1993

A Roundtable Conference On Traditional Cultural Advocacy Program

Indian Health Service, Office of Program Planning, Evaluation, and Legislation

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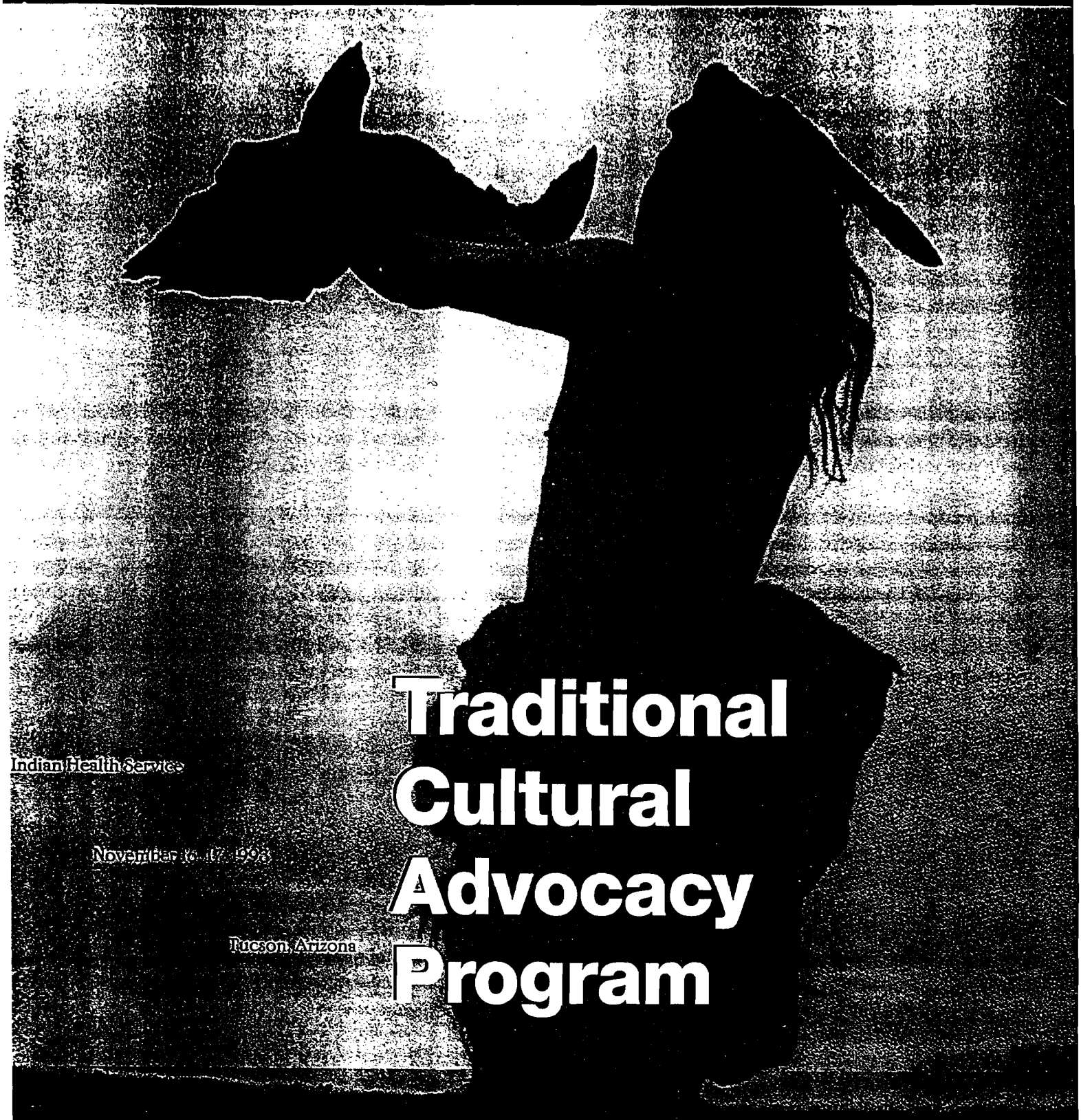

Traditional Cultural Advocacy Program

Indian Health Service

November [illegible] 1998

Tucson, Arizona

FINAL REPORT

DEPARTMENT OF HEALTH AND HUMAN SERVCES
Public Health Service • Indian Health Services

A ROUNDTABLE CONFERENCE

ON THE

TRADITIONAL CULTURAL

ADVOCACY PROGRAM

FINAL REPORT

INDIAN HEALTH SERVICE
NOVEMBER 16-17, 1993
TUCSON, ARIZONA

THIS REPORT IS AN INDEPENDENT

STATEMENT OF THE ROUNDTABLE GROUP

AND IS NOT A POLICY STATEMENT BY THE

INDIAN HEALTH SERVICE OR THE FEDERAL

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INTRODUCTION:

The Indian Health Service (IHS) Office of Planning, Evaluation, and Legislation (OPEL), sponsors Roundtable Conferences that bring together experts in specific subject areas of health care for American Indians and Alaska Natives (AI/AN). These expert group participants may represent health care providers, members of the academic community, national health policy makers or AI/AN community members. Roundtable Conferences provide a forum for examining important topical issues from a variety of perspectives. The results of these conferences are documented in reports that have included consensus statements on each issue addressed by the Roundtable participants.

This report presents the results of a two-day Traditional Cultural Advocacy Program (TCAP) Roundtable Conference that was co-sponsored by the IHS Division of Clinical and Preventive Services (DCPS) and OPEL. This report includes consensus statements, highlights from the conference discussions, a list of participants, and the conference agenda. The attachments contain comments from a TCAP Roundtable Conference participant and information on the IHS Area policy regarding traditional practices. The conference was held on November 16-17, 1993, in Tucson, Arizona.

TCAP ROUNDTABLE CONFERENCE PURPOSE AND OBJECTIVES:

The purpose of the TCAP Roundtable was to develop a consensus of the IHS roles and responsibilities in addressing traditional cultural beliefs, values, and practices; and to discuss and identify issues on holistic beliefs in health care as it relates to traditional culture.

The following were four main objectives identified to be accomplished by the TCAP Roundtable:

1) Identify roles and responsibilities of the IHS, tribes, and individuals for addressing traditional cultural beliefs, values, and practices;

2) Identify the specific types of policy currently needed by the IHS and recommend content where appropriate;

3) Identify holistic beliefs that are generally viewed as those commonly held by the AI/AN throughout the U.S; and,

4) Discuss the need, purpose, and objectives of a national conference in 1994.

TRADITIONAL CULTURAL ADVOCACY PROGRAM ROUNDTABLE GUIDELINES:

The following processes were used for conducting the Roundtable discussions and developing consensus statements on key issues selected for the TCAP Roundtable agenda:

1) All Roundtable participants had the opportunity to contribute to each issue in the Roundtable discussions. For each agenda topic, a discussion leader was selected to begin the discussion by sharing her or his experiences, ideas, papers, or other information on that topic. The topic was then discussed by seeking additional comments, ideas, and information from all participants.

