don't want to do that? Then I will tell you what you have to do to get rid of these bugs. First take this comb and comb her hair good. That is going to take you quite a while. ——— Is it all combed? That looks a lot better already. You ought to comb her hair every day if she can't do it herself. Now come over here and wash it for her in this basin with this yellow soap. Yucca root would be good to wash it with, but I don't have any yucca. Get a lot of soap into it, and then rinse it all out so there isn't any soap left. There, that looks good. I think most of the bugs are killed now, but you see all these little white things in her hair? Those are kind of like seeds. A new bug comes out of every one of those white things unless you get rid of them or kill them.

"Now here is some kerosene. That is the same stuff you put in lamps to make a light. This will get into those little white seeds and kill them. You don't have to use a whole lot. Just sprinkle a little on her hair. Try not to get it into the sore places or it will make them sting. Put it on the hair in back too, the long hair. Now we have to put her hair up on top of her head and tie some cloth around it so that kerosene will stay there a while and won't dry up too fast. That is good. Now leave it there till sundown. Tonight she can take that cloth off and let her hair loose.

"You have to do these things I showed you for the next four days. Every day right after breakfast do all these things, and then leave that cloth on her head till sundown.

"Do some of your other children have bugs? Not so bad as this



girl? Well, I think you ought to do all these things to their hair, too, to get rid of the bugs. You ought to try to find out where the bugs come from. Maybe there are a lot of them in the sheepskins or in the blankets. If you find a lot in the blankets, wash them in real hot water and hang them in the sunshine to dry. If there are a lot in the sheepskins, try to get rid of those sheepskins and get some new ones.

"Don't forget after you get rid of all the bugs to wash all the children's hair every week with yucca and water. That way you won't have any more trouble with them, I think."

Table 1 - 2 Sample questions for the American SPIRITual history
To Identify Indians using Traditional Indian Medicine (TIM)

| | |
|---|---|
| **S**<br>Spiritual Belief System | What is your spiritual belief system?<br>Do you culturally identify with a tribe?<br>Do you follow or ascribe to the traditional beliefs of your tribe?<br>Do you know your tribes creation story?<br>Do you believe in the Traditional Indian medicine of your tribe? |
| **P**<br>Personal Spirituality | Describe the beliefs and practices of your spiritual system that you personally accept.<br>What does your spirituality mean to you?<br>Do you participate in the spiritual ceremonies of your tribe?<br>Do you know the purpose of your tribal ceremonies?<br>Do you know where your tribes' sacred places are? |
| **I**<br>Integration with Spiritual Community | Do you belong to an Indian spiritual or religious group such as:<br>Shaker Church<br>Native American Church<br>Tribal specific religion<br>What is your position or role?<br>Is it a source of support?<br>Could this group help in dealing with health problems?<br>Who are the traditional healers or herbalists that may help you with health problems?<br>Would you like me as your physician to collaborate with your healer(s) in regard to your health? |
| **R**<br>Ritualized Practices and Restrictions | Do you participate in the spiritual ceremonies of your tribe (sweat lodge, smudging, Shaking tent, Blessing way, peyote, to name a few).<br>Which ceremonies used vary by tribe and geographic location?<br>Do you use herbal remedies recommended by your tribal healer? If so, how often?<br>Are you allowed to share the herbal medicine you use?<br>Are you using both TIM and modern western medicine (MWM) to treat your health problems?<br>Should you become hospitalized, are there ceremonies to be performed in this setting (e.g., birthing, illness specific)?<br>Do you speak your tribal language?<br>Are you knowledgeable of your tribes native medicines? |
| **I**<br>Implications for Medical Care | What aspects of your spiritually would you like me to keep in mind as I care for you?<br>Do you wish me to collaborate with your TIM healer as you make your decisions about your health care?<br>Is it important to you that I am aware of the TIM practices and herbs you use?<br>Do you want a MWM perspective in the TIM practices and herbs you use?<br>(to acknowledge a positive outcome or to prevent side effects or potential harm with drug interactions)<br>Do you want me to participate, if asked, in TIM ceremonies used as a part of your health care? |
| **T**<br>Terminal Events Planning | As we plan for your health care near the end of your life, how does your faith impact your decisions?<br>Are there particular aspects of western allopathic health care you wish to forgo because of your faith?<br>Are there TIM ceremonies that may be required near the end of our life - where my role may be to facilitate these occurring in a hospital, nursing home or long-term care facility?<br>(**Be aware of discussing terminal events with certain tribes, i.e., Navajo, should only be done, if at all, with special technique). |

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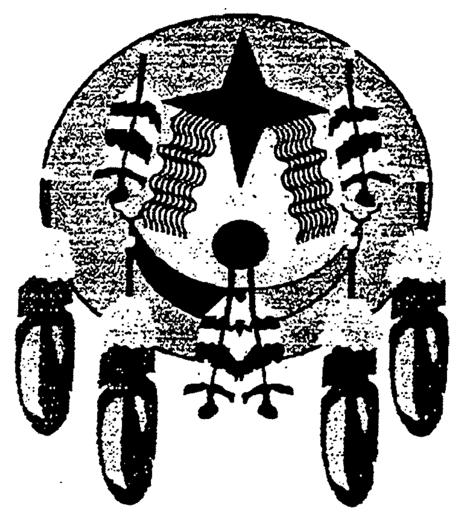

# Association of American Indian Physicians

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## Traditional Medicine Bibliography

**Compiled By: David Baines, M.D.**


Avery, Charlene, M.D. *Native American Medicine: Traditional Healing*. Journal of American Medical Association, v. 265, no. 17, May 1991, pp. 2271-2273.

Backup, R. W., RN, MN. *Health Care of the American Indian Patient*. Critical Care Update, February 1980, pp. 16-22.

Beauvais, F., Ph.D. *Drug and Alcohol Abuse Intervention in American Indian Communities*. The International Journal of the Addictions, v. 20(1), 1985, pp. 139-71.

Bell, Cathy. *The Navajo Patient: Illumination of Cultural Differences*. Colorado Medicine, v. 77(4), April 1980.

Berlin, E. A. *A Teaching Framework for Cross Cultural Health Care*. Western Journal of Medicine, v. 139(6), December 1983, pp. 934-938.

Borkan, Jeffrey. *A Developmental Model of Ethnosensitivity in Family Practice Training*. Family Medicine, v. 23, no. 3, March/April 1991, pp. 212-217.

Bozof, R. P. *Some Navaho Attitudes Toward Available Medical Care*. American Journal of Public Health, v. 62(12), December 1972, pp. 1620-1624.

Buehler, Janice. *Traditional Crow Indian Health Beliefs and Practices*. Journal of Holistic Nursing, v. 10, no. 1, March 1992, pp. 18-33.

Bushnell, Jeanette M., RN. *Northwest Coast American Indian Beliefs About Childbirth*. Issues in Health Care of Women, v. 3, 1981, pp. 249-261.

Camazine, Scott M. *Traditional and Western Health Care Among the Zuni Indians of New Mexico*. Social Science Medicine, v. 14B, pp. 73-80.

Carrese, Joseph. *Western Bioethics on the Navajo Reservation*. Journal of the American Medical Association, v. 274, no. 10, September 1995, pp. 826-845.

Coulehan, J. L., M.D., MPH *Navajo Indian Medicine: A Dimension in Healing*. The Pharos, July 1976, pp. 93-96.

Coulehan, J. L., M.D., MPH. *Navajo Indian Medicine: Implication for Healing*. The Journal of Family Practice, v. 10(1), 1980, pp. 55-61.

Dekrey, Ramona, RN, BSN. *The Medical Tribe: A Trans Cultural Teaching Device*. The Journal of Practical Nursing, December 1988, pp. 35-37.

Deloria, Vine Jr. *Indian Education, Traditional Technology*. AISES Magazine, pp. 12-17.

Flores, Phillip John, Ph.D. *Alcoholism Treatment and the Relationship of Native American Cultural Values to Recovery*. The International Journal of the Addictions, v. 20 (11 & 12), 1985-86, pp. 1707-1726.

Fortune, Robert, M.D. *Traditional Surgery of the Alaska Natives*. Alaska Medicine, J.F.M., 1984, pp. 22-25.

Fuchs, M. *Use of Traditional Indian Medicine Among Urban Native Americans*. Medical Care, v. 13(11), November 1975, pp. 915-927.

Green, Henry J., M.D. *Risks and Attitudes Associated With Extra Cultural Placement of American Indian Children: A Critical Review*. Journal of the American Academy of Child Psychiatry, v. 22, 1983, 1: 63-67.

Guilmet, G. M. *Health Care and Health Care Seeking Strategies Among Puyallup Indians*. Culture Medicine and Psychiatry, v.8, 1984, pp. 349-369.

Guilmet, George. *Cultural Lessons for Clinical Mental Health Practice*. The Puyallup Tribal Community. American Indian and Alaska Native Mental Health Research, v. 1, no. 2, October 1987, pp. 32-49.

Halfe, L. B. *The Circle: Death and Dying from a Native Perspective*. Journal of Palliative Care, v. 5:1, 1989, pp. 37-41.

Hamerschlag, Carl A., M.D. A Doctors Journey of Healing: The Dancing Healers. New York: Harper Row, 1988.

Heber, Lou. *Self Theory: Framework to Cross Cultural Nursing Practice*. Saskatchewan Registered Nurses Association, December 1992, pp. 18-19.

