Describing a Sustainable Model of Harmonization between Culturally Congruent Traditional Healing and Evidence Based Biomedical Models in the Context of Alaska Native Tribal Health

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Executive Summary

An understanding of the importance of culturally sensitive care has progressed immensely in the last few decades. The theory of enculturation has proven that promoting cultural identity and cultural humility improve the health of indigenous communities. This project incorporates cases, themes and practices that are useful in the integration of traditional medicine (TM) with biomedical (BioM) services. This project was tailored for the clients of the Chief Andrew Isaac Health Center (CAIHC) in Fairbanks, Alaska, but has implications for any healthcare system working with tribal/indigenous groups.

The CAIHC has been operated by the Tanana Chiefs Conference for nearly three decades. Despite being a tribally owned clinic, the CAIHC uses a prototypical approach to clinic organization and management. Recently some of the principle stakeholders have become interested in the possibility of incorporating a more holistic, traditional approach.

The question to answer is: How do you successfully and sustainably integrate TM with BioM in the context of evidence based practice and cultural humility and how can those principles be applied to the Chief Andrew Isaac Health Center?

The objectives of this project include:

- Completing a clinical rotation at the CAIHC in Fairbanks, Alaska
- Recruit content experts to assist in refining the project in an ongoing fashion.
- Develop a manuscript on the subject of integrative models suitable for submission for peer review
- Develop a poster that summarizes the key points of the manuscript.
- Develop a formal presentation with specific principles and recommendations for the Tanana Chiefs Conference, to be presented in Fairbanks Alaska.

This paper is not an exploration of the common practices known as Complementary and Alternative medicine (CAM) where traditional healing practices and philosophies are brought into western medical clinics for non-indigenous peoples. The theme of this paper does not question the validity of that model but I suggest that there is something different at work in the context of enculturation and the use of medicine as promoting cultural continuity and identity.

. The objectives of this project are specifically directed, and the end result of this project will be applied to the Tanana Chiefs Conference in Fairbanks Alaska as a means to improve the healthcare they are providing to their people.

This project was approved by Dr. Dianne Fuller, director of the Nurse Practitioner, Primary Care Program and chaired by Dr. Tamara Melville of the University of Utah, College of Nursing. The content experts consulted during the course of this project include Dr. Peter DeSchweinitz from the University of Utah, School of Medicine and the Chief Andrew Isaac Health Center, Fairbanks Alaska; Dr. John Lowe, Wymer Distinguished professor, Florida Atlantic University; and Dr. Georgia Kyba, of the First Nations Health Council, British Columbia.

Introduction

In 2006, while traveling in Ecuador with a medical expedition, I fell in with an interpreter who had a keen interest in medical anthropology. During the course of our work we found a small clinic in the mountain region of Ecuador, Imbabura province. Nestled there, in the city of Otovalo is the Jambi Huasi clinic. While there we met a biomedically trained M.D., and a Fregadora (folk healer). Dr. Conejo, the MD, also told me about their Yachac (medicine man). Dr. Conejo told us about their pharmacy and herbarium as well as the dental clinic they operate. She described their clinical laboratory ability as well. Jambi Huasi is run as a highly integrated, successful, self-sustaining clinic that meets the cultural and medical needs of the Kichwa, Mestizo, and Afroecuatoriano population in Otavalo (Conejo, 2009). It is an enviable blend of culture care and medicine.

In 2010 I did an in-depth literature review and found no indication of a similar model in North America. Networking throughout 2011 and 2012 produced leads on a small number of clinics including one in Anchorage, AK and another in Piñon, AZ – in the Navajo Nation. Although it is likely there are more clinics operating in some integrated fashion they are difficult to locate as there is no formalized network and many hold the proprietary nature of their integration very close.

In 2012 I had the opportunity as part of my training to spend five weeks on rotation at the Chief Andrew Isaac Health Center (CAIHC), a tribally owned clinic held by the Tanana Chiefs Conference (TCC), in Fairbanks, Alaska. Despite a large amount of cultural pride in the population served by this health center there was no significant, formal integration of cultural values and traditional practices into the clinic setting. Evidence in the literature supports

promotion of cultural identity as a strong health-risk modifier and yet it was lacking in the interface of medicine and community for this group.

Purpose

The purpose of this project is to understand models of integration between traditional healers and biomedically grounded providers that have been described in the literature, and apply it to the CAIHC in Fairbanks. With that in mind the question I want to answer is: How do you successfully and sustainably integrate traditional medicine with biomedicine in the context of evidence based practice and principles of cultural humility

The original title of this project used the word integration instead of harmonization. Historically harmonization has been synonymous with consensus building, or mediation. The term integration has been used as a euphemism for assimilation, especially as associated with 1940s era policies to ‘improve’ living conditions of indigenous populations by assimilating or integrating them into the ‘national society’ (PAHO/WHO, 2002). Throughout this paper the word integration and harmonization are used interchangeably in the hope that we can see our way to a respectful and culturally humble approach in bringing the best health outcomes to tribal communities.

Problem

The Chief Andrew Isaac Health Center (CAIHC) has been operated by the Tanana Chiefs Conference for nearly three decades. Despite being a tribally owned clinic the CAIHC uses a prototypical approach to clinic organization and management. Recently some of the principle stakeholders have become interested in the possibility of incorporating a more holistic, traditional approach.

Significance

Global Significance

Cultural perspectives in healthcare have experienced increased recognition during the past two to three decades. With increased awareness has come improved models of culture care. Newer models of culturally sensitive care are centered on the principle of Cultural Humility. Cultural Humility recognizes that culturally-congruent care is most effective as a mode of collaboration. This departs from the classic paradigm of cultural sensitivity where it was considered sufficient for health care providers to possess a list of facts about a culture (Tervalon & Murray-Garcia, 1998).

This shift is important relative to the protective nature of enculturation in ethnic communities and the role that traditional practices play in promoting cultural identity (Winderowd, Montgomery, Stumblingbear, Harless, & Hicks, 2008). By integrating traditional practices using proven methods of collaboration the quality of health care in and the strength of the Native community can be significantly strengthened(Jones & Galliher, 2007; Winderowd et al., 2008). Integrating traditional medicine has the additional benefit of improving access to care by promoting health-seeking behaviors in traditionally rooted populations. When communities validate traditional medicine and cultural values as part of a holistic environment of healing, more individuals from the community are likely to seek care and adhere to treatments (Mignone, Bartlett, O'Neil, & Orchard, 2007; Novins et al., 2004).

Efforts to eliminate health disparity such as the Healthy People initiatives look at different means to this end. Traditional medicine is one area that needs to be focused on when trying to meet these goals(Struthers, Eschiti, & Patchell, 2004). The Pan American Health

Organization(PAHO) has discussed what an end to health disparity might look like and describe equity in terms of certain requirements.

In the context of health conditions, equity means reducing avoidable and unjust differences to the minimum level possible. Equity in health services means receiving care according to need and contributing economically according to the ability to pay. (PAHO/WHO, 2002). Both of these ideas can be fostered in the context of traditional medicine which is often low-cost relative to biomedical services. Ultimately traditional medicine could become a critical resource in addressing global health disparities (Burke, Wong, & Clayson, 2003). Encouraging traditional healing may be one way to achieve this (Struthers et al., 2004).

Significance for the TCC

The TCC provides health care for nearly 11,000 Alaska Natives in the Fairbanks region. This is an area of 235,000 square miles – roughly three quarters the size of the state of Texas. The Chief Andrew Isaac Health Center (CAIHC), affiliated satellite clinics, and other outreach programs have been run by the TCC for nearly three decades. During that time they have sought to "promote and enhance spiritual, physical, mental and emotional wellness through the delivery of quality services" (Tanana Chiefs Conference, Inc., n.d.). Despite being a tribally owned clinic the CAIHC uses a prototypical approach to clinic organization and management. In early 2012 the TCC entered into a joint project with the Indian Health Services (IHS) to build a new 'Super Clinic' to house the CAIHC. Until they relocated to the new clinic space at the end of 2012 the CAIHC operated out of leased space at Fairbanks Memorial Hospital.

This facility upgrade provides an ideal opportunity to expand the healing modalities offered through CAIHC to the Alaska Natives of the TCC region (Erickson, 2009; Tanana Chiefs Conference, Inc., n.d.) To date, cultural and traditional medicine practices have not been closely

integrated into the delivery of healthcare. With the advent of a community based suicide prevention program in 2011 they have only recently begun to look at specific and concrete ways to promote culture care in the context of healthcare delivery.

Objectives

- Completion of a clinical rotation at the CAIHC in Fairbanks, Alaska
- Recruit content experts to assist in refining the project in an ongoing fashion.
- Develop a manuscript on the subject of integrative models suitable for submission for peer review
- Develop a poster that summarizes the key points of the manuscript.
- Develop a formal presentation with specific principles and recommendations for the Tanana Chiefs Conference, to be presented in Fairbanks Alaska.

DNP Essentials

This project is a synthesis of the DNP curriculum. I have identified the key DNP essentials as outlined by the AACN that are taken into consideration by this project.

I - Scientific underpinnings: Integrate nursing science with knowledge from ethics, the biophysical, psychosocial, analytical, and organizational sciences as the basis for the highest level of nursing practice. Develop and evaluate new practice approaches based on nursing theories and theories from other disciplines.

II – Organizational and Systems Leadership: Develop and evaluate care delivery approaches that meet current and future needs of patient populations based on scientific findings in nursing and other clinical sciences, as well as organizational, political, and economic sciences.

III – Clinical Scholarship and Analytical Methods for Evidence Based Practice: Use analytic methods to critically appraise existing literature and other evidence to determine and implement

the best evidence for practice. Apply relevant findings to develop practice guidelines and improve practice and the practice environment. Function as a practice specialist/consultant in collaborative knowledge-generating research. Disseminate findings from evidence-based practice and research to improve healthcare outcomes.

VI – Interprofessional Collaboration: Employ effective communication and collaborative skills in the development and implementation of practice models. Employ consultative and leadership skills with intraprofessional and interprofessional teams to create change in health care and complex healthcare delivery systems.

VII – Clinical Prevention and Population Health: Synthesize concepts, including psychosocial dimensions and cultural diversity. Evaluate care delivery models and/or strategies using concepts related to community, and cultural dimensions of health.

VIII – Advanced Practice Nursing: Educate and guide individuals and groups through complex health and situational transitions. Design, implement, and evaluate therapeutic interventions based on nursing science and other sciences (AACN, 2006).

Literature Search Strategy

In order to understand the implications of bringing biomedical healthcare models together with traditional healing practices a review of the literature was conducted. Particular emphasis was placed on informing a validation of this model of care and locating previously published works that described specific instances of collaborative efforts i.e. case studies; as well as any potential difficulties and how they might be surmounted.

The Mesh terms ‘traditional medicine’ and ‘integrative medicine’ were used alone and in the following search strings: ("traditional medicine" OR "spiritual therapies") AND (allopath*

OR Biomed* OR Western OR Modern) and ("Spiritual Therapies"[Mesh] OR "Medicine, Traditional"[Mesh]) AND "Integrative Medicine"[Mesh].

Some additional terms were used in combination including: Native American, Alaska Native, tribal, culture, cultural, enculturation, identity, and maintenance. Inclusion criteria are any article published in the last 10 years regarding traditional medicine and its relationship to cultural identity as well as the relationship between cultural identity and health risk behaviors. Also included without restriction to time are any descriptive studies of specific models or incidents of integrative health clinics.

The search was conducted in CINAHL, Medline and PubMed using the strings and direct key word searches noted above as well as searches for known cases in the literature. Additional search strategies include author-as-keyword using academics and clinicians known to be involved in this field as well as ancestry methods of bibliographic review. Searches using strings and key words similar to those above were done in Google Scholar to identify pertinent grey literature.

Review of the Literature

Although this project draws influence from various theoretical and philosophical foundations including Madeleine Leininger's Culture Care theory and the principles of Cultural Humility; by far the main theoretical underpinning is that of Enculturation theory.

Discussions of culturally appropriate care often use the terms *assimilation* and *acculturation* in reference to the effects observed when minority cultures are surrounded by a dominant one. These terms describe the fairly expected outcomes of typical scenarios: dilution and or loss of cultural identity along with the adoption of the dominant-culture symbol and behavioral constructs. One of the first formal discussions of acculturation is found in a brief

paper from 1936 by Redfield, Linton and Herskovits. At that time the term acculturation had a fairly general definition: “Acculturation comprehends those phenomena which result when groups of individuals sharing different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups”(p. 149).

Over time this definition has been broken down into more nuanced descriptions of the patterns of knowledge/behavior distribution and sharing associated with cultural interactions. The term diffusion is the most general term merely indicating a spread of cultural elements. Acculturation has come to reference the changes that one experiences due to the influence of being in contact with another culture. Specifically, changes to attitudes, values and identity (Kim, Ahn, & Lam, 2009). Although initially considered equivalent to or a subset of acculturation, enculturation shows up as a distinct set of phenomena in the 1948 book *Man and His Works: The Science of Cultural Anthropology* by Melville Herskovitz. In this work Herskovitz suggested that enculturation is “the process of socialization into and maintenance of the norms of one’s indigenous culture including its salient ideas, concepts and values” (Kim et al., 2009, p. 26). This is the definition that has driven the development of enculturation scales to measure levels of enculturation and the subsequent large numbers of studies that have explored the effects that various levels of enculturation might have on health and health-risk behaviors in many different ethnic groups.

