THE INTERACTION BETWEEN TRADITIONAL MEDICINE
AND THE INDIAN HEALTH SERVICE ON THE NAVAJO
RESERVATION

by

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I. INTRODUCTION

A. Background and Description

In 1954, the federal government transferred responsibility for Native American health to the United States Public Health Service (USPHS), establishing the Indian Health Service (IHS). Prior to this change, the Bureau of Indian Affairs had administered medical services for Native American tribes. At that time, the main challenges to Navajo health resembled those facing most other tribes: tuberculosis was epidemic, severely overtaxing the existing facilities; and infant diarrhea was primarily responsible for an infant death rate over four times higher than that of the general population (Adair et al. 1988: xii). In 1950, there were six hospitals, and sixteen physicians on the Navajo Reservation, serving a population of over 60,000 people (Iverson 1982: 65; Kunitz 1989: 40). Physicians during that period were often contemptuous of both traditional healing, and lifestyle differences between themselves and their patients. The resulting atmosphere of antagonism lead to problems of low utilization of existing services, and skepticism about the recommendations of Anglo physicians.

When the IHS assumed responsibility for Navajo medical care it rapidly began to build a more extensive system of hospitals, clinics, and providers. In 1952, a team of researchers from Cornell medical school began working on the Reservation to try to find more effective ways of delivering health care. The IHS granted the Cornell team funds to develop a model health clinic for this purpose. The clinic was built at Many Farms, in the central region of the Reservation, and operated from 1955 to 1962. Until then, the efforts to provide health care had been primarily directed to controlling and treating the major diseases which troubled the Navajo population, with little attention directed either to prevention or to the cultural acceptability of the services. The Cornell team, which included physicians, nurses, and anthropologists, endeavored to create a more effective model of health care delivery, based on
placing more emphasis on preventive care, and tried to generate an atmosphere of mutual respect and better understanding between the Anglo providers and traditional healers and Navajo patients (Adair et al. 1988: xii-xiii). Aside from a philosophy of acceptance and respect for people's traditional beliefs and practices, the primary innovation employed by the team entailed "cultural interpretation" by the anthropologists. This approach was intended to help physicians and nurses in understanding their patients' concerns, as well as to find ways of making biomedical information more "culturally palatable" to Navajo patients (Adair et al. 1988). Though the relationship between the Navajo people, traditional healing, and the IHS has undergone many changes since that time, the IHS has for the most part attempted to maintain the general atmosphere of respect begun during the tenure of the Many Farms clinic.

The IHS continues today as the primary source of medical care for Navajo people, who now number over 200,000. The services available to Navajo people through the IHS include primary medical care, dental care, mental health and substance abuse counseling, nutrition, public health nursing, community health nursing, and environmental health nursing. (Haraldson 1988: 135). Additionally, the Health Promotion and Disease Prevention program (HPDP) attempts to develop community interventions to cope with the current health problems.

Like other remote rural areas, reservations face a challenge in recruiting physicians and nurses. In an effort to ameliorate the shortage of providers, the IHS offers several loan forgiveness and scholarship programs. In general, these programs give students scholarship funding or loan payback benefits in exchange for working on the reservation; participants are generally required to work for at least two years in an IHS service area, for which the USPHS provides two years of scholastic support in exchange. For health care providers this offers not only the benefit of financial assistance with educational expenses, but also a chance to work with a Native American culture to sharpen both medical and cross-cultural communication skills.
However, although some providers choose to remain in the IHS for a more extended period of time, most will leave within four years. The net result is that the majority of physicians on the Reservation have relatively little experience or knowledge of Navajo culture or traditional belief systems.

Despite the centuries of assault by Anglo society, Native American religion and traditional medicine remain an integral and active part of life for many Navajo people. Thus, health care providers trained in the belief system of biomedicine face a challenging situation in which their patients come from an entirely different cultural background, and often hold vastly different views of health and illness from their own. Complicating this challenge is the multitude of religious and educational influences which have produced a complex, heterogeneous mix of Christian and traditional religious affiliation, and widely varying levels of education and degrees of assimilation into Anglo culture. Thus, a provider cannot make the anachronistic assumption that his/her Native American patients hold uniformly traditional beliefs, nor can s/he assume that these beliefs do not inform the health care choices patients make, and their interpretation of, and confidence in, medical information. Compounding the difficulty is the fact that the centuries of mistrust, equivocal and dishonest support by US agencies, and the short tenure of most non-native providers on the Reservation lead many patients to feel extremely protective of their privacy, and therefore less likely to discuss their beliefs openly with an Anglo provider.

This thesis will entail a descriptive analysis of this complex interaction between traditional and biomedical systems of health care. The Native American Church (NAC) and Christian faith healing have become increasingly important contributors to the health care available to Navajo people. These systems will also be discussed where relevant, in order to put the relationship between IHS and the Navajo traditional healing system in a context which more accurately
reflects the experience of patients and providers on the Reservation. First, I will explore the institutional framework underlying the interaction between the IHS and traditional medicine. This section will include topics such as formal aspects of the IHS relationship with traditional healers; cultural orientation programs for newly arrived providers; and attempts to incorporate traditional values and health care into the programs funded through the IHS. At a more personal level, I will consider the perspectives of individual providers -- both IHS physicians and nurses, and Navajo medicine people -- on the challenges involved in trying to provide effective health care to people with a broad spectrum of beliefs and values. I will also incorporate discussions with several patients regarding their experiences using each system and their feelings about combining health care practices based on two very disparate models of health and illness. Informing this discussion will be a framework, derived from critical medical anthropological theory, for analyzing the interaction between biomedical systems of health care and other cultures and their healing systems.
B. Methods

I gathered information for this thesis from several sources. First, a review of literature provided material for the following chapter, in which I draw primarily on written information about the Navajo Tribe as well as theories of cross-cultural health care and critical medical anthropology, to provide both a background understanding of the context of health care and a theoretical basis for understanding the relationship between the IHS and traditional medicine. Second, I had the opportunity to discuss health care in informal conversations with a number of Navajo people, most of whom were IHS employees, and some of whom were community members with no ties to the IHS. Finally, I conducted formal interviews with patients (4 participants), biomedical providers (4 physicians; 3 public health nurses), and healers (1 herbalist; one NAC "roadman"). The majority of these conversations and interviews took place in Crown Point, on the Eastern edge of the Reservation; additional interviews were conducted in Chinle, which lies in the heart of the Navajo Reservation.

I developed separate sets of questions for the interviews with patients and providers. Instead of rigidly applying each set of questions to each interview, I used the questions as a guide to discussion. Often, a participant's response would lead to questions or discussion outside of the basic structure of the interview. However, the questions were organized around several basic subject areas, all of which were addressed at some point during each interview. The areas I chose to discuss were intended to form an overview of the thesis topic. Patients and providers often raised concerns and issues outside of my original interview framework, and I will include those in my discussion and analysis. At other times the questions considered to be important drew little response from participants; I will discuss this lack of response to some questions as a significant result in itself.
For the patient interviews, I focused on the following general areas of discussion. (1) I asked patients how they made decisions regarding the type of health care sought for a particular problem. (2) I asked them whether the differing explanations of illness and healing have generated conflicts for them, and how they try to rectify these very different portrayals of disease causation and the mechanisms of healing. (3) I asked people if they have found their providers to be sensitive to and knowledgeable about Navajo culture and beliefs systems, and how important they feel the providers' cultural sensitivity is to their interaction with him/her. (4) Finally, I discussed the practical barriers such as transportation and finances which might impact on decisions between traditional healing and biomedicine.

Questions for the provider interviews were drawn from the following general areas. (1) I asked how the patients' culture and belief systems affect or change the ways the provider's way of communicating and practicing medicine. (2) As a subset of (1), I discussed what providers do when they can tell there is a conflict between a patient's belief system and their own understandings of illness and methods of curing. (3) I asked how each provider views his/her role in providing health care to Navajo patients, and how s/he views the role of traditional medicine.

All but one of the interviews were conducted in English. In my interview with the Navajo herbalist, an IHS employee served as a translator. The translator later told me that because my questions had been somewhat abstract, they were very difficult to translate directly, and she had frequently had to give the healer example situations to try to explain the content of my questions. As a result of this difficult, multi-step communication process, this interview addressed fewer of the core issues than I had hoped. Nevertheless, the results will be included where they contribute to the discussion.
My intent in analyzing responses from the formal interviews has not been to demonstrate or "prove" a specific result or conclusion. Rather, I have used comments and issues raised in these interviews to form the basis for a discussion of the conceptual context of providing biomedical care to a population with a powerful and extensive traditional healing system, and of obtaining care where there are two well-developed and accessible systems of health care to choose from.
II. NAVAJO TRIBE

A. The Dine — a Brief Introduction to the Navajo People

The purpose of this section is twofold. First, it is intended as a general introduction to the people and their culture and environment. Second, it will provide an overview of the impact of the societal, cultural, and environmental influences on Navajo health.

1. History

The Navajo people -- known as the Dine in their own language -- are thought to have immigrated to the southwestern US in the fifteenth or early sixteenth century. Because their language is closely related to the athabascan language group, they are thought to have migrated from tribes in Canada and Alaska. While the date of their arrival in the southwest is somewhat speculative, their initial contact with Europeans can be traced to the early sixteenth century, based on records from Franciscan missionaries in the area (Iverson 1981: 3). Initially, they were located in North central New Mexico, but they gradually migrated south and west into Arizona, finally settling in a diffuse area around Canyon de Chelly, in Arizona (Kunitz 1989: 26-27). The next two hundred years, from the period of initial contact with Spaniards to 1846 until the arrival of English-speaking Americans in the area produced enormous changes in the lifestyle, demographics, social structure, and culture of the Navajo people. The Pueblo tribes, inhabitants of the area long before the Navajo entered the southwest, were predominantly sedentary agriculturists. By the time of initial contact with Europeans in 1626, the Navajo had adopted a similar lifestyle, with agriculture forming the foundation of their subsistence. However, they also achieved a reputation as raiders, and there are common historical references to Navajo raids on Spanish camps and the Pueblos for food, livestock, and horses.

