

AT THE BEDSIDE: TRADITIONAL NAVAJO PRACTITIONERS IN A PATIENT-CENTERED HEALTH CARE MODEL

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Abstract: The growing national racial and ethnic diversity has created a greater need for health care delivery systems and health care providers to be more responsive to unique patient needs, that goes beyond meeting the immediate health problems to include attention to other critical component of patient care that take into account cultural competency such as health literacy, health beliefs and behaviors, cultural practices, etc.

INTRODUCTION

Patient-centered care is one of the critical benchmarks used in evaluating the quality of care provided by health care facilities. Quality measurements usually take into account various factors, such as the patient's cultural traditions, language, religion, values, and lifestyle. The promotion of patient-centered care has been motivated not only by the need to address the nation's health inequities, but also by the need to respond to the ever-growing racial and ethnic diversity of the nation's population.

As a part of the ongoing discussion about closing the health disparity gaps, key determinants of health, including sociocultural determinants, are stressed. Little, however, is known about how cultural considerations are embedded in these national efforts to address health disparities and improve patient-centered care.

This case study explores how one health care facility has developed a model that emphasizes the cultural aspects of its patient-centered care. This culturally oriented model has been implemented for Navajo patients served by the Chinle Comprehensive Healthcare Facility (CCHCF), a federal Indian Health Service (IHS) Unit located on the Navajo Reservation in northern Arizona (Hubbard, 2004). While this and other IHS health care facilities routinely have given attention to the cultural

aspects of their services, the Chinle model has expanded patient-centered care by adding a team of traditional Navajo (Diné) practitioners to work alongside physicians and other providers in the hospital, clinics, and other community public health programs.

The case study reported here was conducted in partnership with the hospital and the staff of the Office of Native Medicine (ONM). The study team was composed of the three practitioners, the associate hospital administrator, and an ONM board member, all from the Chinle facility, and the investigator and two research assistants from the University of Arizona. The central aim of the team was to explore how the traditional Navajo practitioners hired by the hospital provide patient care in the hospital and other clinical settings; how they interact with physicians and other service providers; and how their services are perceived by their colleagues, their co-workers, other Native practitioners, the hospital administration, and the community. In addition to a description of some day-to-day activities of the ONM practitioners, this report also discusses some unique challenges faced by these practitioners as they negotiate their role and their services within the complex world of health care regulations and policies.

It should be noted that this report is the first of a two-part series; the second, *A Collaborative Case Study: The Office of Native Medicine*, provides a detailed description of the study design and methods.

Background: Delivering Culturally Appropriate Health care

As the population of the U.S. grows more ethnically and racially diverse and as the number of health disparities continues to worsen, policymakers and major health agencies have initiated a number of programs to reduce some of these disparities. These federal and other governmental initiatives targeted cultural, linguistic, and other barriers to improving health. For example, most called for improving the cultural competence of the nation's health care workforce (Jayadevappa & Chhatre 2011; Saha, Mary, & Cooper, 2008; Silow-Carroll, Alteras, & Stepnick, 2006). Betancourt and colleagues (2002, p. V) defined cultural competence as “the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet the patient's social, cultural, and linguistic needs.”

Other key health agencies, such as the Institute of Medicine (IOM), also have recommended improving the quality of patient care by respecting and responding to an individual patient's preferences, needs, and values in clinical decisions (IOM, 2001). Saha and colleagues (2008) perceive cultural competence and patient-centered care as having different goals, but they suggest that patient-centered care can incorporate cultural competence, thereby improving health care equity and quality. Silow-Carroll et al. (2006) propose eight components in delivering patient-centered care: 1) a welcoming environment, 2) respect for patients' values and expressed needs, 3) patient

empowerment, 4) sociocultural competence, 5) coordination and integration of care, 6) comfort and support, 7) access and/or help with navigation skills, and 8) community outreach. Patient-centered care, therefore, requires attention to elements that impact health care decisions and outcomes, such as the patient's cultural traditions, religion, values, and lifestyle (Association for Healthcare Research and Quality, 2010; Hibbard, Peters, Dixon, & Tuster, 2007; IOM, 2001).

Current Health care Delivery on the Navajo Reservation

The role of the federal government in the delivery of health care services to AI/ANs is part of the federal-Indian trust relationship, historically rooted in various treaties the federal government signed in exchange for lands ceded by the tribes (Brophy & Aberle, 1966; Joe, 2003). The history of this nation's first prepaid health plan for tribes, however, has never resulted in consistent or adequate funding. Instead, funding always has been piecemeal and allocated at the discretion of Congress. Consequently, health care services for AI/ANs continue to be a patchwork of resources, some of which are funded only for a short term (U. S. Commission on Civil Rights, 2004).