In the American Indian/Alaska Native population enculturation has been demonstrated to be protective in nature. Affiliation with traditional ways promotes resilience in the face of adverse life conditions (Winderowd et al., 2008). Although a successful model as demonstrated by exploration of the theory and a review of isolated case studies, during preliminary searches a comprehensive review on the subject of integrative models could not be identified.

This project seeks to utilize the benefits of strong tribal affiliation by applying it directly into the healthcare service model via the integration of traditional, culturally congruent, healing methods as an additional way to promote enculturation. A review of the literature will be used to inform this project and the objectives listed below in order to synthesize information from any models currently operating and identify common themes, methods, and theories that can be used to build a tailored and sustainable model of integration for the TCC.

Methods

Implementation of Objectives

Clinic rotation. In order to have a better understanding of the patient population and culture of healthcare within the TCC I was invited to spend a portion of the summer semester 2012 working at the CAIHC. To accomplish this I explored options for funding via local philanthropic foundations, applied for a grant through the Utah Nurse Practitioners Association (UNP) and applied for the preceptorship through the TCC and the Alaska Interior Area Health Education Council (AHEC).

Content experts. Content experts were sought out during the review of the literature as well as via networking through the College of nursing, the CAIHC and professional connections.

Literature review. The literature review was pursued as outlined above over the course of approximately 2 years with varying degrees of intensity. The search strings and terms used were refined over that time period with the greatest amount of literature identified during the Summer and Fall of 2012.

Manuscript. I identified the Journal of Transcultural Nursing (JTCN) as an ideal prospect for submitting the manuscript for peer review. This appears to be a good fit for my topic

and the JTCN has a preferred submission style of APA which suggests less worry about learning a new style of citation and reference at this time.

Poster. As part of the College of Nursing requirements for this project I developed a poster that summarized the key points of the manuscript. Poster presentations were held on campus the third week of April 2013.

Presentation. I worked with the content experts, especially Dr. de Schweinitz to synthesize the information gleaned during my literature review into specific recommendations for the TCC and CAIHC. This was done in a PowerPoint presentation.

Results

Evaluation of Objectives

Clinic rotation. After successfully obtaining funding via the groups noted above I commenced with the actual rotation at CAIHC. Evaluation of the clinical rotation objective takes into consideration the quality of the rotation itself. I spent a total of 5 weeks under the preceptorship of Dr. Peter de Schweinitz from the University Of Utah, College Of Medicine. While clinical rotations are designed to enhance the synthesis and application of clinical knowledge, I had the additional goal at CAIHC to understand something of the culture of healthcare within the TCC. Although it was a cursory introduction; I was able to see the environment at CAIHC in Fairbanks as well as travel out to a more remote clinic that served some isolated villages and get a feel for some of the unique challenges of that aspect of the healthcare operations. I was able to work directly with the staff of the clinic and meet a representative selection of the client base served by the TCC. I had hoped to be able to identify at least one traditional healer during my time there but was met with difficulty as not only was there no knowledge of any practicing traditional healers, I could find no-one with first hand

memory of a traditional healer operating within the TCC region with the exception of an elder woman from a remote village who recollected someone from the village practicing what amounted to witchcraft or dark medicine and driving people out of the village. This was, per her memory, as recent as the mid-1990s.

Content experts. Content expert (CE) recruitment was successful with the recruitment of not two but three CEs. Dr. Peter de Schweinitz is a Family Practice physician and Director of Health Integration and Development at Chief Andrew Isaac Health Center. Dr. John Lowe is a PhD prepared RN from the Cherokee Nation who teaches at Florida Atlantic University and has extensive experience developing substance abuse prevention programs based on traditional tribal values. The third content expert is Dr. Georgia Kyba, Naturopathic Doctor and Advisor to the First Nations Health Council, British Colombia, Canada. I was able to meet with Dr. Lowe in person at the outset of my project and received some good insight and direction from him. Dr. Kyba gave feedback on manuscript drafts and suggested some additional resources to incorporate in the future as I pursue this project post-graduation. I had excellent input from Dr. de Schweinitz though this is not particularly surprising. Dr. de Schweinitz has some personal investment in the outcome of this project as he is one of the advocates for an integrated medicine program at CAIHC.

Literature review. The literature review totaled forty-five pages including review of topics pertinent to the theoretical underpinning and background information. A total of twenty-five pages of information were developed that directly answered the inquiry of this project including a review of case studies. Themes that contribute additional information were also identified. Some desired articles identified in the searches were unable to be obtained within the time constraints of the project timeline. However, repetition of themes began to be apparent, with

Table 1: Project Implementation and evaluation summary

Objectives	Implementation Status	Evaluation
CAIHC clinical rotation	• Completed	• Successful including obtaining funding, not able to identify TCC affiliated tribal healer as hoped.
Content Experts • Dr. Peter de Schweinitz • Dr. Georgia Kyba • Dr. John Lowe	• CV and contract on file for all 3 content experts • All CE and project chair networked via email	• Successful • Able to recruit 3 CE instead of requisite 2
Literature Review	• Completed: 45 pages including review of topics pertinent to theoretical underpinning and background information • 24 pages answering question • Some desired articles were unable to be obtained within the time constraints of the project timeline	• Successful • Generally repetition of themes began to be apparent, unconcerned about missing articles given scope and time constraints of this project
Manuscript	• 17 page manuscript meeting requirements of the Journal of Transcultural Nursing completed	• Successful • Manuscript approved by Dr. Melville
Poster	• Completed • Presented poster defense on April 18, 2013	• Successful • Difficult to summarize such qualitative work on a poster but reasonable content and aesthetic achieved.
Presentation	• Completed using PowerPoint • Travel to Fairbanks in August of 2013 to present	• Presentation complete • Travel plans arranged

the articles that were readily accessible. There was some concern as to whether case studies from different parts of the world could inform any kind of unified model. While the literature demonstrates a wide cultural variety in TM treatment models there was sufficient congruency in worldview across different TM paradigms to warrant the use of any case studies found. A copy of the literature review is attached in appendix A.

Manuscript. The literature review was condensed down to meet the requirements of the JTCN. It was quite challenging to reduce the literature review into the 17 page limit set by the JTCN but it helped to focus the findings of the review into a more accessible format. A copy of the manuscript can be found in appendix B.

Poster. It was difficult to summarize such qualitative work when poster presentations lend themselves best to graphical representations of data driven work. However, I believe I was able to achieve a reasonable level of content reporting and aesthetic based on the manuscript. This leaves the poster general enough that I will be able to use it at other poster presentations in the future. A copy of the poster can be found in Appendix C.

Presentation. Initially I had planned to have the presentation ready by March but soon realized that I needed the benefit of condensing the information from the literature review into manuscript and poster format in order to identify the most pertinent information possible. A meeting with the medical staff and the executive board of the TCC is scheduled for August of 2013. The slide outline of the presentation can be seen in appendix C.

Recommendations

Practical advice from the case studies is demonstrated with good recurrence of themes consistent across the case studies and in accordance with recommendations from the WHO and PAHO. Key principles involve Communication, environmental considerations, Attitudes of

employees, qualifications of TM providers, and strategies for reconciliation of EBP with evidence from tradition and cultural humility.

Communication

Communication issues encompass communication regarding referrals and interdisciplinary treatment plans. Communication between TM and BoM providers needs to be open in order to promote collaboration. Setting up standardized documentation formats is one method of promoting this as is offering education on interdisciplinary communication. Referrals between providers would be enhanced with communication that both were able to understand and apply to their setting. Referrals into the service lines have been provided in two ways: self-referral or PCP referral. Both options were seen in cases and both were successful. Consideration of cultural and logistical needs regarding funding and reimbursement would likely promote one mode over the other. It did seem that self-referral tends to lead to more compartmentalization of therapies i.e. certain illness being treated by one modality and other illness by the other at the preference of the clients although this was certainly not only a feature of self-referral.

Environmental Concerns

Promoting an environment that is culturally appropriate was demonstrated to be a key part of successful integration across multiple clinics. Environmental concerns included geographic, designation of spaces and aesthetic considerations. Organization of clinic space, orientation of buildings and rooms to the cardinal direction, having a place for TM set aside with its own aesthetic and promoting an environment that facilitates a culturally oriented provider/client interaction were all key elements demonstrated in the cases.

Attitudes Toward TM

Successful employee education initiatives were noted to be crucial to promoting a respect for TM. Acknowledging and promoting TM is one of the key recommendations from the WHO. St. Mary's and SCF both accomplished this through series of seminars and workshops which emphasize respect for the ideas behind TM rather than trying to teach the mechanics of TM. This approach makes the most sense in the context of clinic employees who may not share the cultural background of the tribal group they are working with.

Qualifying TM Providers

This is probably one of the most important considerations with the least amount of information available. Tribal elders should play a consistent role in qualifying healers but beyond that the WHO recommends that a standardized qualifications for TM healers should be considered. Further information could certainly be gleaned from SCF as to the process that they followed although the specifics could not be found in the literature. One beneficial feature of new IHS funding guidelines is that Naturopathic Doctors are eligible to bill for services provided in direct care and will now be eligible for loan repayment if hired on at a qualified clinic (Indian Health Services, n.d.a; Roubideaux, 2012). ND will still not be reimbursed for contract-health work (Indian Health Services, n.d.b), but the congruency of philosophy between many tribal cultures and Naturopathic medicine may make this a good starting place for finding a central, supervising provider for the TM branch of an integrated clinic (Fleming & Gutknecht, 2010).

Reconciling EBP with Evidence from Tradition

While historical trauma, discussed at length in the literature review, may function as a significant barrier to harmonization; by and far the greatest concerns are those mounted in defense of EBP and the randomized controlled trial as the gold standard for all approaches to

healthcare. While EBP has provided significant improvements in the treatment of many illnesses the literature supports the idea for an alternative, reasonable standard of measuring efficacy and effectiveness of treatment for traditional medicine practices. Mignone et al. (2007) whose case studies were the most comprehensive, suggest that best practice treatments should satisfy thirteen criteria. Seven of these seem particularly relevant to TM treatments and the EBP paradigm. They should: have a positive impact; be sustainable; be relevant to patient, community, culture and environment; be client focused; improve access; have potential for replication; and have capacity for evaluation. These principles represent a reasonable approach that fits with the WHO standards for healthcare organizations and the importance of validating TM.

Conclusion

As evidenced by the content of the review, information on contemporary practice of traditional AI/AN is scarce; even knowing the names of some clinics that have experimented with various levels of integration led to minimal descriptive information during the course of the literature search. Factors that have contributed to this over the years are fear of ridicule and concern about misuse or co-optation of the information. Healing is often considered a private matter, and even a sacred process. (Struthers et al., 2004).

While there are some demonstrable challenges to developing a harmonized clinic model; by acknowledging the cultural variations of TM and BioM we can tap into the validation of culture as a way to overcome past patterns of colonization, cooptation and appropriation. To succeed at integrative efforts we must accept and respect the differences inherent in each system while understanding that health is not just physical fitness (Conejo, 2009).

Tina Melin, a provider from Kotezebue, Alaska said it best:

> The people of this region wish to put their heads and hearts together with guidance from our creator to attempt to get to the root of the cause or suffering… they have their own legitimate ways of knowing how to do this. Those of us who are a part of the health care system need to work together with them… They wish to remember the healthy ways of the days of old blended in with the new… they wish to regain and strengthen their cultural identity and pride. They wish to help themselves and each other to get on that path to health and stay there (Morgan, 2009, p. 89)

At this time perhaps more than any other previously we are in a place that recognizes the need for a holistic approach within BioM models of care. Increasingly this holistic element in BioM is in alignment with TM principles meaning that these challenges should not be considered insurmountable and efforts like those seen at Jambi Huasi and the Southcentral clinic are within the grasp of any clinic desiring to improve culture care to their clients.

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Appendix A

Describing a Sustainable Model of Harmonization between Culturally Congruent Traditional Healing and Evidence Based Biomedical Models: A Comprehensive Review of the Literature

Definitions and Conceptualization of Traditional Healing.

Traditional medicine is a comprehensive term used to refer broadly to systems like Chinese medicine and the Indian tradition of Ayurveda as well as others that are rooted in indigenous cultures. An indigenous person is someone who self-defines as indigenous or tribal. These are peoples, communities, and nations that have historical continuity with a pre-invasion/pre-colonial society (Struthers et al., 2004; WHO, 2005).

It is important to recognize that traditional medicine has been making contributions to the health of communities since long before the development and spread of the 'western' medicine that originated in Europe subsequent to the development of modern science and technology (Bruce, 2002; Zhang, 2000). Traditional medicine is not "embryonic modern medicine or a predecessor to advanced modern medicine… [it] is an entirely different entity"(Struthers et al., 2004, p. 142).