In the early 1700s, Navajo people began herding sheep and goats, and to a lesser extent cattle
and horses. Weaving also became important to the Navajo during this period, probably introduced through contacts with the Pueblo groups.

Contacts with Europeans increased gradually until the beginning of the "American Period" -- which began with the arrival of the English-speaking Anglos in the middle of the nineteenth century. By this time, trading of woven materials and livestock sales contributed significantly to the economy, although agriculture remained the staple (Kluckhohn and Leighton 1974). The US assumed control over the region in 1846, after the Mexican War. By the early 1850s the US had built Fort Defiance, which lay in the heart of Navajo territory. Occupying a site near Window Rock, this fort became a point of major contention between Navajo people and the US government. Also contributing to escalating tensions between Anglos and Navajos during this time, the Navajo raids continued, and the federal government's reprisals became increasingly brutal. In this atmosphere of hostility, the leaders of the Tribe planned a massive attack on Fort Defiance, with the intent of removing the US from their land. In April, 1860 over 1000 Navajos attacked the Fort. The effort was unsuccessful, and sparked the fury of the troops in the area. The military soon began to run rampant over the region, murdering Navajos and destroying crops and property. In the winter of 1862 Colonel Kit Carson led a campaign to remove the Mescalero Apaches and the Navajos from their homelands, and relocate them over 300 miles to the south, at Fort Sumner in the Bosque Redondo area of New Mexico. Now known as the "Long Walk" period, both the trip itself and the life the people led in the ensuing years became one of the most traumatic and most significant landmarks in the history of the people. Over 8,000 Navajo people made the exhausting trip during the two years following Carson's campaign. An unknown number of people remained behind by retreating farther into remote mountains and canyons, but the majority of Navajos relocated. The conditions at Fort Sumner proved to be horrendous. Under the leadership of a General named Carleton, the people lived in cramped and unhealthy conditions, suffering from diseases, hunger, and
homesickness. Up to 3,000 Navajos were illegally kept as slaves by politicians and military officers during this period (Terrell 1970: 184). Carleton's desire was that the Navajo should learn to live content, Christian lives. His experiment in socialization proved tremendously costly, both in government funds and Navajo lives. In 1868 federal support was withdrawn because of the expense and tremendous problems which plagued Carleton's project.

Upon termination of their incarceration at Fort Sumner, the government allotted the Navajos three and a half million acres in their homeland -- a far smaller area than they had left. The government also aided their return, and provided some sheep and goats to help families start their lives over. By the end of the Bosque-Redondo tragedy, over 3,000 Navajo people had died. While this experience served to introduce the people to Anglo ways in a much closer and more organized manner than their previous contacts had provided, it also deepened their connection with and reliance on traditional religion, which had been an indispensable source of strength during their incarceration, and their unity as a tribe (Aberle 1982: 24-25; Iverson 1981: 9-13).

The next decades brought relative prosperity, with large increases in the size of herds, and a tremendous growth in the population. The area of the Reservation also increased over this time. Although the battle for more land was sometimes very difficult, this period was characterized by a relative wealth of resources and land. By 1880, just twelve years after their return, the population had grown to over 15,000. Over the next 40 years, the growth rate averaged 1.5-2.5% per year (Kunitz 1989: 31).

Growth in stock was similarly rapid. Warnings about overgrazing came as early as 1883, but no federal efforts to deal with this problem occurred until nearly fifty years later. The grazing land on the Reservation deteriorated due to soil erosion and consequent depletion of the water
table, leaving a once fertile and productive region barren. By 1930 the problem had become severe, and the federal government began to consider a mandatory reduction in stock. In 1933 John Collier, the new head of the Navajo Indian Service, the federal government's agency in charge of Navajo relations, began the now infamous Stock Reduction program. For many people, this decision came without warning, and it seemed to have been conceived with little planning or care. Collier proposed federal compensation for the sheep, but the government would not buy the goats taken from Navajo herds, because the meat could not be sold or used even to feed people on federal relief. Compensation in other forms, such as schools, water programs, and land, was also offered, but very few families felt that their losses had been adequately recovered through these measures. The blow was spiritual as well, as the sheep and goats represented far more than simple economic assets for people who lived, raised, and derived sustenance from these animals for so long. Over the first year stock were cut by 8%. By 1936, stock had been cut by over 200,000 animals, but this still fell short of the government's original goal of reducing holdings by 50 percent. Many of the sales and government dealings over this time were badly mismanaged, which lent to a general atmosphere of mistrust and anger over the government's actions (Aberle 1982: 52-64).

Despite the job programs and mandatory compensation, Navajo income actually decreased steadily over the next decade, owing both to Stock Reduction and to decreasing wages from the government. Stock Reduction continued as a part of Indian Service policy through the 1950s. The chairman of the Tribal council from 1946 to 1954, Sam Ahkeah, said that Stock Reduction had been "the most devastating experience in Navajo history since the imprisonment at Fort Sumner." (Iverson 1981: 23).

Stock reduction was not the only significant event in Navajo life during this time. Thousands of Navajo people participated in World War II, both in combat, and in war-time production in
the US. The "Navajo Code Talkers" earned the Tribe recognition and appreciation for their role in helping to maintain military security. The Navajo involvement in the War also speaks to the general tone of this period, which was characterized by increasing and diversified contacts and ties with the "outside" world, new sources of income such as oil, coal, and forestry, and an increasingly sophisticated and complex tribal government. Iverson labels the decades of the 1940s and 1950s as the period when the "Navajo Nation was born," (Iverson 1982: 82) referring to the changes which brought about a diversified economy, increased independence from the federal government, a sophisticated and strongly independent Tribal government, and improvements in health and education. But the end of the war brought a new round of problems for the Navajo people. "Severe weather, the return of large numbers of discharged veterans and unemployed workers, and the cessation of soldiers' allotments and migrant workers' remittances brought about an economic disaster requiring emergency relief" (Kunitz 1989). These conditions prompted the passage of the Navajo-Hopi Long Range Rehabilitation Act by congress in 1950, which authorized funds for the construction of schools, health care facilities, roads, and general stores, with the hope that this boost would eventually lead to financial independence for the Tribe, and termination of the Federal Government's fiscal responsibility. (see also "Economic History" below).

The social movements of the 1960s brought changes to the Navajo Nation as well as the US in general. The tribal chairman, Raymond Nakai, took advantage of the Lyndon Johnson's War on Poverty to develop the Office of Navajo Economic Opportunity. The ONEO used funds from the federal government to attempt to "revitalize Navajo life at the local level." (Iverson 1981: 90). These programs served many Navajos through "home improvement training, Navajo Culture Center, Neighborhood Youth Corps, Head Start" and other community-based programs. Also in the 1960s, Nakai's administration actively sought to bring jobs and industry to the Reservation. The natural resources on Navajo land began to be exploited in earnest
during these years. The tribal council signed leases with the Utah Mining and Manufacturing company and the Peabody Coal company in 1961, opening large areas of Navajo land to strip mining and power production. An ironic symbol of the contradictions between traditional values and life in the "outside world," the Four Corners power plant belched so much smoke that it became the one Man-made creation visible to Astronauts orbiting the earth (Iverson 1981: 106). And while the development of coal and oil brought tremendous financial gains for the Tribe, there was also concern that these corporations were exploiting Navajo people at a tremendous profit.

However, during the 1970s, what had started to seem like another instance in the long history of duplicitous interactions and exploitation of Navajo people by various US interests became the focus of the Navajo Nation's emerging autonomy and nationalistic pride. In 1970 Peter MacDonald became the new tribal chairman, elected on a platform of increased Navajo control over their resources and affairs. He soon became a nationally known symbol of outspoken advocacy for his people. He was perhaps best known nationally for his work on the development of the Council of Energy Resources Tribes (CERT). As its founder and chairman, he led this group on an outspoken campaign to develop natural resources in a way which would most benefit Native peoples. He went as far as threatening to approach OPEC, until the federal government gave in and began to negotiate seriously.

In the late 1970s, charges were brought against Peter MacDonald for misuse of federal funds (Iverson 1982: 205). He was exonerated of these charges, and, despite considerable damage to his political reputation, he went on to lead the Tribe throughout the 1980s. However, in 1989 he again faced charges, this time including embezzling Tribal funds, bribery, and inciting a riot after his removal as tribal chairman (Navajo Times 1993a: 1-2). After a long and controversial series of trials in federal and tribal courts, MacDonald was convicted and
sentenced to 14 years in Federal prison. His successor, Leonard Haskie, finished MacDonald's term, and was succeeded by the present chairman, Peterson Zah. In 1993, Haskie was indicted by a federal grand jury on charges that he accepted large bribes and offered bribes in several business deals during his time as the tribal leader (Navajo Times 1993b: 1,8).

In the last several years, there have been numerous calls for a restructuring of the government to give more power to the Council and the individual Chapters to balance the Executive branch. (The Chapters are the smallest unit of electoral politics; each Chapter elects one representative for the Tribal Council). The upheavals in the tribal government during the last five years reflect the challenges which have faced the Tribe. As they have grown to a Nation of over 200,000 people, and developed increasingly complex ties with the "outside" world, the Navajo have had to rapidly build a bureaucratic structure sophisticated enough to negotiate effectively in the arenas of United States politics and business. The political leaders of the Tribe during this period of rapid change and growth had to struggle to find new and more effective ways to withstand the multiplying pressures from outside the Reservation in order to protect the interests of the Navajo people.

Thus, in the 130 years since their return from the Bosque-Redondo, the Navajo have evolved from a widely dispersed, loosely-organized tribe living a secluded and isolated existence to a Nation with multi-million dollar budgets, an increasingly sophisticated and complex political structure, an immense bureaucracy, a diverse and troubled economy, and an increasingly complicated relationship with the Anglo world.