Today, the IHS and a few private hospitals provide care on or near the Navajo Reservation (IHS, 2013). With provision made possible by federal support for tribal self-determination, a number of tribes, including the Navajo Nation, have assumed greater responsibility for health care delivery (Joe, 2003, 2008). For example, most community-based preventive health services are now provided by the Navajo Nation's Division of Health, while most medical care services continue to be provided by the IHS and/or by not-for-profit facilities that contract with the IHS and are managed by local tribal communities (Dixon & Roubideaux, 2001). The contracting arrangements are made possible under two legislative policies (and subsequent amendments), the 1975 Indian Education and Self-Determination Act (P.L. 93-638), and the 1976 Indian Health Care Improvement Act (P.L. 94-437), which have had a significant impact in transferring some responsibility for health care and/or educational programs from the federal government to tribes. For example, four health facilities formerly operated by IHS on the Navajo Reservation—two health centers and two hospitals—are now managed by local community organizations (Roanhorse, 2004, 2005). The ongoing operations of these tribal facilities, however, depend on funding from various sources, including the IHS. The sustainability of these efforts has recently been buttressed by the passage of the 2010 Patient Protection and Affordable Care Act (P.L. 111-148). The Navajo Area IHS also contracts with several nearby off-reservation non-federal health facilities for specialty care.

In spite of these gradual management changes, the IHS continues to operate 4 rural hospitals, 6 health centers, 15 health stations, and 22 dental clinics on the Navajo Reservation, which offer services to approximately 200,000 patients. The IHS health care delivery system on the Navajo Reservation includes approximately 333 physicians, 703 registered nurses, and 73 dentists (Hubbard, 2004).

The IHS and Culturally Sensitive Health Services

Gradually, the federal government has recognized the importance of cultural traditions and language barriers in delivering health care to American Indians and Alaska Natives (AI/ANs), most notably within recent years under the IHS. While federal efforts to address language barriers has a longer history (i.e., the use of interpreters), the IHS and other Western health care facilities serving AI/ANs did not always welcome or accommodate the services of traditional tribal practitioners. However, when the expanding mental health needs of the AI/AN patient population became more acute and could not be met with existing limited resources, the IHS began to utilize traditional Native practitioners as consultants in a number of its behavioral health treatment programs, especially those programs engaged in substance abuse treatment (Abbott, 1998; Nelson, McCoy, Setter, & Vanderwagen, 1992).

The more formal inclusion of traditional practitioners in the allopathic arena, however, did not occur until after 1994 when the then-director of the IHS, Michael H. Trujillo, an AI physician, issued an administrative initiative asking all regional IHS facilities to find ways to work more closely with local Native practitioners (Knoki-Wilson, 2008; Trujillo, 1994).

Establishing the ONM

The CCHCF established the ONM after a feasibility study recommended such a program, which also had the support of the hospital's Traditional Native Medicine Committee (Hsu & Corbin, 1998). The ONM was officially opened in 2000 with the hiring of the first traditional Navajo practitioner (Knoki-Wilson, 2008). Once the community learned about the new program, patient referrals increased rapidly, forcing the hospital to recruit two more practitioners. Within the hospital, the practitioners have their own office space; they utilize consultation rooms while working at the hospital's two off-site comprehensive community health centers.

Administratively, the ONM is located in the Public Health Division, an arrangement that gives the practitioners greater access to patients in the hospital as well as to the larger community. The ONM mission statement indicates that its major purpose is to promote and

empower the practitioners of Native medicine to provide health care to Navajo patients by complementing the services provided by physicians and other health care providers (Dennison, n.d.). In addition to the mission statement, the ONM also has the following objectives:

- 1) to ensure delivery of culturally appropriate care in partnership with allopathic medical providers;
- 2) to strengthen cultural sensitivity education of health care providers by providing educational programs about Native medicine, Navajo healing, culture, and language;
- 3) to provide outreach and education on various aspects of Navajo culture and health practices to local communities and/or organizations; and
- 4) to implement and maintain a program of excellence in Native medicine for the patient population served by the Chinle Service Unit (Dennison, n.d.).

To enhance ongoing coordination and oversight, the ONM has its own Advisory Committee consisting of allopathic providers, community leaders, and other local traditional practitioners. The committee meets quarterly to review program activities and to discuss new programs or requests.

WHY THE CASE STUDY APPROACH?

Because ONM was one of the first programs to employ and place a team of Native practitioners in a clinical setting, it was necessary to describe and analyze firsthand the interworking of the program and those involved. The method of study proposed was an exploratory, descriptive case study. The case study approach and methods of data collection are detailed in the second article in the series, later in this journal issue. This article provides in-depth findings about the practitioners and their work.