Although many cultures have an historical medicine tradition there should be some caution about assuming that there is a globally homogenous 'traditional medicine' body of thought and practice. Lumping together everything that is "not ours" i.e., not biomedical is extremely ethnocentric and can lead to gross generalizations (van der Geest, 1997). Traditional medicine covers a wide variety of therapies and practices which may vary greatly from country to country and from region to region. The kinds of therapies seen in these traditional medicine or traditional healing modalities can include the use of medication if that medication comprises herbal preparations, or medicines derived from various mineral and animal sources; as well as

non-medication therapies such as acupuncture, manual therapies and spiritual therapies (WHO, 2005, 2009).

Despite this lack of homogeneity, there are some unifying themes that are useful to understand especially in the context of this project as we look around the world at various models of harmonization that have been implemented or principles that have been observed. In this context it is useful to know whether these ideas are reflective of a congruency in world-view and therefore potentially more or less useful as points of reference (van der Geest, 1997). Traditional medicine paradigms around the world operate in an indigenous spiritual realm that is very different from biomedicine which has its roots in Cartesian dualism (Bruce, 2002; Struthers et al., 2004). There is a religious dimension to the medical reasoning of traditional tribal medicine.

> In this world we are too much in the physical world. You know, we have an operation that physically heals. When we have any kind of injury to our body, we have to know our spirit, our heart and our emotions are also affected. That physical scar, or whatever surgery we have, heals. That inside part, does not it require [its own] treatment?... So healing comes with a soul wound and the solace requires a different way. We have to find [the wounds] because the physical, emotional, spiritual - they all have to heal (Dolchok, 2003, pp. 20, 22).

In light of this the perspective utilized in conceptualizing health and wellness within indigenous health systems go well beyond conventional reductionist paradigms and hold unique knowledge and insights that are different from the biomedical models (PAHO/WHO, 2002). Keeping the concept of Cultural Humility in mind there is significant possibility of mutual enrichment (van der Geest, 1997).

For the indigenous people of the world health and illness are typically more comprehensive notions than we conceptualize in western society. Some languages don't even have a single word translation for the English word 'health' as it is too complex an idea to be rendered in a single locution. For most it is holistic in the greatest sense of the word (van der Geest, 1997). "The concept of health is not limited to the absence of pain or illness, but the harmony and the internal balance of the person in the family, the community, the nature and the cosmos" (Jambi Huasi, 2005). This idea aligns with the World Health Organization (WHO) definition of health that has developed increasing favor in biomedical circles. The WHO definition describes health as a state of complete physical, mental and social well-being not merely the absence of disease or infirmity (PAHO/WHO, 2002; van der Geest, 1997) .

This idea of complete health, inclusive of social well-being, puts an orientation towards the community as participants of individual and group health as well as towards prevention. The emphasis on the community and family brings a social character to traditional medicine. Disorder in the community ultimately leads to disorder in the health condition of its members. An illness of one family member is seen as an illness of the entire family. Any solution to the problem is the responsibility of the entire group (Eby, 1998; van der Geest, 1997).

Ideas of prevention come from a concentration on the deeper origins of illness. Once identified, it is not acceptable to ignore them. Something should be done about the root cause of the illness in order to have a healthy life and avoid a repetition of the misfortune or illness in the future. The concepts of prevention and community are linked in the idea that the origins of illness, the treatment of illness and the prevention of illness are all linked to the quality of human relationships (van der Geest, 1997; Weil, 2011).

One of the key unifying constructs of historical and cultural medicine traditions is the lifelong nature of the pursuit of health. “To benefit from Indian medicine power one has to possess conviction and feeling in it and be involved in that particular way of life”(Struthers et al., 2004, p. 143) ultimately what makes traditional healing is the history of the tradition and the endurance of practice through time (Wing, 1998). This differs from the ideas of western utilization of Complementary and Alternative Medicine (CAM) which may share common ground in reliance on herbal or spiritual remedies but at the end of the day it is a comprehensive way of living, a way of viewing the world the way that your ancestors viewed the world, “not something we take off a shelf when it’s convenient and then put it back when we are done” (Lowe, 2012).

Comparing Systems of Traditional Healing With the Biomedical Model

If looking at the unifying themes across traditional medicine practices is useful, knowing how traditional medicine and biomedical services compare is also pertinent to the discussion (Morgan, 2009). Sociologists and anthropologists use a culture’s healing traditions as a way to understand that culture. We appreciate then, that health belief is a key measure of the core principles of a society. Trying to bring together two biased systems is challenging and involves comparing the setting, the paradigm of healing knowledge, the social implications of being or seeking out a healer, and the costs associated. (Eby, 1998)

The practice setting of biomedicine is essentially institutional; it takes place in formal spaces set aside specifically for the practice of medicine. This differs from the typical setting of the traditional practitioner who more often will treat in the community setting often with direct involvement of family members(Bruce, 2002; Morgan, 2009). For many traditional healers medical knowledge is considered personal property, there are even further implication of the proprietary nature of traditional healing that are discussed further on in this paper. This differs

from western society where biomedical knowledge, the science that drives medical treatment and decision making, is considered public (van der Geest, 1997). One only need look to the proliferation of biomedically oriented websites and public domain presentations on the internet to see evidence of this.

Within many traditional societies the social context of a therapeutic action on the part of a healer requires reciprocity from the recipient as a sign of respect and appreciation. If no payment is made there is an implication that there is no obligation to the healer. If no appreciation is shown it implies that there is no relationship and in the context of a worldview that typically emphasizes the interrelatedness of all things you run risk of negating the medicine and falling ill again if the respect and appreciation are absent. Alternatively, until relatively recently biomedicine in most traditional communities was a socialized program, given away essentially for free (van der Geest, 1997).

Table A1: Comparison of Traditional Medicine with Biomedical Models

Traditional Cultural Healing Pathways	**Biomedicine/Allopathy**
• Mind, body, spirit - holistic approach	• Reductionist approach
• Tribal beliefs of health and illness used with physical, social and spiritual information to make diagnosis	• Patient centered history and physical along with biochemical, physiologic, anatomic, laboratory based data used to make diagnosis
• Healer teaches patient to heal self	• Doctors taught that their interventions do the healing
• Health and harmony emphasized	• Disease and curing emphasized
• Honor patient for restoring wellness	• Honors physician for curing
• Herbal medicines may be used	• Pharmaceuticals (some derived from herbals) may be used
• Preventative medicine taught	• Preventative medicine taught

Adapted from: Struthers et al., 2004, p. 147

There are some commonalities between traditional medicine and biomedical healthcare services though, and it would be a huge disservice to ignore these, especially when trying to bring the two together in a collaborative effort. Both models of care have a perspective of

prevention and a desire to protect against diseases and health problems. Both models also have (within their paradigm) a desire to determine the cause of the disease, and promote health by eliminating the problem (Bruce, 2002).

Case Studies

In a series of case studies Mignone, Bartlett, O'Neil, & Orchard (2007) describe some of the efforts at collaborative healthcare in various countries in South America. Additional case studies identified through the literature search are also described.

Kwamalasamutu, Suriname

The southern Suriname village of Kwamalasamutu which is located in the interior amazon basin has two clinics, one provides western, biomedical services and is operated by a local non-government organization (NGO) with primarily govt. funding. The other clinic, a traditional indigenous medicine clinic is operated by elder tribal shamans and is financed by the Amazon Conservation Team a U.S. based NGO. The choice to be treated in either clinic is entirely elective and is left up to the individual client (Mignone et al., 2007).

Individuals from both clinics: shamans, medical mission health workers, and physicians lead workshops to raise awareness about traditional health, medicinal plants and indigenous concepts of health and illness. The providers from the biomedical clinic also offer training to the traditional healers on basic primary care issues and preventative health practices. Referrals are routinely made between the two clinics (Mignone et al., 2007).

The indigenous medicine clinic hosts a Shaman's apprentice program to preserve traditional knowledge. However, an interesting part of the training for new apprentices is in filling out health and treatment record forms that are used to document the conditions and ongoing treatments provided to the clients by the Shaman. (Mignone et al., 2007).

Comadronas in Guatemala

In San Juan de Comalapa a city with a population of around 36k Comadronas provide midwifery care to 85% of pregnant mothers within the Mayan community. Comadronas are responsible for assisting with pregnancy/childbirth and for offering spiritual guidance to mothers and families. Their scope of practice also includes the administering of spiritual and empirical treatments to infant with cultural illness such as susto (soul fright) and mal de ojo (the evil eye). This case study is less about integration in a specifc setting and more about the integration of Comadronas in general with the healthcare system.

A government sponsored training program to improve the quality of care provided by the Comadronas was implemented. The program consists of a one week program in pre-natal care and recognition of complications associated with pregnancy. Completion of the course certifies the Comadronas to register births and serves as a de-facto license to practice. Certifying a live birth and registering the newborn is an important function although the lack of this license has not been noted as a deterrent to those Comadronas who opt not to participate in the training (Mignone et al., 2007).

Temuco, Chile

Temuco, Chile has a population approaching 300 thousand. Healthcare services in the area are provided by one rural, outlying hospital and several clinics. In Temuco there is an intercultural program where *machi* (traditional healer) are offered as an equal/complementary alternative to western medicine in each of these healthcare settings. The motivating factor is that of self-determination and as such the program is run primarily by western-trained Mapuche. The Mapuche are the predominant indigenous culture of the region. Intercultural health workers are

on staff at these facilities and operate a referral program to traditional medicine providers when seen fit.

Machi care is not actually provided in the hospital but in neighboring Boroa, another Mapuche community center patients have the option of pursuing treatment with western medications or Machi herbals or both.(Mignone et al., 2007).

Jambi Huasi – Ecuador

In the mountain town of Otovalo, population thirty-thousand, Jambi Huasi offers a full range of western and indigenous health services. The operate on a fee for service basis, offering care to the ethnic groups of Kichwa, mestizos (biracial group descended from indigenous and conquistadores) and Afroecuatorianos (Conejo, 2009).

The clinic offerings include two biomedical physicians, clinical psychology, dentistry, a pharmacy, and a clinical lab as well as the traditional indigenous services of a Yachac (medicine man), Fregadora (herbalist/massage therapist) and a Pakarichik mama (midwife). In addition to the offerings of western biomedicine and traditional indigenous medicine they also have a Traditional Chinese Medicine (TCM) practitioner on staff. They operate an aggressive, well received health promotion program in order to integrate systems of knowledge from western and indigenous perspectives. They offer treatment for organic diseases, emotional disorders, and energetic diseases (Conejo, 2009; Mignone et al., 2007).

Jambi Huasi operates on mixed funding. Some government and NGO moneys come in but these are insufficient to sustain operations so they also rely on a modest fee-for-service (Mignone et al., 2007). The Ecuadorian Ministry of Public Health funds one doctor and one nurse, and the ECU School of Obstetrics funds one OB/GYN. Additional funding from the Blue Sky Foundation provides for one nurse (Conejo, 2009).

Jambi Huasi is functionally a western health care organization offering intercultural health care services and managed by indigenous entity (Mignone et al., 2007). Dr. Conejo, a native Kichwa is bilingual in Kichwa and Castilian.

The clinic's goal is to provide health care with consideration toward the sociocultural situation and local worldview as well as revaluing the role of indigenous medicine and all Jambigkuna (healthcare workers) by institutionalizing Indian and western medicine together. To this end the medical center is located on sacred ground and the Clinic is oriented to the four cardinal directions, to promote individual value the various Jambigkuna were encouraged to select their own offices (Conejo, 2009).

South Central Foundation – Anchorage, Alaska

Perhaps one of, the best examples of integrative healthcare efforts in North America is that of the South Central Foundation (SCF) in Anchorage, Alaska. SCF was established in 1982 as a 501c(3) and obtained its first self-management contract under Public Law 93-638, the Indian Self-Determination Act in 1985. The years 1987 – 1994 expanded offerings to include dental and optometry services as well as behavioral health services. SCF assumed management of the primary care system for the region in 1998 and ownership of the Alaska Native Medical Center in 1999. They serve a population of AI/AN which approaches 58,000 individuals; these are referred to as 'customer-owners'. They operate more than sixty five different programs (Mala, Dolchock, & Daney, 2011). One of these is the Traditional Healing Clinic which has been described as the "most integrated program of traditional tribal and modern medicine in all of North America" (Daney, 2012).

In 2010 the Traditional healing clinic received 1074 referrals (Mala et al., 2011). This is important as access to the Traditional Healing clinic is only available via referral from primary

care providers (PCP) (Barber, 2011; Daney, 2012). Chronic pain is the leading diagnosis referred in at just over 50%. Counseling, acute and chronic pain, smoking cessation and other medical concerns account for eighty-six percent of the referrals from the primary care providers of SCF. The traditional healers that work in the clinic are 'tribal doctors' that are certified in traditional native medicine as well as according to criteria that includes approval from the SCF traditional healing Committee of Elder Advisors. (Benson, 2003; Mala et al., 2011; Morgan, 2009).

The tribal doctors have had remarkable success in treating chronic pain, chronic fatigue and psychogenic reactions using approaches like energy healing, massage, body manipulation and spiritual support (Benson, 2003; Morgan, 2009). In order to promote a collaborative practice environment the practitioners in the Traditional Health clinic hold regular consultations with PCPs and other practitioners, engage in weekly clinical rounds with the primary care clinic medical staff, mental health and pediatric clinics. In addition to these in house duties they network and attend to educational opportunities with traditional healers from other states and countries (Mala et al., 2011).

