Civic Engagement Capstone Project

Capstone for Master of Professional Studies in Civic Engagement

Holistic Healthcare: Recognizing traditional practices of the American Indian community

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Abstract

The American Indian community has had traditional healing practices, herbs, and medicines to cure their people long before Western medicine dominated the landscape. This holistic approach to healthcare including these traditional practices and medicines were not included in what we see offered at Western clinics nor are they covered by health insurance companies in the United States. The purpose of this work was to personally observe to understand the marriage of traditional healing and spiritual care in a Western clinic setting. During this observation period at the Native American Community Clinic, simply referred to as NACC in the community, I found that even while an American Indian clinic might offer both types of services, not as many patients are using both. This could be for many reasons including personal preference, the surrounding community's racial makeup, and the population being served at the clinic. In order to increase the number of people being served in this holistic manner, I name a few recommendations including: adding traditional healing and/or spiritual care service components to other clinics and perhaps hospitals; creating a formal referral network for physicians, nurse practitioners, nurses, and other healthcare providers to use; creating a database of available traditional healing and spiritual care services in a geographic area for community members and organizations to use; and expanding the post-event participant surveys to collect more identifiable information and potential barriers to service their participants face to better serve the community.

Purpose

The American Indian community has had traditional healing practices, herbs, and medicines to cure their people long before Western medicine dominated the landscape.

This holistic approach to healthcare including these traditional practices and medicines were not included in what we see offered at Western clinics nor are they covered by health insurance companies in the United States. Current health disparities faced by American Indians have roots in the historical trauma they were subjected to with the arrival of Europeans. It will take more than a Western medicine approach to improve overall wellbeing, traditional healing and spiritual care are essential to better health outcomes. The Native American Community Clinic in Minneapolis, MN is working towards this. The purpose of this work was to personally observe to understand the marriage of traditional healing and spiritual care and was afforded the opportunity to conduct this observation at the Native American Community Clinic. Throughout this paper are the terms “Western medicine” and “Western clinic” represent mainstream medicine in the United States where doctors and other healthcare professionals treat patients using prescription drugs, radiation, and/or surgery. These terms are compared to American Indian holistic wellness which NACC defines as representing “the whole self and the interconnectedness of the mind, body, spirit, and emotions/relational elements of the Medicine Wheel.” As Glen Aikenhead and Masakata Ogawa stated in their paper on Indigenous knowledge and science, “Indigenous knowledge fills the ethical and knowledge gaps in Eurocentric education, research, and scholarship” (Aikenhead & Ogawa, 2007).

Photo Courtesy of NACC

Methodology

The methodology used in this work was a mixture of qualitative and quantitative. The

qualitative data came through an exploration of the American Indian approach to health through articles, journals, and other readings as well as reviewing the services offered at NACC along with any stated correlation with traditional healing practices. By attending community events additional qualitative data was collected through personal observation, listening to prayers, storytelling, and traditional teachings. These opportunities were necessary for observing the intertwining of traditional ways at community events. At these events I worked as a member of the NACC staff and engaged with the community which looked different event-to-event such as serving popcorn at the Kid's Day Event, administering participant surveys at the Ma'iigan Mashkiki Gitigaan Event (Community Harvesting Event), and setting up tables, canopies, chairs, and free lunches at the Fall Harvest Health Fair. For most of the events that I participated in, I created the first draft of the post-event survey that was then sent to the Operations Manager. I am familiar with the American Indian community, so it was genuinely enjoyable to be at these events and visit with previous colleagues and community members.

The quantitative data came from post-event participant surveys and spiritual care reports from NACC, fact sheets on health disparities and inequities, United States Census Bureau data, the Minnesota Department of Health's Poverty Map, and other sources to understand the ill-effects of historical trauma on the current health outcomes of American Indians. The post-event participant surveys are heavily used at NACC to inform their grant funders reports. The survey templates generally collected the following information:

1. Have you used / do you use spiritual care services at NACC? Examples: Appointment with Elder in Residence or Spiritual Care Coordinator and/or attended a ceremony hosted by NACC (Full Moon/Cedar Ceremony):
2. If you replied no, what is the main reason for you not using these services?
3. I gained knowledge and feel more comfortable going to ceremony after today's event.
4. I will share this knowledge with family, friends, and/or my community.
5. What was the most interesting thing you learned today?