The case study approach allowed the team to examine and describe this complex and dynamic culturally oriented patient-centered care model within its own context (Baxter & Jack, 2008). In addition to firsthand observations, the methodology requires the collection and examination of data from multiple sources, including input and perspectives from the study team as well as the study participants (Hancock & Algozzine, 2006).

Appropriately, a case study approach explores “how” and “why” questions within a study environment where the investigator(s) cannot manipulate the behavior of the study participants (Yin, 1994). Moreover, Baxter and Jack (2008) define case study approach as a constructivist paradigm and state that “Constructivists claim that truth is relative and that it is dependent on one’s perspective and recognizes the importance of the subjective human creation of meaning, but doesn’t reject outright some notions of objectivity” (p. 545). The case study method therefore adds authenticity to what is learned by placing importance on the discourse of the participants, which in this study was expressed in both English and Navajo.

The data collection in this case study incorporated informal and structured interviews, focus groups, and review of documents and reports related to the program. The case study led to the production of a 35-minute video, *Two Ways of Healing*, that tells the story of the ONM and includes the perspectives of hospital staff, physicians, board members, and patients.

THE CHINLE COMMUNITY

The outer geographic boundary of the major Navajo Reservation extends into three adjoining Southwestern states: Arizona, New Mexico, and Utah. Internally, the Reservation is further subdivided into five regional geographic districts that include eight IHS service units. One of these eight IHS service units is Chinle (Hubbard, 2004).

The CCHCF is a 60-bed hospital and serves as the medical hub for 16 surrounding geopolitical areas referred to as chapters. The facility employs 978 people and serves a patient population of approximately 35,000. In addition to primary care, the hospital provides adult intensive care, general surgery, operative obstetrics, and 24-hour emergency services (Chinle Service Unit, 2013). Patients with serious injuries or other life-threatening conditions routinely are evacuated by air to larger non-IHS hospitals or to one of the two larger IHS hospitals in Gallup, NM, or in Phoenix, AZ (Knoki-Wilson, 2008).

According to the 2010 Chinle Census, the communities within the Chinle area reported 7,145 households with a population of 25,991. Approximately 93.3% of this population is Navajo. As is true for rest of the Navajo Reservation population, members of the community are predominantly young (36% of the population is under age 18), and the median age is 30.5 years. The median household income for this population in 2010 was \$20,331, significantly lower than that reported for the rest of the Reservation. Fifty percent of the families reported income below the poverty line (Chinle, Arizona Population, 2013).

The present Chinle hospital, housing the ONM, was built in 1982, replacing an older, inadequate hospital. The patient population, however, has continued to increase; as a result, additions to the hospital are underway. The hospital is centrally located on the Navajo Reservation, near the point of entry to the popular Canyon de Chelly National Monument (Chinle Service Unit, 2013). Many in the population served by the hospital are strongly grounded in the Navajo culture; therefore, the facility has always given special attention to the culture in its service delivery, an approach fostered by its staff, many of whom are members of the tribe (Knoki-Wilson, personal communication, April 4, 2009).

Such attention to the Navajo culture by the facility included the construction of a hogan on the grounds of the hospital for local practitioners to use when conducting brief ceremonies for patients and their families. In addition, one wing of the hospital has a circular healing room with the round interior shaped like the inside of a hogan. This room is utilized by ONM staff for patient consultation or for minor ceremonies when a patient is too ill to leave the hospital. The hospital grounds also have two sweat lodges, one for men and one for women (Dennison, 2009).

Another area where the hospital attends to cultural sensitivity is the maternity ward. Two birthing rooms are set up for women who want to deliver their babies in the traditional squatting position, facing east in conformity with tribal cultural practices, a position that symbolizes the dawn and the beginning of a new day or a new life. In these rooms, a traditional Navajo sash belt is anchored to the ceiling with an accompanying letter “E,” indicating East. The sash belt symbolizes the rainbow, associated with the amniotic fluid that represents rain or water, a necessity for all living things (King, 2007).

TRADITIONAL NAVAJO HEALTH BELIEFS AND PRACTICES

Many researchers and observers of Navajo culture have written or documented various aspects of the tribe’s healing ceremonies (Begay & Maryboy, 2000; Csordos, 1999; 2000; Gill, 1997; Kluckhohn & Leighton, 1974; Landy, 1974; Lewton & Bydone, 2000; Milne & Howard, 2000; Sandner, 1979; Spickard, 1991; Storck, Csordos, & Strauss, 2000; Waldram, 2000). Because extensive information is available, specific healing ceremonies will not be discussed in detail here. However, it is necessary to discuss some Navajo health beliefs that dictate the form and process of traditional healing, especially those that are helpful in explaining how traditional healing complements allopathic medicine.