Key components of the SCF program, which allows such close integration with biomedicine and more traditional healing models includes attention to the environment and the implementation of their proprietary model of care called Circle of Healing (Benson, 2003; Morgan, 2009). Healthcare operations are provided on a campus with native décor and art; there is an emphasis on native management; and specific space is allocated for traditional tribal medicine, integrative medicine and allopathic (biomedical) medicine. Musical presentations by native performers are frequently present, the Traditional Healing Clinic opens into a courtyard with a traditional herbal garden (Morgan, 2009). And an annual gathering/health fair style event

brings community members together to celebrate their native culture, educate about health resources and promote healthy lifestyles (Helvey, 2010).

The care model, Circle of Healing, brings together three modalities: allopathic medicine, alternative medicine and traditional native medicine. A central person, called a Pathfinder, who is knowledgeable in all three areas meets with the patient to determine needs and health goals, then works with the other disciplines to formulate a wellness plan and help improve health literacy by teaching the customer-owners to access library and internet resources. The Circle of healing incorporates “prevention, outpatient, inpatient and after care” (Benson, 2003)
Another key component that promotes the success of the cultural efforts at SCF is the training that goes into the employees. New employees at all SCF facilities attend a three day orientation to learn the SCF expectations and approach to care. Additional training is provided when they attend a 3 day workshop that emphasizes the importance of empathy, compassion, and relationship building in promoting the health of the customer-owners served by SCF (Helvey, 2010).

Clalit Health Services – Israel

A study by Ben-Arye, Scharf and Frenkel (2007) looked at communication between biomedical providers and complementary practitioners employed by Clalit Health Services, a health maintenance organization in Israel with an extensive network of biomedical physicians and CAM practitioners. They wanted to understand attitudes and expectations relative to inter disciplinary communications and collaborations. While this literature survey has mostly shied away from CAM oriented integration it is an illuminating study on the communications between providers across modalities in the same health system.

A low rate of communication between disciplines is a well-established fact. A large majority of the physicians in the U.S. (82% in one survey) indicated that they had a strong referral relationship with other physicians but no formal referral relationship with chiropractors. The majority of providers surveyed by Ben-Arye et al. were interested in some level of clinical practice collaboration and would be willing to communicate, preferably by medical consultation letter to formulate treatment plans. They go on to suggest that formalizing educational modules on communication between disciplines to overcome "language" barriers would promote collaboration at least via the consultation letter (Ben-Arye et al., 2007).

North Korea – Historical attempts

By the beginning of the 20th century much of Asia, under various governmental pressures and influenced by the success of hygiene practices promulgated by germ theory and the success of the smallpox vaccine, had adopted models of western biomedicine (Hong, 2001). Over the next 50 – 75 years though the traditional medicine practitioners had made some sort of come-back and each country modeled a different approach (Lim, Park, & Han, 2009). Integration in North Korea was an outgrowth of the need to use indigenous resources while modernizing the healthcare system during reconstruction efforts in the wake of the Korean War. In 1956 a governmental directive encouraging the application of the science of biomedicine to evaluate and promote effective traditional medicine was issued. In 1962 a formal 3 month training course to help biomedical doctors correct their misconceptions about traditional medicine was organized. These courses also encouraged the combination of eastern and western medicine. Since 1975 training in traditional medicine has become the focus of 1 and even 2 year 'reorientation' programs required for the faculties of medical schools. The use of western diagnostics combined with eastern or traditional therapeutics has become a standard in most

hospitals and clinics with some of the providers licensed in traditional medicine trained in and allowed to prescribe western medications as well as some biomedical providers offering traditional treatments. This is due at least in part to the organization of medical schools which will have a department of clinical (biomedical) medicine as well as a department of Koryo (traditional/eastern) medicine (Lim et al., 2009).

For many of these schools the department of Koryo medicine was originally a subdivision of the department of clinical medicine. However the degree of cross training is not necessarily equal. The curricula of the biomedical services have less exposure to Koryo medicine when compared with Department of Koryo student's study of biomedical topics. This leaves the students from the Department of Koryo medicine better prepared to offer an integrative treatment plan. The increased use of biomedical diagnostics is in response to the sometimes ambiguous nature of traditional diagnostic criteria which often led two different Koryo providers to give two different traditional diagnosis to patients with the same pattern of illness as classified by western diagnostics and taxonomy (Lim et al., 2009).

Despite the attempt at integration and utilizing traditional resources North Korea does not compare well in WHO rankings of health system performance. In this regard North Korea consistently falls into the bottom 25^{th} percentile in all domains of measurement when compared to the other 190 countries evaluated. The constant state of economic and political crisis in North Korea likely has a large role to play in the poor performance of its health systems but the persistence of outmoded and crude practices within the integrative efforts as well as the demonstrated lack of safety of many of the therapies that persist in use must also be part of the critical appraisal (Lim et al., 2009).

Waikiki Health Centers

The last two decades, subsequent to the Native Hawaiian health care act of 1988, has brought a resurgence in traditional medicine to the islands. The Waikiki Health Centers have two locations highlighted in an article by Broad & Allison (2002). The Ho Ola Like Outreach Project and the inner city Palolo community clinic bring together nurse practitioners and traditional Hawaiian healers. The traditional offerings include Kahuna la au lapa au (pharmacotherapists who use plants, herbs, corals and seaweed to treat illness); Kahuna lomilomie (physiotherapist); and Ho oponopono, which is practiced by Kahuna ehu who, much like psychiatrist and psychologist, focus on social discord, relationship and harmony building in family and friends.

Clients who come to the clinics can self-select a western or traditional healthcare provider as well as the option to choose both and the NPs and Healers have freedom to refer patients to each other. As with SCF environment is key to the therapeutic nature of the clinic. There is a purposefully casual atmosphere cultivated in order to enhance the therapeutic nature of the relationships between the clinic clients and providers. Typically clients choose Hawaiian medicine for the treatment of chronic health conditions especially musculoskeletal problems, with the exception of diabetes and hypertension. Treatment by the Nurse practitioners was favored for acute illness and some other chronic illness such as asthma and gout (Broad & Allison, 2002).

St. Mary's Hospital

St. Mary's Hospital is a Catholic faith-based hospital in Arizona. Recognizing that many of the Navajo clients they served were entering a very foreign environment they sought to create a more welcoming atmosphere to the Native American population and to provide a more culturally sensitive experience. During the course of their exploration of these efforts they

identified the following challenges inherent to the integration of culture consideration and healthcare

- Acknowledgement that TIM spiritual beliefs and practices are integral to the healing process.
- Deciding how specific spiritual practices could be addressed in assessments.
- Accommodation of the physical space needed for some spiritually oriented practices
- Fostering an environment that is welcoming to spiritual practitioners.
- Blending cultural spiritual practices of patients with the cultures of the healthcare professionals at the hospital (Hubbert, 2008).

The answer to these challenges was a series of educational conferences that were 5 to 7 days in length. These were developed by a 'Guiding team' who worked with a Comanche medicine man, Mr. Edgar Monetathchi Jr.. Mr. Monetathchi was the national Traditional Indian Medicine (TIM) specialist for the IHS. The strategy that ultimately proved effective in driving the changes and promoting the staff at the hospital to be open to TIM was a sharing not of the mechanics of the traditional healing ceremonies, but rather teaching them to identify and appreciate the philosophy of TIM so that they could personalize their approach to it with individual patients (Hubbert, 2008).

Two main educational concepts drove the sharing of this philosophy. The first was entitled 'The seven sacred Aspects'. The seven sacred aspects, according to Mr. Monetathchi, are: respect, honesty, truth, humility, compassion, wisdom, and unconditional love. The second concept was that of 'The essence of the holistic individual'. Health equals balance was the underlying principle communicated with this idea; the individual being representative of balance

between the physical being, the mental being, the spiritual being, the environment and that individual's relationship with God. Illness and disease are conceptualized as one or more of these items being out of balance. Ultimately the education of the staff towards these underlying philosophies and principles enabled them to accommodate those individuals who were entering a culturally foreign environment and improve the relationships and treatment outcomes (Hubbert, 2008).

General Principles of Integration/Harmonization

Besides case studies, I identified articles that discussed principles of integration and harmonization more generally, in the context of communities and cultures but in a less case oriented fashion. Despite the desire to focus on case studies it would be a disservice to the topic to ignore the input these articles have on developing models of integrative care.

The WHO and Pan American Health Organization (PAHO) have suggested key principles that should be considered in developing healthcare systems. The PAHO cites the need for creating of a legal framework that facilitates access by the indigenous population to quality health care while officially recognizing the contributions of indigenous health systems to the maintenance and restoration of the population's health. Indigenous knowledge, practices and resources should be recognized as a legitimate health system and safety, efficacy, and quality of the traditional medicine should be promoted in ways that encourage rational use. The standardization of education and certification required in biomedicine stands in stark contrast to the methods of developing and passing down traditional medicine (Eby, 1998). This is not to suggest that we should hold them to the exact same standard, but developing methods to ensure the safety of the practices and the quality of the practitioners should be part of the agenda.

Lastly, nations should promote the formulation and implementation of models that prioritize an understanding of the social and cultural characteristics of the beneficiary population, their resources and specific epidemiological profiles (PAHO/WHO, 2002; WHO, 2005, 2009). While developing these policies some very specific guidelines should be considered:

- Knowledge of traditional medicine, treatments, and practices should be respected, preserved, promoted and communicated widely and appropriately based on circumstances…
- Governments should establish systems for the qualification, accreditation or licensing of traditional medicine practitioners.
- Communication between conventional and traditional medicine providers should be strengthened and appropriate training programs established for health professionals, medical students and relevant researchers (WHO, 2009, p. 11)

When evaluating indigenous cultures for their healthcare needs it is important avoid overemphasizing the cultural identity within an agenda based solely on what they don't have. This approach homogenizes otherwise distinct populations and obscures their individual capacities and resources. Models of integration should incorporate an indigenous perspective, medicine and therapy while maintaining technical excellence in addition to promoting an understanding of the social and cultural variables that impede access to healthcare (PAHO/WHO, 2002).

Challenges

For many indigenous cultures modern technology and medicine are seen as reinforcing of the values and practices of western society. In some views this is undesirable and creates tension

(Bruce, 2002). The reciprocal effect is then hoped to be at work with models of integration. Ideally the inclusion and harmonization of traditional practices will be seen to reinforce cultural identity and continuity. That said though it is not necessarily a smooth road to integration.

Historical context and historical trauma.

> As a Native woman coming into the western system, going to the doctor and you have 15 minutes. That's the time allowed. And as a Native woman coming into a system that has been notoriously abusive to you throughout your whole life, you have 15 minutes to go in and say what's wrong with you. You're never going to say it. It's not going to happen (Benson, 2003, p. 11).

Understanding the cultural context of bringing together 'Western/European' models of care with indigenous culturally bound healing traditions must necessarily look, even if briefly, at the historical conflict between the cultures and what has brought us to a place of wanting to harmonize our approach to healthcare. Why we even need to take steps down that road. Why, we aren't already doing it and why we haven't been doing it all along. The concepts of colonialism, historical trauma and subsequent decolonization efforts are pertinent to the discussion.

The arrival of Europeans brought disease and oppression via war famine and genocide to the native cultures of North America. The toll of these historical events also yielded grave cultural destruction (Lucero, 2011). The total costs of these events is described in the concept of Historical Trauma which describes the loss of culture, self-esteem, self-determination and sense of well-being suffered over the generations by Native cultures (Morgan, 2009).

As progressive as our country might be now, there is a long history of the kinds of traumatic practices that stripped native peoples of their culture etc. For decades upon decades

public policies and laws made it essentially, or even literally at times, illegal to live or act "native" (Benson, 2003; Dolchok, 2003).

It will probably be surprising to some to see how only very recently these disparities began to be addressed. It was not until 1974 with the passing of PL 93-638 also known as the Indian Self-Determination and Education assistance act that any real change was made. This, after a century of persistent policies that subjugated AI/AN tribal peoples to the oppression of the reservation system, to the relegation of second-class citizen standing. While the Self Determination act improved tribal entities ability to direct their own social agendas it wasn't until 1988 with the Ethnic identity and political entities extension with the allocation of funds in a block grant style that the way was paved for tribes to take over management of health care organizations and facilities (Lucero, 2011; Morgan, 2009)

Even the World Health Organization has been slow to address the issue of the loss of culture as it relates to traditional tribal healing. In 1993 a division of the WHO, The Pan American Health Organization (PAHO) laid out the Health of the Indigenous people's initiative. The principles of this initiative state that indigenous peoples have a right to a holistic approach to health, the right to self-determination, the necessity of respect to and revitalization of indigenous cultures, reciprocity in relations, and the right of indigenous peoples to systematic participation in healthcare (PAHO/WHO, 2002).

More recent trends such as the Beijing Declaration of November 2008 are consistently more reassuring. The Beijing Declaration, from the WHO, recognizes traditional medicine as one of the potential resources of primary health care services (WHO, 2009). It has only been in the last couple of decades that the culture of biomedicine has been encouraged to shed its

ethnocentricity and begin looking at healthcare through the lens of cultural humility and mutual respect.