Positionality

Dr. Andrew Holmes (2020) of the University of Hull states:

The term positionality both describes an individual's worldview and the position they adopt about a research task and its social and political context. The individual's worldview or 'where the researcher is coming from' concerns an individual's beliefs about the nature of social reality and what is knowable about the world, an individual's beliefs about the nature of knowledge and an individual's assumptions about the way we interact with our environment and relate to it. These are colored by an individual's values and beliefs that are shaped by their political allegiance, religious faith, gender, sexuality, historical and geographical location, ethnicity, race, social class, and status, (dis)abilities and so on.

Since the purpose of this work was to personally observe to understand the marriage of traditional healing and spiritual care in a Western clinic setting, it was imperative to be fully aware of my positionality to this work.

Within positionality exists both an insider (emic) account and an outsider (etic) account. An emic account is the insider's view of reality within a cultural relativist perspective meaning that the researcher understands a person's culture is relative to their actions and behaviors. On the other hand, an etic account is the outsider's view based within a realist perspective where the researcher aims to remain culturally neutral. With most things in life, there are advantages and disadvantages to each account. A responsible researcher will take time to practice self-reflection around their positionality and perceived positionality.

When reflecting on possible emic accounts to this work, I realized two important insider perspectives I have: I have previously worked in the American Indian community, and I personally know the Native American Community Clinic's Operations Manager. Previous work experience in the American Indian community has significant advantages to this work because I was familiar with traditional ceremonies, sacred medicines, and community terminology. However, a possible disadvantage related to this insider perspective is an unconscious bias from personal experiences working with the community. Having personal familiarity with the Operations Manager at NACC also had a significant impact on my work with the clinic because she vouched for me and there was comfort already there which made asking questions and gaining access easier. A possible disadvantage could be any unintended pressure on our relationship during my work observing the clinic and any recommendations that came out of those observations. Specifically, I wanted to be a value-add to the clinic's ongoing work and not get in the way.

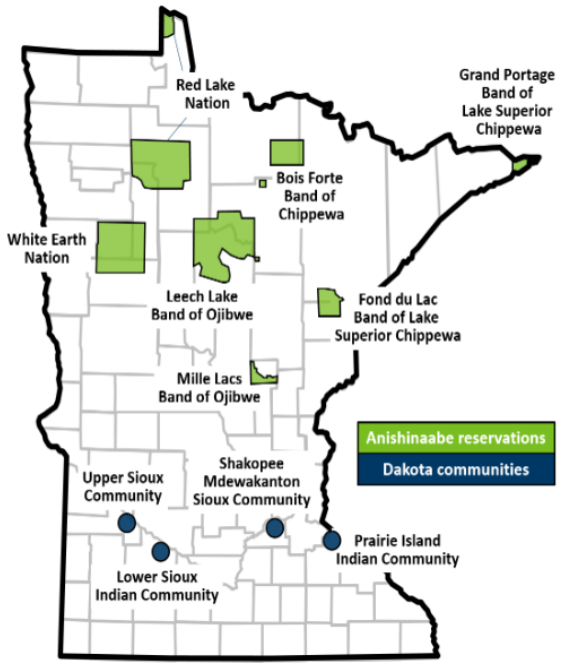
After working through the emic accounts, I turned my attention to the etic accounts and noted two outsider perspectives I hold: I do not identify as American Indian and my role as a student conducting research on traditional healing and spiritual care. And again, I took the time to reflect on the advantages and disadvantages with these outsider perspectives. An advantage to doing this work and not identifying as American Indian is the observation of a culture different from my own and being able to identify and appreciate similarities and differences. However, a very significant disadvantage to this account is that there is a historical distrust (and rightly so) of outsiders observing, researching, and reporting on American Indian culture. This disadvantage was the most active in my self-reflection while observing because I felt this is the most out of my control disadvantage to my work. The reality and perception of a non-American Indian observing and researching can and should make a researcher think, speak, and act with more intention and respect. My role as a student with the University of Minnesota was advantageous because I gained access to NACC more easily than a professional. A disadvantage to working with the clinic as a student observer was that I could not always get what I wanted like a professional person might have. For example, some staff at NACC were more responsive to my requests than others and there was not much I could do in situations where I had previously asked for access with little to no follow through. I do not believe that these actions were intentionally meant to be a barrier but more so an example of how my needs were prioritized in their work.