Traditionally, the Navajo, or Diné, view spirituality as an integral part of being Navajo, not as a separate set of beliefs or rituals to be observed only during special occasions or in times of special need. Moreover, spirituality and traditional medicine are often viewed as one and the same. For example, an illness does not always need to have a physical cause but can be attributed to causes brought on by spiritual, mental, or cultural disharmony that might be linked to a number of cultural explanations (Roessel, 2002).

Regardless of the outward manifestation of a health problem, therefore, the cultural diagnosis may attribute the “unusual” aspects of the problem to such etiologies as excessive or inappropriate personal conduct; impropriety with other living things or other forces of nature; misuse of, or poorly performed, ceremonies; and/or contact with malevolent forces that might carry intentional harm in the form of spells. Sometimes, a culturally based illness may come in the form of retribution or

as the result of inadvertent contact with something disruptive (Wyman, 1983). Many Navajo also believe that words are powerful, and that spoken words or bad thoughts can bring on illness. Navajo emergence stories describe how thoughts and prayers by the holy people, or “*diyin dine’é*,” brought the Diné world into existence (Griffin-Pierce, 2000, p. 129). Therefore, it is not unusual to link a health problem to the use of harmful words such as those expressed in a curse.

For traditional Navajo, these cultural beliefs promote personal and group health and also prescribe the proper conduct for one’s relationship with all that is in the environment, including other humans, animals, and nature. In some cases, ceremonial interventions address deteriorating, frayed relationships and the disorders they cause (Roessel, 2002). In others, practitioners counter negative words with “good” words by accentuating the positive and empowering the patient by having him or her repeat the appropriate prayers (Willging, 2002; Witherspoon, 1977). Ultimately, the diagnostic process acknowledges the cultural etiologies that have allowed for ill health or misfortune to occur, and one or more courses of action will be recommended to address the problem.

The central aim of all Navajo healing ceremonies is, therefore, not to cure but rather to empower the patient so he/she can work towards restoring balance or harmony of mind, body, and spirit, which is essential because most illnesses are perceived as conditions in which these three elements are out of harmony (Adair & Deuschle, 1970). A cultural diagnosis helps the patient understand why an illness occurred or persists. From this perspective, it is readily understood that the allopathic provider treats the “illness,” while the cultural intervention focuses on why an illness or health problem has occurred and how the patient can best help him- or herself to restore harmony (Dennison, 2009; Roessel, 2002). In the case of a spinal cord injury, for example, the aim of the traditional healing intervention is to help empower the patient so that the prescribed therapy or rehabilitation is perceived as positive and attainable. In every case, the goal of a healing ceremony is to evoke the assistance of spiritual helpers or deities to restore harmony (Kunitz, 1989). The ceremony is concluded with a specific set of chants, prayers, and other required steps to reaffirm harmony (Wyman, 1983).

Navajo diagnosticians use several means to establish culturally based causes of culturally based illnesses and, in some cases, to pinpoint possible causes of misfortune. Although there are others, the four most common diagnostic methods utilized today include hand trembling, star gazing, listening, and the use of crystals (Dadosky, 2008; Davies, 2001). In hand trembling, the diagnostician places him- or herself in a trance to search for the cause of the ill health. While in the trance, he/she makes the diagnosis by tracing this information in the sand. Diagnosticians who use the star grazing method interpret the positions of the stars to determine the etiology of ill health, and “listeners” listen to the wind to help define the cause of an illness (Franciscans Fathers, 1910;

O'Bryan, 1956), while those who use crystals read the patterns in the crystal for diagnosis. The ONM practitioners are most likely to use crystal gazing, but the hospital does not require them to use a specific method.

Most Navajo healing ceremonies are seasonal, and these ceremonies always take place in a hogan (Griffin-Pierce, 2000). The preparations often are extensive and expensive, requiring family and kin to invest time and financial resources, including preparing needed supplies, obtaining food to feed the attendees, and sometimes building a temporary dwelling or shade house to serve as the kitchen. The patient's family is asked not only to contribute their labor, but also to donate food or assist the practitioners with some of the ceremonial preparation. The presence and support provided by the family and kin is considered an important part of healing. (Brown, 1992; Willging, 2002) It is not unusual, therefore, to hear on the local Navajo radio station a call to clan relatives to help assist with larger ceremonies.