Critical views of integrative efforts. It is worth noting that integrative/harmonization efforts are not universally thought of as necessary or even important. Many communities don't actually expect an improvement in health care when services are integrated and it has been suggested that pleas for integration are inspired by overly romantic notions concerning traditional medicine and indigenous cultures (van der Geest, 1997).

In an editorial in the British Medical Journal (BMJ) Margaret McArtney calls the concept of integrative medicine a rebranding of alternative medicine which is really just medicine that doesn't work. This is a response mostly to homeopathic medicine; a European alternative medical paradigm that Dr. McCartney says is effective only in so far as the placebo effect can carry it. These providers, she opines, are attempting to corner the market on the one thing that they have that does work: listening and spending time with patients. Listening carefully, being patient centered, encouraging your patients, and being compassionate are not a specialty she argues and dressing them up with placebo pills and questionable therapies is just an attempt at creating a specialty out of something that is already in the domain of evidence based physicians; as if EBP medicine somehow precludes good listening and humanism. Not true she says and argues that "real evidence based care" can only be offered by biomedical physicians grounded in the context of evidence based practice (McCartney, 2011).

This editorial is a perfect example of the strain that exists between biomedicine and alternative paradigms, including traditional medicine. When looking at efforts to harmonize biomedicine with traditional medicine a few theoretical models have been suggested. Boon et al. have a framework wherein the outline seven relationships on a continuum from 'Parallel'

progressing in a continuously more integrated fashion through ‘consultative’, ‘collaborative, ‘coordinated’, ‘multidisciplinary’, ‘interdisciplinary’ and ‘integrative’ (Adams, Hollenberg, Lui, & Broom, 2009).

An alternative model is suggested by Mann et al. where a continuum of attitude and educational advancement in the practitioner is described. This theory starts first with the ‘informed clinician’ and progressing through the ‘informed networking clinician’, the ‘informed CAM-Trained clinician’, ‘multidisciplinary integrative group practice’, ‘interdisciplinary integrative group practice’, ‘hospital based integration’, and ‘integrative medicine in the academic medical center’ (Adams et al., 2009).

Adams et al. (2009) calls into question the typical framework/continuum models that describe the variety of potential relationships that have been observed to exist when biomedical and traditional medicine meet. The concern is that these models don’t adequately take into consideration the tensions and power struggles that exist between biomedical and traditional medicine, the contradictions in philosophy, diagnosis and treatment that exist, and the fact that these framework style models are based on ideal circumstances that rarely are observed in reality when the biomedical and traditional medicine worlds collide.

The current generations of integrative medicine seem to support these concerns in light of research that has demonstrated a lack of legitimate professional level integration of traditional and alternative therapies in observed practice settings. Unfortunately cases describing marginalization, cooptation and exclusionary practices are more common in the integrative setting than the ‘ideal’ situations described in the framework/model scenarios proposed in the literature (Adams et al., 2009).

Evidence based practice arguments. With evidence based practice (EBP) being the standard of care in biomedical clinics there is some concern about how traditional medicine will hold up to the scrutiny of EBP. Others have little concern when looking at the definitions of EBM as according to William Sackett and cite his statement that EBM is the "integra[tion] of clinical expertise with the best available external clinical evidence from systematic research"(Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, pp. 71 – 72). If clinical expertise is equal in footing with 'external clinical evidence' then there is little concern when considering that many traditional medicine knowledge funds extend back thousands of years. However, further reading suggests that the gold standard to which all interventions ultimately must be held accountable to are the results gleaned from "patient centred clinical research… [This] external evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious and safer"(Sackett et al., 1996, p. 72). The question then is asked will traditional medicine hold up under such scrutiny? Should it be expected to?

According to Mignone et al. (2007) best practice treatments in healthcare should satisfy a set of criteria: tangible, positive impact; be sustainable; be responsive and relevant (to patient/community/culture and environmental reality); be client focused; improve access; coordinate and integrate services; be efficient and flexible; demonstrate leadership; be innovative; have potential for replication; identify health and policy needs, and have capacity for evaluation. There is a movement that seeks to legitimize the use of AI/AN traditional healing practices as valid stand-alone EBP in the context of culturally specific systems of care (Lucero, 2011).

A counter argument to the EBP movement suggests that standards of care expressed in the literature may not be reliably validated in the AI/AN community due to their status as a significant population minority who are not well, if at all, represented in many of the trials used to establish the evidence (Lucero, 2011; Struthers et al., 2004). There is additional concern that the funding requirements from agencies such as the Substance Abuse and Mental Health Administration (SAMSHA) are biased against implementation of culturally relevant but heretofore untested interventions. For some tribal entities, the approval process is onerous and in the context of historical trauma: concern over cultural appropriation and co-optation leads many tribal organizations to be hesitant in formalizing requests for funding and implementation of these traditionally derived interventions. Yet the ability or AI/AN groups to exercise legitimate self-determination and break the mentality of colonization require that they be allowed to implement these proprietary, community based evidentiary practices (Jagtenberg et al., 2006; Lucero, 2011).

For many the EBM movement promotes a view that evidence from tradition is less valid and less reliable than the gold standard of ‘patient centred clinical research’. In response to this some have suggested that an evaluation of the philosophical assumption underlying EBM and CAM should be evaluated (Jagtenberg et al., 2006) These philosophical differences include not only the approach of treatment but also the ultimate goal of treatment suggesting that EBM may have a place in evaluating traditional medicine but as part of a mix of evidence rather than the only judge of validity (Jagtenberg et al., 2006; Sackett et al., 1996).

“Evidence based medicine is not restricted to randomized trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions… When asking questions about therapy… we should try to avoid the non-experimental

approaches… however some questions about therapy do not require randomized trials… we must follow the trail to the next best external evidence and work from there" (Sackett et al., 1996, p. 72)

Waldram (2000) suggests that there is disconnect between what western science considers evidence of effectiveness versus what tribal peoples consider it to be. He argues that the conceptualization of efficacy is wrapped up in culturally based concepts of health and illness. This is relevant in the context of recognizing and understanding that every medical system, including biomedicine is a cultural system. Due to cultural perspectives healing and curing may ultimately be different things as well as understanding that concepts of disease and illness may not be equivocal. For many cases in the indigenous paradigm healing may not actually entail curing (Waldram, 2000; Young, 1983).

Much of this may go to a problem with understanding the root of illness/disease. The philosophical root of American western culture maintains an emphasis on the individual – the individual in the free market, individual ownership, etc. Classic religion driven duality has given way to secular science driven rationality in the management of disease and populations. Faith in science leads to medical care being synonymous with healthcare. The emphasis on causative agents i.e. germ theory of medicine or physiologic disorder fits well with mechanistic reductionist perspectives but leaves a difficult gap in the treatment of illness that does not fall into a specific category (Eby, 1998).

In some instances a traditional healer may attribute a metaphysical causation to a disease with an otherwise clearly defined biomedical taxonomical designation. A classic example of this is an illness like *susto* or soul loss due to fright, as experienced in Hispanic communities. In biomedical surveys individuals diagnosed with *susto* by a traditional or folk medicine

practitioner could be found to have no distinct cluster of biomedically designated features (Waldram, 2000). There is a reasonable concern that some of this is distinctly cultural but one must ask if the misunderstanding of efficacy in treatment speaks to postcolonial biomedicalization of traditional medicine or Tribal healers confounding biomedical terms along with biomedicine co-optation of traditional treatments? In this context perhaps it would be beneficial to use definitions more specific to themselves: Curing as specific to pathogenic disease where healing is predicated on the particular perception and expectations of sick people (Young, 1983).

Resistance. Another issue is the importance of asking if the population wants collaboration and harmonization. In many African cultures people have divided their use patterns between biomedical and traditional providers based on the nature of the given illness. Integrated services would not serve to change the pattern of use because they have already developed a system of their own in which they classify certain illness as being more appropriate for one approach and others for the alternative (van der Geest, 1997).

In some areas participation in traditional-medicine based integrative processes may meet with resistance. If they correlate traditional healing with mystical practices such as black magic and witchcraft they will be reticent to participate. Incorporating the traditional healing practices in a harmonized fashion legitimizes them and distances from these other exploitive forms of 'medicine' (Bruce, 2002). Not as severe as perceiving traditional medicine as witchcraft but still damaging to efforts in integrating is seen when biomedicalization of the healthcare environment has taken place and indigenous knowledge is considered primitive or unscientific (Barbee, 1986; PAHO/WHO, 2002). In other areas resistance from some churches, especially evangelical

Christian churches to traditional medicine or aspects of traditional medicine has led to the sidelining of ceremonial practices such as shamanic rituals (Mignone et al., 2007).

Lastly, there is a concern about individuals having a desire to invest in traditional medicine. The move towards western medicine parallels increasingly busy lifestyles where "People do not have time for frequent visits or preparing herbal teas" (Burke et al., 2003, p. 1083)

Discussion

As evidenced by the content of this review, information on contemporary practice of traditional AI/AN is scarce; even knowing the names of some clinics that have experimented with various levels of integration led to minimal descriptive information during the course of the literature search. Factors that have contributed to this over the years are fear of ridicule and concern about misuse or co-optation of the information. Healing is often considered a private matter, and even a sacred process. Additionally for many of these traditions there is no written documentation. Sometimes this is because the tradition is passed orally, but in many instances it is because there is a lack of formal educational experience for practitioners. This, combined with processes and diagnosis that don't necessarily rely on the biomarkers or taxonomy used in biomedical 'evidence based practice', leaves the treatments and their effectiveness outside the paradigm of the scientific community (Struthers et al., 2004).

Basic themes identified during the course of this literature review include a priority to respect individual right to choose religious/spiritual paths (Benson, 2003). A culturally sensitive service must consider the cultural diversity of people, their beliefs, culture, language and worldview. To succeed at integrative efforts we must accept and respect these differences. We must understand that health is not just physical fitness (Conejo, 2009).

The South American cases highlighted by Mignone et al. (2007) demonstrate that systems do not have to function in opposition to one another. They also support a shift from exclusively biomedical models to intercultural health programs and practices that support indigenous organizations.

Aside from cultural resistance and concerns about how traditional medicine fits in an EBP directed world, funding is a legitimate concern. In all the case studies that were surveyed from south America funding for traditional operations came from NGO donors, fee for service or re-allocation of surplus administrative funds. It was rare for government funding to be adequate or even directly available (Mignone et al., 2007).

With funding tied to the biomedical treatment models it becomes a challenge to bring traditional medicine into the mainstream healthcare setting without imposing the biomedical framework of diagnosis and illness onto the traditional methods. As an extension of public law 93-638 the Indian self-determination act of 1975, the potential and opportunity for restructuring and reprioritizing the funding to bring it into alignment with traditional values is there; however, we need to develop a pattern of alignment that does not have biomedicine co-opting tradition nor traditional medicine being blindly accepted without critical appraisal. Efforts to recognize that what is effective and what is being treated are defined by cultural constructs will play an important role in this and therefore need to be evaluated in that light (Eby, 1998).

In all south America case studies except Suriname where shaman’s apprentices were being taught to use a medical record, adequate data collection was a barrier to long-term planning, operations, monitoring, evaluation and research (Mignone et al., 2007). This is unlikely to be a problem in the North American setting of building an integrated program from the ground up.

There is also recognizing the importance of having not just government facility resources, but community resources and indigenous community leaders who are willing to take charge and ownership of the programs (Benson, 2003). True pluralism in health care will create a resource that is socially desirable, will serve people best, be cost effective and culturally important to preserve (Burke et al., 2003; Weil, 2011).

Tina Melin, a provider who worked in Kotezebue, Alaska said it best:

> The people of [Alaska] wish to put their heads and hearts together with guidance from our creator to attempt to get to the root of the cause or suffering… they have their own legitimate ways of knowing how to do this. Those of us who are a part of the health care system need to work together with them… They wish to remember the healthy ways of the days of old blended in with the new… they wish to regain and strengthen their cultural identity and pride. They wish to help themselves and each other to get on that path to health and stay there (Morgan, 2009, p. 89)

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Appendix B

Describing a Sustainable Model of Harmonization between Culturally Congruent Traditional Healing and Evidence Based Biomedical Models

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Abstract

Purpose

This paper explores models of integration bringing together traditional medicine (TM) with biomedicine (BioM) to answer the question: How do you integrate sustainably within the context of evidence based practice and cultural humility?

Design

This is a review of the literature. The search was conducted using: MeSH terms ‘traditional medicine’ and ‘integrative medicine’ in strings; keywords: Native American, Alaska Native, tribal, cultur*.*, enculturation, identity, and maintenance; author-as-keyword; and bibliographic review in CINAHL, Medline, PubMed and Google Scholar.

Findings

Globally, there are diverse approaches to healing. Unifying concepts of TM were identified to validate using cases from different cultures. Key principles of integration were identified. Six case studies suitable for application are included.

Discussion

Four areas of focus were identified. Integrative efforts should focus on communication including modes of entering treatment, space and aesthetic concerns, attitudes of employees toward different modalities, and qualification of providers.