2) A group discussion facilitator and recorder was provided by the IHS. The role and responsibility of the group facilitator was to:

   Review with the group the Roundtable agenda, objectives, and process for building consensus statements. Provide the opportunity for individual members to add important issues or questions that may have been missed on the prepared agenda.

   Function as a guide for the group to achieve its purpose and objectives, ensure that each participant had an opportunity to contribute in the group discussions and consensus building sessions, and ensure that issues were thoroughly discussed.

   Ensure that the consensus building process was followed and that topic discussions were kept within time frames necessary to accomplish the tasks of consensus building by participants.

3) The recorder kept a record of discussion highlights, key issues, and content of each consensus statement. Flip charts were used, as necessary, to capture the group's identification of key issues and the development of consensus statements.

4) Following presentations and topic discussions, key issues from those discussions were selected to develop consensus statements and recommendations related to the agenda topics.

5) Participants developed consensus on key issues based on information presented and group discussions. Consensus statements and recommendations were made to the IHS or other health agencies and relevant organizations.

BACKGROUND:

In February 1992, the IHS established the Traditional Medicine Program, which was recently renamed the Traditional Cultural Advocacy Program. This program was established by the Office of Health Programs (OHP) and is located at the IHS Headquarters West, Albuquerque, New Mexico, as part of the DCPS. The establishment of this program provides a national focus for AI/AN traditional beliefs and practices within the IHS. The TCAP is under the direction of Mr. A. Paul Ortega. Mr. Ortega is a member of the Mescalero Apache Tribe from New Mexico, and has devoted much of his life studying his own tribe's traditional culture and healing practices. In his role as a spiritual leader of his tribe and in his work as a Public Health Advisor within the IHS, Mr. Ortega has acquired a great deal of information and knowledge on traditional beliefs, values, and healing practices of various tribes throughout the U.S.

The stated mission of the TCAP is to promote integration of culturally-sensitive values, beliefs, and practices into each communities' health care system, which enhances the quality of life for the AI/AN. To carry out its mission, the TCAP staff advise, advocate, educate, act as a liaison, orient health professionals, and establish linkages with traditional medicine practitioners.

Medical Services from the Allopathic or "Western Model":

Indians received health care from the U.S. Government as early as 1802 when the U.S. Army first provided health care to prevent outbreaks of smallpox among Indians located near military posts. The responsibility of the U.S. Government to provide health care services to Indian people has been maintained through numerous treaties signed between the U.S. and tribes with specific provision for such health care services, and is based on numerous laws passed by Congress.

Since 1955, the U.S. Public Health Service (PHS), through its IHS component, has had the responsibility for providing comprehensive health care services to the AI/AN. In the IHS 1992 Trends in Indian Health Data Report, the IHS shows 1.2 million individuals as being eligible for services, roughly 63 percent of the total 1.9 million AI/AN. The balance of the AI/AN receive health care from urban Indian clinics, through private or employer-based health insurance coverage, indigent care systems, emergency rooms, or have no health care available for themselves.

American Indians and Alaska Natives Traditional Healing Practices:

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

The AI/AN traditional values, beliefs, and healing practices have long been respected by many Indian health professionals as major influences on the health of the AI/AN. As stated in the IHS Comprehensive Health Care Program for American Indians and Alaska Natives, "[t]he traditional beliefs of American Indian and Alaska Native people regarding wellness, sickness, and treatment are very different from the medical model or public health approach used in training health care providers today. The beliefs, traditions, and customs handed down through many generations played the principal role in the establishment of individual and collective AI/AN identity. The effectiveness of any health care approach is greatly affected by the inherent beliefs of the patient."

There are those who view the "western medical" model to be in conflict with the traditional AI/AN healing practices. This may create a dual health care system and lead to confusion and frustration among those receiving health care and those providing health care. However, within the IHS, it has been demonstrated that these two philosophies of health care can be successfully integrated in a way that complement each other. However, the IHS is continually working to improve the integration of the two health care approaches.

CONSENSUS STATEMENTS, CONFERENCE HIGHLIGHTS, AND RECOMMENDATIONS:

The following statements, highlights, and recommendations from the two days of consensus building discussions represent an "open door" that may lead to changing how the IHS addresses AI/AN traditional cultural beliefs, values, and practices. This Roundtable Conference may be a catalyst for developing new approaches for building peer relationships among allopathic or "western" medical health care providers and AI/AN traditional practitioners/healers. During the TCAP Roundtable Conference, six consensus statements and a number of recommendations were developed:

CONSENSUS STATEMENT:

Roles and responsibilities for fostering, supporting and nurturing AI/AN cultural values, beliefs, and traditional health practices into the health care systems for the AI/AN:

The roles and responsibilities of the IHS are to:

1) Elevate the health status of the AI/AN to the highest level possible.

2) Ensure availability and accessibility of a comprehensive high quality health delivery system that includes traditional practices and traditional practitioners/healers.

3) Provide for maximum involvement of the AI/AN in managing and controlling a health program that includes traditional practices and traditional practitioners/healers.

4) Advocate for AI/AN in matters relating to health that includes traditional practices and traditional practitioners/healers.

5) Develop policy with appropriate tribal consultation.

6) Provide orientation and education on AI/AN cultural values, beliefs, and traditional health practices to IHS staff and other federal agencies.

7) Provide legal and ethical protection for traditional practitioners/healers practicing in the IHS and contract facilities.

8) Re-examine Tribal Specific Health Plans and their updates, and Tribal Action Plans.

9) Acknowledge, respect, and support the fact that traditional health practices and spiritual needs are critical to the health and wellness of AI/AN communities and provide a means to ensure delivery of traditional health practices.

10) Maintain and fully support the IHS TCAP.

11) Ensure and advocate for cooperation with traditional practitioners/healers.

The roles and responsibilities of TRIBAL LEADERS AND HEALTH STAFF are to:

1) Ensure that policy is developed within parameters established by tribal leaders and traditional practitioners/healers.

2) Assist in identifying traditional practitioners/healers.

3) Provide legal and ethical protection for traditional practitioners/healers practicing in tribal facilities.

4) Provide AI/AN cultural values, beliefs, and traditional health practices orientation and education to the IHS, tribal staff, and contractors.

5) Be role models for healthy behavior.

The roles and responsibilities of COMMUNITY MEMBERS/PATIENTS are to:

1) Accept responsibility for one's own health and wellness.

2) Be role models for healthy behavior.

3) Identify and support traditional practitioners/healers.

4) Provide and encourage the transfer of knowledge by continuation of traditional practices.

5) Acknowledge and respect the existence of other belief systems in the community.

TRADITIONAL PRACTITIONERS/HEALERS:

It is the understanding of the Roundtable participants that the role of the traditional practitioner/healer may include: 1) teaching, listening, and ensuring the integrity and continuity of the tribal cultural belief system; 2) advising tribes and the IHS on appropriate methods for fostering a cooperative spirit of traditional health practices into the health care systems of the AI/AN; and 3) preserving the teachings and traditions through sharing, as appropriate, knowledge of traditional ways and respect for language, land, religion/spirituality, songs, and other traditional beliefs.