2. Economic History
The development of the Navajo economy is characterized by an evolution from a self-contained, self-sufficient livelihood drawn from agriculture and later livestock, to a complex economy which relies primarily on federal and tribal government-based wages and financial assistance programs.

After their return from the Long Walk, the growth of sheep and goat herds afforded the opportunity for the Navajo to expand sources of livelihood from subsistence to include exchange-based income. Through the sale of both stock and products such as hides and wool, people were able to buy products such as metal tools for cultivation (Kluckhohn and Leighton 1974: 39). Probably learned from contacts with the Pueblos, weaving also became important as a source of income for some families.

Probably an early consequence of overgrazing, the livelihood of the Navajos seems to have taken a turn downward by 1900. Despite the fact that the first significant efforts to deal with overgrazing came more than 30 years later, the growth of the population and of the herds of sheep and goats appears to have outstripped the capacity of the land and water supply much earlier (Aberle 1982: 31-34). Thus, the initial period of prosperity brought by livestock ranching had also served to deplete the soil and deteriorate the water supply, making self-sufficient farm-life far more difficult. Young men began to seek off-Reservation employment to compensate for the losses their families suffered over the early decades of this century (Kluckhohn and Leighton 1974: 59-60). The federal government's work program, which provided jobs in soil conservation, road building, irrigation, teaching, and interpretation, further boosted the importance of wages to the Navajo economic picture (Aberle 1982: 55-57; Kluckhohn and Leighton 1974: 59-61). By 1940, an estimated 44% of Navajo income came from livestock, 30% from wages, 11% from crafts, with the majority of that coming from weaving, and 14% from agriculture. Almost all of the wage income came from the
government, despite the growing numbers of Navajos looking for work off of the Reservation (Kluckhohn and Leighton 1974: 55).

With World War II, the importance of wages in the Navajo economy took another leap. Approximately 3,600 people entered the armed services; even more importantly, the labor shortage encouraged more people to find off-Reservation employment in the railroad, mining, and war industries, as well as continuing off-Reservation farmwork (Aberle 1982: 75). This new source of income proved short-lived, however. With the end of the war, over 10,000 Navajos employed during the war found themselves displaced by returning Anglo veterans and the down-sizing of the war industries.

The passage of the "Navajo-Hopi Rehabilitation Act" (P.L. 81-474) by Congress in 1950 brought nearly $110,000,000 in federal funds for roads, school construction, development of industry and business, hospitals, and water projects over the next ten years. The Act also allowed the federal government to reimburse states for welfare programs supporting Navajo families with dependent children and the elderly. Its authors hoped that P.L. 81-474 would enable the Navajos to become self-sufficient, and result in the termination of the Navajo's special legal status and their "integration in the larger society." (Iverson 1981: 56; Kunitz 1989: 40).

Another critical shift which occurred in the 1950s was the development of coal, oil, gas, and uranium resources on the Reservation. Income from oil and gas rose from a high of around $1,000,000 in the late 1940s to over $35,000,000 in 1957. Uranium revenues brought up to $750,000 per year during the same period. However, this money did not come in the form of individual income for Navajo families, but rather as payments to the Tribal government, providing it with a strong financial foundation. Much of this new income went to fund still
more services. The tribal court and police system was able to develop into a sophisticated and autonomous system; a program which gave children clothing for school was instituted; community centers were built; and a $10,000,000 scholarship fund was created for college students (Aberle 1982a: 80-81).

A look at the sources of Navajo income at the end of the 1950s reveals the scope of the changes which the previous 15 years had brought. By 1960, over 60 percent of Navajo income came from wages. Unearned income, largely in the form of federal aid programs, accounted for nearly 20 percent of the total. The major source of livelihood only fifteen years earlier, the income from livestock and agriculture had dropped to only ten percent of the total Navajo income (Aberle 1982: 80). Furthermore, Kunitz estimates that by 1961, nearly 40 percent of earned cash income came from service sector jobs in the BIA, IHS, public schools, and the Tribe. Hence, the anticipated freedom from federal support anticipated by the authors of P.L. 81-474 had instead turned to an economy which depended even more heavily on federal aid.

The next two decades cemented this trend. The 'War on Poverty' extended to the Navajo Reservation as the Office of Navajo Economic Opportunity (ONEO). The ONEO sought and obtained numerous federal grants for programs such as vocational training, Project Headstart, a Navajo Culture Center, and various youth support and enrichment programs. Also begun under this program was the "DNA," a Navajo-directed agency which provides legal aid to Navajo people. Two new federal laws, the Indian Health Care Improvement Act (P.L. 94-437) and the Indian Self Determination and Education Assistance Act (P.L. 93-638) were passed in the mid 1970s. Self Determination was a much-needed opportunity for Tribes to begin to gain control over the services funded by the federal government. Again, however, this led to an increased opportunity for wage-earning positions in the service sector, and failed to address the underlying need for a productive and self-sufficient economy (Kunitz 1989: 47-48). In terms
of the basic composition of the economy, it appears that little has changed in recent years. In 1983, 40 percent of wage earning Navajos were employed in service-oriented jobs, and another 20 percent in government positions (NAIHS 1993). The average income figures for Navajo families highlight the troubled economic picture. In 1979, the median family income was $8,412 for Navajos -- the lowest of any Native American Tribe -- compared with $16,841 for the general population (IHS 1992: 25)

The figures above should be interpreted with an understanding of the changes to the economic base of the Navajo Nation which had occurred over the previous 50 years. In 1940, the average income for a Navajo individual was approximately $80.00 (Kluckhohn and Leighton 1974: 62-64); prior to this time the figure was undoubtedly far lower, as 1940 marked the beginning of the shift to wage work. Yet this strikingly low income was not accompanied by similarly severe living conditions, since the livelihood of the people was not so heavily based in monetary income and exchange. In the coming decades, wage work displaced self-sufficient means of support such as farming and ranching, and currency became the main form of exchange. Consequently, the significance of economic indicators such as family income has grown, and now perhaps reveals similar living conditions to those faced by other poor communities across the US. The case of "unemployment" is similar. Prior to the rise of wage work, unemployment could almost have been considered a measure of the economic strength of the Navajo economy, as most families were able to support themselves. As of 1993, nearly 35 percent of the Navajo labor force were unemployed (NAIHS 1993). Because of the shift to a wage-based economy, these figures perhaps more than any others speak to the failure of the Navajo nation to develop an economic structure capable of supporting the over 200,000 members of the Tribe. Thus, ironically, the dramatic increases in employed Navajos since the turn of the century have rendered them susceptible to, and left them suffering from, the problems of unemployment and poverty.
3. Educational History

Perhaps more directly than any other single force, education has brought Navajo people in contact with Anglo values and culture, speeding the pace of change. The first formalized government involvement in Navajo education came after the return from the Bosque-Redondo. The federal government built a number of boarding schools and day schools around the Reservation. Some children attended these schools, while others were removed from the Reservation, and taken to "Indian Schools" in other states. The removal was voluntary at times, but by force at others. In the latter 1800s, empowered by the congressional Compulsory Indian Education Law, police and Indian Affairs agents made trips around the Reservation, forcibly removing children from their homes and placing them in boarding schools (Terrell 1970: 224). The educational efforts during this time represented the prevailing philosophy that Native Americans should be "civilized" and taught to live in the "greater society."

...they were taught as if they were white children and would always live in white communities. Ninety-five percent of the children went home and entered a life for which their education had given them little preparation and many handicaps. Moreover, the schools in which they had spent their early years had been much like the orphan asylums, and had deprived them of the many advantages to character formation afforded by family life in even the poorest Indian home. (Leighton 1944: 46)

Kluckhohn and Leighton say that this early educational philosophy had the goal of going "behind the existing social organization in order to dissolve it. In order to accomplish these goals, the schools forbid children to speak their own languages and placed the children under rigid discipline." (Kluckhohn and Leighton 1974: 141). Families resisted these programs, and enrollment remained low throughout this period, with the drop out rates very high.

One of the great failings of the boarding schools was that children returned to the Reservation entirely unprepared for more traditional family life, lacking the skills for farming or herding.
Beginning in the 1930s, this assimilationist philosophy began to change, and schools started to try instead to prepare students to "take (a) place in either the white or the Navaho world" (Kluckhohn and Leighton 1974: 142). The Federal Government built a system of day schools, so that Navajo children could return home each day. However, severe weather, poor roads, and long distances between families soon forced many of these schools to convert to part-time boarding schools. Here, the children stayed at the school for the five day school week, returning home on weekends. As of 1958 there were "49 day schools, 37 trailer day schools, 17 off-Reservation boarding schools, and approximately 25 mission schools." (Kluckhohn and Leighton 1974: 143). Nearly two thirds of the students were enrolled in boarding schools (Kluckhohn and Leighton 1974: 147). Throughout this time, enrollment remained inconstant, and graduation from high school was a rarity. Some of the programs made variable efforts to incorporate Navajo culture, or at least to tolerate its presence. But particularly in the boarding schools, the efforts to "mainstream" and acculturate students remained central to the philosophy of Navajo education. In 1953, the passage of Public Laws 815 and 874 provided funds to establish a system of public schools on the Reservation. These laws reflected the federal government’s increasing commitment to providing adequate financial support on Reservations, but also grew out of an growing involvement and activism among Navajo people and the Tribal government. The prevailing goal among those in the Tribe who fought for educational improvements was "educational competency for all Navajo People so that they may participate in the local community, state, and national life equally with other citizens" (Young 1961: 382-83). By 1961, nearly 16,000 students attended BIA schools, including boarding and day schools, and over 10,000 students used the public school system.