Hershman, M. J. *American Indian Medicine*. The Royal Society of Medicine, v. 78, June 1985, pp. 432-434.

Hill, Robert F. *Culture in Clinical Medicine*. Southern Medical Journal, v. 83, no.9, September 1990, pp. 1071-1079.

Horn, Beverly, RN, Ph.D. *Cultural Beliefs and Teen Pregnancy*. Nurse Practitioner, September 1983, p. 35.

Judkins, Russell A., Ph.D. *Diabetes and Perception of Diabetes Among Seneca Indians* New York State Journal of Medicine, July 1978, pp. 1320-1323.

Kaufert, J. M. *Role Conflict Among Culture Brokers: The Experience of Native Canadian Medical Interpreters*. Social Science Medicine, v.18(3), 1984, pp. 283-286.

Krumenacker, Mona. *Goal Planning in a Culturally Specific Program*. Saskatchewan Registered Nurses Association. December 1992, pp. 20-21.

Kunitz, S. J. Disease, Change and the Role of Medicine In The Navajo Experience. Berkeley: U of California Press, 1983.

LaFromboise, Theresa A. *Cultural and Cognitive Considerations in the Prevention of American Indian Adolescent Suicide*. Journal of Adolescence, v. 11, 1988, pp. 139-153.

Lang, G. C. *Making Sense About Diabetes: Dakota Narratives of Illness*. Medical Anthropology, v. 11, 1989, pp. 305-327.

Lawson, Lauren. *Culturally Sensitive Support for Grieving Parents*. Material Child Nursing, v. 15, March/April 1990, pp. 76-79.

Levy, Jerrold. *Indian Healing Arts*. The American Way, September 1971, pp. 24-33.

Long, Walker A., M.D. *Lessons From the Traditional American Indian Medicine Man*. The Pharos, Winter 1984, pp. 7-10.

McWhorten, John. *American Indian Medicine*. Southern Medical Journal, v. 185, no. 6, June 1992, pp. 625-627.

Miller, Jay. *Native Healing in Puget Sound*. Caduceus, Winter 1992, pp. 1-15.

Miller, Patricia. *Health Beliefs and Regimen Adherence of the American Indian Diabetic*. American Indian and Alaska Natives Mental Health Research, v. 9, pp. 24-36.

Murray, Raymond H. and Scrinaing, Bernard. *Physicians and Healers: Unwitting Partners in Health Care*. New England Journal of Medicine, v. 326, no. 1, pp. 61-64.

Peterson, Paul B. Counseling Across Cultures. 3rd ed. Honolulu: U of Hawaii Press, 1989, ISBN O-8248 1231-X.

Prieto, David. *Commentary on Native Americans in Medicine: The Need for Indian Healers*. Academic Medicine, July 1989, pp. 388-389.

Putsch, Robert. *Ghost Illness: A Cross Cultural Experience With the Expression of a Non-Western Tradition in Clinical Practice*. American Indian and Alaska Native Mental Health Research, v. 2, no. 2, pp. 6-26.

Roessel, Ruth. *Questions and Answers Dealing With Navajo Religion*. Personal Paper.

Rose, Balerie. In Harmony With the Earth. Nursing Times, v. 88, no. 15, April 1992, pp. 58-60.

Ross, J. A., MA. *Indian Shamans of The Plateau, Past and Present*. Medical Bulletin, Fall 1989, pp. 52-57.

Shebala, Barbara. *The Navajo Way*. New Mexico Nurse, December 1983.

Slagle, Logan. *The Indian Shaker Church and Alcoholics Anonymous Revitalistic Curing Cults*. Human Organization, v. 45, no. 4, 1986, pp. 310-319.

Slonim, A. B., R.D. *The Cultural Appropriateness of the WIC Program in Cherokee North Carolina*. Journal of the American Dietetic Association, v. 79, 1981, pp. 164-168.

Sobralske, Mary C., RN. *Perceptions of Health*. Navajo Indian Topics in Clinical Nursing, October 1985, pp. 32-39.

Straight, William M., M.D. *Disease and Medicine Among the Pre-Seminole Indians of Florida*. Journal of Florida Medical Association, v. 71(7), 1984, pp. 429-490.

*Traditional Navajo Theories of Disease and Healing*. Arizona Medicine, July 1972, p. 571.

Waldram, James. *Access to Traditional Medicine in a Western Canadian City*. Medical Anthropology, v. 12, pp. 325-348.

Walker, Dale. *Definitions, Models and Methods in Research on Socio-Cultural Factors in American Indian Alcohol Use*. Substance and Alcohol Actions/Misuse, v. 5, 1984, pp. 9-19.

Wiedman, Dennis. *Big and Little Moon Peyotism as Health Care Delivery Systems*. Medical Anthropology, v. 12, 1990, pp. 371-387.

Wuest, Judith. *Journey Together: Students and Faculty Learn About Transcultural Nursing*. Journal of Nursing Education, v. 31, no. 2, February 1992, pp. 90-92.

# WHAT IS THE CULTURAL COMPETENCE PROTOCOL?

- It Is A Tool By Which Health Care Providers And Organizations Can:
  - Determine Provider Knowledge Of And Effectiveness In Meeting Patient's Health Care Needs
  - Document Characteristics Of Their Relationship With Their Patients And Their Communities
  - Assess Workforce, Administration And Management Roles And Status Regarding Cultural Diversity
  - Review The Current Status Of Their Diversity Activities
  - Document Positive Actions Within Their Settings
  - Identify Areas For Improvement
  - Provide A Framework For Developing Measures Of Progress In Achieving Desired Process And Outcome Measures

# DEVELOPMENT OF A FRAMEWORK FOR CONSIDERING CULTURAL COMPETENCE FROM A BROAD PERSPECTIVE

- Premise: That a Systems Approach Involving Health Care Providers, Organizations and Their Community Is Most Effective If Not Required in Developing and Sustaining Cultural Competence

# CREATING A GUIDE AND METHOD FOR REVIEWING CULTURAL DIVERSITY

- Develop a Design That Includes Opportunity for Self Assessment and/or External Assessment
- Create Information for Application of Assessment
- Establish a Way for Health Care Providers/Organizations to Measure and Compare Themselves
- Develop Resources for Organizations
- Promote Highlighting Promising Innovations

# POTENTIAL IMPLICATIONS OF THE CULTURAL COMPETENCE DESIGN FOR MANAGED CARE, PROVIDERS AND THEIR COMMUNITIES

- A Tool for Review -- An "Audit" of the Organization's Diversity Activities
- A Way to Measure the Level of Effort on Diversity Throughout the Organization
- A Tool for Identifying Diversity Strengths and Areas Requiring More Attention
- A Framework for Comparing Diversity Progress with Other Organizations
- An Education/Information Tool and Process for Involving Students, Community Representatives, Board Members, Health Care Staff, Other Staff and Administration in Improving and Understanding Diversity
- Provide a Framework for Developing Diversity Guidelines for Health Care Organizations

# II. A DESIGN FOR MEASURING HEALTH CARE ORGANIZATION AND SERVICE EFFECTIVENESS FOR DIVERSE COMMUNITIES

# WHAT ARE THE LIMITATIONS OF THE CURRENT CULTURAL DIVERSITY INITIATIVES?

- Lack of an Overall Vision and Systems View for Cultural Competence -- A "Gestalt" -- Within Organizations
- Fragmentation Within Organizations in Addressing Diversity
- Failure to Effectively Assess the Cultural Factors in the Community and to Involve the Community
- Lack of Buy-in or Active Involvement From Critical Parts of the Organization—Health Care Professionals and Administration in Particular
- Limited Scope of Workforce Diversity Efforts

# WHAT HAVE BEEN THE TYPICAL "INITIATIVES" UNDERTAKEN BY THE HEALTH CARE COMMUNITY TO ADDRESS DIVERSITY?

- Workforce Diversity Training
- Some Effort to Address Interpretation and Translation Needs
- Ad Hoc Service Programs

# WHY SHOULD MANAGED CARE PROVIDERS AND ORGANIZATIONS CONSIDER CULTURAL COMPETENCE IN HEALTH CARE A PRIORITY?

- Efficiency and Cost-Effectiveness in Provision of Services
- Delivery of High Quality Care
- Marketing/Recruitment/Retention of Enrollees in Plans
- Marketing/Recruitment/Retention and Productivity of the Health Care Workforce
- Facilitating Access to Care

**CONSIDERED IN THE CONTEXT OF THE CHANGING DEMOGRAPHICS AND ECONOMICS OF THE US POPULATION, IT IS BECOMING A MATTER OF HEALTH CARE ORGANIZATION SURVIVAL AND SUCCESS**

# THE SPECTRUM OF CULTURAL COMPETENCE

Stage Zero: Inaction

Stage One: Symbolic Action and Initial Organization

Stage Two: Formalized Internal Action

Stage Three: Patient and Staff Cultural Diversity Initiatives

Stage Four: Integration and Measurement of Cultural Diversity Programs and Dimensions

# DIMENSION IV: POINTS OF INFLUENCE

## The Provider / Patient Relationship

- Provider Pressures (managed care)
- Students & Medical Education
- "Irrelevance" of Cultural Issues for Physicians
- Patient Attitudes Toward staff
- Medical Hierarchy
- Staff biases (re: minorities)
- Interpreter Services
- Generational Differences
- Authority Figures