DISCUSSION HIGHLIGHTS:

- There are varying views on when, where, and how the IHS becomes involved in traditional healing practice.

- There are concerns about the IHS (as a bureaucracy) and its involvement with the traditional practice.

- Will the new Director of the IHS embrace traditional medicine? What will he do? How does he feel about it?

- How far is the IHS willing to go in supporting the ways of ceremonies/healing? Currently, singing, prayers, and some herbs are allowed. What happens when the traditional practices go beyond this?

    - The Navajo Tribe built a hogan by the hospital at Chinle; the Navajo Area pays for traditional services.
    - How can AI/AN patients get access to natural immune boosters? What can the IHS do?
    - Clinic staff sometimes forget the option of traditional healing for the patients.
    - Traditional healing is seen as the last resort treatment.
    - Incorporating traditional medicine in hospitals will take time to implement.

- Tribes should make the final decision on the IHS involvement - some tribes help support traditional medicine. However, some tribes don't want to get involved in traditional medicine.

- There is a need to create a vision for interaction among the IHS and traditional practices.

- Eligibility is still an issue; there is a general belief that it is a tribal decision.

- Health care reform and its impact on the IHS services and eligibility should include traditional practices.

- Costs - Who Pays?

    - If the family asks, the family should be responsible for payment. Payment does not necessarily mean money. If doctors ask for the consultation of a traditional practitioner/healer, the asking organization should pay them as consultants.

    - Once money is involved, all the issues of accountability arise with the Federal Government, state government, and insurance companies, etc.

        - Some tribes and tribal organizations don't expect the IHS to pay for traditional practitioner/healer services, but they would like the IHS to pay for expenses, such as travel, gas, food, hotel, etc.

- The IHS and bureaucracy generally want scopes of work, productivity measures, and results. However, traditional practitioners/healers are not ready to document as the bureaucracy requires.

- There is a legal basis for the IHS to fund traditional medicine; it is the American Indian Religious Freedom Act, Public Law (P.L.) 95-341, (Hereinafter P.L. 95-341).

- If Contract Health Service funds are going to be used, how does payment cross the IHS Areas?

• Traditional practitioners/healers are not as concerned with payment; their main concern is healing.

♦ Traditional practitioners/healers teach, listen, and assist in the continuation of the tribe's belief system.

♦ Words synonymous with traditional medicine are kindness, love, honor, respect, caring, and sharing; this is a way of life.

♦ In traditional practices, the simple things are important and healing begins with the individual; ceremonies belong to the people.

♦ Traditional healers receives power from the creator.

♦ Healing comes from the individual and group (ceremonial circle).

♦ Language programs need to be established to keep tribal languages intact; this should be advocated within the TCAP.

♦ Apprentice programs for traditional practitioners/healers needs to be established in partnership with the IHS.

♦ Tribes must take responsibility for identifying traditional practitioners.

♦ Public schools and the Bureau of Indian Affairs' (BIA) schools diminish the traditional role.

♦ The IHS needs to review the Tribal Specific Health Plans; there are cultural components in these plans.

♦ There is a formula for balance, harmony, and respect. Elements to that formula include: sacred lands and sacred animals (in accordance with healing).

♦ There is a concern about protection of the traditional practitioners/healers.

- A key to the future is going back to the past - back to tradition.

- Teaching wellness education by both traditional and western approaches is imperative.

RECOMMENDATIONS:

1. Create a vision statement on how AI/AN cultural values, beliefs, and traditional healing practices can be nurtured and fostered, through a cooperative spirit, into the health care systems for the AI/AN.

2. Examine and resolve the conflict between bureaucracy requirements and traditional needs, values, and beliefs.

3. Define appropriate method(s) to pay traditional practitioners/healers services.

4. Recognize that spirituality is a highly sensitive subject and is best viewed on an individual tribal level.

5. Support and expand the development of tribal language programs.

6. Ensure that AI/AN cultural values, beliefs, and traditional healing practices are included in any IHS health care reform.

7. The IHS should further research the extension of the Federal Tort Claims Act coverage to traditional practitioners/healers and make funding available for such research.

8. The IHS has an ethical responsibility to fund traditional practices that would require additional appropriations.

CONSENSUS STATEMENT:

IHS policy is needed for fostering, supporting, and advocating AI/AN cultural values, beliefs, and traditional healing practices into the health care systems for the AI/AN:

First and foremost, the IHS Acting Director should redistribute the current policy on the implementation of P.L. 95-341, as amended. Second, the IHS, with appropriate tribal consultation, should update and distribute a circular implementing the P.L. 95-341, as amended. The updated policy and procedures should include, at a minimum, the following points:

- Affirm patients rights to choose.
- Provide compensation for traditional practitioners/healers services.
- Require minimal documentation.
- Affirm support of P.L. 95-341, as amended.

- Provide support for a tribal orientation for health care providers.
- Allow traditional practitioners/healers to set criteria for services.
- Establish traditional practitioner/healers apprenticeship programs in partnership with the IHS.

Third, the IHS, with appropriate tribal consultation, needs to develop a manual issuance in accordance with the IHS circular for implementing P.L. 95-341, as amended.

DISCUSSION HIGHLIGHTS:

- There are all types of patients and health care delivery systems, such as the IHS, tribal, and urban programs. It will be difficult to come up with one policy to fit all these diverse needs.

- It is difficult to develop policy that eliminates individual beliefs and biases.

- The Phoenix Indian Medical Center is researching IHS Area policies for guidance; they are finding that Area policies vary widely.

- Policy development can start with information on what is happening now and build on that.

- The current policy on traditional practices, now in place, is an IHS circular. The circular is a permissive form of policy; whereas, the manual issuance (higher accountability) is a prescriptive form of policy.

- Policies can either be prescriptive or permissive.

- Inform everyone that there is a current IHS policy on traditional practices.

- Not all IHS Areas practice even a permissive form of policy.

- The IHS Areas need to be informed of current policy.

- The IHS policy statement issued in 1979 needs current reinforcement. A vision statement needs to be developed as well as a 1993 or 1994 manual issuance.

- At the least, the current IHS circular on traditional practices can be updated and distributed in all the IHS Areas.

- There is a need for the PHS and the National Institutes of Health (NIH) to adopt a manual issuance.

- Policies should not over-power community needs.

- Review of a new or revised policy should extend to the local level, which includes the IHS Areas, Service Units (SU), tribes, tribal councils, cultural liaisons, and traditional practitioners/healers.

- How to monitor policy? What falls in the IHS policy domain? Accountability issues?

- Talk with interested tribes and tribal medicine persons on how and what they want to do.

- The preamble to health care reform should contain a statement about AI/AN traditional practices.

- It is hoped that this Roundtable Conference will begin the process for traditional healers to work with the IHS.