Background and Historical Trauma

Before discussing the services and ongoing work of the Native American Community Clinic, I believe it is important to understand the historical trauma and its ill-effects on the American Indian community as well as an introduction to the American Indian population within the state of Minnesota. In a January 2020 report by Melanie Ferris and Dimpho Orionzi, of Wilder Research, it was stated that “differences in health outcomes caused by social and economic inequities are pervasive and persistent in Minnesota, and impact multiple populations, including Indigenous communities. . .” (Ferris & Orionzi, 2020). There are two tribes in Minnesota, the Anishinaabe (also known as Chippewa and/or Ojibwe) and the Dakota (also known as Sioux). There are seven Anishinaabe reservations and four Dakota communities within the state.

Having familiarity with the historical trauma the American Indian community has dealt with makes the work of NACC that much more impressive. There is an argument to be made that some of the current health disparities of American Indian began when the Europeans arrived in what is now the United States. American Indians were victims of colonization efforts which included warfare, intentional and unintentional diseases (i.e., diphtheria, smallpox, and tuberculosis), forced relocation to reservations, cultural life and language

Minnesota's tribal reservations and communities



Source: Minnesota Department of Health

banishment, and unwanted diet and lifestyle changes because of their dependence on the United States government due to their relocation to reservations where they could no longer hunt or harvest traditional crops.

In 1819, the Civilization Fund Act was passed by Congress to open residential boarding schools for American Indian children. The first of these boarding schools opened in 1860 by the Bureau of Indian Affairs on the Yakima Indian Reservation in Washington state. Through the 1960s, these boarding schools abused and neglected (physically, sexually, culturally, and spiritually) American Indian children and many died from disease, starvation, and improper healthcare. To this day, the total number of children removed from their homes and families to attend these boarding schools is unknown. By 1900, there were 20,000 children in Indian boarding schools, and by 1925 that number had more than tripled to 60,889 children (National Native American Boarding School Healing Coalition, 2020). To promote assimilation into white society and the genocide of Indigenous culture, they were not allowed to speak their native language, wear traditional clothing, and the boys were forced to have their hair cut. While tribes' beliefs might slightly differ, generally men and women are encouraged to have long hair because it connects them to the land and Mother Earth. It is a significant part of their identity and usually is only cut when someone close to them passes away. It is important to make the connection between what American Indian children endured at these boarding schools and their current health disparities. Whole generations spent their formative years in these horrible conditions without knowledge of traditional family structures, unable to develop parenting skills, and without loving family relationships.

Health Disparities and Inequities

The historical trauma and boarding schools discussed above “are believed to contribute to the population's high rates of alcohol and other substance use disorders, domestic violence, child abuse, and suicide” (Carron, 2020). Disparities in physical health continue to exist from smoking, diabetes, obesity, and metabolic syndrome which “is a condition that includes a cluster of risk factors specific for cardiovascular disease” (Johns Hopkins Medicine, 2021). Suicide, violence, poor education, alcohol consumption, and socioeconomic status contribute to the current disparities in mental health and their social determinants of health. Approximately 2% of the United States population, about 6.6 million people, self-identify as having American Indian heritage (United States Census Bureau, 2016). However, American Indians have the highest poverty rate of any race or ethnic group, with 26.6% living in poverty compared to the national poverty rate of 14.7% (United States Census Bureau, 2016). The life expectancy of newly born American Indians is 4.4 years less than the national average, 73.7 years compared to 78.1 years (Brave Heart et al, 2011). The forced relocation to reservations that they historically did not occupy, hunt on, or harvest on has led to the disparities in environmental determinants of health. These cumulative disparities and ill-affected determinants of health produce chronic illness and poor health outcomes for American Indian communities. American Indians “continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases” (Carron, 2020). Although the rates of infant mortality are decreasing across the state of Minnesota, “American Indian and African American babies are twice as likely to die in their first year of life compared with Asian

and white babies" (Minnesota Department of Health, 2018). It is believed that the treatment for and improvement of these health disparities lies within cultural practices and traditions such as community events that include praying, drum (hand or group) and song, sacred medicine(s), traditional food/ingredients, and cultural activities. It should be acknowledged that not all health disparity gaps will be closed with cultural practices and traditions alone, some gaps (conditions, syndromes, diagnoses, etc.) will require a Western medicine element in their treatment towards improved health such as diabetes.