During the 1960s and 1970s, people became increasingly concerned that, with Navajo education almost entirely in the hands of non-Navajo people, children would not learn the language, traditions, and history of their people. The BIA responded to the increasing
demands for education appropriate to Navajo students with the establishment of two "community schools," Rock Point and Rough Rock. These programs were designed with the goals of increasing participation of Navajo parents and professionals in planning and teaching, and incorporating education in Navajo culture and language.

At the public schools, education remained entirely based in Anglo culture and the English language. In these new demonstration programs, however, Navajo people participated as teachers, aids, and in curriculum development. These programs sought to include families as an integral part of their children's educations, as well as drawing on community members to teach Navajo language and help give children a sense of their heritage and culture.

In 1971, the Rough Rock Demonstration Project opened another type of school. Funded by the National Institute of Mental Health, this program drew on written, spoken, and filmed material to train both experienced and new traditional healers (Iverson 1982: 157). As of 1983, more than 90 singers had graduated. This program also helped facilitate communication between traditional healers and biomedical providers, as the students had a regular opportunity to meet with physicians over the course of their training (Iverson 1982: 157).

Also growing out of the successes and innovations of the Rough Rock school, Navajo Community College (NCC) was established in 1969. As with the demonstration schools, the guiding philosophy of NCC was to provide a high quality education which would also be sensitive to and help foster and maintain traditional Navajo values and culture. The college opened for classes in 1969, in a temporary location at Many Farms. It moved to its permanent site in Tsaile -- a community in the heart of the Reservation -- in 1973 (Iverson 1982: 143).
In 1979, the Tribe founded the Native American Materials Development Center (NAMDC) to continue and coordinate the efforts to create an educational system which fostered and strengthened Navajo children's connections with traditional culture and language (Iverson 1982: 198-199). Undoubtedly, all of these efforts have served to sensitize both Anglo and Navajo teachers and administrators to the need for this type of culturally-appropriate education. However, a Navajo woman who had taught for over 20 years in Navajo schools told me that Navajo language and culture are still only sporadically incorporated into school curricula. In part, this stems from the complex mix of schools on the Reservation. Statistics for 1988 show that 62 percent of students attend public, state-run schools (administered by three different States); 24 percent attend BIA schools; 5 percent attend community schools such as Rough Rock; and 2.5 percent attend mission schools (Navajo Nation 1988: 87-90). Thus, because of the multiplicity of systems and administrative agencies responsible for education, it is particularly difficult to apply uniform standards for culturally appropriate education. Perhaps a deeper problem stems from the lack of Navajo teachers. While their number continues to grow, thanks to promotion of teaching careers and scholarship opportunities from the tribal government, they still comprise a small minority of the overall teaching force. The goal of a uniquely Navajo system of education may be very difficult to realize until there are more teachers who share a common heritage with their students.

4. Living Situations

The Navajo Nation spans over 25,000 square miles in Arizona, New Mexico, and Utah (NAIHS 1993) As of 1992, the population was estimated at over 200,000. It is both the largest Reservation in the US, and the Navajo are the largest Tribe. Until the 1950s, a large majority of Navajo families lived on widely separated farms and ranches throughout the Reservation. Because of the enormous size of the Reservation, a large number of families still live far from running water, telephones, electricity, or natural gas. As of 1980, for example,
almost 75 percent of Navajo families had no telephone -- more than 20 percent fewer than any other US Tribe (IHS 1992: 26).

Traditionally, Navajo people lived in "hogan"s -- round or six to eight-sided structures made of wood beams or stones and earth. In a "typical" living situation, a hogan housed the nuclear family, and often several related families lived together in a cluster of hogans. Because the Navajo are a matrilineal society, husbands usually moved to the area where their wife's family lived. Particularly in the Western and Central regions of the Reservation, which are more geographically isolated, this arrangement still predominates. However, the depletion of grazing land and water have made it increasingly difficult to live a self-sufficient life in isolated regions. Furthermore, the demands of wage work often prevent families and individuals from living so far removed from larger metropolitan areas. Furthermore, the burden on children, who sometimes have to travel for hours per day to and from school, makes this lifestyle even more difficult. Consequently, growing numbers of families are moving to small housing communities on the Reservation, which offer single-family homes, electricity, sewage disposal, running water, proximity to shopping areas, and easy access to roads. Many people argue that the ready access to convenience shopping has led to radical diet changes, including increased consumption of sugar, fat, and salt. This hypothesis is certainly supported by the increased prevalence of obesity. Likewise, electricity, running water, and television have created new and perhaps more sedentary patterns of daily activity. A Navajo woman who works as a public health nurse told me that gang violence has become a problem recently, and teen substance abuse and pregnancy appear to be rising as well. She attributes these problems to the changes in lifestyle which result when families move to these housing communities.

Finally, and perhaps most significantly, the move to these housing areas often splits families, as the wage-earning adults are forced to leave their parents or grandparents to be closer to work.
B. Changing Health

The preceding 100 years has witnessed a profound evolution in the health status of Navajo people, from a time when infectious diseases and high perinatal mortality were the most significant health problems, to the present, when "manmade" diseases such as alcoholism, accidents, and domestic violence, as well as degenerative diseases such as hypertension and diabetes mellitus present the primary foremost challenges to health.

From the turn of the century until the mid 1950s tuberculosis ranked as perhaps the single most important cause of death in most Native American communities, including the Navajo. The rates from various sources over the early half of this century range from 200 to 300 deaths per 100,000 of population, up to 60 times the national rate. The death rate only partially reflects the impact of this disease. Skin testing surveys between 1910 and 1952 showed frequently that the prevalence in school age children exceeded fifty percent (Kunitz 1989: 68). Although the data from this period is very poor, all indications are that the general category of infectious disease accounted for a large majority of other illnesses and deaths. High rates of influenza and pneumonia were reported, as well as infant diarrhea and malnutrition. In the 1930s, infant mortality rates for the Reservation were estimated at over 300 per 1,000 live births, and remained over 100 per 1,000 live births until the mid 1950s. During this period, infant diarrhea, respiratory infections, and to an uncertain extent malnutrition probably accounted for a large number of these deaths (Kunitz 1989: 77-86).

At the inception of the IHS in 1954, the crude death rate per 100,000 people from tuberculosis was estimated at 190, compared with 22.5 in the general US population (Kunitz 1989: 68). The first priority for the new agency was to attack this devastating epidemic. With the advent of isoniazid in that year, the rates began to drop precipitously, and by the end of that decade, they had reached 41 per 100,000 (compared to 6.1 per 100,000 for the general US population)
(Kunitz 1989: 68). This trend continued through the coming decades, and the prevalence reached a low of 5.7 per 100,000 in 1988 (compared to 0.5) (IHS 1992: 55). The IHS also provided improved access to the sulfa drugs developed in the previous decade. These drugs had a significant impact on the deaths from respiratory infections other than TB, and also appear to have improved survival from TB appreciably. This effect probably derives from the treatment of co-infections, thereby reducing the stress on an individual with active pulmonary TB (Kunitz 1989: 75-76).

Over the past four decades, infant mortality also dropped significantly, from approximately 85 per 1,000 live births in 1955 to 10.1 per 1,000 in 1986-1988 (IHS 1992: 30-32). The reasons for these changes are more complex. For example, a reduction in the neonatal mortality rate may be explained by the availability and use of prenatal care, mortality in the postneonatal period is more likely due to a complex of social and economic factors (Baris and Pineault 1990: 191). Nevertheless, it is reasonable to assume that with the advent of readily available biomedical care, children with problems such as chronic diarrhea and malnutrition were detected and treated more frequently. Additionally, improvements in availability of running water, sanitation, and food storage techniques may also contribute to the decrease in infant mortality.

However, as the IHS has found ways to control infectious diseases over the past five decades, other problems have begun to emerge. The leading cause of death among Navajo people presently is "accidents," which includes motor vehicle and other types of accidents, as well as violent injuries and homicides. In 1955, the accident rate per 100,000 was approximately 120, approximately twice the national figure. However, by 1973 this figure had climbed to approximately 200 per 100,000; in 1988 it was reported to be 160 per 100,000, compared with 34 per 100,000 for the general population (Kunitz 1989: 66-67; IHS 1992: 50). Kunitz points out that no studies have adequately explained this extraordinarily high rate of accidental
deaths. He quotes an inconclusive study which reported that only twenty percent of the automobile accidents could be explained by alcohol consumption, and another survey of police officers which reported over 40% association between alcohol intoxication and accidents. The increases in mortality rates from accidents parallel changes in the composition of the economy and the occupations held by Navajo people. By far the most heavily affected group is young adult males. Among this group are also the highest rates of alcohol abuse; this is also the population which is most subject to the hardships of an uncertain wage-based economy. Young men may be exposed to feelings of marginalization from the larger society with which they have contact through work, as well as to a certain degree of alienation from traditional Navajo life because of their involvement in the wage economy. Kunitz suggests that these factors may lead to a propensity for "acting out." When combined with a high degree of reliance on cars, poor maintenance of cars and other machinery, and long distances traveled per year, this type of frustrated behavior may account for the increased prevalence of accidents. Another problem which most providers feel is increasing is domestic violence. This problem may have similar origins in both the uncertainty of wage work, and the other changes in lifestyle discussed in the previous sections.

The category of "degenerative diseases" has increased dramatically since the IHS took responsibility for Navajo health care. Under this category, illnesses such as diabetes mellitus and hypertension are included. Presently, the Navajo tribe is experiencing an epidemic of diabetes mellitus, which parallels that found in many Native American communities at present. Again, early studies give often incomplete data, but taken as a group they reflect a dramatic increase in this disease. In 1940 a survey of the Reservation revealed only four cases. In admission data from 1950-1952, only 0.6% of Navajo people admitted to the Phoenix Indian Medical center had diabetes; in 1965, studies indicated a prevalence of between one and two percent. After 1965, the prevalence began to climb steadily. By 1989, several studies
identified the prevalence of diabetes as between 10-11 percent, compared with 6.4% in the general population. It was particularly prevalent in people between the ages of 45 and 74, where it affects nearly 20% of the population. Early reports of diabetes among the Navajo had suggested that when found, it was generally a benign chemical abnormality. However, by 1988, the age-adjusted mortality rate from diabetes was, 26.5 per 100,000, compared with 9.8 for the general US population (Sugarman et al. 1990, 141-145).