- Points of Policy:

  - Respect the choice for traditional treatment.
  - Let the traditional practitioners/healers set criteria for service.
  - Include compensation in tribal compacts in order to establish a mechanism for payment.
  - Traditional practitioners/healers need input on establishing payment methods.
  - Treat traditional practitioners/healers as contractors.
  - Provide AI/AN with the best of both worlds for balance and harmony.
  - It is important for traditional practitioners/healers to work with doctors.
  - How can traditional practitioners/healers be appropriately compensated? What is the appropriate compensation?

- The orientation of new employees is very important in understanding the health care system and the AI/AN people:

  - There is a need for a generalized video or presentation that the IHS Areas could make Area specific.
  - For [orientation] videos to work, they should be tribal specific.
  - Orientation should provide for continuing education for non-Indians about Indians.
  - Orientation is needed for the IHS providers to create awareness and become informed about the community, family, individual, and tribal culture.
  - The health providers' orientation should include orientation on the tribe(s).
  - Orientation is needed for Indians (multi-tribal setting) as well as non-Indians.
  - Tribes could develop a video or educational materials for orientation specific to their particular tribe.

- The Self-Determination Act (P.L. 93-638) (hereinafter P.L. 93-638) programs and compact programs have more flexibility in hiring traditional practitioners; the decision would be left up to the tribes.

- The issue of malpractice with traditional practitioners/healers needs to be considered.

- There is a concern that traditional practitioners/healers would not like to be considered contractors.

- Bureaucracy and rigid accountability is out of balance with traditional services.

- When one gets caught up in looking at money, it becomes accountability versus spirituality.

- What we do in the area of traditional medicine should be based on traditional values.

- Working with young people is needed to teach traditional ways.

RECOMMENDATIONS:

1. Define a method to monitor policy implementation and define the limits of accountability.

2. Ensure policy review at local levels to include:

   - IHS Areas/SUs
   - Tribal
     - Councils
     - Cultural liaison
     - Traditional practitioners/healers

3. Further define the legal protection that would be afforded to traditional practitioners/healers (i.e., Federal Tort Claims Act).

4. Inform all the IHS Areas on current policy and direct Areas to begin implementing actions.

5. The IHS SUs and tribal health programs should reassess the patient advocate role and services to include and assure access to traditional cultural practices.

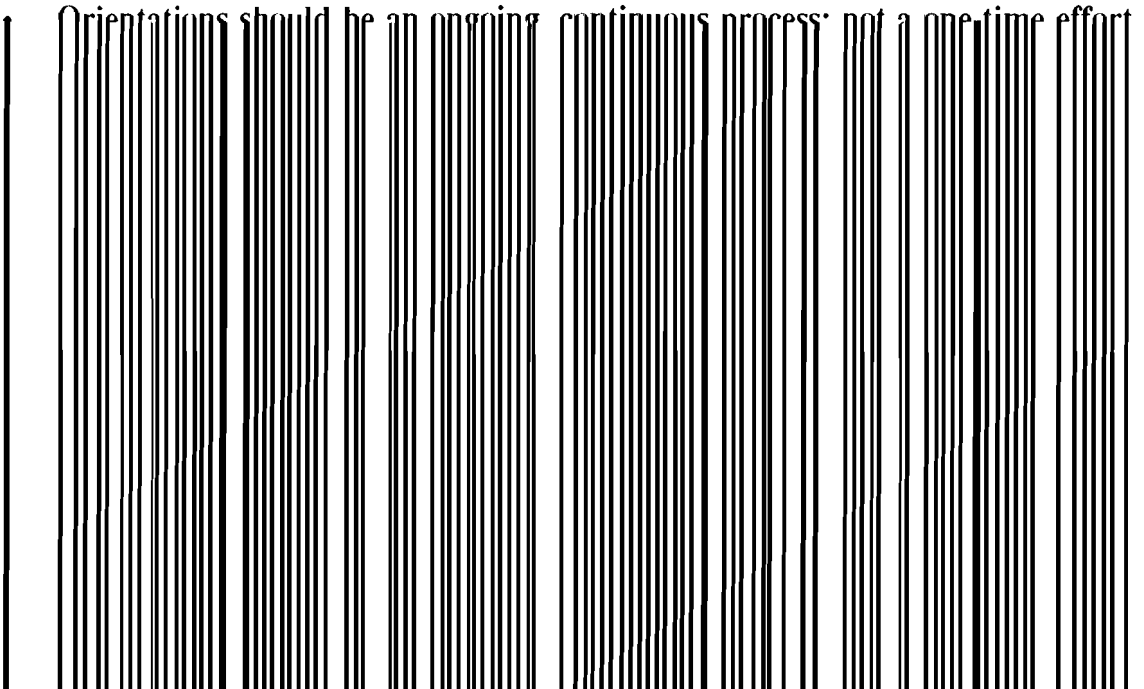
CONSENSUS STATEMENT:

Approaches to achieve a cooperative spirit between traditional beliefs and healing practices with western medical methods:

The key approach to achieving a cooperative spirit between traditional beliefs and healing practices with western medical methods is the commitment and practice of both the western health care providers and the traditional practitioners/healers to work together side by side as peers.

DISCUSSION HIGHLIGHTS:

- The term integrating or integration, in this context, is more appropriately defined as a collaboration or cooperation between the two groups.
- It is critical to involve traditional practitioners/healers at the beginning of a patient's treatment and not as a last resort.
- Education should focus on the total community.
- There is a need for the allopathic providers to endorse practices and behaviors of a "wellness model."
- A liaison is needed between groups such as the providers and the patients, and the traditional practitioners and the non-traditional, or allopathic providers.
- All health care providers need the belief and trust of their patients.
- Considerations for orientation to the IHS, tribal, and contract health care providers:



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- A liaison is needed between groups such as the providers and the patients, and the traditional practitioners and the non-traditional, or allopathic providers.
- All health care providers need the belief and trust of their patients.
- Considerations for orientation to the IHS, tribal, and contract health care providers:
    - Orientations should be an ongoing, continuous process; not a one-time effort.
    - Tribal people need to be involved in developing orientation content.
    - Mutual respect among traditional and non-traditional providers is very important and should be stressed.
    - Include the role and responsibilities of tribal governments and the tribal structure (i.e., tribal chairman or chief, council, medicine people, etc.).
    - Recognize tribal lines of authority.
    - Recognize tribes and tribal representation as sovereign nations.
    - Avoid using only current physicians for orientation presentations to new doctors; new ideas need to be introduced.
    - Provide for continuing education.
    - Do not make the assumption that all AI/AN medical students have sensitivity and knowledge of the AI/AN traditional belief systems.

- Expectations of the IHS health providers:

  - Provide the best health care possible.
  - Access all available resources (e.g., third party payments).
  - Respect the work of others including traditional practitioners/healers.
  - Sensitize all providers to the need for balance and harmony for a persons health and well being (i.e., spiritual, physical, mental).
  - Understand and teach the basics of health - nutritious food, water, and sleep
  - Understand and teach that the best medicine is preventive medicine.
  - Emphasize health maintenance to increase the early recognition of disease.
  - Provide access to traditional practitioners/healers.
  - Work with students to ensure the future quality of health care.
  - Be flexible.
  - Make confidentiality one of the highest priorities.