FINDINGS: THE SERVICES PROVIDED BY THE ONM

The three practitioners in the ONM are employed by the CCHCF. While all are skilled diagnosticians, two specialize in a number of other traditional Navajo healing ceremonies. Their daily routine is a busy one. They indicated that over 50% of their patients are self-referrals, while others are referred by other health care providers. Some patients request services when the practitioners make grand rounds with the physicians (Chinle Service Unit, 2008). In addition to providing cultural diagnoses, the practitioners conduct abbreviated ceremonial interventions, mainly within the realm of protection or prevention. For example, patients facing a medical emergency who must be air evacuated to another hospital may request the services of a practitioner for a Protection Prayer not only to ease anxiety, but also to help focus on a positive treatment outcome.

Although the practitioners deem many of the services they provide to be minor, this designation does not imply "simple" or "easy." Although they are significant, they are called minor because they are brief interventions, rather than more complex or lengthy ceremonies. One practitioner distinguishes minor and major ceremonies with this example: "A protection prayer is a short intervention because it takes less resources and time, while a major ceremony can take one to nine days. In this respect, a diagnostic ceremony is considered a minor ceremony." In clinical settings, their work is limited to brief interventions, which one practitioner calls "first aid ceremonies."

When consulting with patients, the practitioners encourage them to accept medical diagnoses and follow recommended treatments in addition to the practitioners' cultural diagnoses and recommended cultural intervention(s). In explaining the need to pay attention to both the medical and cultural diagnoses, the practitioners remind patients that multiple etiologies and interventions

are found in many Navajo healing processes. Once the practitioner has made a cultural diagnosis and discussed it with the patient and family, the next step requires recommendations for the appropriate healing ceremony or series of ceremonies.

If requested by the patient, the practitioners will provide a list of other local practitioners who specialize in the specific ceremony needed. This list is developed by ONM in consultation with practitioners in the community who give their permission to be included; it is utilized by the hospital staff when ONM practitioners are not available.

As mentioned before, two of the ONM practitioners specialize in several traditional healing ceremonies, but they do not include these in their hospital services. Upon request, they will conduct the ceremony at the patient's home. To accommodate these off-duty arrangements, the practitioners work 4 days a week and utilize the 3-day weekends or take leave from work.

As part of their services, the practitioners frequently are called upon to help ensure patient or staff safety by conducting a spiritual cleansing of a room after a death. When there is a difficult birth, the mother also may ask one of the practitioners to offer an appropriate song or prayers to ensure safe delivery, or in some cases, to conduct a special ceremony to help unravel an umbilical cord. Some new mothers also ask practitioners for a special blessing to welcome the newborn. In other instances, patients or families may request a blessing, giving thanks when death has been averted or the patient has been discharged from the hospital.

The regular day-to-day services provided by the practitioners also include several hours of counseling patients or participating in various educational activities. During counseling sessions, practitioners give patients and families an overview of the ceremony recommended as well as a list of materials or items they will need to furnish.

Practitioners take turns participating in morning grand rounds with the physicians so that they can learn as much as they can about allopathic diagnoses and treatments in case patients have any questions about their care. Patients can request to see a practitioner at both grand rounds and at the Family Practice Registration Desk. Other patients are referred by physicians or other clinical staff. Following up on these referrals is part of the practitioners' daily activities. After seeing a patient, the practitioner enters his or her notes on the patient's chart, as well as a brief description of the actions taken on referral, which is routed back to the referral source. It should be noted that many of the hospital employees, both Native and non-Native, also utilize the services of the practitioners.

On most days, therefore, the practitioners are kept busy attending scheduled appointments with patients and their families, making home visits, conducting brief ceremonies, providing in-service training or community education, and participating in various hospital or community meetings, including monthly meetings of either the Diné Medicine Men Association or the *Diné*

Hatathile (Chanters) Association. The former has an all-inclusive membership of healers, and the latter usually includes only those practitioners specializing in the traditional Navajo healing ceremonies.

Because the practitioners are employees of the IHS, Navajo patients do not pay for ONM services. Although payment for service is not an issue, the practitioners have their share of “noncompliant” patients who return to request another diagnostic procedure even though they have not carried out the previous recommendations. Far more patients, however, are serious and do follow the recommended healing ceremonies.

The ONM staff lacks the financial resources to conduct systematic patient follow-ups, although all of the practitioners readily recall some of their cases anecdotally, especially when former patients come by to express their appreciation or speak about their health improvements.

FINDINGS: IN-SERVICE TRAINING PROVIDED BY ONM PRACTITIONERS

The other major activity of the ONM practitioners is cultural competence training (ONM, 2008a). The team conducts one or more formal in-service training sessions per month at the Chinle hospital for professional staff; these sessions also are open to other employees. Topics include Navajo Health Beliefs and Practices, the Navajo Wellness Model, Herbal Medications, the Protection Way and Protectors, Mental Illness, and Navajo Culture 101 (ONM, 2008b).