The Native American Community Clinic

The Native American Community Clinic opened in 2003 to address the health disparities of urban American Indian communities using a holistic approach with the mission to promote the health and wellness of mind, body, and spirit of Native American families. Located in the Native American cultural corridor of South Minneapolis, NACC is geographically close to the Minneapolis American Indian Center and Little Earth of United Tribes. Founded in 1973, Little Earth is a Department of Housing and Urban Development (HUD) subsidized housing complex and remains the only Indigenous preference project-based Section 8 rental assistance community in the United States. The Little Earth community includes residents from 38 different Tribal Affiliations.

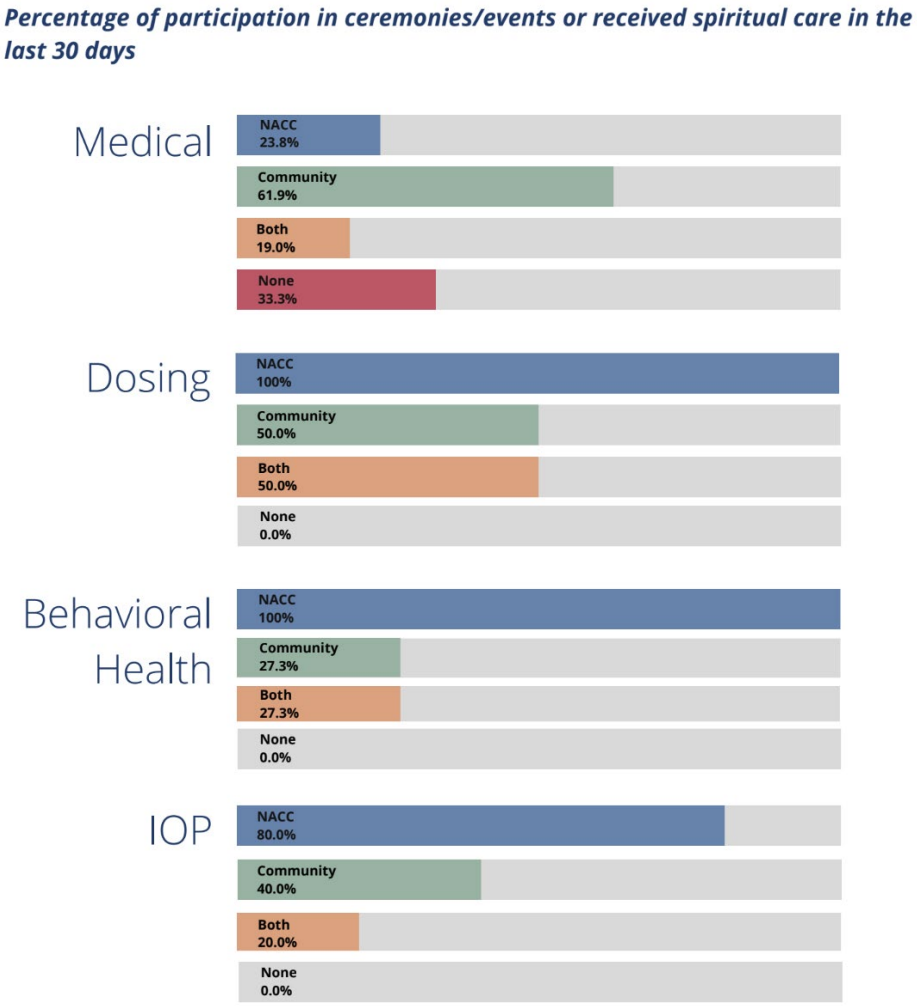
The Native American Community Clinic offers a full range of healthcare services including medical, behavioral health, dental, and substance abuse programs. NACC strives to honor health and tradition by providing spiritual care and access to traditional healing and education through their Elders in Residence. It is important for NACC to offer a full range of services because American Indian "people who meet the criteria for depression, anxiety, or substance abuse disorders are much more likely to seek help