Describing a Sustainable Model of Harmonization between Culturally Congruent Traditional Healing and Evidence Based Biomedical Models

In 2006, while traveling with a medical expedition, I stumbled across a unique clinic in the mountain region of Ecuador. Nestled there, in Otovalo, is the Jambi Huasi clinic. On staff at Jambi Huasi are physicians, a medicine man, and a folk healer. The clinic also has a pharmacy, herbarium, dental clinic and a laboratory. It is a highly integrated, self-sustaining operation and an enviable blend of culture care and medicine. Models like this, especially in North America, are rare.

Objectives

The purpose of this paper is to explore models of integration between TM and BioM. TM is a broad term that refers to systems of health and wellness that are rooted in indigenous culture. BioM is synonymous with allopathic or 'western' medicine. Efforts at integration that have been described in the literature are reviewed with an eye toward answering the following question: How do you successfully and sustainably integrate TM with BioM in using proven methods of collaboration?

Significance

Cultural perspectives in healthcare have experienced increased recognition. With increased awareness has come improved models of culture care. Newer models of culturally sensitive care use the principle of CH which recognizes that culturally-congruent care should be based on collaboration, allowing both parties to bring valuable information to the table. This departs from previous standards where it was considered sufficient to possess a list of facts about a culture (Tervalon & Murray-Garcia, 1998). This is key relative to the protective nature of enculturation and the role that traditional practices play in promoting cultural identity

(Winderowd, Montgomery, Stumblingbear, Harless, & Hicks, 2008). When Native communities validate cultural values in an environment of healing individuals are more are likely to seek care and adhere to treatment (Mignone, Bartlett, O'Neil, & Orchard, 2007; Novins et al., 2004).

Tina Melin, a provider who worked in Kotezebue, Alaska with the American Indian/Alaska Native (AI/AN) population summed up the driving sentiment for an effort directed at harmonization:

> The people of this region wish to put their heads and hearts together with guidance from our creator… they have their own legitimate ways of knowing how to do this. [We] need to work together with them… They wish to remember the healthy ways of the days of old blended in with the new… they wish to regain and strengthen their cultural identity and pride. They wish to help themselves and each other to get on that path to health and stay there (Morgan, 2009, p. 89).

Methods

Review of the Literature

In order to understand the implications of bringing BioM together with TM practices a review of the literature was conducted. Emphasis was placed on locating published works that describe instances of collaboration and key principles that drive successful integration.

Search Strategy

The MeSH terms 'traditional medicine' and 'integrative medicine' were used in search strings. Additional keywords used include: Native American, Alaska Native, tribal, culture*.*, enculturation, identity, and maintenance. Inclusion criteria were initially limited to any article published within 10 years regarding TM and cultural identity as well as any case studies without restriction to time. Due to a dearth of topic specific articles the time constraint was opened to an

unrestricted timeline for all subjects queried. The search using the terms noted above, as well as searches for reports of cases known anecdotally to the author was conducted in CINAHL, Medline and PubMed. Additional strategies included author-as-keyword using individuals involved in the field of enculturation and integrative medicine, as well as ancestry methods of bibliographic review. Searches in Google Scholar were used to identify pertinent grey literature.

Results

Through a review of the literature I identified a series of cases studies and some reports by the World Health Organization (WHO) which offered practical suggestions for the development of healthcare systems including the role of TM in those systems. Ten case studies were found. Only six of these were useful with observations suitable for application. These cases were based on a specific setting of collaboration that described the interface between TM and BioM providers within a defined relationship. Other cases not included had descriptions that were too general or described the presence of TM providers in a community but without specific collaborative relationships in place. Two of the best described clinics: Jambi Huasi in Ecuador and the Southcentral Foundation (SCF) Traditional Healing Clinic (TC) in Anchorage, Alaska; stand out as exemplary.

Conceptualization of Traditional Healing

TM is a broad term that refers to systems rooted in indigenous culture. For the purposes of this paper indigenous culture is comprised of persons who self-identify as indigenous or tribal. These are communities, and nations with continuity to a pre-invasion/colonial society (Struthers, Eschiti, & Patchell, 2004; WHO, 2005).

Although many cultures have an historical medicine tradition there should be caution in assuming a globally homogenous ‘traditional medicine’ body. Grouping together everything “not

ours" i.e., not BioM, is ethnocentric so the approach should be cautious (van der Geest, 1997). Despite a lack of homogeneity it is useful to identify themes that reflect congruency in world-view among TM paradigms. By identifying common themes we validate the use of models from multiple cultures as points of reference when designing systems of integration from the ground-up.

TM models around the world operate in both the physical and spiritual realms. This perspective differs from the more reductionist patterns of BioM which has roots in Cartesian dualism (Bruce, 2002; PAHO/WHO, 2002; Struthers et al., 2004). For indigenous peoples health and illness tend to be holistic in the greatest sense (van der Geest, 1997). "The concept of health is not limited to the absence of pain or illness, but the harmony and the internal balance of the person in the family, the community, the nature and the cosmos" (Jambi Huasi, 2005). Indeed, the WHO describes health as a state of complete physical, mental and social well-being, not only the absence of disease (PAHO/WHO, 2002; van der Geest, 1997) .When complete health includes social well-being, the community becomes a contributor to individual health. Any solution to a problem is potentially the responsibility of the group (Eby, 1998; van der Geest, 1997).

Another unifying construct of cultural medicine traditions is health and balance as a life-long pursuit. "To benefit from Indian medicine power one has to possess conviction and feeling in it and be involved in that particular way of life" (Struthers et al., 2004, p. 143). TM has an endurance of practice through time (Wing, 1998). It is a way looking at the world through the lenses of your ancestors. "Not something we take off a shelf when it's convenient and then put it back when we are done" (Lowe, 2012). It is a complete way of life passed down generation to generation (Kyba, 2013).

By finding specific cases of effective integration and considering the congruent facets of TM we can create a system that has a strong foundation built on proven principles of success.

Case Studies

Six cases are presented here. More sources with information about Jambi Huasi and Southcentral Foundation were located than for the others which, while less detailed, still provide useful practice considerations for the integrated setting.

Clalit Health Services – Israel. A study by Ben-Arye, Scharf and Frenkel (2007) looked at interdisciplinary communication among the broad network of BioM providers and Complementary and Alternative Medicine (CAM) practitioners employed by Clalit Health Services, a health maintenance organization in Israel.

Low rates of communication are already a well-established fact. As litmus for this, in response to a survey conducted in 2006, a majority of U.S. physicians indicated a strong referral relationship with other BioM physicians but no referral relationship with any chiropractors. The majority of the providers surveyed by Ben-Arye et al. were interested in collaboration and indicated a willingness to communicate, preferably by consultation letter, to formulate treatment plans. The authors suggest that education on communication between disciplines to overcome "language" barriers related to differences in training and philosophy could promote collaborative communications (Ben-Arye et al., 2007).

Waikiki Health Centers. The Ho Ola Like Outreach Project and the inner city Palolo Community Clinic in Hawaii, staff nurse practitioners (NP) and traditional Hawaiian healers. Clients come to the clinics, self-select a NP, a TM provider, or may work with both. The NPs and healers are free to refer patients to each other and they cultivate a casual atmosphere to enhance therapeutic relationships between clients and providers. A minor compartmentalization

of treatment is in place as clients typically choose Hawaiian medicine for chronic conditions like musculoskeletal problems. Treatment by the NP is favored in acute illness and chronic disease states such as diabetes, hypertension, asthma and gout (Broad & Allison, 2002).

St. Mary's Hospital. St. Mary's is a Catholic hospital in Arizona. Seeing that many of their Navajo clients were entering a foreign environment they sought to create a more culturally sensitive atmosphere. During a study of these efforts they identified five challenges inherent to the integration of culture concern and BioM healthcare: 1) Acknowledging that spiritual beliefs and practices are vital to a healing process. 2) Deciding how to assess for spiritual practices. 3) Accommodation of the space needed for spiritual practices. 4) Fostering an environment welcoming to spiritual practitioners. And, 5) blending cultural practices of patients with the cultures of the healthcare professionals employed at the hospital (Hubbert, 2008).

The strategy that proved effective in promoting staff to be open to TM was teaching them to identify and appreciate its philosophies. This was accomplished via a series of educational conferences up to seven days in length. The training was developed with a Comanche medicine man, Mr. Edgar Monetathchi Jr., who was the national Traditional Indian Medicine (TIM) specialist for Indian Health Services (IHS). The training did not teach the mechanics of TM, but opened employees to the ideas behind TM so that they could personalize their approach to it with individual patients (Hubbert, 2008).

Kwamalasamutu, Suriname. This village, located in the interior Amazon basin, has two clinics. One provides BioM services and is operated by a local non-government organization (NGO). The other, a TM clinic, is operated by elder tribal shamans with assistance from a U.S. based NGO. The choice to be treated in either clinic is entirely up to the individual client (Mignone et al., 2007).

Individuals from both clinics: shamans, medical mission health workers, and physicians lead workshops to raise awareness about TM, medicinal plants and indigenous concepts of health. The BioM providers offer training on basic primary care and preventative health issues. Referrals are routinely made between the clinics. The TM clinic hosts a Shaman's apprentice program to preserve traditional knowledge. Part of the training for new apprentices is in filling out assessment and treatment forms used to document the conditions diagnosed and treatments provided by the shaman (Mignone et al., 2007).

Jambi Huasi – Ecuador. In the mountain town of Otovalo, Jambi Huasi offers a full range of BioM and indigenous health services to the ethnic groups of the region (Conejo, 2009).

Services. The clinic offerings are quite varied. Physicians, dentistry, pharmacy, and a clinical lab comprise the BioM services. An indigenous Yachac (medicine man), Fregadora (herbalist/massage therapist) and a Pakarichik Mama (midwife) are available. This team of providers offers treatment for organic illness, emotional disorders, and energetic diseases. They also operate a community health program (Conejo, 2009; Mignone et al., 2007).

Management. Some government and NGO moneys come in to support the physicians, and nurses but these are insufficient to sustain all operations so they also rely on a modest fee-for-service. Jambi Huasi is functionally a western style health care organization offering intercultural health care services managed by an indigenous entity (Conejo, 2009; Mignone et al., 2007).

Environment. The clinic's goal is to provide health care with consideration to the local sociocultural situation and worldview, while valuing the role of TM by institutionalizing TM and BioM together. The medical center is on sacred ground and the Clinic is oriented to the cardinal directions. The various providers were encouraged to select their own offices (Conejo, 2009).

Southcentral Foundation – Anchorage, Alaska. Southcentral Foundation (SCF) was established in 1982 as a 501c(3) and obtained its first self-management contract in 1985.

Services. SCF is in a collaborative ownership of the Alaska Native Medical Center (ANMC) and operates over sixty five programs including a Traditional Healing Clinic (TC) (Mala, Dolchock, & Daney, 2011).

Access to the TC is only available via referral from a primary care provider (PCP). In 2010 the TC received 1074 referrals (Barber, 2011; Daney, 2012; Mala et al., 2011). Counseling, acute and chronic pain, smoking cessation, and chronic fatigue are all reported as having been effectively treated in the TC. Of these, chronic pain is the leading diagnosis referred in. Treatments include energy healing, massage, body manipulation and spiritual support (Benson, 2003; Morgan, 2009). Although the report of success is an anecdotal self-reporting, the SCF and ANMC have a reputation for excellence in the provision of healthcare for the region. That fact, and the large number of individuals referred in demonstrate that the PCP affiliated with SCF are sufficiently pleased with their outcomes.

Management. The healers that work in the TC are 'tribal doctors' approved by the SCF Traditional Healing Committee of Elder Advisors and are certified in traditional native medicine (Benson, 2003; Mala et al., 2011; Morgan, 2009). An unfortunate weakness in the literature that was identified is that the definition of and the process for certification in traditional native medicine as conceptualized by the SCF is not explicated.

To promote a collaborative practice environment with the PCP, the providers in the TC use a standardized assessment and treatment form to document encounters (Daney, 2012). They hold regular consultation with other providers and engage in clinical rounds with the PCP staff,

mental health and pediatric clinics. They also attend to networking and educational opportunities with traditional healers from around the world (Mala et al., 2011).

SCF's model of care called Circle of Healing (COH) brings together BioM, CAM, and TM. A Pathfinder, who is familiar with all three areas, meets with clients to determine needs and goals. The Pathfinder works with each discipline to formulate a wellness plan (Benson, 2003).

A certain amount of the success of the cultural efforts at SCF can be credited to employee training. New employees at SCF facilities attend a three day orientation to learn expectations and approaches to care. Further training comes during a three day workshop which emphasizes empathy, compassion, and relationship building in promoting the health of the 'customer-owners' (Helvey, 2010).

Environment. Attention to the environment is also important (Benson, 2003; Morgan, 2009). Healthcare is provided on a campus with native decor and space is allocated for TM, CAM and BioM. Musical presentations by native performers are frequently present and the TC opens into a courtyard with an herbal garden (Morgan, 2009). An annual health fair builds on a tradition of community gatherings bringing community members together to celebrate their native culture, educate about health resources and promote healthy lifestyles (Helvey, 2010).