The in-service training sessions are popular, with average attendance ranging between 15 and 20. Typically, annual attendance averages 1200. In their written evaluation of these sessions, most attendees rate them as informative and useful in their work. The average evaluation score attendees is 3.61 on a scale of 0 (*not useful*) to 4 (*extremely useful*).

The cultural competence training also covers topics that are requested by staff, including Cultural Sensitivity, the Diné Perspective on Mental Illness, the Enemy Way Ceremony, Growth and Development, and the Diné Paradigm of Human Anatomy (ONM, 2008a). The practitioners also are invited by area schools, chapter officials, and other agencies to provide classes on these and other cultural topics at community meetings or special assemblies.

FINDINGS: COLLABORATIVE TRAINING BY ALLOPATHIC PROVIDERS AND PRACTITIONERS

The practitioners are natural educators, but also report that they are constantly learning new things as a part of their work in the hospital. In one 7-day workshop session, the practitioners and physicians co-taught a course to a group of traditional practitioners from the community about diabetes and some of its complications. The workshop, “Encouraging Healthy Lifestyles of Diabetic

Patients through Native Practitioners,” was developed and taught jointly by physicians and the ONM practitioners to 15 practitioners. Type 2 diabetes mellitus is a prevalent health problem on the reservation, so this educational program was especially important. The educational goal, therefore, was to help the practitioners learn more about the treatment of diabetes, so that they can provide patients accurate information about the different allopathic treatments they have been prescribed. The practitioners provided not only the Navajo interpretation of the lessons, but also cultural explanations of the disease process, as well as the impact of diabetes on physical and psychosocial well-being (Chinle Service Unit, 2008).

The workshop attendees included herbalists, diagnosticians, chanters, and Native American Church practitioners. The ONM coordinator recalled that one workshop participant remarked that the training program helped her understand more about the complications associated with diabetes and why it is important for her to remind her patients to follow medical treatment plans. Another workshop participant told an ONM practitioner that the physiological consequences of diabetes were especially meaningful for him after a visit to one of the dialysis centers, where the workshop participants had a session on treating renal failure.

While these anecdotal assessments from attendees were deemed helpful by the ONM staff, the ONM director wished that workshops, especially their impact on the care provided by attendees, had a more formal evaluation. Staff and budget limitations, including lack of resources for professional development, prevent more extensive program evaluation. The three ONM practitioners noted that there were no continuing education programs or courses focused on Native medicine available to them. While they can learn a new specialty by taking on an apprenticeship with another practitioner, their workload at the hospital often does not allow enough free time to pursue this option. It is possible that, as more of the reservation hospitals establish their own ONM programs, the number of practitioners will not only increase, but the practitioners are likely to have planning meetings to organize their own continuing education programs. The desire to continue their training has undoubtedly been influenced by their own involvement in conducting training for hospital staff and other providers.

FINDINGS: SEEKING A COMFORTABLE NICHE IN AN ALLOPATHIC SETTING

Utilization of traditional practitioners in other Indian health care facilities has been increasing (Basset, Tsosie, & Nannauch, 2012; Buchwald, Beals, & Manson, 2000; Commins, 2008; Driscoll et al., 2011; Marbella, Harris, Diehr, & Ignance, 1998). However, the work of practitioners does not always fit comfortably with the everyday demands of an allopathic setting. Practitioners may view some requirements for documentation of health care delivery as daunting. For example,

some mentioned that the requisite paperwork and charting was something they did not expect. As do physicians, practitioners have to report services provided and enter information and referrals on charts for each patient encounter. In addition, they have to consult the physician's Patient Care Component Encounter (PCC) form to become familiar with the patient's health status. The PCC form summarizes pertinent information about the patient's chief complaint or purpose for the visit, treatment plan, medications, types of laboratory tests ordered, referrals initiated, and instructions offered.

While the PCC form works well for physicians and other providers, it is not necessarily designed for use by the practitioners. For example, the form's instruction space and section on prescribed medications do not make any references to herbal medications, nor does the section on routine medical procedures include a space for cultural diagnoses. The transition to electronic health records also has been challenging for the practitioners, as they had to learn to enter all their notes and referral information electronically.

Other challenges are more within the realm of moral or ethical dilemmas, especially cultural conflicts over advanced directives. One of the practitioners, for example, discussed the following case where a patient had signed an advanced directive and did not want other medical interventions:

A 45-year patient on dialysis wanted to discontinue this procedure against the family's wishes. As the patient's health was failing, the family requested the help of ONM to conduct a minor ceremony, but because the patient had signed an advanced directive, the practitioners had to deny the request.