Photo Courtesy of NACC: top to bottom, left to right: tobacco, sweetgrass, sage, cedar

from a spiritual and/or traditional healer than from specialty or other medical sources" (Mental Health America, n.d.). Visitors to the clinic are encouraged to smudge when they arrive for an appointment as well as given access to any of the four sacred medicines: sage (cleanse and remove negative energy), cedar (restorative medicine for healing), tobacco (used as an offering of prayer), and sweetgrass (sacred hair of Mother Earth). Smudging is a traditional practice to cleanse one's thoughts and intentions. Sage, sweetgrass, and cedar are commonly burned medicines during a smudge. NACC explains that the medicines are burned to call on the spirit of the medicine to come into our lives for help. The graph on the next page shows the percentage of participation in ceremonies/events or receiving of spiritual care either at NACC, in the community, or both over a 30-day period. Dosing represents the Medication-Assisted Treatment Clinic which is for patients who struggle with heroin, prescription opioids, or other opioid addictions. Behavioral Health provides care in various areas including individual and

group therapy, depression and anxiety, grief and loss, post-traumatic stress disorder, substance use disorders, and behavioral assessments. IOP is the clinic's intensive outpatient program which is rooted in Indigenous spiritual practices and offers a culturally centered approach to treating substance use disorders. NACC reports that 75% of participants stated that spiritual care participation (i.e., attending ceremonies and receiving individualized care) greatly helped with their recovery. The medical clinic reported much lower participation with 33.3% of the respondents reporting no participation in ceremonies/events or receiving spiritual care. This could be because the medical clinic sees more patients that do not identify as American Indian (there is a large Somali population in this zip code) and Western medicine does not root itself in traditional healing and spiritual care.

American Indian healing traditions emphasize a holistic approach to maintain a balanced, fulfilling lifestyle and view



Source: NACC Spiritual Care Survey Report, 09/07/2022

health and wellbeing as a balance among physical, mental, emotional, and spiritual factors. NACC approaches healthcare by addressing root causes of health disparities including access to food, housing, and health insurance with services such as resource navigation, care coordination, outreach, and community-based activities. This is necessary because the Minnesota Department of Health reported the zip code (55404) that NACC is in has 41.7% of its population living in poverty which is higher than the average for the state.

Community Events to Improve Health Outcomes

During my time with NACC, I observed and assisted with the following Community Health and Outreach events:

- Kid's Day: this event provided free backpacks and school supplies to families with children who were up to date with their annual pediatric wellness exams, a free lunch, traditional lacrosse instructor, and a visit from the Minneapolis Fire Department.
- Fall Harvest Health Fair: this event provided free produce with recipes, a health-related vendor fair, a free lunch, and a food demonstration using traditional ingredients to make nettle hummus.
- Open Enrollment and Winter Gear Event: this event provided winter gear for adults and children, flu shots, HIV testing, and assistance from staff in navigating MNsure to ensure the community has the appropriate health insurance coverage.

In addition to the Community Health and Outreach events, I also observed and assisted with the following Spiritual Care events:

- Ma'iigan Mashkiki Gitigaan Event (Community Harvesting Event): this event offered the community an opportunity to harvest traditional medicines growing around the clinic, a make-your-own sage bundle, traditional ingredient tea blends, and an introduction to mosaics for youth in the traditional Ojibwe style.
- Feast Bag Workshop: this workshop offered the community the chance to design and create a feast bag with reusable utensils and a cup to bring to ceremonies and included an oral history and teachings on when and how to use the feast bag.
- Virtual Food Preservation Workshop: this workshop taught the community how to make escabeche (pickled jalapeños or carrots), all the necessary materials were provided beforehand since the workshop was held on Zoom.
- Epoxy Workshop: this workshop offered the community the opportunity to create epoxy resin jewelry using traditional medicines, meaning they could wear a sacred medicine in the form of a necklace or earrings.
- Dreamcatcher Workshop: participants in this workshop created a traditional style dreamcatcher and learned about the history of the dreamcatcher.
- Rattle Making Workshop: participants in this workshop designed and made a rattle for ceremony and other events.
- Cedar Ceremony: this ceremony occurs monthly, a spiritual and emotional wellbeing healing ceremony.
- Winter Storytelling Event: this was a virtual event that included three elders who told stories meant for the winter season.

- Full Moon Ceremony: this is a monthly women's ceremony, the Moon is called Grandmother Moon and this ceremony is a time to cleanse mentally, physically, emotionally, and spiritually.