Principles of Integration/Harmonization

Some key principles of practice are demonstrated with good recurrence of themes throughout these case studies. Elements of practice; from the suggestions on communication proposed by Clalit Health Services, the environment of the Waikiki Health Centers, the educational model of St. Mary's and the collaboration and communication of the partnered clinics in Suriname are brought together in the models of Jambi Huasi and the SCF TC. The

principles demonstrated by these case studies fall into four categories: communication, environment, employee attitudes, and qualifications of TM providers.

To give further credence to this synthesized model of care, these key elements align with recommendations from the WHO and PAHO regarding the development of healthcare systems.

The items outlined by the WHO and PAHO include: 1) Communication between conventional and TM providers should be strengthened. 2) Knowledge of TM treatments, and practices should be respected, preserved, and promoted. 3) Training programs regarding TM should be established for health professionals. And, 4) governments should establish systems for accreditation or licensing of TM practitioners (WHO, 2009). These global organizations find each of these areas critical to the improvement of healthcare systems and recommend that they be implemented in a way that incorporates an indigenous perspective of medicine and therapy while maintaining technical excellence (PAHO/WHO, 2002; WHO, 2005).

Discussion

Communication

Communication matters encompass referrals and interdisciplinary treatment plans. The recommendation from Clalit Health services to offer training in interdisciplinary communication is in alignment with the WHO recommendation to improve communication between TM and BioM providers in order to promote collaboration. Standardized documentation like that seen in Suriname and at the SCF clinic is one method of promoting this. In their review of Jambi Huasi Mignone et al. (2007) found a lack of standardized documentation to be their only significant shortcoming.

Referrals into the service lines can be done via self-referral like that seen at Suriname the Waikiki Health Centers and Jambi Huasi; or through PCP referral as noted in the SCF model.

Neither model was demonstrated superior in outcome so consideration of cultural and logistical needs regarding funding and reimbursement would likely promote one mode over the other for any given clinic. All three of the clinics that use a self-referral mode are operating in cultures that value a more casual approach where SCF with its requirement for PCP referral operates within the schema of IHS documentation and funding requirements.

Environmental Considerations

Promoting an environment that is culturally appropriate was part of successful integration in multiple clinics. Environmental principles include geographic, space designation, and aesthetic considerations. For the Waikiki Health Centers this was accomplished through the promotion of a casual environment consistent with Pacific Islander values. St Mary's acknowledged that finding the space for spiritually oriented healers to operate would have to be a critical consideration. Jambi Huasi focused on principles of geography and space by orienting the clinic to the cardinal directions, building on sacred ground and allowing the healers to define their own needs with regard to work space. The SCF approach emphasizes aesthetic through the use of indigenous art, a traditional healing herb garden and traditional native music performances. Any combination of these has the potential to promote a harmonized healthcare model by validating the needs of the traditional healer who is coming out of their traditional place in the community, into the potentially foreign clinic setting (Bruce, 2002; Morgan, 2009).

Attitudes Toward TM

Ensuring indigenous management of the clinic is the first step toward ensuring a practice centered on the needs and culture of the people being served. This is specifically noted in the shaman's clinic in Suriname, at Jambi Huasi, and the SCF TC. Jambi Huasi built into their mission statements that they desire to provide care with the utmost respect for people and their

culture in conditions of equality but how they promote a positive attitude toward TM in their employees is not described. St. Mary's and SCF both implemented aggressive employee education initiatives which are in alignment with the WHO recommendation to recognize and promote TM. St. Mary's and SCF accomplished this through seminars and workshops.

For St. Mary's the training was focused on two main educational themes. The first was entitled 'The Seven Sacred Aspects'. The Seven Sacred Aspects, according to Mr. Monetathchi, are: respect, honesty, truth, humility, compassion, wisdom, and unconditional love. The second workshop series emphasized 'The Essence of the Holistic Individual'. Health equals balance was the underlying principle communicated with the individual being representative of balance between the physical being, the mental being, the spiritual being, the environment and that individual's relationship with God. This is consistent with the medicine wheel model of balance that has been adopted by many AI/AN. Ultimately the education of the staff towards these underlying philosophies enabled them to accommodate those individuals who were entering a culturally foreign environment and improve the relationships and treatment outcomes they experienced (Hubbert, 2008). One of the key points is that the training emphasizes respect for the ideas of TM rather than trying to teach the mechanics of TM.

Qualifying TM Providers

Tribal elders should have a role in qualifying healers but the WHO endorses formal qualification of traditional healers. In Suriname the Shaman's clinic was operated by the Elders, and St. Mary's sought out the IHS TIM specialist to consult on their project. Jambi Huasi uses three different modalities of traditional healer but details on how those individuals were qualified was not part of any of the literature.

As noted above in the case study review section, SCF healers are qualified by tribal elders and through a specific certification process. As outlined, this particular set of requirements is most in line with the WHO recommendation. Unfortunately, the lack of detail on the specifics of what qualifies an individual as a 'Tribal Doctor' for the SCF TC or the Yachac at Jambi Huasi means that information would have to be gleaned directly from the sites themselves rather than relying on the literature.

There is a provocative newer feature of IHS funding rules that provides for Naturopathic Doctors (ND) to be eligible for loan repayment (Indian Health Services, n.d.; Roubideaux, 2012). The congruency of philosophy between TM and Naturopathy may make NDs ideal to serve as a provider for the TM branch of an integrated clinic (Fleming & Gutknecht, 2010). This would speak to both formal qualification requirements and potential issues with reimbursement for traditional therapies.

Limitations

Information on contemporary practice of traditional AI/AN is scarce. Information about integrative efforts is equally so. Factors that have contributed to this over the years are fear of ridicule and concern about misuse, appropriation, or co-optation of the information. Healing is often considered a private matter, and even a sacred practice. This, combined with processes and diagnosis that don't necessarily rely on the biomarkers or taxonomy used in BioM 'evidence based practice', leaves the treatments and their effectiveness outside the paradigm of the scientific community (Struthers, Eschiti, & Patchell, 2004). Because of this many tribal organizations are hesitant to publish about or formalize request for funding and implementation of these traditionally derived interventions. Despite having firsthand knowledge of clinics pursuing integrative efforts it was a challenge to find published information about them.

However, networking through professional contacts I was able to identify specific tribal organizations that are formally pursuing some level of integrated health care. When contacted they seemed welcome to the idea of sharing organization to organization or healer to healer but less interested in being part of any scholarly or academic inquiry. The exception to this was the First Nations Health Authority out of British Columbia, Canada. They are developing a significant amount of material including a highly anticipated Traditional Wellness Strategic Framework (Kyba, 2013).

Moving Forward

By identifying those specific concrete activities that have lead organizations such as Jambi Huasi and the SCF to be successful in their efforts of integration we have a replicable pattern to follow. Four simple areas provide the beginnings of a harmonized system. With promotion of good communication, creation of a healing environment that meets the needs of BioM providers and TM healers alike, clinic employees who respect the philosophies of TM, and a staff of qualified TM providers, a healthcare organization can begin down the path to a truly harmonized provision of health and wellness to the community they serve.

A Healing Path

True harmonization in health care creates a model that is desirable, cost effective, and culturally important (Burke et al., 2003; Weil, 2011). Instead of pining: “Two roads diverged in a yellow wood; And sorry I could not travel both, And be one traveler…” We will find ourselves saying: “Two roads *converged* in a wood… And both that morning equally lay, *and both I kept to on that day*… and that has made all the difference” (Frost, n.d.).

This review only scratches the surface of what is being done to promote optimal culture care by implementing harmonization of TM and BioM within healthcare systems. Effective

efforts in clinics desiring to pursue this model will come with assistance of organizations already pursing harmonization whose work may not be described in the literature. Replicable models are achievable and integrative efforts are well within the reach of the organization desiring to pursue this optimal level of culture care.

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Appendix C

Poster Project: Harmonizing Evidence Based Biomedical Models of Healthcare with Culturally Congruent Traditional Healing

Attached is a copy of the poster that was presented during the University of Utah, College of Nursing, Poster Session on April 18, 2012.

Harmonizing Evidence Based Biomedical Models of Healthcare with Culturally Congruent Traditional Healing

UNIVERSITY OF UTAH COLLEGE OF NURSING
Family Nurse Practitioner Program

Jeremy C. Norton, BSN, RN, DNP-Candidate • jeremy.norton@utah.edu

Objective: How do you successfully integrate traditional medicine (TM) with biomedical (BioM) oriented practices in the context of evidence based practice and principles of cultural humility?

Theoretical Framework: Enculturation theory.

"the process of socialization into and maintenance of the norms of one's indigenous culture including its salient ideas, concepts and values" [11]

This project seeks to promote enculturation via the integration of traditional, culturally congruent, healing practices within the mainstream healthcare service model.

Methods: A review of the literature for themes and cases

A review of the literature was conducted using:

- MeSH terms 'traditional medicine' and 'integrative medicine' in search strings
- Terms : Native American, Alaska Native, tribal, cultur*.*, enculturation, identity, and maintenance.
- Author-as-keyword as well as ancestry methods of bibliographic review.
- The search was conducted in CINAHL, Medline, PubMed and Google Scholar

Results: Themes

1) Diverse approaches to healing, but unifying concepts of TM identified to validate the use of cases set in a variety of cultural backgrounds.

There is a congruency of worldview that informs most traditional healing models.

2) A comparison between TM and the BioM model.

A Comparison of Traditional Medicine with Biomedical models [16]

Traditional Cultural Healing Pathways	Biomedicine/Allopathy
• Holistic approach	• Reductionist approach
• Cultural definition of health and illness used with physical, social and spiritual information to make diagnosis	• Patient centered history and physical along with biochemical, physiologic, anatomic, laboratory based data used to make diagnosis
• Health and harmony emphasized	• Disease and curing emphasized
• Honor patient for restoring wellness	• Credit to provider for curing
• Herbal/mineral/animal medicines may be used	• Pharmaceuticals (some herbals) may be used
• Preventative medicine taught	• Preventative medicine taught

3) Challenges to integration

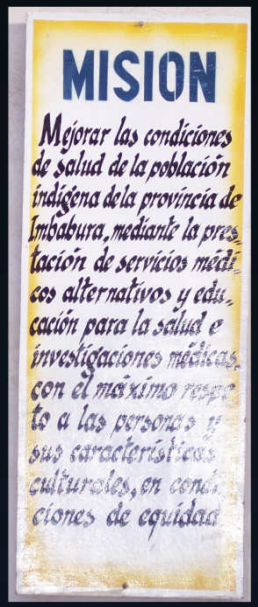
- Historical Trauma
- Tension and power struggles: BioM vs. TM
- Evidence Based Practice – Randomized Control Trial vs. Evidence from tradition

Best practice criteria:
Treatment should: have a positive impact, be sustainable, be relevant, be client focused, improve access, have potential for replication, and have capacity for evaluation. [13]

4) Principles of integration - WHO guidelines

- Knowledge of TM: respected, preserved, and promoted
- Governments should establish systems for accreditation or licensing of TM providers.
- Communication between conventional and TM providers should be strengthened
- Training programs re: TM should be established for health professionals.[17]

'*El Encuentro*' – Jamie Zapata - 1991



Mission
To improve the health conditions of the indigenous population of Imbabura Province through the provision of alternative medical services; also to provide education for health and medical research; with the utmost respect for people and their culture in conditions of equality
(Posted in the courtyard at Jambi Huasi, photo c.2006 ~ J. Norton)

"The concept of health is not limited to the absence of pain or illness, but the harmony and the internal balance of the person in the family, the community, the nature and the cosmos"
(Jambi Huasi, 2005).

Results: Cases from the literature.

Ten case studies were identified, six of which had useful recommendations or observations suitable for application.

Clalit Health Services – Israel. A health maintenance organization in Israel with a broad network of BioM physicians and CAM providers. This study: covers inter-disciplinary communications.[2]

Waikiki Health Centers. Two clinics operated by Waikiki Health Centers in Hawaii. Nurse Practitioners and traditional Hawaiian healers. Casual atmosphere to enrich therapeutic relationships. [4]

St. Mary's Hospital – Arizona. Recognizing that many of their Navajo clients were entering a foreign environment - sought to create a more culturally sensitive atmosphere. Identified five challenges to integration of culture care and BioM healthcare.[8]

Kwamalasamutu, Suriname. Village in the interior Amazon basin - two clinics, one provides BioM services operated by a NGO. The other is a TM clinic operated by elder tribal shamans. Individuals from both clinics lead workshops about TM, indigenous concepts of health, basic primary care issues and preventative practices. The indigenous medicine clinic hosts an apprentice program.[13]

Southcentral Foundation – Anchorage, Alaska. Southcentral Foundation (SCF) operates more than sixty five programs among these: the Alaska Native Medical Center and a Traditional Healing Clinic (TC). Counseling, acute and chronic pain, smoking cessation, and chronic fatigue have all been successfully treated. Healers are certified in traditional native medicine and approved by the Traditional Healing Committee of Elder Advisors.[1, 3, 7, 12, 14]

Jambi Huasi – Ecuador. Offers: physicians, dentistry, pharmacy, and clinical lab; An indigenous Yachac (medicine man), Fregadora (herbalist/massage therapist) and Pakarichik Mama (midwife). Treatment for organic illness, emotional disorders, and energetic diseases. Operate community health promotion program.[5, 13]

Mamá Juanita, the Fregadora from Jambi Huasi (L). A child (R) receiving IV fluids at a makeshift clinic in Esmereldas, Ecuador. Photo c.2006 ~J. Norton

Discussion: Application

This project demonstrates that pursuit of harmonized healthcare is beneficial and gleaning information across cultures is an appropriate approach. While different in philosophy, BioM and TM have common ground. The biggest challenges lie in resolving historical trauma and finding a unified definition of efficacy in practice.