# DIMENSION III: POINTS OF INFLUENCE

## Intra-Staff Experience at All Levels of the Workforce

- Staff Longevity
- Staffing at all Levels as a Reflection of the Community
- Role of Unions
- Employee Assistance History (mentoring, promotions)
- Class vs. Race

# DIMENSION II: POINTS OF INFLUENCE

## Policies and Actions of Administration & Management as They Affect Staff

- Role/Image of CEO Regarding Cultural Diversity
- Leadership Regarding Cultural Diversity
- Importance of Financial Commitment
- Role of Medical Education
- Employee Focus vs. Staff focus
- Levels of Management & Departments Involved
- Crisis Management vs. Planning around Cultural Diversity
- Community Services Outreach (community care)

# DIMENSION I: POINTS OF INFLUENCE

## The Organization's Relationship with Its Community

- Community History
- Environmental Pressures (financial, public issues)
- Community Perceptions of Hospital/Health System
- Hospital Characteristics (volume, wait time, work pressure, layout, age of physical plant)
- Hospital History (strikes, suits, national & local issues)

# THE FOUR DIMENSIONS OF CULTURAL DIVERSITY IN HEALTH CARE

1. The Organization's Relationship With Its Community
2. Policies and Actions of Administration and Management As They Affect Staff
3. Intra-Staff Experience at All Levels of the Workforce
4. The Patient-Provider Relationship

# WHAT IS CULTURAL COMPETENCE IN HEALTH CARE?

- No Single Definition
- But Can Be Described As Effectively Incorporating the Ethnic/Cultural Characteristics of Individuals and Their Communities in Addressing Their Health Care Needs in Promoting Health

# WHY HAS CULTURAL COMPETENCE IN HEALTH CARE BECOME MORE IMPORTANT AT THIS TIME?

- Increasing Diversity of the US Communities *Throughout the Country* and For Major Urban, Suburban and Other Areas
- Increasing Financial Leverage of Diverse Populations Exerted in Business Sector — the Power of the Purchaser
- For Poorer Populations From Diverse Communities, New Power and Greater Choice Through State Medicaid Managed Care Programs
- Growing Diversity of the US Workforce

# I. OVERVIEW -

## WHAT IS CULTURAL COMPETENCE IN HEALTH CARE ?

# TOWARD A MORE CULTURALLY COMPETENT SYSTEM OF CARE: CREATING OPPORTUNITIES FOR MANAGED CARE ORGANIZATIONS, PROVIDERS AND COMMUNITIES

## AMERICAN ASSOCIATION OF HEALTH PLANS CONFERENCE: REINVENTING MEDICAID: NEW SOLUTIONS FOR NEW CHALLENGES


DENNIS P. ANDRULIS

PRESIDENT

NATIONAL PUBLIC HEALTH AND HOSPITAL INSTITUTE

WASHINGTON, DC


SEPTEMBER 10, 1997

| STAGE | ASSUMPTION | OUTCOME | EXAMPLE |
|---|---|---|---|
| **Cultural Competence** | The organization or person values differences and power in meaning. | Recognition of our responsibility for the health of **all** patients. | Policies & structures that govern health systems take into account the broad and specific needs of all people. |
| | Culture is not understood as a trait that other people or groups possess, but it is understood as a dynamic relationship between individuals and the context from which it emerges. | A comprehensive plan developed with a capacity for ongoing self-assessment to incorporate the concerns of all populations, including traditionally excluded populations. | There is a fluid relationship between the curriculum and the health realities of communities. |
| | | | The curricula reflects the knowledge, skills, and attitudes necessary to work with diverse populations. |
| | An appreciation of the inherent self- interest in considering the values of others gained. In learning about the "other", we learn about ourselves. | Diversity initiatives are no longer seen as initiatives, rather they are seen as part of the work mission of the institution at all levels. | The environments where health care is delivered or taught are considered as important as the the patient. Empathy fostered for the patient is extended to oneself. |
| | Acquiring a deeper understanding of interdependence. | Community input and influence felt in the institution. | |

| STAGE | ASSUMPTION | OUTCOME | EXAMPLE |
|---|---|---|---|
| Valuing Difference | Differences are valued and perceived as needed. | Efforts set to understand what is invisible. | Clinical services designed with diverse populations in mind as reflected in hours of operation, location of services, management, staffing and institutional policies. |
| | Belief in the underlying vitality of difference without confusing diversity with oppression. | Increased awareness of the limitations of current frameworks. | |
| | Understanding of the dynamics of difference. | Commitment to diversity reflected in involvement of leadership and allocation of resources. | Institution conducts self-assessment, identifies strengths and gaps in education. Develops a plan of action to develop a culturally competent curriculum and |
| | Difference exists in all. | Institutions acknowledge historical and social context of difference with policy statements and procedures. | |

| STAGE | ASSUMPTION | OUTCOME | EXAMPLES |
|---|---|---|---|
| **Symbolic Action & Organization** | Increased awareness of diversity.<br><br>Multiculturalism seen as something important for others.<br><br>Difference something others have. | Peripheral, altruistic, ad hoc efforts to address issues.<br><br>No formal mechanisms or dedicated resources in place. Not a priority.<br><br>Individuals efforts, fending for yourself. | Special days to celebrate diversity, ethnic dishes in the cafeteria, bilingual signs without bicultural services.<br><br>Lectures examining diversity, access to information is voluntary. Students not held accountable for developing the competencies necessary to work with diverse populations.<br><br>Nutrition department translates recipes for diabetics without adapting them to patients economic realities/preferences. |
| **Formalized Internal Action** | Need to address diversity seen as practical, political, economic.<br><br>"Business" motive.<br>"Culturalists" approaches. | Increased hiring of diverse staff, but not for key positions. Committees formed. Management involved, no integration. | Effects of for profit model are obscured in marketing campaigns. Bilingual, bicultural staff hired, system of care still a "translation."<br>No community input, tokenism. |

# SPECTRUM OF CULTURAL COMPETENCE

| STAGE | ASSUMPTION | OUTCOME | EXAMPLE |
|---|---|---|---|
| **Cultural Destructiveness** | Superiority of one group | Inequality | Colonial structures/genocide |
| | Difference = deviance | Cultural destruction of targeted "lesser" group. | Discriminatory hiring, lending, law enforcement practices. |
| | | | Silence in the curriculum re: destructive health effects of discrimination, or worse, justification for them i.e. Tusgegee experiments. |
| **Cultural Blindness** | Being non-biased = denial of difference | Myth of theoretical sameness. | "English only" system of care. |
| | Assumed equity | Dominant groups position prevails. | "One size fits all" curriculum. |
| | | Only the most assimilated benefit. | Disregard for race, gender, or ethnic based responses to meds. |

# AAIP

## Traditional Medicine

Native American Plant and Herb Knowledge

Native American Food Guide

CDC's Diseases: Closing the Gap

Other Links - Plants & Herbs

AAIP Speaker's Bureau

Cross Cultural Medicine Workshops

Traditional Medicine Clerkship

Tobacco Seed Bank

Univ of Washington Medicinal Herb Garden

Native American Health History - Univ of New Mexico database of articles

Traditional Medicine Bibliography

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Just as there are many tribes with unique cultures, there are many approaches to traditional medicine. AAIP does not endorse any single method but recognizes the diversity that exists and supports the rights of the tribes to continue the traditions that have been passed down through many generations.

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Who We Are | Activities | Resources for Health Professionals
Traditional Medicine | Student Activities | Policy
Membership Information/Newsletter | Classified | NEW!

## AAIP Traditional Medicine Clerkship Program

The Association of American Indian Physicians (AAIP) is currently accepting applications for the Traditional Medicine Clerkship Program. It involves Native American physician preceptors providing educational experiences in the provision of health care for Native Americans through a community health care system (urban or reservation) which encompasses the sociocultural implications of Native American medical practice as provided through traditional Native American healers.

This program will provide the American Indian medical students with a greater understanding of traditional healing practices and how it could be integrated into a health system utilizing both western and traditional medicine. Expected outcomes will include an expanded understanding of Native American focused community health care systems and health issues particularly pertinent to this population and how these are impacted by traditional Native American healers. Other expected outcomes will include but are not limited to greater insight by the students into the healing practice of traditional medicine men; perceptions of Native American patients with respect to disease and health care; and interfaces between traditional Native American and western medicine.

The program is open to Native American medical students who are in their third and fourth year and are in good standing with their respective medical schools. Students selected for the program will be provided airfare/mileage to and from their home or school to the clerkship site. A weekly stipend will be issued to the student. Housing for the student will be arranged in available apartments or hotels or in some cases students will stay with a family in the area as close to the clerkship site as possible. Some of the clerkship sites are located in New Mexico, Montana, Arizona, Alaska, Minnesota, Washington, Wisconsin and Oklahoma.

The clerkship is 4-6 weeks in duration, The student will spend 3 days in the clinical setting, 1 day in the community and 1 day with the traditional healer. Clerkships are limited and efforts will be made to accomodate students in scheduling. Contact the AAIP office for more information and an application. (405) 946-7072.