- Compared to other health care systems, the IHS has one of the best systems in the world.

RECOMMENDATIONS:

1. Expand the mission and goals of the IHS to include availability and accessibility to traditional practices and traditional practitioners/healers.

2. Eliminate barriers and bureaucratic processes that hinder the availability and access to quality health care.

3. Provide opportunities for traditional practitioners/healers and the IHS/tribal staff to work out a plan to achieve good health care by working together.

4. Provide orientation to the IHS and tribal health care providers regarding traditional beliefs and healing practices.

5. Increase the flexibility of the Federal bureaucracy to fit the traditional model.

CONSENSUS STATEMENT:

Common traditional values and beliefs among the AI/AN:

The AI/AN traditions have been in existence for thousands of years and are handed down by each generation through tribal and family rituals, ceremonies, stories, and songs. Although these traditions vary from tribe-to-tribe, there are four common elements that represent the basis of all AI/AN traditions, values, and beliefs. The four elements are: 1) Language, 2) Land Base*, 3) Religion/Spirituality, and 4) Songs/Stories.

*Land base does not only mean a Federal designation but also, and more importantly, the spiritual connection to Mother Earth.

DISCUSSION HIGHLIGHTS:

- Beliefs about creation are central to a spiritual connection and are often included in songs.
- Indigenous people have universal values in common.
- It is important to recognize and respect the fact that a spiritual language exists.
- Everyone has a universal birth right and a universal commonality which includes knowing who we are [as AI/AN people] and knowing our tribal identity.
- Accepting responsibility is part of accepting the traditional way; it is important to remember that what we do affects others.
- Learning occurs from listening to stories and through respect for and participation in family rituals and tribal traditions.
- Honesty is valued.
- The traditional way is:
  - Respect for the knowledge of a traditional practitioner/healer.
  - Power is given by people through their belief.
  - One gives before one gets.
  - People let you know what they need and a traditional practitioner/healer listens.
  - People heal themselves.
- Healthy people are not angry or judgmental.
- Spirit starts at the cellular level and includes earth, fire, water, and minerals.
- A holistic approach is important; this includes the mental, physical, and spiritual aspects of health.
- Traditional medicine [healing] is powerful and represents everything we do and think; all actions and thoughts are prayers and are heard in the entire universe.
- Preventive medicine includes how we think of ourselves and our belief system; it also includes how we treat others, and what we are doing for our children.
- To be whole and healthy, we need to find the strength of our spirit; traditional practitioners/healers know this.
- Each of us have a responsibility to be role models.

- Common values exist in preventive and traditional practices.
- It is important to learn about life and to listen to the teachers in nature.
- Spiritual strength is stronger than our physical being.
- There is the belief that we are entering an age of a paradigm shift, or new model of thinking, which will incorporate an integration of various ways of thinking.
- The meaning of "success" has different meanings between and among cultures.
- Many things cannot be shared in certain settings (i.e., settings where non-traditional people are present and information is being recorded).
- This type of conference may represent only 50 percent of what might be shared in a more appropriate or safe place. There needs to be respect for that body of knowledge that cannot be shared with the general public.
- The traditional way has a learning period (maybe as little as four years to life) that all must go through regardless of "western" credentials (degrees and skills). One must be able to humble oneself and to accept the responsibility that goes with this learning.

RECOMMENDATION:

There is a concern that since there is such wide-spread use of the word holistic, its meaning may be unclear and confusing. Therefore, it should not be used interchangeably with traditional healing.

CONSENSUS STATEMENT:

Research on treatment outcomes of alternative medicine practices:

Any research on treatment outcomes of alternative medicine practices directed toward AI/AN traditional practices should be reviewed by the tribal and the IHS Institutional Review Boards and focused on tribal and IHS programs and activities with available data, information, and outcomes/results, such as community health promotion and disease prevention activities and alcohol and substance abuse programs.

However, the top priorities for all programs and resources directed toward traditional medicine practices and practitioners/healers are AVAILABILITY, ACCESSIBILITY, AND ORIENTATION/EDUCATION.

DISCUSSION HIGHLIGHTS:

- The NIH Office of Alternative Medicine has the responsibility of researching treatment outcomes of alternative medicine practices.
- The IHS research efforts need to be sensitive to traditional needs.
- The word "success" may have a different meaning in the traditional way.
- The "western" thinking of accountability may be inappropriate in the traditional world.
- Many things cannot be shared in certain settings, such as those where information is being recorded or where non-traditional people are involved. There must be respect for that body of knowledge that cannot be shared with the general public.
- Traditional ways are kept in memories and not in written documents.
- Some research on traditional ways has been well received (e.g., Dr. Robert Bergman's study on the Navajo reservation.)
- Any research/evaluation needs to be respectful of the traditional belief system; traditional people will let you know what is or is not appropriate.
- Too much examination in the name of research/evaluation can take away or destroy what is the traditional way.
    - Once you start questioning something, it may not work.
    - Everything we do affects others.
- There may be data that supports traditional healing practices.
- The data available may be derived from program reports in response to scopes of work language that indicate that traditional approaches and/or providers may be used by the health programs. Such language is not uniform from program to program.
- If data [on traditional practices] is being collected, it has not been distributed.
- There is no formalized method of funding traditional health activities by the IHS.
- The IHS has a need for resources for research and research materials.
- The tribes and the IHS need funding for traditional healing activities.

- Evaluation is working well in California's traditional programs and conferences.

- Questions to consider before conducting research/evaluation:

  - What are the things that could/or should be considered when conducting research?
  - What is the most appropriate and effective use of resources?

- The IHS TCAP has ideas on some types of program activities involving research/evaluation.

- There are currently programs in "Indian country" that have data and information on traditional practices.

- Based on past experience, there is a concern that research/evaluation could have a negative effect.

- On the matter of confidentiality, it was noted that research data are subject to subpena and may be reviewed by the courts.

- There is concern that a recommendation to do research may not be appropriate for this Roundtable. Therefore, anecdotal information could be considered satisfactory.

- The IHS, Office of Health Program Research and Development in Tucson, Arizona, and Albuquerque, New Mexico (where IHS data is collected and available) could take a lead on research with the condition that tribe(s) must approve such research.

  - Identify research issues that impact on cultural values, beliefs, and traditional healing practices and do not infringe on traditional ways.

RECOMMENDATIONS:

1. When and where appropriate, the IHS, tribes, and contract health care providers should record all healing services.

2. Consideration needs to be given to the most appropriate methods and form(s) to record traditional healing practices.

CONSENSUS STATEMENT:

The most appropriate format for follow-up to this Roundtable discussion on traditional practices and the Traditional Cultural Advocacy Program:

The momentum begun by this Roundtable discussion must continue through the encouragement and support of open dialogue between the IHS and tribal health staff and traditional practitioners/healers. Given the objective to foster a cooperative spirit between the groups, a series of smaller forums in settings such as the IHS Areas or SUs would better serve this purpose rather than a national forum. In addition, an advisory committee should be established for the IHS TCAP.