The picture for hypertension and coronary artery disease appears similar, but data on both past and present prevalence of hypertension are incomplete. Early surveys consistently found very low levels of hypertension (Kunitz 1989: 97). However, based on data from 1965 to 1979, the prevalence of hypertension has increased strikingly (Klain et al. 1988: 1352). Furthermore, the highest prevalence of hypertension is in Navajo men of 20-30 years, a much younger population than normally suffers from this disease in the general population. Thus, since coronary artery disease progresses slowly over a period of decades, the consequences of hypertension have yet to become fully visible. However, between 1976 and 1983, the rate of diagnosis of acute myocardial infarction (AMI) has tripled among younger men, and doubled in older men. The percentage of AMI patients with a diagnosis of hypertension increased from 28 percent to 51 percent, and the percentage of patients with diabetes increased from 34 percent to 50 percent over the same time period. Over the same period, smoking rates actually decreased from 28 percent to 6 percent in AMI patients. This concomitant decrease in one of the major risk factors for coronary artery disease highlights the importance of the changing patterns of hypertension and diabetes mellitus in the increasing incidence of coronary artery disease. Given the long period between development of one of these risk factors and the development of severe coronary artery disease, and the young age at diagnosis of hypertension, it is likely that rates of AMI will continue to climb in parallel with the increases in hypertension and diabetes (Klain et al. 1988: 1352).
The explanation for the rise of behavioral and manmade disease is unquestionably complex. A dramatic increase in obesity over the past thirty years suggests that changes in diet, lifestyle, and physical activity may partially account for the climbing rates of hypertension and diabetes. According to data from the 1950s, only 5% of males and 14% of females were obese; by 1989, this figure had climbed to 41% for males and 55% for females (Sugarman et al. 1990: 143). As reported by early observers, staples of the traditional diet had included squash, corn, melon, pinyon nuts, mutton, and goat's milk. This diet began to change during the years of Stock Reduction, as economic hardships and poor growing conditions forced an increased reliance on trade and commerce for food, instead of ranching and farming. More recently, the increased availability of high calorie "convenience" foods in supermarkets and small grocery stores has undoubtedly contributed to an increased reliance on foods with a high content of fat, salt, and refined sugar. One problem which suggests the magnitude of the dietary changes is the problem of "baby-bottle tooth decay," which has reached epidemic levels in recent years. Some providers attribute this problem to the relatively new practice of feeding infants and young children sweetened beverages and softdrinks — which are in abundance in convenience stores. However, changes in diet comprise only one domain of the complex transitions through which the Tribe has passed. The dietary changes probably reflect the many and rapidly changing environmental influences on Navajo health.
C. Systems of Health Care

Although the topic of this thesis is the relationship between traditional medicine and the Indian Health Service, other forms of healing -- most notably the Native American Church (NAC) and Christianity -- contribute strongly to the overall Navajo health care system. I will discuss these other important systems here, in an effort to place the relationship between traditional medicine and the biomedical system in a more meaningful context. My objective in this section is not to summarize the vast body of information about Navajo belief systems, but rather to provide a basic framework from which to understand the experiences of Navajo patients in obtaining health care, and the relationships between providers and their patients.

1. Traditional Navajo Religion

Most accounts divide providers of traditional medicine into three general categories: herbalists, diagnosticians, and singers, also known as "hataalii." Herbalists are a poorly understood segment of the healing system. In its more traditional form, the use of herbs involved more than the simple dispensing of plants in a secular manner -- as physicians use drugs. Instead, herbalism entailed a far more complex and ritual-based means of contacting and using the spiritual power found in plants and nature. The numbers of experienced herbalists have dwindled, although there appears to be a growing segment of 'lay people' who dispense herbs for common conditions. Diagnosticians use a variety of methods to determine the cause of a patient's problem; based on the etiology, they recommend a specific ceremony, or 'sing'. In general, these practitioners enter an altered state of consciousness to find the reason for a patient's illness. There are a variety of 'types' of diagnosticians, the most common of which are 'hand tremblers; other methods used include gazing at stars, coals, or fire. The hataalii perform a variety of elaborate, multi-day ceremonies which form the core of the Navajo healing system. The ceremonial system is an inseparable part of what is commonly referred to as the Navajo "religion," and constitutes the main mode of articulation of Navajo
cosmology and world view. The Judeo-Christian concept of "religion" may be inadequate to explain the nature of the Navajo belief system. In our society, religion has become a somewhat separate entity in an otherwise secular atmosphere, with often distant and tenuous relationships with other aspects of an individual's life. Traditional Navajo religion, on the other hand, suffuses every aspect of Navajo life. Language, music and art all stem from and remain integral components of this "world view"; it engenders traditional culture, from the origins of the people to their relationships with nature; it explains internal emotions and thoughts; it structures social organization and family relations; and it describes the nature and origins of health and illness. However, it is not based, as is Christianity, on written doctrine, but rather forms a more fluid, intuitive, and intrinsic understanding and perception of the world. The outward articulation of Navajo cosmology is found in healing ceremonies, though individuals may also use prayers and small ceremonies for such uses as blessings of crops, livestock, and houses, as well as in personal prayer.

Since the primary focus of religious ceremonies is on healing, many have concluded that the religion's primary focus is on curing disease (see, for example, Leighton, D 1944: pg. 24-37). However, this statement holds little meaning without an understanding of the nature of illness from a traditional perspective. Health may generally be defined through the concept of harmony. As Reichard describes this central unifying theme:

All parts of man's body and spirit are coordinated by 'mind, will power, volition, reason, awareness'...Mind keeps body and spirit in adjustment; when the body is complete with organs, breath, sound, voice, and the power of motion, it is said to have 'i'naí, 'life, the quality of being alive.' A universal expression of life, 'i'na, refers to the relation between simply being alive, aliveness, and all phases of nature culture and experience. ... One purpose of ritual is to extend the personality to bring it into harmonious relation with the powers of the universe. (Reichard 1990: 34-35)

In this interrelated cosmology, the "tiniest object, being, or power, even minute insects; the most stupendous, the great mountains that bound the Navajo country and the thunder and
lightening that crash above them; and man himself -- all have their place and significant function in the universal continuum." (Wyman 1972: 536). All parts of nature hold intrinsic importance because they are endowed with a spiritual life. The mountains, the land, winds, thunder and lightening, plants and trees, and the earth itself have "inner forms," similar to the Christian concept of a soul. Even material objects such as arrows may be endowed with power and conceived of as 'people.' Health is defined as the maintenance of a harmonious relationship the other beings which make up the Navajo universe, and disease arises when this delicate balance is in some way disturbed.

In as much as disease represents any disruption or imbalance in the complex interrelationships between people and their environment which make up Navajo life, the religion may be seen as being oriented toward curing. However, because it articulates and renews the values of traditional Navajo culture and lifeways, it functions not only to heal the individual, but perhaps even more importantly to maintain the people in a harmonious relationship with the rest of their universe, and hence in a state of health.

Within the general category of "disharmony," a long list of specific causes of disease has been compiled by the many researchers who have studied Navajo culture and healing. For example, Reichard says that ...

...bad dreams -- of death, the dead, snakebite, tooth pulling, fire, lightening --...Excess in any activity may bring sickness. Too much weaving or silversmithing, sexual indulgence, undue concentration, hoarding property may bring affliction...Contact with the dead or anything remotely connected with them...Ignorance, either of the ceremonial law or of transgressing it, is a major source of ills. (Reichard 1990: 80-81)

There are many other commonly mentioned causes of illness. Any ceremony has the potential to cause illness if the participant is to weak, if mistakes are made during the ceremony, or if presence at the ceremony is forbidden, as in the case of pregnancy. Proximity to a lightening strike, incest, and contact with certain animals such as some snakes and insects are other
commonly mentioned sources of disease. Finally, "witchcraft," representing intentional spiritual harm done by one person to another may also cause illness. Often referred to in the literature as "taboos," this rather exotic and foreign-seeming list seems to have little to do with the concept of "harmony" described above. Indeed, the presence of such an extensive network of specific taboos and laws for avoiding disease has often prompted researchers to observe that Navajo life seems to consist of a fearful attempt to avoid contracting illness through improper behavior. But Reichard notes that in general Navajo people do not seem inordinately concerned with the potential of breaking one of these "taboos" and becoming ill. It may be that researchers have extracted this exotic list of etiologic agents out of their context in Navajo cosmology, focussing on them because they seem strange and unusual. Since spiritual beings inhabit all parts of the Navajo universe, this list probably represents a fragment of the complex, interdependent relationships which people have with the other elements of their environment. The biomedical "germ theory" -- in which our environment is inhabited by billions of invisible microbes, many of which can become pathogenic if appropriate care is not taken to avoid undue contact -- might seem similarly foreign if taken out of context within the biomedical perception of the universe.

As the discussion above shows, Navajo religion tends to classify diseases by the cause rather than by the symptoms and physical signs. However, there are important exceptions to this generalization. For instance, Levy says that

Navajo tradition gives a prominent position to (a) the signs of grand mal seizure, said to be caused by sibling incest; (b) the signs of psychomotor seizure of any bout of irrational behavior that culminates with the patient falling to the ground and losing consciousness, attributed to a form of witchcraft; (c) unilateral convulsions, shaking or trembling, thought to indicate the gift of 'hand trembling' (Levy 1989: 133).