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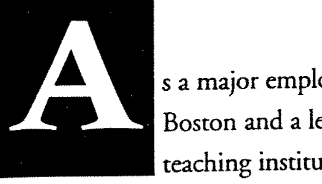
# A Mosaic of Partnerships

## Beth Israel Deaconess Medical Center Community Report 1997-1998

# Building Community

## Through Education and Career Opportunities



s a major employer in Boston and a leading teaching institution nationally, Beth Israel Deaconess has a commitment to education. Through the years we have participated in a number of programs, including encouraging elementary school youngsters to consider careers in health, providing on-site learning experiences for teens, and hosting classroom-based sessions for community residents. From programs at the Winship Elementary School, to ABCD's summer youth employment program, to the Visiting Clerkship Program for minority third- and fourth-year medical students, Beth Israel Deaconess is committed to building the community through education and career opportunities. Below are highlights of two special programs:

### Project ProTech

Through this school-to-career program, Boston public high school students are given the opportunity to prepare for careers in healthcare and other fields. This year again, Beth Israel Deaconess participated in Project ProTech by having students work in various medical center settings such as the Histology Lab, EEG, the Animal Research Labs, and the Department of Nursing.

### Jovenes Latinos Pro Salud

Motivated by curiosity about careers in medicine, as well as the opportunity to earn money this summer, 15 high school students from Mission Hill participated in Jovenes Latinos Pro Salud. Co-sponsored with Sociedad Latina, Inc.—Boston's only Latino youth agency—the program required each student to complete a "cultural competence" project while working in one of seven different medical center departments. Whether they were creating a Spanish Speakers' Bureau or developing nutritious menus incorporating Latin foods, Beth Israel Deaconess learned as much from the students as they did from us. ■

# Creating Partnerships:

## A Good Neighbor

Beth Israel Deaconess prides itself on being a good corporate citizen. Employing close to 10,000 people, many of whom are Boston residents, the medical center is a major economic force. We are awarded approximately $100 million in research funds annually, most of which comes from out of state and is spent largely in Boston.

### Helping the Fenway/Mission Hill Communities

The adjacent neighborhoods of Mission Hill and Fenway enjoyed a special relationship with the former Beth Israel and Deaconess Hospitals, and that partnership continues today. Through the Mission Hill/Fenway Neighborhood Trust, Beth Israel Deaconess contributed $1.62 million dollars to enhance quality of life through affordable housing, youth programs, elderly programs, and social services. Our Jobs Contribution Grants to the City of Boston also target the Fenway and Mission Hill communities, adding another $330,000 of support to residents of these neighborhoods.

### Supporting Local Community-based Organizations

Good health goes beyond medical services provided by physicians and nurses. It involves adequate housing, good nutrition, and a healthy environment free of toxins, cockroaches, and lead paint. Many of these ancillary social services are provided by local community-based organizations with whom we work on a regular basis. So whether it's working with the Kit Clark Senior Center to help Haitian elders obtain United States citizenship, or hosting a reception to support gay and lesbian violence-prevention programs, Beth Israel Deaconess supports community-driven initiatives. These efforts include financial support, but more importantly, they bring human resources and the richness of the medical center's expertise to a variety of important fronts.

### Uncompensated Healthcare

Over the past few years, we have heard much about the uninsured and underinsured in our nation. Yet in Massachusetts, we are fortunate that a system of care has evolved to ensure that those who need care can access appropriate services. To help make this possible, Beth Israel Deaconess and our colleagues provide unreimbursed charity care and also contribute to the statewide uncompensated care pool. For Beth Israel Deaconess this amounts to more than $29 million each year, and reflects our belief that everyone is entitled to quality healthcare.

### Payment in Lieu of Taxes

Being a good not-for-profit corporate citizen means not only providing special programs and free care to the underserved, but also making payments in lieu of taxes. This year, Beth Israel Deaconess made payments of more than $200,000 to the Cities of Boston and Chelsea. ■