One practitioner said that cases like this are always difficult for practitioners because their traditional training tells them that they cannot deny a request for help, and that they also are responsible for helping patients maintain hope and an appreciation of life to the end, not to discourage them or hasten death. The language in the advanced directives (e.g., about preparing for death) is disturbing for practitioners because they do not want to give power to the words within the document, as well as for many patients, who do not want to have such a discussion, thinking that speaking of death has the power to bring about or speed up the undesired event.

While most physicians interact primarily with their patients, the Native practitioners tend to work with both patients and their family members, and they expect the family members to be informed and supportive in carrying out the prescribed treatments or other therapeutic interventions. In describing their approach to working with patients and their families, the practitioners explain that establishing clan relationship (*K'e*) with the patient comes first. For example, one practitioner commented that, upon meeting a patient for the first time, clan memberships are immediately exchanged so that kinship connections can be understood, establishing the proper etiquette in how the interaction is to proceed. One practitioner went on to elaborate that "as a practitioner, I might

learn that I am a clan uncle to this patient.” Such an acknowledgement not only sets up rules of engagement, but also calls for mutual reciprocity in the relationship (Archie, 2007). This type of engagement also paves the way for mutual trust. The practitioner trusts the patient to be forthcoming, and the patient expects the practitioner to do all that he/she can to help.

While reciprocal kinship obligations are useful in patient-practitioner interaction, they can also challenge confidentiality. Therefore, the Native practitioners have extensive training on regulations governing patient confidentiality and why it is important in patient care.

It should be noted that similar kinship obligations are not expected in patients’ interaction with a non-Navajo physician or with other health care providers, due in part to the structure of health care delivery. For example, most Navajo patients generally are not seen by the same physician each time they come to the health facility. Fortunately, the Chinle Service Unit fortunately does not experience staff turnover rates as high as those of other IHS facilities, but it still conducts ongoing recruitment of physicians to help sustain long-term provider-patient relationships.

The amount of time spent with patients is another interesting cultural issue. Initially, some medical staff complained that practitioners appeared to be spending more time with each patient and seeing fewer patients than the medical staff. Not all staff understood that a practitioner’s interactions require more time with patients and their families. In addition to the diagnostic process, there is considerable discussion about what the cultural diagnosis means, what interventions are called for, and the specific requirements of the interventions or ceremonies. These include when the treatment should be conducted (if the required ceremony is seasonal), who might be asked to do the intervention, how this practitioner or another specialist should be approached, and how the patient or family should prepare for the treatment, (e.g., what herbs have to be gathered and what baskets, deerskin, or other necessary items have to be obtained).

If patients have not participated in these ceremonial activities before, they may need more information, which the practitioner usually provides by recounting the relevant oral history. The time commitment in this type of diagnostic counseling is perhaps more in line with mental health treatment practices than medical care in a busy outpatient or hospital setting.

FINDINGS: OTHER CHALLENGES IN THE WORKPLACE

The practitioners, allopathic providers, and community members all agree that trying to fit the Navajo cultural model into the Western medical model is not easy because of the differences in understanding what these types of healing procedures mean, and the difficulty in fitting “cultural illness” and cultural interventions into the existing administrative forms and standards of medical treatment. In any clinical encounter, the physician’s service is recorded or documented through a

set of codes, generally the International Classification of Diseases (ICD-10) codes, that reflect an array of health problems and typical medical services. However, the ICD-10 does not include, for example, a code for protection prayer or smudging.

The need to code patient service and diagnosis is a challenge because without such documentations, practitioners' services cannot be institutionalized, and the hospital cannot request reimbursement for these services. Payment requests for services provided have to contain required medical information that has been approved and accepted by credentialing agencies and health insurance companies. In a focus group discussion on this topic, one physician noted that spirituality is not part of the language used in the medical arena. He added that his medical training did not include a course on how to treat patients needing this kind of service, nor did he learn about assessments or a "laboratory test that indicated a patient was low on his Native medicine." Because spirituality is not part of the routine set of questions asked of patients by physicians, some providers are unsure when to refer patients to the ONM. Some say they do so "intuitively."

Both physicians and practitioners also are concerned about quantification of patients served by the ONM. One provider noted: "How do you quantify the healing of the spirit? How do you put this into a set of numbers? We providers [physicians] may see 40 patients a day, but we may have less impact on these patients than the one who was seen and helped by the practitioner."

When asked if patient health was ever compromised by conflicting advice or treatment offered by Native practitioners, the physicians answered "no"; one explained that this has not happened because the physicians and practitioners work together. He went on to say that some incidents have been reported elsewhere, usually in disconcerting situations where patients were advised by a community practitioner to stop taking medication recommended by a physician.