Sometimes a given etiology is associated with a loosely defined cluster of symptoms, or a symptom with several possible etiologies. So while symptoms and physical signs do not play the central role which they do in biomedicine, they do enter into causal reasoning at times.
The Navajo ceremonial "system" included over 50 ceremonies and variations, ranging from the two day "Blessingway" to a number of nine-day sings. Once the etiology and nature of a patient's illness is understood, a specific ceremony may be recommended by a diagnostician, or the patient her/himself may decide what type of sing is appropriate. Each ceremony articulates important aspects of Navajo creation and cosmology, and involves relationships with different groups of supernatural beings. Many of the beings derive from the Navajo Creation Story, an all-encompassing mythical journey which describes the peoples' emergence from four previous worlds before reaching the present one. Each world was beset with its own set of problems, which have become important sources of illness, or disharmony, in this world. Many of the supernatural beings, or "Holy People" were important figures in the creation of the Navajo people, as recounted in Navajo religion. Curing ceremonies frequently re-tell parts of this Creation Story in an effort to invoke the power of these beings and implore them to help the patient. The patient often identifies with one of the spirits from the Creation Story. For example, in the "Shooting Chant," the patient identifies him/herself with the time when the Holy Person Changing Woman was "restored to youth and beauty" (Reichard 1990: 116). Sandpaintings allow the patient to be placed within the story which is being told, and to "absorb the powers depicted." (Reichard 1990: 112).

A two-day ceremony known as the Blessingway is used for somewhat different purposes. Healers have described it as the "main beam in the chant-way house" (Sandner 1978: 58). When practiced in its entirety for it has variety of uses from general blessings, restoration, and protection of harmony to celebrating a woman's first menstrual period or aiding a birth. It has been said to 'control' the other ceremonies, and parts of the Blessingway are present in all of them to "ensure the effectiveness of the performance" (Wyman 1972: 540). The imagery in the Blessingway is
chiefly concerned with the creation and placement of the earth and sky, sun and moon, sacred mountains and vegetation, the inner forms of these natural phenomena, ...the inner forms of the cardinal points and life phenomena that may be considered the harbingers of blessing and happiness (Leighton 1944: 26)

Hence this ceremony, which governs and lends its strength to each of the others, serves to re-create the harmony and order which existed when the world was created, and to reaffirm this fundamental value for participants in any healing ceremony.

2. The Native American Church

The Native American Church (NAC), also commonly referred to as the "Peyote Church," is a pan-tribal religion with members in many US tribes. In its contemporary form, it draws on elements of Christianity as well as concepts which are common to many traditional Native American religions. The impact of the NAC on Navajo life is difficult to evaluate. For example, estimates of membership have varied, but many accounts claim numbers as high as 40 and 50 percent of the Navajo population. However, one of the central tenets of NAC has been its "inclusionist" philosophy. It does not forbid membership or participation in traditional Navajo ceremonies, or Christianity. Indeed, NAC members are often actively encouraged to continue participating in Navajo traditional religion (Aberle 1982: 221-228). Furthermore, many people attend meetings sporadically, or just to find out more about the church, and it is unclear whether these people are counted in estimates of membership. Among all of the people with whom I spoke, five individuals mentioned having been to an NAC ceremony, but only two, both "roadmen" (NAC healers), considered themselves members. Nevertheless, by any estimate, it is clear that the NAC plays a very significant role in health care and spirituality.

The origins of the religion are somewhat unclear. Various authors have suggested that many elements of the basic structure of the ceremonies, and the central role of peyote in them originated in either Mexico or the plains of the United States. In its modern form, the religion appears to have arisen from the Comanche or Kiowa tribes in the plains. By 1892, Christian
beliefs had been incorporated into the religion. After this time, it spread rapidly through tribes in the US and Canada, and by 1955 it had members in nearly 80 tribes throughout this region.

At the core of the NAC's belief system is the combination of Christian and Native American beliefs in an attempt to form a more universal spirituality. According to Slotkin, an anthropologist who also served as an official in the NAC in the 1950s, God is equated with the "Great Spirit," a common power in many Native American religions. In its original form, the other primary spiritual forces included Waterbird and Peyote. Because the NAC accepts and even fosters people's connections with traditional religion, important figures in each tribe's cosmology are frequently included in its services (Slotkin 1956: 65-70). Peyote, and the spirit it embodies, have been seen as the envoy between people and God, and the ceremony of Peyotism provides a means of access to this great spiritual power.

As with traditional Navajo medicine, most NAC meetings are held for the purpose of curing an individual, but people also use these meetings to celebrate weddings and special events such as Christmas, as well as for functions such as baptisms, funerals, and rain-making. The NAC also prescribes behavior for the maintenance of health. Most significantly, the NAC does not permit the consumption of alcohol. The use of peyote is also strictly forbidden outside of the ceremonial setting.

A typical ceremony lasts from nine to twelve hours, beginning at sundown and lasting until the next morning. The "roadman" conducts the ceremony, with assistance from other officiants who drum, tend the fire, and sprinkle cedar chips on the fire. The ceremony begins with a prayer to announce the purpose of the meeting, after which the participants eat peyote. The remainder of the ceremony consists of singing, prayers, and drumming, usually interrupted
once or twice for the participants to drink water. In the morning, a breakfast of corn, meat, fruit, and water is served (Aberle 1982a: 11-12).

There are many similarities between the world views expressed through NAC ceremonies and traditional Navajo religion. Both view nature as being suffused with spiritual life, such that plants, water, and earth itself are the embodiment of sacred beings. The frequent incorporation of important figures from Navajo religion enhances this apparent congruence. Consequently, causal reasoning is often similar, with illness seen as arising in the spiritual rather than a solely physical domain. Also, as with Navajo sings, the NAC ceremonies can be used like a Blessingway -- not only for the restoration of health, but for the maintenance of health and prosperity. It has even been suggested that NAC ceremonies may be used to bolster the strength of, and facilitate the use of traditional Navajo ceremonies. Finally, NAC prayers are most often sung in Navajo, or sometimes in a combination of English and Navajo. As discussed above, language is significant in traditional religion not only as the means of expression of the religion, but as the embodiment of spiritual power. Thus the use of Navajo language in NAC ceremonies probably fosters the appeal of the ceremonies.

However, there are also fundamental differences between the two religions. Unlike Navajo religion, in which every aspect of nature and the environment may be endowed with tremendous power, the NAC casts power in a more hierarchical framework, wherein "God" is an all-powerful being which rules over both nature and people. Whereas traditional religion portrays health as arising from a balanced and harmonious relationship between all of the powers which suffuse and surround people, the NAC is more concerned with the notion of morality, as mediated by God (Aberle 1982a: 195). Other differences are more concrete. The NAC ceremonies are far shorter than most Navajo ceremonies, and in general do not require
payment from the "patient." Furthermore, the training to become an NAC roadman is far shorter than that required to learn a Navajo ceremony, and hence more accessible for people wishing to become healers.

Accessibility is certainly one of the bases of the appeal of the NAC in Navajo communities. Its single-night ceremonies, the short time required to learn the ceremonies, and the low cost of the ceremonies allow people to experience a form of spirituality which conveys traditional values, ideas, and sentiments in a manner which is more compatible with the restrictive schedule of wage work, and the economic hardships faced by Navajo people since the time of Stock Reduction (Kunitz 1989: 121). The pan-tribal nature of the NAC may also create a sense of empowerment for a people used to feeling shut off from the "outside world" by their beliefs. Aberle argues that empowerment was the central reason for the success of the NAC in the Navajo nation. He notes that people who lost stock during the early days of Stock Reduction were more likely to become members than those who did not, reasoning that this stemmed from a desire to find a new source of power in order to re-establish control over their lives (Aberle 1982b: 221). From this perspective, not only the similarity to traditional religion, but also the philosophical differences would have added to the popularity of the NAC. Because of the feelings of helplessness engendered by the Stock Reduction, Navajo families may have begun to doubt the ability of traditional religion to protect against forces from the outside. The NAC's omnipotent God, who holds power not only in Navajo lands but also in the Anglo world, may have afforded comfort and hope that the people might regain more control over their lives.

3. The Indian Health Service

From its beginnings as a loose network of clinics and outlying hospitals which had been administered by the BIA, the IHS system has grown to comprise an extensive network of
inpatient and outpatient facilities. It administers a wide array of biomedical care, emergency medical services, dentistry, optometry, preventive care, and community outreach programs. At present, there are six hospitals, seven health centers, and twelve outlying health stations and school clinics which serve the Navajo Reservation. Additionally, there is a comprehensive referral system to outside hospitals such as the University of New Mexico, which covers cases that exceed the capacities of the IHS facilities and staff.

A large proportion of the NAIHS' resources are directed toward primary medical care. In recent years, the leading reasons for outpatient visits have included otitis media, prenatal care, well-child care and immunizations, upper respiratory infections, diabetes mellitus, and hypertension. Common reasons for hospitalization include obstetrical delivery, respiratory diseases, injuries and accidents, and digestive system diseases such as cholelithiasis (NAIHS 1992). Additionally, the IHS conducts outreach programs to increase the utilization of prenatal care, to immunize children, to improve nutritional status and food storage, and infection control. The declines in infant mortality, infectious diseases, and overall mortality rates may be attributed largely to these efforts, although other environmental changes such as improved access to electricity for refrigeration and running water have had strong impacts as well.

The department of Public Health Nursing provides a wide array of services, including home visits, school health, some inpatient care, and various health education programs. The bulk of the nurses' time is generally spent in home visits, often to families who live in remote regions. Home visits allow nurses to assess a family's health status or an individual's illness in the context of the home environment, which helps in the design and implementation of necessary interventions. The visits may include a number of specific services, such as medical care, immunizations, prenatal counseling and checkups, and nutritional interventions. One of the
most important roles these nurses serve is as a link between patients who resist coming to the hospital for their health care and the IHS system.