# THE ASSOCIATION BETWEEN WESTERN AND NAVAJO MEDICINE

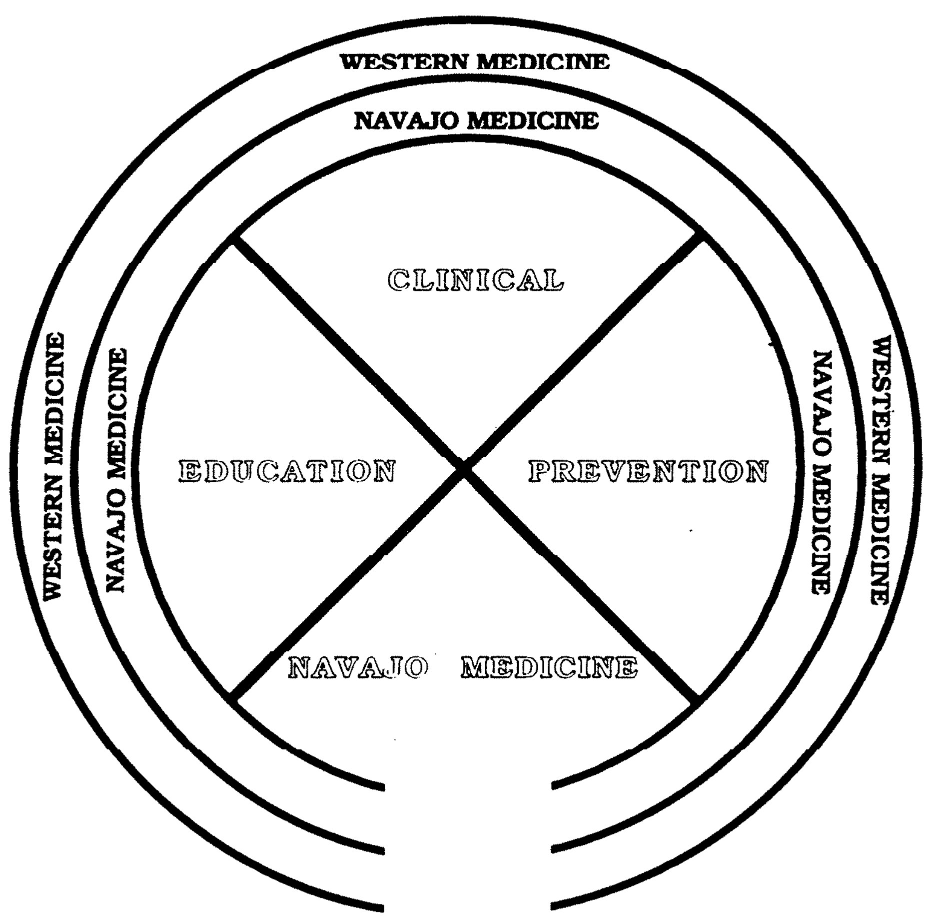



FIG.1

# THE ASSOCIATION BETWEEN WESTERN AND NAVAJO MEDICINE

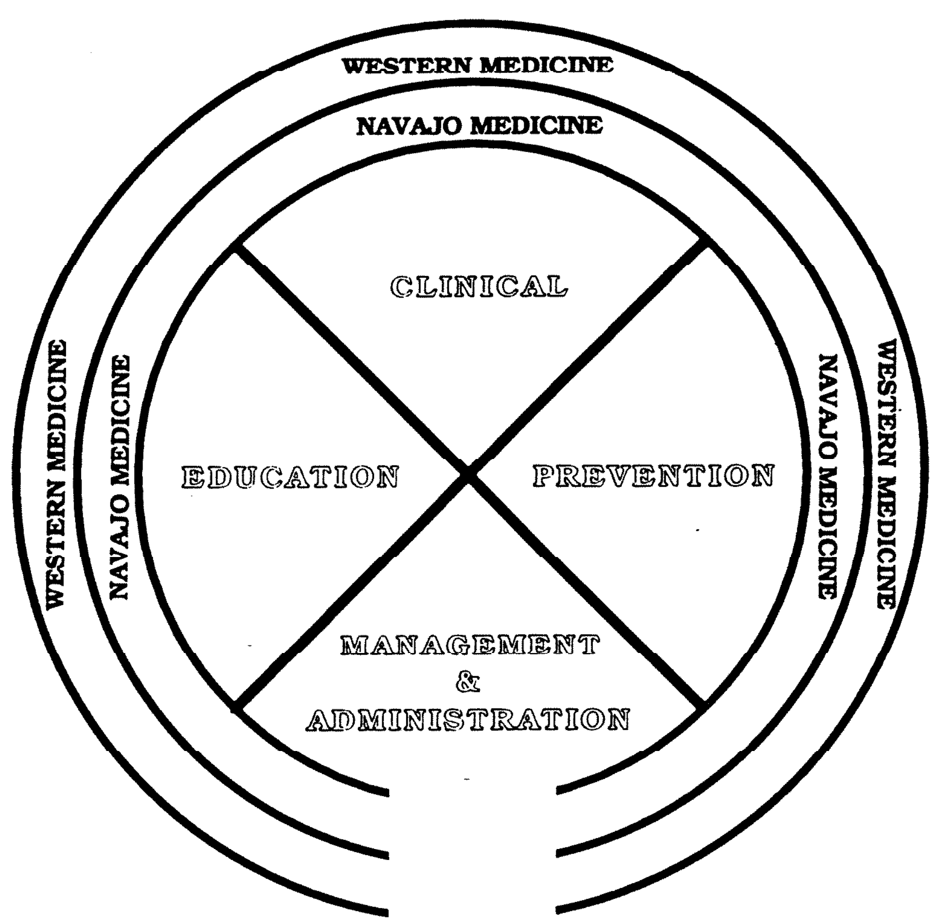
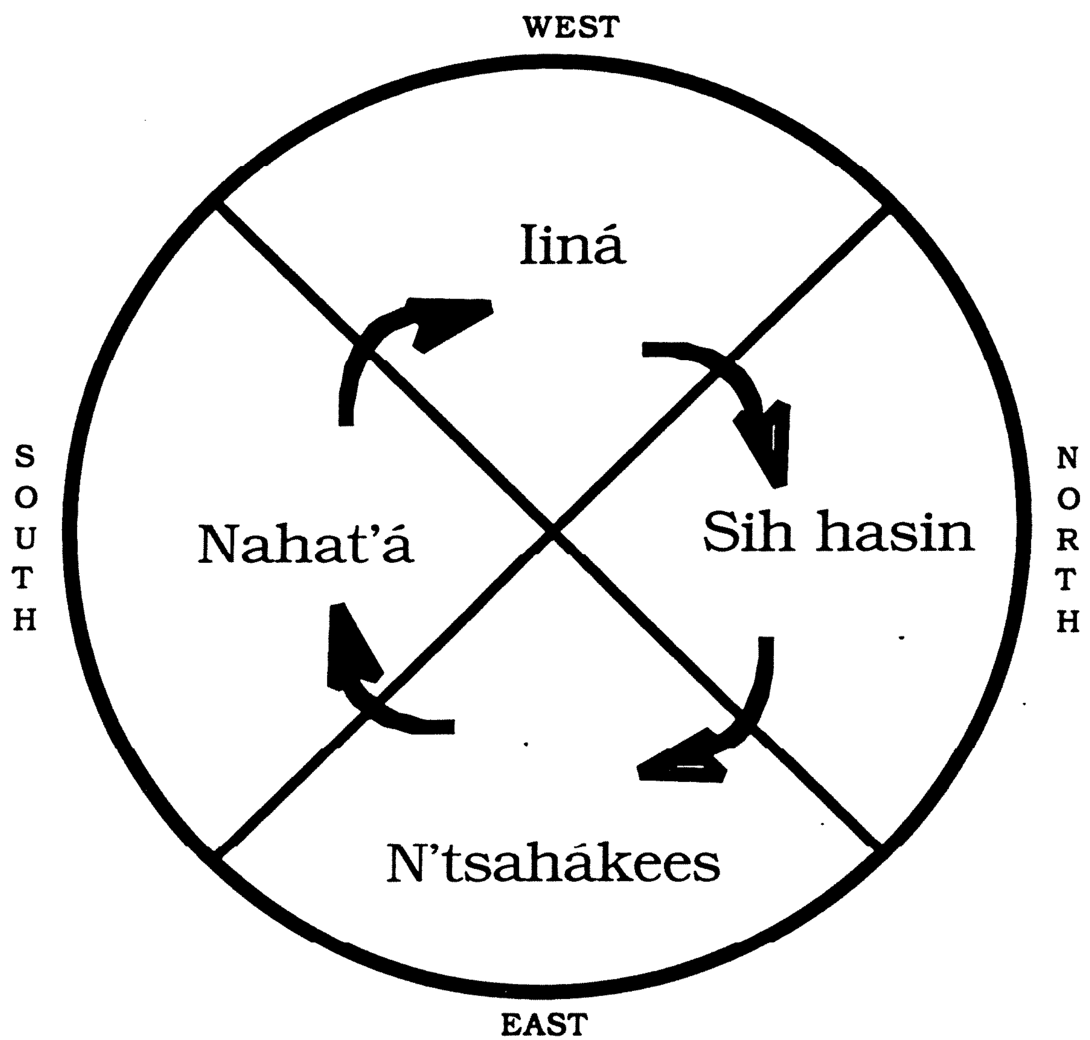