DISCUSSION HIGHLIGHTS:

- The California Indian Rural Health Board, Inc., in cooperation with the State of California and tribal councils and committees, have sponsored traditional Indian health conferences and programs for over a decade. The overall purpose has been to address traditional health practices on wellness. They are currently in the planning stage of incorporating continuing education units as credits for health care providers who participate in these annual events.

- The following are keys points made during the California conferences:

  - The gathering (being together) is a healing process.
  - All food is provided by the conference organization to ensure proper nutrition, with an emphasis on native foods.
  - There is an inter-tribal commission to assure the quality of the conferences.
  - Traditional practitioners/healers are always present.
  - The people who attended the conferences have relayed to the Traditional Health Advisory Committee that the conferences were all a success.
  - The sponsors are able to conduct an evaluation that meets all the requirements of their funding agent - the State of California.
  - The IHS has never provided any funding for these conferences.

- The IHS-operated hospitals and the tribally operated clinics are two distinctly different models of health care delivery; the utilization of traditional practitioners within each system differs greatly. This is a possible subject for a future TCAP Roundtable Conference.

RECOMMENDATIONS:

1. The Roundtable participants agreed that there should be additional attention given to follow-up sessions and discussion forums. It was recommended that a number of approaches be considered, such as:

- Convene small groups of traditional practitioners/healers and allopathic practitioners to plan how they may work together.
- Combine efforts at the Annual National Tribal Consultation Conference with the National Indian Health Board (NIHB) taking the lead particularly for review and comment on traditional healing policies.
- Conduct annual or on-going follow-up to this Roundtable.
- Select small group settings in regional, IHS Area, or SU sites.
- Establish an advisory group to the IHS TCAP.

2. The proposed purpose of follow-up to this Roundtable is:

   - Promote ongoing discussions and interaction among the IHS health care providers and traditional practitioners.

3. Other possible conferences in 1994 are:

   - Five Regional Tribal Councils scheduled to meet sometime in 1994.
   - Congressional Subcommittee on National Health Care Reform.

4. The IHS should look into exemptions that will allow support of traditional conferences and other related activities.

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ROUNDTABLE AGENDA
TRADITIONAL CULTURAL ADVOCACY PROGRAM
Tuesday, November 16, 1993
Tucson, Arizona

8:30 am	Blessing	Mr. Emmett White
	Opening Remarks	Mr. Richard Ramirez
	Introductions	Mr. Leo J. Nolan
9:15 am	Review Agenda and Roundtable Objectives	Ms. Tonya Parker
9:30 am	Roles and responsibilities for integrating AI/AN cultural values, beliefs, and traditional healing practices into the AI/AN health care system (hospitals, clinics, and communities) of:	
	• IHS **Discussion Leader**	Dr. Lois Steel
	• Traditional Practitioner **Discussion Leader**	Mr. A. Paul Ortega
10:30 am	BREAK	
	• Tribal Leaders and Health Staff **Discussion Leader**	Mr. Gordon Belcourt
	• Community members/patients **Discussion Leader**	Ms. Lisa Tiger
12:00	LUNCH	
1:00 pm	IHS policy to support and advocate the integration of AI/AN cultural values, beliefs, and traditional healing practices into the AI/AN health care system (hospitals, clinics, and communities).	
	• Current National Policies and Practices **Discussion Leader**	Dr. Craig Vanderwagen
	• Needed IHS Policies Area Perspective **Discussion Leader**	Dr. Francis Owl-Smith

ROUNDTABLE AGENDA
TRADITIONAL CULTURAL ADVOCACY PROGRAM
Tuesday, November 16, 1993
Tucson, Arizona

Afternoon Session: Continued

3:00 pm BREAK

3:15 pm IHS policy to support and advocate the integration of AI/AN cultural values, beliefs, and traditional healing practices into the AI/AN health care system (hospitals, clinics, and communities).

- Needed IHS Policies
  Tribal Perspective
  Discussion Leader ..... Ms. Jeannie Lunsford

- Needed IHS Policies
  National Health Organization Perspective
  Discussion Leader ..... Mr. Gordon Belcourt

4:30 pm Review Day's Accomplishments and Wednesday's Agenda

Discussion Leader ..... Ms. Patricia Parker Levi

5:00 pm ADJOURN

ROUNDTABLE AGENDA
TRADITIONAL CULTURAL ADVOCACY PROGRAM
Wednesday, November 17, 1993
Tucson, Arizona

8:30 am	Open Session and Blessing ..... Mr. Emmett White
9:00 am	Discussion and Identification of Traditional and Holistic Beliefs
	• Traditional Values and Beliefs Generally Viewed as Common Among AI/AN **Discussion Leader** ..... Mr. Emmett White
	• Approaches to Integrating Traditional Beliefs and Healing Practices with Western Medical Methods **Discussion Leader** ..... Dr. Roger GrayEyes
10:15 am	BREAK
10:30 am	• Traditional Solutions for Coping with Today's Problems **Discussion Leader** ..... Ms. Marilyn Youngbird
12:00	LUNCH
1:00 pm	Development of a National Conference. Define a Purpose and Objective for a Conference of National Scope.
	• Previous Conference Achievements and Future Needs **Discussion Leader** ..... Ms. Linda Navarro
	• Develop Conference Purpose and Objectives Recommendations **Discussion Leader** ..... Dr. Everett Rhoades
3:00 pm	BREAK
3:15 pm	Review Consensus Statements on all Key Issues **Discussion Facilitator** ..... Ms. Patricia Parker Levi
4:30 pm	Review and Summary Roundtable Accomplishments **Discussion Facilitator** ..... Ms. Tonya Parker
5:00 pm	BLESSING AND ADJOURNMENT

ATTACHMENT A

PARTICIPANT COMMENTS

GORDON BELCOURT

1. There are 510 sovereign nations defined by treaty/statues.

2. Traditional health practices and practitioners are defined by each of the 510 sovereign nations.

3. Traditional health practices can exist separately or integrated as defined by each tribe.

4. In a separate or integrated model of health care, the western health providers and traditional health practitioners are peers.

5. In an integrated health model, the western health care model will not continue to assume preeminence over tribal-specific health models.

6. Each tribe defines the boundaries of its traditional health care model, certifies the components of its traditional health care model, and certifies its traditional health care practitioners.

7. Tribal traditional practitioners define the level, extent, and integration of their role in separate or integrated health models of Indian health care and traditional health practitioners.

8. Each tribe needs to establish traditional health practitioner apprenticeship programs in partnership with the IHS.

9. Each tribe needs to develop tribal-specific needs assessments in providing traditional health care models.

10. Each tribe needs to conduct a resource inventory of all elements necessary for their definition of a traditional health care model.

11. Each tribe must take responsibility to orient/educate Indian health care professionals and tribal health professionals on their traditional health care model.