Currently, NACC is exploring how to get Spiritual Care services into the health insurance copay system with Blue Cross Blue Shield. This could be beneficial to all parties including NACC, clients, healthcare providers, and health insurance companies. Clients receiving Medical Assistance or Medicare cannot afford to pay out-of-pocket for services that are not covered by their insurance so this would eliminate that barrier. NACC does not refuse care if a patient cannot afford to pay for services, so payment from a health insurance company instead would assist them in covering staff and overhead costs, therefore allowing them to continue providing services. Both the healthcare providers and health insurance companies would be providing the needed care and coverage to their patients by extending their education and coverage of spiritual care services at NACC.

Limitations

While this work is happening, the time that I spent with NACC was not enough to see change being made on a larger scale. Health insurance is a very slow-moving system so implementing changes to coverage on a company-wide scale will take time. Another complex piece of this is determining the dollar value of spiritual care since the qualifications of the person giving care does not follow the Western pathway of education and certifications. For example, Elders in Residence are spiritual, highly respected, and role models in their respective communities for their actions, their teachings, and their wisdom – not because they have a diploma. This was a recent

challenge at NACC because they needed to create job descriptions for their Elders in Residence to send to Blue Cross Blue Shield, as a piece of this larger project.

Access was also a limitation, but I believe the short timeframe I was involved with NACC contributed to this. I was unable to secure interviews with an Elder in Residence during my time with NACC. I believe this would not have been an issue if I had been working with them for a longer period. I asked the spiritual care coordinator a few times for access which she was happy to provide but was unable to follow through. With the hierarchy of the clinic, I did not feel it was appropriate to go directly to the elders. I also did not want to ask her supervisor and have her perceive that I was going above her and possibly get her reprimanded.

Recommendations

Looking at what the Native American Community Clinic is working towards is so inspiring. Some ideas that have formed over the time I have spent with them to better serve the community at-large include the following.

First, I thought of adding traditional healing and/or spiritual care service components to other clinics, perhaps even at Western clinics. To me this might look like having an Elder in Residence at a clinic or hospital to serve the community that is seen there instead of going to NACC. This could remove any possible barriers around transportation that patients might face if they do not have reliable transportation to get to NACC or if they would prefer not to be seen at NACC for personal reasons. This recommendation comes from the idea that more people could be treated if it were part of a larger facility and offered at various locations across the state. Here are a few questions to guide further thought in this recommendation:

- How do Western clinics ensure the person they are looking to acquire for traditional healing and/or spiritual care is a role model in their community?
- Who do they contact to confirm this status?
- Does this only work in Western clinics that serve a certain percentage (perhaps at least 25%) of American Indian people or should it be strategically located based on the surrounding American Indian population?
- How do you measure success or effectiveness in this position?
- Does this position accept patients of non-American Indian backgrounds? Is that decided by the person performing these services?

Second, the creation of a formal referral network that physicians, nurse practitioners, nurses, and other healthcare providers can use to connect their patients with traditional healing and/or spiritual care services near their home. This would mean forming relationships with clinics and hospitals to make connections with the non-Western clinics providing these services, providing education on why these services are important and necessary for the overall wellbeing of their American Indian patients, and ongoing professional relationship maintenance. The first recommendation is a big picture idea, would take a lot of organization and time, this recommendation seems like a natural first step to the larger in-house services because it is the relationship-building, education, and dot-connecting piece. One of the first things I asked the Operations Manager at NACC was if other clinics (non-American Indian) or hospitals knew about the Spiritual Care services offered there, and she said she did not know but assumes that knowledge is based more on word-of-mouth through individual physicians, nurses, and healthcare practitioners that have or had a formal relationship with NACC. I

understood this to mean that the surrounding clinics and hospitals did not know about the Spiritual Care services available at NACC. This recommendation could effectively aid in the overall wellbeing of American Indian people because it would be the combination of both Western and traditional healing by receiving care at a Western clinic and then also learning about or possibly being connected to traditional healing services at the same appointment. Here are a few questions to guide further thought in this recommendation:

- How does this conversation begin and with whom?
- Who “owns” the network creation and maintenance?
- Who ensures the credibility of those who end up in the network?
- What if a physician, nurse, or other healthcare provider refuses to take part in the education around the importance of traditional healing and/or the network?
- What if a patient has not disclosed their racial identity to the clinic or hospital?