FIG.2

FIG.3

Ordin-Ceremo-Sacred

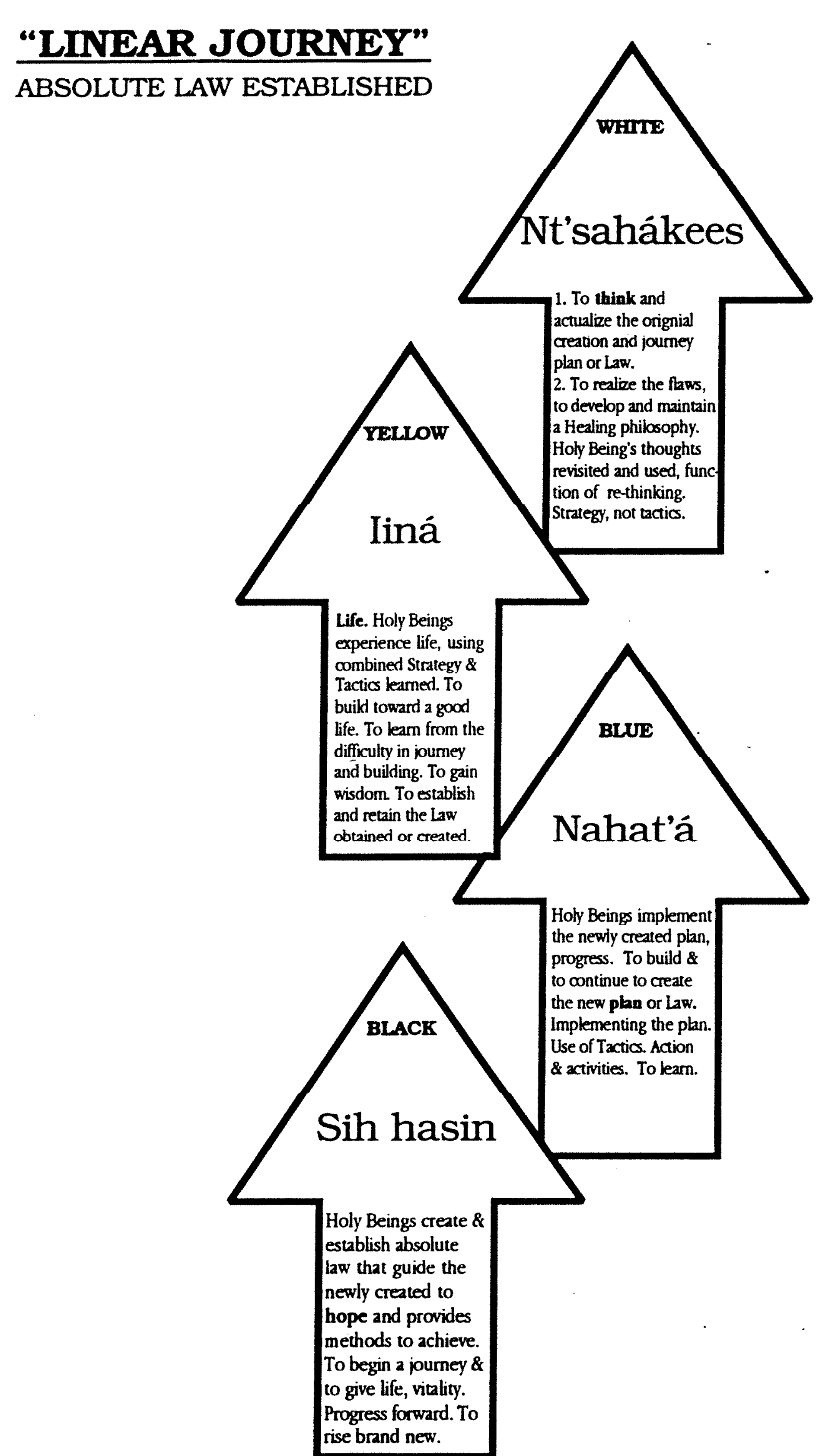


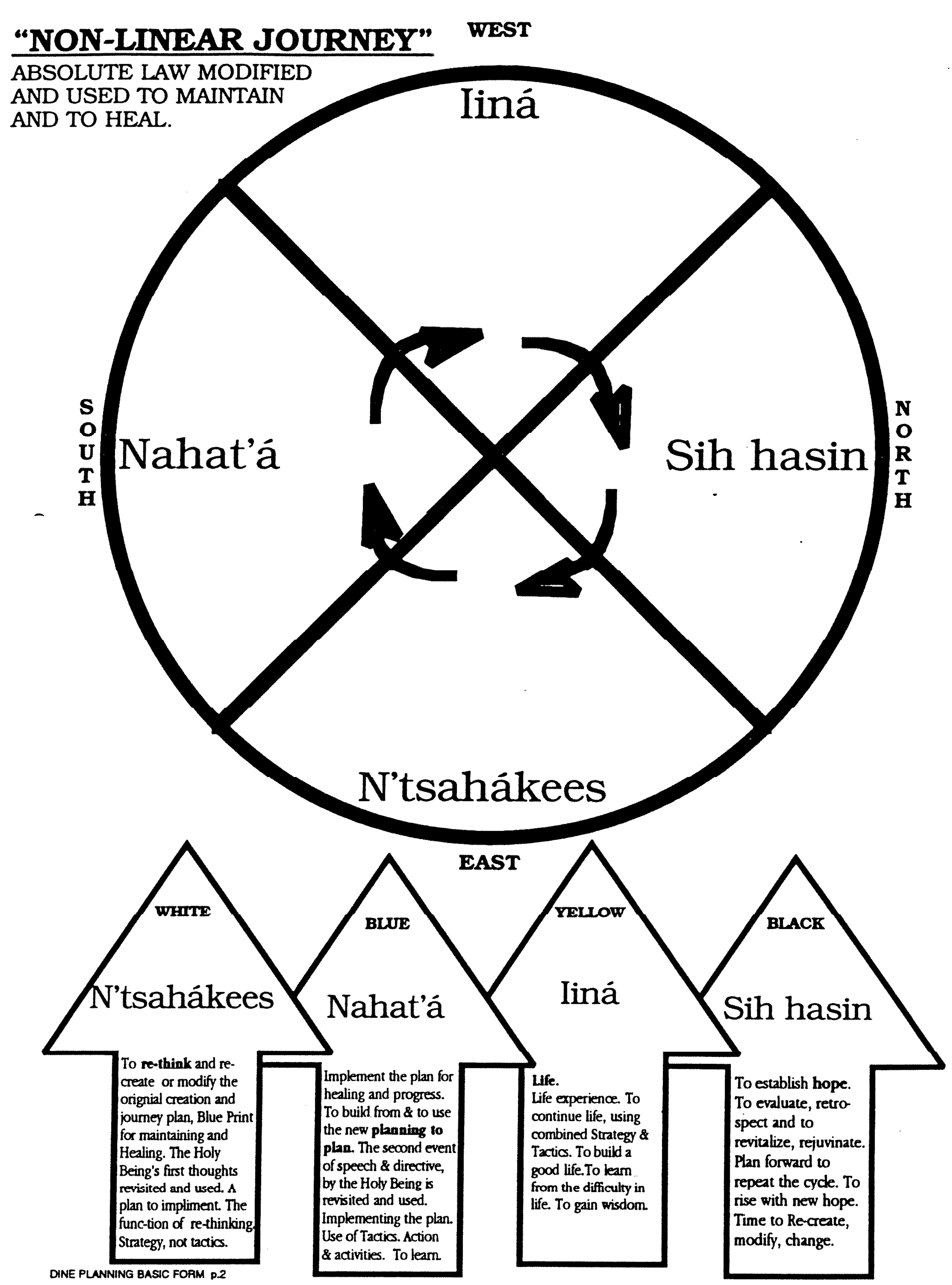

| N'tsahákees | Nahat'á | Iiná | Sih hásin |
|---|---|---|---|
| To **think** and create.<br>To plan.<br>To create a Plan.<br>To create a Bluc Print.<br>The first event (think-ing) the Holy Being did.<br>A plan short of implementation.<br>The function of thinking.<br>Strategy, not tactics. | Receive & Implement the plan.<br>To carry out the plan.<br>To use the plan.<br>To build from & **use the plan to plan.**<br>The second event (speech, directive, commandment) the Holy Being did.<br>Implementing the plan.<br>Use Tactics.<br>Action & activities.<br>To learn. | **Life.**<br>Experience from life.<br>Continue life, using Strategy & Tactics.<br>To build a good life.<br>To learn from the difficulty in life.<br>To gain wisdom. | To establish **hope**.<br>To evaluate. to retrospect the past, & to return to think.<br>To revitalize, to gain vitality & the final truth.<br>Look forward to re-peating the cycle.<br>To rise again.<br>To begin again with new hope.<br>The time to Recreate, to modify, to change. |

NAV.Planning Cycle

# "LINEAR JOURNEY"

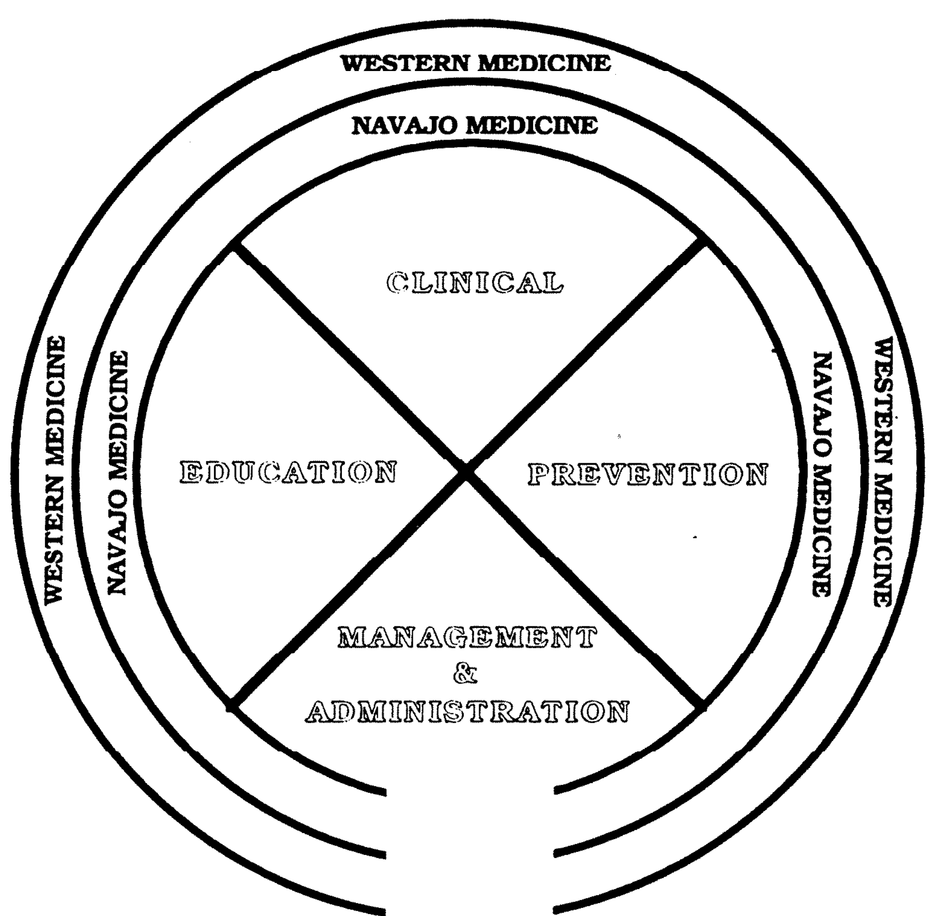
ABSOLUTE LAW ESTABLISHED





"NON-LINEAR JOURNEY"
WEST
ABSOLUTE LAW MODIFIED AND USED TO MAINTAIN AND TO HEAL.
Iiná
SOUTH
Nahat'á
Sih hasin
NORTH
N'tsahákees
EAST
WHITE
N'tsahákees
To re-think and re-create or modify the orignial creation and journey plan, Blue Print for maintaining and Healing. The Holy Being's first thoughts revisited and used. A plan to impliment. The func-tion of re-thinking. Strategy, not tactics.
BLUE
Nahat'á
Implement the plan for healing and progress. To build from & to use the new planning to plan. The second event of speech & directive, by the Holy Being is revisited and used. Implementing the plan. Use of Tactics. Action & activities. To learn.
YELLOW
Iiná
Life.
Life experience. To continue life, using combined Strategy & Tactics. To build a good life.To learn from the difficulty in life. To gain wisdom.
BLACK
Sih hasin
To establish hope. To evaluate, retro-spect and to revitalize, rejuvinate. Plan forward to repeat the cycle. To rise with new hope. Time to Re-create, modify, change.
DINE PLANNING BASIC FORM p.2

# "THE ASSOCIATION BETWEEN WESTERN AND NAVAJO MEDICINE"




# A WORKING MODEL

© PHILMER BLUEHOUSE, FEB.1998

## "THE ASSOCIATION BETWEEN WESTERN AND NAVAJO MEDICINE"

By Philmer Bluehouse

During a meeting of the Navajo Health Design Team in Albuquerque, NM on February 19 and 20, 1998 I became very anxious as we discussed the Service Delivery of Navajo Health under the processes of eventual P.L.93-638 of the Services currently provided by USPHS-IHS. I asked if the group has studied the Methodology of Medicine Delivery by Navajo Traditional Medicine Practitioners (Navajo Medicinemen and women). I received no response and offered a model fashioned after the Navajo Paradigm of Creation and Journey and a verbal description of how the model would apply to our endeavor. In the first event, a drawing was made which reflected my first thoughts see, **FIG. 1**. At that time, it was an idea based upon my understanding of "Navajo Planning" contained in the Navajo Creation and Journey Narratives. In further analysis of what I had initially prepared in FIG. 1, and after I left the group session I thought the process through and there was necessity to modify FIG. 1. The modification is in **FIG.2**. The model is offered through my understanding I gathered from listening to, by participating in, and apprenticing to be a Traditional Ceremonial Practitioner. I offer this here as a model for consideration based on that experience.

More specifically, FIG. 1 has error. I repeat "Navajo Medicine" twice in improper places in the paradigm. I will point this out on an overhead transparency. One of your colleagues asked me about this and I want to thank him for graciously giving me the inference. Thank You. As indicated earlier, I errored and have provided you with FIG.2 in place of FIG. 1.

Navajo philosophy of planning has a process established in a framework of an otherwise free flowing process or what I call "Navajo Brainstorming". I won't describe the process here. I will, however, describe the following. **"Ceremonial Planning Process"** is a "Formal Planning" mechanism and has the same planning framework as "brainstorming". Formal Planning, as it were, involves a rigid ceremonial practice which has a feature of using "Sacred Knowledge" to achieve objectives and consulting with the "Sacred Realm and the Beings in the Realm" from where all Sacred Knowledge emanates, it includes healing knowledge among other things. For this presentation, I will refer only to a healing system. I will use an overhead transparency help you to visualize the process (See **FIG.3**). A brief description of brainstorming, a fluid process where decisions are based on intimate knowledge of creation and journey narratives known by the group and are simply brought out for the moment to process planning for and in preparation for ceremony or to handle an event as it occurs with the knowledge at hand:

The reason I share this here is the rigidity of the formal process and the placement of information in relation to one another is of vital importance. Systems and process are critical to it's own ability to function or even to be sanctioned by "the Holy Beings" for healing purposes. When the relationships in the system and the process are not congruent, there is imbalance and the opportunity to fix it is present. In this situation it is fixed and still there is room for refinement as a part of planning.