12. Tribal specific health plans should be updated and integrated into tribal long-range plans, especially as it pertains to traditional health care models in existing IHS and tribal programs.

13. The 1979 IHS circular needs to be updated and elevated to manual issuance status. Provisions and plans should be developed to provide contingency efforts to further

elevate to general regulation or law status by each tribe working in concert with all 510 tribes.

14. All sacred geography needs to be protected and set aside for traditional health programs for relevant tribes as a precursor to traditional health.

15. Traditional tribal practitioners need to be protected by the Federal Tort Claims Act in all situations in which tribally-recognized traditional health practitioners are providing services.

16. A national conference on traditional health practices needs to be convened.

17. The consensus statements developed from this Roundtable should be conveyed to the following forums:

    - Quality Management Consultation
    - Quality Management Restructuring
    - National Health Care Reform
    - National Congress of American Indians
    - National Indian Health Board National Consumer Conference
    - The IHS National Consultation Conference
    - The IHS Regional Meetings

18. The IHS mission statement needs to be revised to incorporate traditional health care principles.

19. The 510 tribes need to develop a position of the treaty/statutory obligations of the Federal Government to provide the highest quality of care to the AI/AN including traditional health care principles.

20. Separate and integrated health care models need to address tribal specific concerns on providing health care to 510 tribes. These concerns can address, but not be limited to the following:

    - Births
    - Deaths and dying
    - Laboratory specimens
    - Amputations
    - Transplants
    - Disaster drills as prophesy
    - Organ donations
    - Abortions
    - Service to elders

21. All Federal legislation affecting the 510 tribes and health care delivery should incorporate principles and consensus statements derived from this Roundtable.

22. Tribal-specific sacred objects must be returned to each tribe through legislated repatriation legislation, so that they can be re-integrated into traditional health care models for each tribe.

23. The IHS must subscribe and honor all provisions of P.L. 95-341, as amended.

24. Traditional health care practitioners must be certified eligible for IHS compensation under contract health services.

25. Each of the 510 tribes can maintain, acquire, and re-acquire traditional health care principles and practitioners from the Creator in the manner it was acquired in the beginning.

26. This Roundtable subscribes to the implementation of an IHS/tribal model of permissive national policy development on traditional health care in a separate or integrated tribal-specific model.

27. Traditional health care practitioners must be compensated in parity to western trained health care professionals.

28. Traditional tribal practitioners shall not be required to provide job descriptions or to divulge traditional tribal practices when in conflicts with their traditional teachings and prohibitions.

29. We should revisit the following demonstration models of traditional health care training:

    a) Dr. Robert Bergman
    b) Association of American Indian Physicians Traditional Medicine Clerkships

30. All the principles above should be integrated in the core benefit package to be mandated by national health care reform for Indian health care. Contingency plans should be developed for inclusion of these principles in the national health care reform wrap around.

31. The IHS and traditional health practitioners should promote a consensus model of bio-ethics for separate or integrated models of health care on the 510 AI/AN.

32. The 510 tribal-specific nations should be allowed to provide oversight and approval of all IHS sponsored health research affecting their people and nation.

33. Traditional health practitioners should be allowed to participate, direct, recruit, orientate, train, and retain all health care providers in separated or integrated health models.

34. The IHS and 510 sovereign nations will identify and document successful models of traditional health care.

35. All the AI/AN must have access to traditional health care and traditional health care practitioners.

36. The IHS/tribal programs must provide facilities/support for traditional health programs and traditional health practitioners.

37. A tribal-specific patient bill-of-rights must be developed for the IHS and tribal health systems to integrate traditional health practices.

38. Provide full and adequate funding for all components of the IHS to provide access to traditional health care providers at all levels pursuant to the care-benefit package under national health care reform and traditional health programming.

39. All components of the IHS and tribal health care delivery systems will treat traditional health practitioners and tribal patients requiring their unique services with dignity and respect.

40. The IHS/tribal health delivery systems will provide flexible and liberal ceremonial and traditional health leave policy for the IHS/tribal employees either accessing or servicing as a resource in traditional health services.

41. All components and levels of the IHS will develop, implement, and foster central office, Area, and SU policies and procedures on traditional health practices and practitioners pursuant to tribal-specific input.

42. Each of the 510 sovereign nations may change tribal constitutions to incorporate specific language on traditional health practices and practitioners.

43. Each of the 510 sovereign nations must define enrollment criteria as tribal members and by extension, this criteria must apply to services rendered by the IHS and tribal health programs in separate or integrated models incorporating traditional health care principles.

44. Each of the 510 tribes will initiate language/history program, local re-acquisition programs, facilities construction, and resource inventories as precursors to traditional health care models.

45. All national and international museums and repositories must transfer and repatriate tribal human remains and spiritual objects back to each tribe as precursors to tribal special traditional health care models.

46. Wellness and disease principles as they apply to each of the 510 sovereign nations incorporates definitions and plans that addresses the health status of the individual in his/her family, extended family, clan, and tribe.

47. The role of the Federal Government in health care is mandated by treaties/statutes; the role of state government in health care for each of the 510 tribes must be analyzed in a Federal forum.

ROUNDTABLE ASSUMPTIONS

- We can speak and reference any input only as members of our own specific tribe.
- We speak as individual survivors and owe our existence to our ancestors.
- We came together as a race called AI/AN to affect positive change especially as it impacts on traditional health care models and encourages traditional health care professionals to assume their traditional role of community, family, and individual healers.
- Western health care and its practitioners must affirm parity/equity for traditional health care and its practitioners.
- All powers of healing in a traditional health model are derived from the Creator through the traditional health care providers.
- The power of healing of the traditional practitioner is enhanced by his/her helpers, family, extended family, clan, society, and tribe in a ceremonial or ritual setting.
- Health care services in separate and integrated models are not free; they are manifestations of the culture and are guaranteed by treaties/statutes. These guarantees have been reinforced by the fact that AI/AN veterans have served in wars, police actions, and international conflicts for years.
- The IHS and Indian health care has set the goal of providing the highest possible level of health care to the AI/AN.
- Each of the 510 tribes must define its health care model and the role of traditional health care and its practitioners.
- Language re-acquisition, land re-acquisition, protection of sacred geography, tribal-specific resource inventories, repatriation of tribal human remains, repatriation of sacred objects, and tribal history projects all serve as precursors to incorporating traditional health principles and utilizing traditional health practitioners.

- The IHS/tribes need dialogue and planning to insure and assure that traditional health practitioners can transfer their knowledge, wisdom, rights, and authority to younger tribal members.

- The Department of Health and Human Services (DHHS)/PHS/IHS must issue mandatory participatory regulation on traditional health care models, such as "manual issuances, administrative regulations, and/or Federal law."

- We must respect and honor each other; by working with traditional health practitioners, we must pray for each other, our families, our tribe, and our people in healing ceremonies and rituals.

- Mother Earth must not be exploited; the harmony, behavior, and respect of traditional health practitioners must be maintained. Certain animals such as the grizzly bear, eagle, buffalo, etc., cannot be sold or exploited as precursor to traditional health care models and to empower its traditional health care practitioners at the tribal level.