The Health Promotion/Disease Prevention (HPDP) branch of the NAIHS has responsibility for many of the preventive programs discussed above. It administers services which are fairly well established, such as prenatal care and well-child care and immunizations, but in recent years HPDP has also begun to address the major contemporary health problems. The following examples illustrate the types of strategies employed by the IHS in coping with problems in the category of manmade and degenerative disease. For example, a new "Injury Prevention Control" program listed the following interventions: a public information campaign to increase the use of seatbelts by 10 percent; a computerized tracking system to record monitor injuries; modification of the environment where recurrent accidents have taken place (for example, placing a stop sign at a dangerous intersection); and a child safety-seat lending program. Objectives for diabetic and hypertensive patients included interventions -- such as ensuring that diagnosed diabetics would have regular contacts with the health care system in order to improve education and compliance with dietary recommendations and medications -- and improved case-tracking and disease surveillance methods (NAIHS -- Crown Point: unpublished HPDP proposals 1992).

Many of these programs are quite new. Particularly in the area of violent injuries, the NAIHS is only entering the initial stages of planning and undertaking a preventive and interventive strategy. For the chronic diseases, the newer programs basically resemble the standard medical model, extended to teach patients about health maintenance and facilitate "compliance" with diet and lifestyle modifications. Hence, for example, where a physician might discuss basic dietary recommendations with a diabetic patient, a public health nurse or nutritionist will work much more extensively with the patient to help achieve this goal. The resources for such
programs are slow in coming, and often insignificant to cope with the magnitude of the problem. For example, the "infant car seat lending program" had approximately twenty car seats for the entire Service Unit. Similarly, there was only one substance abuse counselor employed by the hospital during my time there.

In summary, though considerable attention and energy goes to preventive care, most resources are directed towards medical management of common medical problems, as well as primary medical care. Organized and developed at a time when the need for acute care for such problems as pneumonia, TB, and other infections, the IHS system now faces a difficult transition to caring for a new set of more chronic problems such as diabetes mellitus and hypertension.

4. Navajo Division of Health Improvement Services

The Division of Health Improvement Services (DHIS) was established in 1977, with the mission of coordinating and regulating health care, as well as direct provision of care, with the intention that "quality, culturally acceptable health care services are available and accessible to the Navajo people" (NAIHS informational packet for incoming providers). As described above, under the Self Determination Act, tribes have had the right to contract to manage and administer health services directly, rather than having them administered by the IHS. Though with the exception of very limited-scale experimental programs, the Tribe has not chosen to contract with the USPHS to directly administer health care, the Act gave the DHIS an implied mandate to exercise considerable influence over the planning and implementation of IHS services. Perhaps the most significant part of the DHIS contribution to planning health care has been the new imperative that providers and services work cooperatively with traditional healers and patients' belief systems.
In addition to its role in planning, the DHIS also administers a number of separate programs. For example, the Community Health Representative (CHR) program provides numerous in-home services, including patient education, geriatric care, transportation in emergencies, and health promotion/disease prevention. The CHRs provide these services through a variety of federally and tribally funded programs. For example, the Navajo Nation Food Distribution program provides food donated by the USDA to households in need, and provides education on nutrition for participating families. The Navajo Nation Women Infants and Children program assists with nutrition and supplemental food for pregnant and breast feeding women. The Navajo Nation Health Education program helps people to understand the "nature and causes of disease" and "reinforces healthy lifestyles." The Elderly Home Care Services program helps elderly people in health-related care, monitoring prescriptions, assistance with clothing and personal care, and transportation to clinic appointments (NAIHS informational packet for incoming providers).

In general, there seems to be an atmosphere of cooperation between the CHRs and IHS providers. However, several IHS providers referred to "politics" between the DHIS and the IHS, and talked about "turf struggles" with the CHRs. Nevertheless, the CHR program represents the most extensive interface between biomedical health care and the Navajo communities it serves. As such, it is a valuable resource for IHS providers in trying to understand how their patients' culture and lifestyles are affecting their health and their health care.

5. Christianity

As with virtually all Native American tribes, the history of contact with Anglo civilization began through contact with missionaries. After the Navajo people returned from the Bosque-Redondo, the first mission established was a Presbyterian mission at Ganado. Franciscans
soon followed. By the 1940s, though the missionary presence of these denominations and others was extensive, relatively few Navajos had abandoned traditional religion to become full converts to Christianity (Kluckhohn and Leighton 1974: 133). The 1950s marked the beginning of a new era, as missionary activity increased dramatically, and tactics changed. Where before, there had been a prevailing attitude of paternalism and missions had tended to place great emphasis on convincing Navajo people to abandon the Navajo language and religion, the newer missionaries, particularly the Protestants, began to take the approach of encouraging Navajo pastors and "indigenous camp churches" (Wood 1982: 178).

A study of religious affiliation on the western Navajo Reservation in 1982 shows several trends. First, approximately 53 percent of the families surveyed said that they had joint affiliations, most commonly involving a combination of traditional religion with one or more Christian denominations, and often Peyotism. Over 60 percent of respondents identified themselves with traditional religion; 11.6 percent said they were traditional alone; 16.4 percent said they combined traditional religion with NAC membership; and the remaining participants who identified themselves as traditional, all belonged to some Christian denomination. The same survey showed that 61.4 percent of Protestants were exclusively Protestant, compared to only 13.9 percent of Catholics (Wood 1982: 177, 184). The survey population included only 146 individuals on one part of the Reservation. Nevertheless, it certainly represents the degree of diversity among Navajo religious affiliations, and the predominance of traditional, NAC, Protestant, and Catholic affiliation is probably an accurate reflection of the prevailing trends as well. A Reservation-wide survey highlights the rapid growth of evangelical Protestant denominations. Between 1950 and the end of the 1970s 300 new Protestant congregations arose in the Navajo Reservation -- leading to a total of 343 congregations, 200 of which were led by Navajo pastors. This is compared with approximately 36 Catholic congregations by the end of the 1970s (Aberle 1982: 224).
The large growth in Protestants reflects primarily a boom in evangelical non-affiliated congregations, often led by Navajo pastors. The "camp churches" mentioned above are large kin groups with one family member serving as the pastor. One of the most significant features of evangelical Protestantism for Navajo people may be the emphasis on healing. Apparently, increasing numbers of Navajo people are seeking these services, which "offer the promise of healing, one of the gifts of the Holy Spirit, accomplished by laying on of hands and anointing." for the purpose of curing an illness (Aberle 1982: 222-223). At this point, the evidence is primarily anecdotal: Aberle cites numerous personal accounts of Navajos seeking healing in these congregations. This impression was affirmed by the providers I spoke with, who felt that significant numbers of their patients are also using Christian sources of healing.

Aberle argues that the foundations of the rise in evangelical Protestantism lie, as they did for the NAC, in the promise of access to a transcendent power, and an emphasis on healing. Furthermore in both of these religions, Navajo language is often used in the services.

Frequently, Protestant congregations forbid members to continue their use of traditional healing. However, this is by no means uniform. Since so many of the newer congregations are overseen by Navajo pastors, many of whom are not ordained, and since many services are conducted in the Navajo language, it is particularly difficult to gauge to what extent traditional beliefs are abandoned by participants. However, the fact that Navajo people seem to have chosen sects which often organize their services around healing, and presence of so many unaffiliated congregations run by non-ordained Navajo pastors, suggest the possibility that Navajo Christians often continue to hold a essentially traditional world view, unchanged by exposure to Christian theology.
III. THE INTERACTION BETWEEN HEALTH CARE SYSTEMS

A. Analysis of the Interaction: a Theoretical Framework
The fields of medical anthropology and ethnomedicine have produced many explanatory models to describe interactions between healthcare systems, and among patients and these systems. These approaches concern themselves both with the relationship between provider and patient ("microanalysis"), as well as with the broader "macrolevel" interactions between health systems and the societies in which they function. The biomedical system has achieved a position of tremendous power and influence within most societies in which it serves as the primary form of health care. Owing to this powerful position an analysis of the interaction between health care systems on the Navajo Reservation must first seek to explicate the foundations of biomedicine's power.

1. The Reification of Biomedicine
Anthropologists have had a long-standing fascination with the healing practices of Native American cultures, resulting in the accumulation of an enormous body of literature documenting traditional ceremonies. Critics of this approach to studying the human response to illness have said that the "endless pursuit of medical and psychiatric exotica" (Hughes and Locke: 1986: 137) leads to a limited understanding which "tends to elevate culture to an omnibus explanation ... with little or no attempt to encompass the totality of the larger society's social structure." (Onoge 1975: 179). The approach focuses on cultural practices as the primary modulators of health, and excludes a broader consideration of the influences of such societal issues as economics, politics, social structure and class, and racism.

As opposed to "traditional" forms of medicine, biomedicine has generally managed to avoid critique as a cultural system. In the awareness of the general public, it enjoys a privileged position as a system grounded in realm of tangible, objective, fact. In the social sciences,
biomedical knowledge has often been treated as a gold standard, against which other systems may be evaluated and their efficacy measured. However, a number of authors have begun to question the premise that biomedicine rests on an unquestionably firm foundation of scientific objectivity, and to try to remove the "aura of factuality" (Rhodes 1990: 160) which cloaks its assumptions, biases, and its construction by and reinforcement of the dominant cultural values. Such commentaries also seek to explicate the ways in which biomedicine's position has affected other health care systems; how biomedicine stems from and mirrors the social and economic patterns in the "dominant" society; and how it powerfully shapes and influences the political and social structures and healing systems of other cultures.