Communication: Strong evidence of a poor history of communication between BioM and TM/CAM providers. Standardized medical record of assessment and treatment. Education on effective communication.

Entering in: Self vs. PCP referral. Both options successful. Need to match to cultural and logistical needs. Self-referral may lead to compartmentalization of therapies.

Environment: Organization of clinic space, orientation of buildings and rooms to cardinal directions, a place for TM with its own aesthetic and environment that facilitates culturally oriented provider/client interaction.

Attitudes: Employee education initiatives crucial in promoting respect for TM. Key recommendation from the WHO. St. Mary's and SCF accomplished this through seminars and workshops emphasize respect for the ideas of TM rather than teaching the mechanics of TM. Important in the context of employees who may not share the culture of the tribal group they are working with.

Qualifying TM providers: Tribal elders should play a role in qualifying healers but the WHO recommends that formal qualifications for TM healers should be implemented. New IHS funding guidelines - Naturopathic Doctors (ND) eligible for loan repayment.[9, 15] The congruency of philosophy between many tribal cultures and ND may make them suited to serve in the TM branch of an integrated clinic.[6]

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Appendix D

Creating a Sustainable Model of Harmonization between Culturally Congruent Traditional Healing and Evidence Based Biomedical Models for Alaska Natives

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Objectives

1. Describe why this matters to the TCC
2. Define Traditional Medicine
3. Validate a model of integrated medicine
4. Address Concerns to models of Integration
5. Explore Case Studies of Integrated Clinics
6. Describe Key points that have lead to successful integration
7. Make specific recommendations applicable to the CAIHC

Background

- 2005 – Jambi Huasi in Otavalo Ecuador
- 2010 - No significant evidence for similar model in North America: Identified none through general literature searches
- 2011/12 - Networking produced leads on two, possibly three in the U.S.
- 2012 – Connected with Chief Andrew Isaac Health Center in Fairbanks, Alaska

Definitions

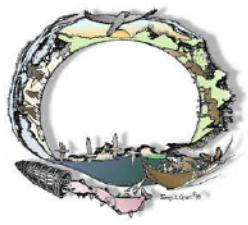
- **Traditional Medicine (TM):**
  - A broad term that refers to systems of health and wellness that are rooted in indigenous culture
- **Biomedicine (BioM):**
  - Is synonymous with allopathic or 'western' medicine
- **Complementary Alternative Medicine (CAM):**
  - traditional healing practices used in western medical clinics as a way to offer diversity in treatment, not necessarily in the context of cultural congruency.
- **Cultural Humility:**
  - A brand of cultural sensitivity that emphasis deconstruction of power imbalances between providers and patients
- **Enculturation:**
  - The process of cultural identity maintenance across generations

Why?

- Best models of intercultural care emphasize principle of Cultural Humility and enculturation
- Validation of Traditional Medicine promotes improved access to care and adherence to treatment plans
- TCC has no specific program to incorporate cultural values and healing traditions into the model of care

CAIHC Mission Statement

"Promote and enhance the spiritual, physical, mental and emotional wellness through the delivery of quality services"



(Tanana Chiefs Conference, Inc., n.d.)

Questions

How do you successfully integrate traditional medicine with biomedically oriented practice in a sustainable way ?

How do you successfully integrate in the context of cultural Humility and Evidence Based Practice?

Image © AlaskaGeographic

"The people of this region wish to put their heads and hearts together with guidance from our creator… they have their own legitimate ways of knowing how to do this. [We] need to work together with them… They wish to remember the healthy ways of the days of old blended in with the new… they wish to regain and strengthen their cultural identity and pride. They wish to help themselves and each other to get on that path to health and stay there".

~Tina Melin

(Morgan, 2009, p. 89)

Theoretical Underpinning

- Old - 'cultural sensitivity'
  - Know a list of facts about a culture
- New - Culturally sensitive care
  - Cultural Humility – the provider and client working in collaboration

(Tervalon & Murray-Garcia, 1998)

El Encuentro" – James Zapata - 1992

"The process of socialization into and maintenance of the norms of one's indigenous culture including its salient ideas, concepts and values"

Enculturation Theory

(Kim, Ahn, & Lam, 2009; Redfield, Linton, & Herskovits, 1936; Winderowd et al., 2008)

"In this world we are too much in the physical world. You know, we have an operation that physically heals. When we have any kind of injury to our body, we have to know our spirit, our heart and our emotions are also affected. That physical scar, or whatever surgery we have, heals. That inside part, does not it require [its own] treatment?... So healing comes with a soul wound and the solace requires a different way. We have to find [the wounds] because the physical, emotional, spiritual - they all have to heal".

(Dolchok, 2003, pp. 20, 22).

TM is a broad term that refers to systems rooted in indigenous culture.

TM models around the world operate in both the physical and spiritual realms. This perspective differs from the more reductionist patterns of BioM which has roots in Cartesian dualism

Concepts of Traditional Medicine

(Bruce, 2002; PAHO/WHO, 2002; Struthers et al., 2004).

Traditional medicine is not "embryonic modern medicine or a predecessor to advanced modern medicine… [it] is an entirely different entity".

Struthers et al., 2004, p. 142)

"The concept of health is not limited to the absence of pain or illness, but the harmony and the internal balance of the person in the family, the community, the nature and the cosmos"

Dr. Conejo, Native Kichwa; Biomedically trained physician at Jambi Huasi; Otovalo, Ecuador

Health is a state of complete physical, mental and social well-being not merely the absence of disease or infirmity

World Health Organization

(Jambi Huasi, 2005; PAHO/WHO, 2002; van der Geest, 1997).

"To benefit from Indian medicine power one has to possess conviction and feeling in it and be involved in that particular way of life"

"It is Not something we take off a shelf when it's convenient and then put it back when we are done"

It is a complete way of life passed down generation to generation

Hannah Solomon - Photo credit: John Wagner, 2010

(Kyba, 2013; Lowe, 2012; Struthers et al., 2004, p. 143)

The value of harmonizing Traditional Medicine and Biomedicine may seem apparent to some, but for others, harmonization is problematic.

Promotion of integration is purely sentimental

- It has been suggested that pleas for integration are inspired by overly romantic notions concerning traditional medicine and indigenous cultures

Barriers

(van der Geest, 1997).

- Integrating traditional practices promotes cultural identity and enculturation
- Enculturation is protective from a health-risk behavior standpoint
- Integration improves access and care

(Erickson, 2009; Jones & Galliher, 2007; Mignone, Bartlett, O'Neil, & Orchard, 2007; Novins et al., 2004; Tanana Chiefs Conference, Inc., n.d.; Winderowd, Montgomery, Stumblingbear, Harless, & Hicks, 2008)

Superiority of Biomedicine

- "Alternative medicine which is really just medicine that doesn't work… [and] is effective only in so far as the placebo effect can carry it".

Barriers

(McCartney, 2011)

Perhaps the placebo effect should be considered evidence in and of itself, evidence for the power of the mind and body to work together to affect healing. Placebo may well be "the most powerful tool in any healer's armamentarium".

(Waldram, 2000)

Evidence based practice arguments

- The "integra[tion] of clinical expertise with the best available external clinical evidence from systematic research"
- The gold standard is "patient centred clinical research… [This] external evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious and safer"

Barriers

(Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, pp. 71 – 72)

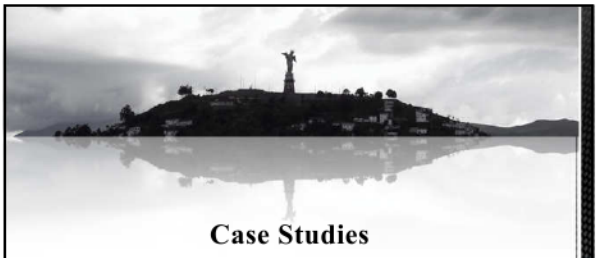
"Evidence based medicine is not restricted to randomized trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions… When asking questions about therapy… we should try to avoid the non-experimental approaches… however some questions about therapy do not require randomized trials… we must follow the trail to the next best external evidence and work from there"

(Sackett et al., 1996, p. 72)

Alternative Best Practice Criteria

1) Have tangible, positive impact;
2) Be sustainable;
3) Be responsive and relevant
4) Be client focused; improve access; coordinate and integrate services;
5) Be efficient and flexible
6) Have potential for replication; and capacity for evaluation.

(Mignone et al. 2007)



Case Studies

Clalit Health Services, Israel

- A health maintenance organization in Israel with a broad network of BioM physicians and CAM providers.
- This study covers inter-disciplinary communications.

L to R: Dr. Eyran Halpern, CEO of RMC, Israel's Minister of Health, Rabbi Yaakov Litzman and Mr. Eli Depes, Director General of Clalit Health Services

(Ben-Arye, Scharf and Frenkel ,2007; The Spokesman Department, 2012)

Waikiki Health Centers

- Two clinics operated by Waikiki Health Centers in Hawaii.
- Nurse Practitioners and traditional Hawaiian healers.
- Casual atmosphere to enrich therapeutic relationships.

(Broad & Allison, 2002)

St. Mary's Hospital – Arizona.

- Recognizing that many of their Navajo clients were entering a foreign environment - sought to create a more culturally sensitive atmosphere.
- Identified five challenges to integration of culture care and BioM healthcare.
- Developed Education for employees to promote acceptance of TM practices.

(Hubbert, 2008)

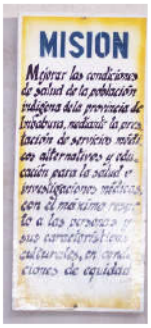
Kwamalasamutu, Suriname

- Village in the Amazon basin: Two clinics, one provides BioM services operated by a NGO. The other is a TM clinic operated by elder tribal shaman.
- Individuals from both clinics lead workshops about TM, indigenous concepts of health, basic primary care issues and preventative practices.
- The indigenous medicine clinic hosts an apprentice program.

(Butler, 2009; Mignone et al. 2007)

Jambi Huasi – Ecuador

- Physicians, dentistry, pharmacy, and clinical lab.
- An indigenous Yachac (medicine man), Fregadora (herbalist/massage therapist) and Pakarichik Mama (midwife).
- Treatment for organic illness, emotional disorders, and energetic diseases.
- Operate community health promotion program.



(Conejo, 2009; Mignone et al. 2007)

Southcentral Foundation – Anchorage, Alaska.

- Established in 1982 as a 501c(3) and obtained its first self-management contract in 1985.
- Southcentral Foundation (SCF) operates more than sixty five programs including: the Alaska Native Medical Center and a Traditional Healing Clinic (TC).

Southcentral Foundation

ALASKA NATIVE MEDICAL CENTER

(Barber, 2011; Benson, 2003; Helvey, 2010; Mala, Dolchock, & Daney, 2011; Morgan, 2009)

WHO and PAHO regarding the development of healthcare systems:

World Health Organization

1) Communication between conventional and TM providers should be strengthened.
2) 2) Knowledge of TM treatments, and practices should be respected, preserved, and promoted.
3) 3) Training programs regarding TM should be established for health professionals.
4) 4) governments should establish systems for accreditation or licensing of TM practitioners.

(WHO, 2009)

Key Principles of Successful Harmonization

- Recommendation from Clalit Health services in alignment with the WHO recommendation to improve communication between TM and BioM providers
- Standardized documentation like that seen in Suriname and at the SCF clinic one method

Communication – Treatment Plans

- PCP referral vs. self-referral
- Neither demonstrated to be better
- Consideration of cultural and logistical needs to promote one mode over the other for any given clinic

Communication – Referrals

- Promoting an environment that is culturally appropriate a key part of successful integration in multiple clinics.
- Environmental principles include geographic, space designation, and aesthetic considerations.

Environmental Considerations

- For St. Mary's employee training focused on two educational themes:
  - 'The Seven Sacred Aspects'
  - 'The Essence of the Holistic Individual'.
- the training emphasizes respect for the ideas of TM rather than trying to teach the mechanics of TM.

Attitude Toward Traditional Medicine

Qualifying Traditional Medicine Providers

- Tribal elders should have a role in qualifying healers but the WHO endorses formal qualification of traditional healers.

Recommendations

- Emphasis Athabascan artwork and aesthetic especially in the traditional healing clinic
- Allow TM providers to define/design space
- Specify how clients will enter the clinic
  - Recommend open access
- Use standardized diagnosis and treatment forms accessible to PCP
- TM providers should issue a consult letter to PCP
- Develop training for all employees on:
  - Athabascan values
  - Philosophy of TM providers
  - Role of TM in CAIHC mission
- Define qualifications for TM provider
  - 'Memory Keepers' conference
  - Consider using Naturopathic Doctor as the anchor provider in TM clinic

"Two roads *converged* in a wood… And both that morning equally lay, *and both I kept to on that day*… and that has made all the difference"

(Frost, n.d.).

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