To demonstrate this, refer to **FIG.2**. The placement of the information on

the chart is extremely important. The Navajo process allocates information into compartments or spaces and then massages the information by selecting the proper information from the matrix within the Compartments. This action, through Ceremony, brings the information and massages it to life through participation by the medicine(wo)man through the use of ritual objects, chants, prayers and instruction of process and procedure. These things represent the Policy,procedure, rules and regulations which must be followed to the letter. It is understood that the healing procedure to heal is put into motion through these ceremonial events, the journey to heal is activated, the messengers are excited and the procedures are affected by all the participants in the ceremony.

The entire graph (FIG.2) represents the Universal and Earthly home of the Navajo People. The graph depicts the "Earth Surface Home" of all who are created and placed on the Earth as the Navajo understand it. The two concentric circles with a uniformed break in them represent our protection and abilities of all creation which is in the form of male and female existence.

The outer concentric circle is the male form. It is characterized as the protector and the bearer of perilous protection tools, dangerous and protective psychological, biological and sacred ways. These tools and abilities are formed and placed with the beings to use as tools and signify a **tactical and or strategic** male warrior. The strategic warrior is usually associated with the characteristics of a nurturing type.

The inner concentric circle is the female form. It is characterized as the

nurturer and the barer of practical life tools of peace and nurturing. She has psychological, biological and sacred ways of nurturing in the ways of a female warrior or a in a gentle way. She is also associated with Tactical and Strategic abilities. These are things and abilities demonstrated by characteristics placed into the beings, they act them out. The ability to carry out or prompt the characteristics of the beings are recited and demonstrated through ceremony. Ceremony may involve specific symbols, colors, sounds, movement and creation of ritual objects which give evidence to the characteristics of the beings used in the procedure. The opening in the concentric circles is the way in or out of the Paradigm of Healing. I've just used symbols, color, sound and movement to demonstrate the process of healing. The concentric forms represent the rainbow, the outer is protection, the inner is life. The outer circle is colored red, the inner is blue.

This is the proper placement and arrangement of things by the Sacred. Care must be taken to describe the abilities of the Male and Female Beings in the matrix or graph drawn at FIG.2. In describing the Male Being, I wrote, "tactical and strategic" abilities of the Beings. This describes the abilities of the Male Being is to be a "tactical" one and the other to be the "strategic" one and ability may occur simultaneously. It is possible to limit or yield one ability over the other, this depends on the situation at hand. In other words, the tactical side may be a predominate personality over the strategic side or vise-versa. Preferably the being would have enough sophistication to understand this ability and endeavor to maintain a balance. I also stated, "It is possible to limit or yield one ability over the other, this depends on the situation...." Here, the situation may

warrant action or a reaction of sorts. In the time of war and warfare, the beings compliment one another, for the most part, to elevate their abilities to confront in warfare and to plan for war and warfare. The best Navajo oral Narrative describing this ability is the "Journey to Father Sun". This Narrative, in my opinion, is the epitome of achievement of peace and healing through warrioring and peace processes.

The Male Warrior Twins named, **Naayéé' Neisghání** and **Tóbájíshchíní** ("Monster Slayer and Born for Water" respectively) were created through a process of asexual reproduction where the first born was fathered by the Beams (energy) of the Sun, he is the Protector". The "life side" is the second born. He was fathered by Drops of Water Formed from Dew (tangible formation). Their mother was created through an asexual process where the Holy Beings counseled to create Peace and named her "Whiteshell Female". The reason she was created was to rid the Earth Surface of the "Monsters" which were conceived through deviant sexual behavior by both male and female creations in the Yellow Realm at the time of the "Separation of the Sexes". The Navajo Narratives describe the boys to be one during war, and to be of distinct and separate beings in peace time. In other words, in war they join their abilities so they sustain one another and the beings on the journey. It takes Tacticians to conduct direct battle and Strategists to plan to achieve peace. In peace time the two separate and sustain the beings on the journey in a protection mode. This provides the opportunity to allow nurturing and to conduct useful activities such as hunting and other life sustaining activities short of actual conflict.

In terms of western healing and thinking, the appropriate tools and the ideas leading to the procedure are very important and are based on science and a study of science. Analogy -"To perform surgery on different parts of the human body require tools which are common to completion of the surgery. To perform specialized surgery requires specialized planning and tools to accomplish the intent of surgery. The two procedures are most likely intended to reveal what was in the prognosis and the opportunity to repair, extract, replace is important at this time.

In Navajo healing philosophy, it involves not only science (systematic processes recited through chant, ritualism of sacred knowledge) but the influence and participation by the healing phenomenon which is believed to be invoked by the progressional ceremony. The phenomenon is the power of the "Sacred" or the things of the supernatural realm. It is some force which is not totally understood, it just is. Western and Navajo Medicine are simply vehicles through which we can see the results of our efforts to assist the "Phenomenon made evident by the supernatural".

The source of the function of the rainbow is dependent on the contents of the four zones within the circle. The sequence is very crucial to affect progress since the four zones contain specific information that effect other parts of the quadrant. Those of you who practice psychology, I know, have an appreciation of this through the study of the brain parts and their function. The four zones or directions suggest the power of the Navajo understanding of psychology and the parts of the brain and their function. The system is contained in the Navajo

Narratives pertaining to the Placement of the Sacred Mountains in the four directions and the function of Minor Mountains (of Equal validity which are the Gobernador knob and Dziłna'oodiłii) and their placement. Further discussion will be made in an overhead projection presentation.

**Combining Traditional Healing with Psychotherapy**

Presenters: Jerry Wilson, Laurie K. Billman

# Agenda

1. INTRODUCTION AND PRESENTATION OF PERSONAL HEALING PHILOSOPHY
   1. Jerry Wilson, Traditional Counselor
   2. Laurie K. Billman, Therapist
   3. Honor our team members at the Shiprock K'e Project

2. DESCRIPTION OF OUR PROGRAM AND HONOR TO OUR K'E PROJECT TEAM MEMBERS.

3. ADVANTAGE TO CHILDREN AND FAMILY WHEN BOTH DISCIPLINES ARE USED. (Handout 1)

4. BARRIERS WE HAVE HAD TO OVERCOME, TO WORK TOGETHER. ( bridge Picture: on flip chart)

5. RULES WE HAVE FOUND USEFUL IN WORKING TOGETHER, WITH CHILDREN AND FAMILIES. (Handout 2)

6. OPEN DISCUSSION

## Advantages to families by combining Traditional Healing with Psychotherapy

(Handout 1)

1. Gives families twice the tools with which to solve problems.

2. Combining Traditional Healing and Western Psychotherapy is culturally competent.

3. Combining demonstrates positive examples of living in both worlds.

4. Helps to increase family and children's self-esteem to see healing come from their own culture.

5. Psychotherapy gives an outsisde and sometimes, to the family, a more objective approach to problem solving.

6. Being able to choose, Traditional Healing or Psychotherapy, gives families a feeling of empowerment and choice over their own treatment.

7. Combining allows families and children to become who they are, not who society or others want them to be.

## Barriers we have had to overcome to work together

| TraditionalHealers fears of Mental Health workers | Mental Health workers fears of Traditional Healers |
|---|---|
| Therapists are not cultrually compentent and could hurt families and children. | Traditionally healers are basing what they do on superstition and could hurt families and children |
| Diagnosis labels people and makes them sicker. | Diagnosis are done strictly by guess work. |
| I don't understand what's being done. | I don't understand whats being done. |
| I will appear like an un-educated person if I ask questions. | I will look like an over educated uptight person, if I ask questions. |
| My back ground has taught me to only believe what I "see' and can observe, to be very objective. | My background has taught me to be more intuitive and avoid judgement from surface. |

Be honest - learn about each other
balance - each other
See where both come together
If they don't - explore why
Explain why and ask questions
and admit - fears
be honest - cut each other slack
respect - each other
both ways are needed - balance each other out

Bridge

## Rules that have worked for us (HANDOUT 2)

1. We go together on a home visit when starting work with a family and display respect towards the family and each other.
2. -We present Therapy and Traditional Healing as options family can choose, according to their needs at any given time in treatment.
   -We validate the fact that they don't have to just choose one with the exclusion of the other.
   -We have had the most success, when families take a combination, according to their particular needs at the time.
3. We stay open to families, only wanting either Traditional Healing, or Western Psychotherapy.
4. We never interrupt each other.
5. We follow each other's themes closely and don't suddenly switch to another theme.
6. We strive to always enjoy our work and process whats happening when we don't enjoy it. Always remember that we need to know when we need to remove ourself from a case.
7. We accept that we cannot help everyone and acknowledge that.
8. We laugh appropriatley and frequently. Humor can help decrease tension.
9. We discuss treatment disagreements away from the family, with the whole team.
10. We continue to share how we "see" a case with each other.
11. We always share with each other reasons for particular strategies.
12. We try to be honest about difficult cases, while also using a strength based philosopohy, when analyzing our families' improvement or lack of it.
13. We always Process, Process, Process.
14. We don't expect either discipline to produce magic or instant cures.
15. We continue listening, talking and respecting each other.
16. We take care of our selves.
17. We keep an open mind and understanding naturally follows.
18. We keep learning and skill building.