There also were situations in which physicians felt the presence of a practitioner could be critical to helping patients. For example, one physician recalled a case where a gravely ill patient was brought to the emergency room by his family at 2:00 a.m. Some family members were distraught because other members had advised against taking the patient to the hospital, predicting that hospitalization would only be fatal. There were no Native practitioners on call at that hour to help counsel or ease the concerns of the family, but, because the patient's condition was extremely serious, the physician was able to convince the family that the patient needed immediate help. The family consented but still voiced concerns about going against the wishes of some members. The physician noted that the patient did recover and thought the positive outcome helped relieve the family's guilt. Using this example, the physician commented that it would be helpful to have practitioners on call for emergency room services.

Community members overwhelmingly support the services provided by the ONM, and acknowledge that such services are necessary and important. One community member recalled how he and his family received help from a practitioner when a relative hospitalized in Phoenix could not regain consciousness. The practitioner conducted a ceremony at the family home and, at the end, informed the family that the patient would awaken shortly. “This did happen,” explained the community member. “He awakened in two days.” A health care provider who is Navajo commented that, in the business of healing, there are always unexplained miracles, and that she has witnessed a number of these “awesome” events when Native practitioners helped patients.

The comfort a practitioner brings to patients, especially those whose health beliefs and practices place emphasis on traditional healing, is viewed by the community as an important service. One community member who is also a practitioner recalled visiting her brother in the hospital on several occasions. She said he had lost his eyesight but knew her when she came to visit. During these visits, she would hold his hand and sing familiar chants, something that brought him contentment and peace in an unfamiliar environment. She and her brother also asked for frequent visits by the ONM practitioners to offer a prayer or encouragement. As a practitioner herself, she valued this support and remarked that she had been taught to ask other practitioners for this service.

CONCLUDING REMARKS

The contribution by the ONM practitioners in a clinical setting represents a significant effort to bring to fruition recommendations made since the mid-1900s for the incorporation of Native practitioners into the clinical and health care arena (Iverson & Roessel, 2002, p. 156), thus enhancing patient-centered care in a number of IHS facilities. Although the scope of services offered by the ONM practitioners is limited as a result of legal policies governing hospitals and the health care delivery system, the practitioners’ services are welcomed by many Navajo patients, especially in identifying cultural explanations for health-related problems that are not visible in laboratory reports or present among physical or mental symptoms identified by medical providers. When these cultural explanations are addressed by practitioners, most patients say they feel empowered in facing their health crises and also find comfort and familial support when they are treated with familiar traditional ceremonies.

The operation of the ONM is not without its challenges. Foremost among them is developing a strategy that accommodates these culturally based interventions (or treatment models) into science-oriented medical models. Presently, there are no easy answers to this problem, but it is widely acknowledged that the services of the practitioners are valuable to a large segment of the patient population. How to sustain and maintain this type of service, however, is another challenge. Would

the medical field at large be willing to accept and incorporate these services, and would the insurance carriers be willing to accept and approve payment for these services? The need to institutionalize the cost of services provided by the practitioners at Chinle and other health facilities on the Navajo Reservation is being discussed with some of the insurance carriers. Tribal government employees do have an insurance carrier that provides partial reimbursement for services provided by Native practitioners, but only outside the hospital or clinical setting. One of the key goals in the ongoing discussions is to reach a consensus on a reimbursable set of codes.

The other challenges described by the practitioners are in the realm of patient care, such as moral or cultural conflicts (e.g., advanced directives). Should there be a Navajo version of an advanced directive? These issues are now being discussed among the practitioners and other health care providers.

It could be said that the establishment of the ONM, and the services it provides, have raised the bar on regarding what is considered culturally appropriate care. Most recommendations call for involvement of traditional healers as consultants to help close the cultural gap in health care, but ONM practitioners actually are delivering care. They do this at their patient's bedside, on home visits, and during counseling sessions. They educate providers on relevant cultural issues, they talk about important health issues from a cultural perspective in the community, and they view their role and services as complementing the allopathic medical care provided to Navajo patients. In this context, the collaboration of Native practitioners with IHS allopathic providers in IHS facilities has resulted in an improved level of patient-centered care for AI/ANs.

Replication of the ONM model will not work in all health facilities serving tribal and urban communities. Each tribe has its own traditional healing system which prescribes who can conduct interventions or ceremonies and where they take place. A Sundance ceremony, for example, cannot be conducted in a hospital or on hospital grounds. Moreover, not every tribal member who seeks health care may want to use the services of a practitioner, or may not want to access such services in a clinical setting.

The health care needs of AI/AN populations everywhere, however, remain critical, making it necessary to provide culturally oriented patient-centered care, which may or may not include services like those provided by ONM. Where intercultural health care models can enhance health care, collaborative efforts should be made to make room for Indigenous tribal health resources.

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