- Traditional health practitioners can only be identified by the tribe through its elders and cultural people.

- We must protect and nurture our traditional health practitioners and traditional health practices at the tribal level.

- The nature of traditional health practitioners and tribal-specific health practices is that it has no goal to attract or convert people. Traditional health practitioners will usually stay in the background and will not define their role or reality without being approached with respect, honor, and dignity.

- There are specific times and seasons in which traditional health practitioners are the strongest and can provide strong healing ceremonies. This can be after the first thunderstorm or on a high point, such as a hill or a mountain. This is a precursor to traditional health practices.

- When westerners arrived, they promoted a series of paradigm shifts such as ownership for the land, dominion over Mother Earth, spirituality which they called organized religion, government, and health care. We need to balance these new paradigms with traditional tribal views and its practitioners.

- There are tribal-specific commonalities and differences between the western health care system and the traditional health care model. This must be explored by practitioners from each discipline:

    - Births
    - Deaths and dying
    - Laboratory specimens

- Amputations
- Organ donations/transplants
- View of the world
- Prophesy
- Good medicine/bad medicine
- Role of objects for healing
- Abortions, miscarriages, etc.

- A forum for a national, regional, Area, or local dialogue is encouraged between the practitioners.

- The IHS and traditional tribal health practices are the primary health care principles as defined by treaty/statute and culture of the tribe.

- Some western health care practices can be destructive to the traditional health care practices of the tribe such as nursing homes, which takes/reinforces the responsibility of taking care of our elders on the state.

- The well-being and health status of individuals.

- Tribes can acquire, re-acquire, and maintain traditional health practices and practitioners, as it is appropriate to the practices of each tribe through the following:

  - Oral knowledge/wisdom
  - Transfer of knowledge/wisdom
  - Ceremonies/rituals
  - Prayers/songs
  - Sweat lodges/Sun Dances
  - Bundles/sacred objects
  - Sacred geography
  - Vision quests/fast
  - Prophesy/elders
  - Medicine people

- The IHS must provide a nurturing and conclusive environment for traditional health practices and practitioners at all levels, especially at the local or SU level.

- The IHS must obey the treaties, laws, statutes, regulations, and circulars as it pertains to health care and the incorporation of traditional health care and its practitioners (e.g., P.L. 95-341, as amended).

- National Indian organizations such as the NIHB must take responsibility to assure that all principles of traditional health care are incorporated into the IHS and National Health Care Reform based on the principles of Indian Self-Determination of each of the 510 sovereign nations and tribes.

- All discussions on traditional health practices and practitioners should be conducted in a traditional setting at the national, Area, and local tribal levels. This dialogue should include the following processes which is based on a traditional model of the Blackfeet Tribe; each tribe will have its' own protocol.

    - Call together with tobacco
    - Prayers/songs
    - Dialogue/plans
    - Gifts
    - Meal
    - Acknowledgements
    - Speeches
    - Farewells

- We need a consensus from traditional health practitioners on how to deal with "false" medicine men. The 510 tribes may need to acknowledge their own medicine people.

Summary of the IHS policy on traditional beliefs and practices:

In June 1993, the OHP initiated a project to collect all current policies pertaining to traditional healing from each IHS Area Office and SU. The majority of the Areas stated that they had no formal policies. However, each IHS administrator responding to this inquiry stated respect for the patients' beliefs and traditional healing practices. Occasionally, there were references made regarding traditional beliefs in other policies (e.g., leave policy). The IHS Navajo Area was the exception because they had up-to-date formal written policy guiding the use of traditional healing methods and traditional practitioners. They also provide space in some of their facilities.

The following is a summary of the information collected from the OHP inquiry:

Aberdeen Area IHS:

- There is no formal Area policy regarding P.L. 95-341. However, they have leave policy that:

  a) Provides a liberal leave policy when leave is requested for the participation in traditional tribal treatment.

  b) Policy that allows the use of sick leave to receive treatment by traditional tribal methods.

Alaska Area Native Health Service (AANHS):

- There is no formal policy in place.
- The general policy of AANHS is that they have been funded for a program of "western medicine" and that resources have not been adequate to meet the demands for such care.
- The AANHS includes a P.L. 93-638 program, Maniilaq Medical Center in Kotzebue, Alaska, that offers traditional healing services to supplement western medical treatment.

Albuquerque Area IHS:

- The Albuquerque Area has no formal policy.

- The informal practice is that patients may make their own arrangements with medicine people, while the patient is in the IHS facility. In addition, space is made available when requested and possible.

- Most patients seek traditional treatment outside the Albuquerque IHS facilities.

Billings Area IHS:

- The Billings Area has no formal policy.

- All SUs have informal methods of interacting with the practice of traditional medicine. The SUs have said they have identified a need for policy and are in some stage of establishing needed policies.

Nashville Area Office (NAO) IHS:

- In the one IHS facility in the NAO, there is no formal traditional healing policy. However, the following statements are in related policy:

  a) Stated in the policy on the spiritual needs of patients is the statement: "traditional healers are welcome to visit . . . a chapel is available for services for any denomination to hold services."

  b) In the NAO, policy regarding identification and referral of organ tissue donor is the statement: "NO policy will be established by the Cherokee Indian Hospital which contradicts the cultural beliefs of the Eastern Band of Cherokee Indians."

Informal procedures:

- Consideration for traditional medicine is an individual patient's choice and can be used in the hospital with physician signature.

- In the NAO, there is a Regional Youth Treatment Center (RTC) that has formal written policies regarding AI/AN spirituality. The RTC also operate sweat lodges.

Navajo Area IHS (NAIHS):

- The Area referred to the Health, Education, and Welfare (HEW)/IHS policy developed and signed by Dr. Emery Johnson, the former Director, IHS.
- Written SU policies are in place in the:
  Chinle SU
  Crownpoint SU (Revised 02/91)
  Chinle and Crownpoint have Patients Bill-of-Rights (Revised 10/91) that includes reference to Indian culture and traditional religious beliefs, and native healing.
- Chinle and Crownpoint have a room set aside for traditional healers. The new Shiprock hospital will have a community-built hogan next to the facility for ceremonial use.
- A good working relationship was reported between the IHS staff and traditional healers.
- Patients are commonly referred back and forth between both provider groups.
- Traditional healers frequently do bedside ceremonies.

- Most SUs have a section on traditional healing in their Patient Rights and Responsibilities Policy.

Tucson Area IHS:

The Sells SU has policy that includes:

- Rights and Responsibilities of Patients Respect and Dignity - the statement . . . "care includes consideration and respect for Indian heritage and culture, religious beliefs, customs, and traditions."

- Policy and procedures spiritual needs of patients - its stated purpose is to ensure that the spiritual needs of Sells SU patients are met, including making available (contacting) a traditional healer, when requested.

California Area IHS: No information is available.

Oklahoma Area IHS: No information is available.

Phoenix Area IHS: No information is available.

Portland Area IHS: No information is available.