# OUR PHILOSOPHY

- FAMILIES AND K'É ARE CENTRAL TO THE WELLBEING OF OUR COMMUNITY.
- THE WHOLE COMMUNITY IS RESPONSIBLE FOR SUPPORTING PARENTS IN THE REARING, EDUCATION AND NURTURING OF OUR CHILDREN.
- A TRADITION OF CHILDREARING EXISTS IN OUR CULTURES WHICH IS NOT ABUSIVE AND CAN BE A MODEL FOR ALL PARENTS.
- HEALTH AND HOZHÓ IS WITHIN EVERYONE AND IS WAITING TO EMERGE - BUT SOMETIMES NEEDS ENCOURAGEMENT.
- ALL OUR PEOPLE NO MATTER WHAT THEIR AGE, CREED, RELIGION, TRADITION, RACE OR GENDER DESERVE OUR HONOR AND RESPECT.

# Our Pledge

- To find and help patients and families suffering from Mental Illness.
- To work with them as people with social,physical, emotional and spiritual needs.
- To help them find the healers they need through our healing network.
- To advocate for their just care.
- To be Rainbow Keepers - working to bridge cultures.
- To communicate respect for our patients and co-workers in the community.
- To help our communities become better places to live for those with serious mental illnesses.

## IHS MISSION

**The Indian Health Service provides a comprehensive health services delivery system for American Indians and Alaska Natives with opportunity for maximum tribal involvement in developing and managing programs to meet their health needs.**

## IHS GOAL

**TO RAISE THE HEALTH STATUS OF INDIAN AND ALASKA NATIVE PEOPLE TO THE HIGHEST POSSIBLE LEVEL.**

## CCHCF VISION STATEMENT

**The mission of the Chinle Service Unit, in partnership with the Navajo Nation, is to provide high quality health care to individuals and communities. We continually improve their health and wellness through our system of comprehensie health care services.**

**We strive for excellence by attending and responding to the needs and desire of our patients and employees, maintaining the competency of our staff, and efficiently developing and utilizing available resources.**

# ACUPUNCTURE PRACTICE POLICY

'INITION:

Acupuncture is the practice of medicine based on traditional oriental medical theories, and involves (but is not limited to) the insertion of needles through the skin at certain points in the body, with or without the application of electric current, heat, or the topical use of herbs to relieve pain or improve bodily function. Electroacupuncture, whether utilizing electrodes on the surface of the skin or current applied to inserted needles and laser acupuncture are considered the practice of acupuncture.

APPROVAL:

A. Acupuncture may be performed only by a fully licensed physician or by an acupuncturist duly licensed by the Commonwealth of Massachusetts. No individual may practice acupuncture at the Brigham and Women's Hospital or its outpatient facilities until his/her credentials and qualifications have been approved by the Chairman of the Department of Anesthesia as described below.

B. Criteria

1. For non-physicians, the individual must:

a. provide a copy of a valid and current Massachusetts license to practice acupuncture;

b. provide a copy of the most recent completed application form for acupuncture licensure (Massachusetts);

c. provide three (3) letters of recommendation from colleagues or teachers knowledgeable in acupuncture and the individuals's abilities. At least one (1) of the letters must be from a teacher or supervisor, and at least two (2) of the letters must be from individuals with current (within the past two years) knowledge of the applicant's abilities;

d. provide proof of malpractice insurance; and

e. satisfactorily complete health screening procedures as required by Occupational Health Services.

2. For physicians, the individual must:

a. be a member of the BWH medical staff with current privileges and licensure;

b. have successfully completed at least two hundred (200) hours of graduate training in medical acupuncture of AMA category I certified programs or equivalents thereof, as determined by the American Academy of Medical Acupuncture;

c. provide three (3) letters of recommendation specifically addressing the individuals's abilities and experience in acupuncture. At least one (1) of the letters must be from a teacher or supervisor, and at least two (2) of the letters must be from individuals with current (within the past two years) knowledge of the applicant's abilities; and

d. provide satisfactory evidence of at least thirty (30) accredited hours, over a three (3) year period, of continuing education in medical acupuncture.

e. Renewal of medical staff privileges shall include a review of the individual's clinical experience and/or quality assurance data with regard to the practice of acupuncture.

SUPERVISION OF NON-PHYSICIAN ACUPUNCTURISTS

The Director of the Pain Service shall be responsible for supervision of all non-physician acupuncturists. The Director is not required to be physically present during the provision of acupuncture services by non-physician acupuncturists.

The Director's supervisory responsibilities shall include a periodic review of each acupuncturist's clinical experience and/or quality surance data.

PROVISION OF ACUPUNCTURE SERVICES

A. Physician/Dentist Referral

An acupuncturist may commence acupuncture treatments on a patient only after the acupuncturist has on file a written letter of referral or a written diagnosis from a physician or dentist who is a member of the BWH medical staff.

B. Location of Acupuncture Services

It is generally anticipated that acupuncture treatment will be provided at the Pain Clinic. Physicians or dentists who wish to have their patients receive acupuncture treatment at another inpatient or outpatient location must obtain the approval of and make arrangements with either the Chairman of the Department of Anesthesia or the Director of the Pain Service.

SPONSOR: Sheridan Kassirer

PROVED: Hospital Management Committee, 2/98
Medical Staff Executive Committee, 2/98
Care Improvement Council, 2/98

For more information contact:

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**Native American COE**
**University of Washington**
**School of Medicine**
**Minority Affairs Program**

**Indian Health Pathway Track: A Program for University of Washington Medical Students**

The Native American Center of Excellence Program is located at the University of Washington School of Medicine (UWSOM) Minority Affairs Program in Seattle, Washington. The Indian Health Pathway Track (IHPT) was established in 1992 to accomplish the following goals:

- To prepare Indian and non-Indian medical students for careers in Indian Health;
- Encourage research on Indian Health issues;
- To increase curriculum on Indian health issues at the UWSOM.

## WHY THE INDIAN HEALTH PATHWAY TRACK?

The UWSOM's mission is to serve and improve the health of underrepresented communities. The American Indian community is one of the most medically underserved minority groups in the nation. Therefore, IHPT will give medical students the necessary information and experiences to make them better practitioners in urban and rural American Indian communities.

## REQUIREMENTS FOR IHPT CERTIFICATION

**I. Independent Study in Medical Science (ISMS) Project:** The ISMS project is a research paper that is required of all medical students to complete before graduation. IHPT students must complete their ISMS project on an approved Indian health topic.

**II. University Conjoint 530: Issues in Indian Health:** The curriculum includes various health professionals presenting on Indian health topics such as traditional medicine, paleopathology, urban/reservation Indian health care, alcoholism and much more.

**III. Elective Preceptorships and Clerkships:** A successful completion of six weeks minimum electives in any of the following areas:

**A. Family Medicine 501 (2.5 cr.):** Introduction to Fam Med Preceptorship: First and second year medical students can participate in this eight week preceptorship at the Seattle Indian Health Board.

**B. Family Medicine 680 (4-12 cr.):** Traditional Indian Medicine Clerkship: Fourth year medical students can participate in 2, 4 or 6 week blocks at an urban primary care setting such as Seattle Indian Health Board to learn how western physicians collaborate with traditional Indian healers in the provision of health care to American Indian populations.

**C. Family Medicine 681 (4-12 cr.):** Indian Health Clerkship: Fourth year students can experience health care delivery at an urban or reservation health care facility in the WAMI region. This includes the Crow reservation, Lap Wai reservation, Seattle Indian Health Board and many other clerkship sites.

**D. Conjoint 680P (Max 16 cr.):** An Introduction to Detoxification and Rehabilitation Programs for Alcoholism and Drug Abuse: is an urban based supervised clinical experience in a variety of addiction treatment programs at sites such as the Seattle Indian Health Board.

## INDIAN HEALTH OPTIONS

There are additional resources available through the COE that assist students in becoming more familiar with Indian health issues, students and health professionals in the Indian health arena, and also gain an extensive amount of knowledge about Indian health and the various Indian cultures. These ar[illegible] required for certification but are highly enco[illegible]

**•Medicine Wheel Society:** This society is group of Native American alumni, medical a[illegible] pre-medical students, and health professionals the University of Washington.

**•ISMS Presentation:** A student can prese[illegible] his/her ISMS project at national and/or region[illegible] Indian conferences and seminars such as t[illegible] Indian Health Service Research Semina[illegible] Association of American Indian Physician[illegible] Annual Meeting and/or other researc[illegible] organization meetings.

**•Rural Underserved Opportunities Progra[illegible] (R/UOP):** This non-credit experience is held at tribal site for four weeks and facilitated by th[illegible] Department of Family Medicine, COE Directo[illegible] and staff.

**•Teaching on Indian Health:** A student ma[illegible] present at local tribal schools, high schools o[illegible] summer programs to teach current health concept[illegible] such as Tuberculosis, AIDS, and/or other issue[illegible] necessary for proper health education.

*Please note that the approval of these othe[illegible] experiences will be determined by the Director o[illegible] the Center of Excellence in conjunction with th[illegible] Indian Advisory Committee.*

## STUDENT RESOURCES AVAILABLE:

In addition to the general Academic Affai[illegible] resources, the Center of Excellence staff i[illegible] available to assist IHPT students in ever[illegible] component of this program. Overall, their missio[illegible] is to help students to fulfill their graduatio[illegible] requirements, achieving not only academic succe[illegible] but cultural awareness.