My third recommendation is to create a database of the available traditional healing and spiritual care services in a geographic area, such as Minneapolis, so that community members know where they can go for certain services. This recommendation comes from another question I posed to the Operations Manager about what other American Indian clinics and nonprofit organizations in the area offer in terms of traditional healing and/or spiritual care. NACC has an idea of what some other American Indian clinics and nonprofit organizations are offering but not a comprehensive list. This could lead to larger, more impactful services and events through collaboration, sharing knowledge of successful business practices and models, and reducing resource competition (i.e., limited grants for funding spiritual care services

like Elders in Residence). This recommendation also comes from an experience during my time at NACC when we did not get the expected turnout at the Kid's Day Event because we learned that day that another American Indian nonprofit organization had held their version of this event earlier in the week. The other organization is located no more than a few miles away from NACC, but the news of the event had not made its way to the organizers beforehand. It was even mentioned by staff after the event that it should have been a combined effort so more children could have received backpacks and school supplies. Like in any large business network, siloes are bound to naturally occur but it seems like more organization and communication between organizations would be beneficial to the community at-large. Here are a few questions to guide further thought in this recommendation:

- Who creates and maintains this database?
- If this was one position's responsibility, which organization would take on the human resource expense?
- How do you start this conversation and get multiple organizations to understand how it is mutually beneficial?

My final recommendation would be to create more intentional and detailed post-event participant surveys by the Community Health and Outreach and Spiritual Care teams at NACC. The post-event participant surveys at NACC are great tools for reporting back to the grant funders for specific events because they collect qualitative data in the form of quotes but could benefit from further details. For example, tribal affiliation and gender were not on the template which could be useful information for the clinic in the future. Also not included in the survey template was a question on why a

participant might not receive spiritual care services at NACC. This is an area that could be built out to understand what barriers to participation in traditional healing and/or spiritual care exist. The surveys also confirm or deny assumptions about the event participants such as the assumption that many participants currently or have previously used spiritual care services at NACC. This assumption proved to be incorrect based on the responses we received from participants at the Community Harvesting Event. Of the 36 responses we received, only 13 participants had gone to NACC for spiritual care services. After being a bit shocked by these results, I suggested that we add in a question asking why a participant does not receive spiritual care services at NACC, and later mentioned that age, gender, and tribal affiliation data might be useful for the clinic to start collecting. One of the last events (Virtual Food Preservation Workshop) that I worked with NACC on had a more robust post-event survey including the following questions:

1. What is your age?
2. What is your tribal affiliation?
3. Have you used / do you use spiritual care services at NACC? Examples: Appointment with Elder in Residence or Spiritual Care Coordinator and/or attended a ceremony hosted by NACC (Full Moon/Cedar Ceremony):
4. If you replied no, what is the main reason for you not using these services?
5. I gained knowledge on food preservation after today's workshop.
6. I feel confident in my ability to make escabeche on my own after today's workshop.
7. I will share this knowledge with family, friends, and/or my community.

8. What was the most interesting thing you learned today?
9. Are there other workshops you would like NACC to host?
10. If you are local, is it easier for you to attend workshops/events online?

I think this is a great start to collecting information on who NACC is serving and a way to see if there are ways to better serve the community holistically.

Unintended Consequences

It should be noted that there can be unintended consequences to each of the recommendations above. As non-Western healing practices and medicines become more mainstream and further from their origin, it becomes difficult to determine who is legitimate. An example of this is people pretending to be American Indian and exploiting sweat lodge ceremonies for monetary gain to those who do not know that real ceremonies are always free. As the Mendota Mdewakanton Dakota Tribal Community state on their website (n.d.):

> *All the elements of the Inipi are sacred, connecting participants to the Creator and the spirit present in all existence. The Grandfather rocks are sacred. The water poured on the rocks is sacred. Steam from the water rises up as prayers to the Creator. Walking in the way of the Inipi provides a path for healing of body, mind, spirit and emotions, touching all four realms on the journey toward wholeness and relationship with the Creator and all people.*

This type of dishonesty is both dangerous to the participants who believe they are being helped by a medicine man and harmful to the community that is being exploited.

Summary

To close the gaps in health disparities faced by American Indian people, a holistic approach to wellness must be used. Physicians, nurses, and other healthcare practitioners treating American Indian people must have at the very least, a baseline understanding of the historical trauma they have faced and how the ill-effects of that trauma have influenced their current health outcomes to effectively help. If Western medicine and clinics are unable to introduce education and professional training around treating the American Indian population then clinics like NACC and other culturally focused organizations will have to continue to fill that gap in healthcare. I am grateful for my time with NACC and enjoyed the opportunity to be back in the American Indian community.

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