In the 1970s, Arthur Kleinman and colleagues elaborated a descriptive system for human maladies based on the "disease/illness dichotomy." Kleinman defined "disease" as "abnormalities in the structure and function of body organs and systems," (Kleinman et al. 1978: 251) whereas "illness" represents the cultural context, social meaning, and psychological responses of a patient and his/her family and social network to the primary disease. Kleinman's formulation created a convenient framework for researchers to explain the efficacy of traditional healing, and to understand patients' often-observed preference for and greater satisfaction with traditional healers. Kleinman and others who followed this basic framework saw that traditional healers concerned themselves primarily with illness -- addressing the patient's own concerns more directly but without recognizing and treating the (biological) disease. In this framework "curing" comprises a complex mix of patient perceptions and objective biological criteria; often, perception of healing is "not the same thing for practitioner and patient" (Kleinman and Sung 1979: 8). A patient may feel cured because s/he has "received and incorporated a personally and socially meaningful explanation of his illness" while at the same time continuing to suffer from the objectively defined disease.
While this theoretical framework expanded our conceptualization of curative processes to include a new emphasis on socio-cultural elements of sickness, and paved the way for a rich array of studies illuminating the deficits in the typical physician-patient relationship, it simultaneously strengthened biomedicine’s image of being the objective and scientific healing system. Since it included no criteria for evaluating the cultural assumptions and biases inherent to biomedical disease definitions, Kleinman’s model allowed the expansion of our understanding of sickness and healing to include some understanding of the impact of psychological and social factors on disease processes, without challenging or undermining the basic biomedical model of disease. This line of thinking had a tremendous and enduring impact on biomedical thought and practice. Hence, physicians now commonly echo Kleinman’s premise through acknowledging the importance of emotional response and social support on an individual’s biological disease process, but seldom do they question their own definitions and explanatory models of the "underlying" pathophysiological process.

Contemporary analyses have begun to reveal the metaphorical and presumptive basis of biomedicine, rendering its status as another culturally constructed system -- the ethnomedicine of capitalism -- more obvious, and shedding light on the process by which it achieved its reified status in society. Authors have used historical analyses to place society's faith in "objective" biomedical "fact" in temporal perspective; they have disclosed the reliance on metaphor to create the illusion that clinical decisions rely on tangible, incontrovertible evidence; and they have sought to reveal the ways in which decisions in biomedicine are often based on conjecture or motivated by concerns other than therapeutic efficacy.

Foucault describes the historical transition from a medicine which classified diseases into families and species based on clinical signs and symptoms, to a new way of understanding dominated by the newfound the ability to visualize microscopic pathology inside the body -- a
medicine "wholly ordered in accordance with pathologic anatomy" (Foucault 1975: 122).
This marked a transition not from a less to a more accurate form of medical knowledge, but from one type of seeing to another, historically shaped by what was possible at the time. Foucault's analysis suggests the probability that a new explanatory model, guided by new ways of perceiving ourselves and our environment, can just as readily displace our current micro-pathophysiologically centered perspective. Hence the biomedical formulation of health and disease can be viewed as the "historically embedded product of particular cultural and social assumptions" (Rhodes 1990: 161).

Another historical analysis seeks to illuminate what has been called the "physical reductionism" (Rhodes 1990: 161) of biomedicine. The origins of the exclusion of the "mind" from medical reasoning can be traced to medicine's origins in the Cartesian philosophy of the separation of the tangible physical body from the mental, a separation not reproduced by other healing systems (Hahn and Kleinman 1983). Much of biomedical reasoning derives from the assumption that the "mind" plays an insignificant role in physical disease processes. From the Cartesian perspective, the "psychological" influences on illness are considered "soft" science -- often portrayed as intangible, unlikely flights of fancy -- contrasted to the tangible, objective reality of the "somatic." Foucault's argument finds a powerful example in the presumption that "mind" and "body" comprise separate domains: with our understanding of the brain so new and so incomplete, it is easy to imagine more sophisticated knowledge will entirely displace our current soma-centered approach to pathophysiology.

Another critique of biomedicine's aura of objectivity reveals the metaphorical nature and the presumptive basis of clinical decision-making and the process of "educating" patients about health and illness. Indeed, it has been stated that only approximately 15 percent of biomedical therapeutic modalities are grounded in scientific fact (Nelson 1993: 1201). For example,
though the general public often has the impression that every drug available has undergone rigorous clinical testing, few understand that once a drug is approved for one use, clinicians often chose to prescribe it for diseases for which it has not been studied, or using regimens which have never been proven effective. Thus, clinicians have and use tremendous latitude in prescribing drugs, and often base their decisions on personal judgment, physiological reasoning, or "educated" guesswork, basing their prescription instead on a belief that it should work, or on a physiological hypothesis (Ray and Griffin 1993: 2029). In a recent issue of the New England Journal of Medicine, an editorial argued against the need for "outcomes research," -- a strategy which seeks to create standards for clinical practice based on therapeutic approaches which have been demonstrated to be effective -- saying that medicine is an "art" in which physicians reason "about individual patients on the basis of personal experience and theories of cause and effect, as well as on the basis of statistical knowledge" (Tanenbaum 1993: 1269) Ironically, it is exactly this type of intuitive reasoning which biomedical researchers and physicians often attack as "unscientific" when used in traditional healing systems.

Because patients tend to perceive physicians as brokers of fact, the assumptions and metaphors which underlie clinical decisions often become ingrained in the lay conceptualization of illness. For example, Millard traces the use of "the clock" in pediatric advice regarding breast feeding. Far from having any objective, health-motivated rationale, recommended breast feeding schedules are grounded in the "historically shaped cultural and social biases, and pediatric authorities participate in the selection of the cultural themes in motherhood." (Millard 1990: 211). Thus, for example, in the early decades of this century -- paralleling the development of the doctrine of efficiency and mechanization in industry, mothers were counseled to follow rigid feeding schedules -- being given the rationale that this is necessary for an infant's health. Similarly, biomedicine casts pregnancy and labor as potentially dangerous, pathological
conditions to be "treated" with "state of the art" obstetrical care, involving intensive medical, pharmacuetic, and surgical intervention whenever the labor deviates from a narrowly-defined medical "norm." For example, "failure to progress" in labor, a common justification given for cesarean section, is commonly defined as failure of the cervix to dilate one centimeter per hour. Such a definition has little relation to the natural broad variation in the duration of labor, but rather finds a more practical rationale in the economics of hospital bed availability, medical-legal liability, and physician scheduling convenience. Yet physicians often cloak these motivations behind the rationale of "medical necessity."

Hence medicine has successfully disguised the presumptive basis of clinical decision-making behind an illusion of objective scientific knowledge. In reality, a multiplicity of cultural biases, economic factors, and personal values enter into clinical judgments. In this way it differs little from any other ethnomedicine. However, because of its illusory objective foundation, biomedicine carries a potent ability to influence culture and belief systems. The ways in which biomedicine influences society in general, and other cultures and their tradition forms the topic of the next section.

2. Biomedical Hegemony

Deriving its power from its reified status -- its "aura of factuality" -- biomedicine plays a critical role in sustaining the dominant political-economy. Through providing pathophysiological explanations of disease -- focusing on the tangible biological processes which occur in the individual -- biomedicine distracts attention from the impact of societal dynamics, power relationships, economics, and racism on human affliction. This ability to turn attention away from societal inequities as a cause of illness protects the dominant power structure in a society by preventing illness from becoming a focus for social uprising and protest. Thus, "Medicine can describe events in a value-neutral language that makes them
appear to be part of the natural world and thus neutralize what are, in reality, social problems." (Rhodes 1990: 168).

Though obscured by biomedicine's attention to the individual and the pathophysiological, the effects of societal power relations and political economy on health and disease are increasingly well documented. However, the extent and importance of this relationship is only beginning to be elucidated and acknowledged. A recent series of articles in the New England Journal of Medicine explores the connection between "privilege and health," commenting that "so closely does socio-economic status (SES) correlate with health that it confounds the interpretation of much clinical research" (Angell 1993: 126). Depressed SES has been found to be a strong predictor of both prevalence and complications from hypertension and diabetes mellitus. Indeed, for virtually every major disease, higher rates of morbidity have been observed in groups with depressed SES (Syme 1986: 499). Yet despite the extremely strong and well documented connection between societal inequities and poor health, very few resources are dedicated to learning more about the mechanisms through which this correlation occurs, or finding ways to intervene.

Not only does biomedicine tend to exaggerate the importance of individual pathophysiology, it often actively seeks to extend the scope of biomedical practice to include problems with no obvious pathophysiological basis. Part of the motivation for this stems from the "professional imperative to survive and expand" (Kunitz 1989: 182). Thus, for example, when pediatric infectious diseases became more controllable through vaccines and antibiotics, pediatrics began to concern itself with "family, developmental, emotional, and community problems." (Kunitz 1989: 182). In this process of medicalization, problems with clear social roots, such as alcoholism, violent behavior, and social withdrawal are fit into the "disease model," thereby being cast as problems which lie entirely within the individual. A striking example of this
occurs in the psychiatric definition of "antisocial personality disorder" -- which includes among the criteria for diagnosis fighting, thefts or other criminal behavior, and lying. Hence a host of social, spiritual, societal, and family problems become symptoms and signs of biomedical diseases.

Through biomedicine, the dominant political economic structure shapes not only patterns of health and disease, but also the belief systems and healing traditions of cultures within the society. This effect derives first from the pervasive presence of biomedical ideas. Conspicuously available through providers, hospitals, and clinics, the media, and public health education programs, biomedical concepts of health and disease become incorporated into lay knowledge. Even in the often isolated community of a reservation the influences of television, public health campaigns, and the Indian Health Service provide powerful and omnipresent influences, teaching people to view health and disease from a biomedical perspective, and to look to biomedical providers for information and care. Hence biomedicine functions as a powerful acculturating force, introducing new beliefs and asserting itself as an arbiter of objective information. Another axis on which biomedicine influences traditional beliefs is through availability. Ironically, while Native Americans have free access to the expensive technology of biomedicine, the services of a traditional healer are often costly to obtain. Furthermore, many authors have noted the increasing scarcity of experienced and respected traditional healers, whereas the IHS has become increasingly accessible to Native Americans living on reservations. In another community, Elling found that the community's economic resources and the availability of traditional and biomedical services are strong determinants of the patterns of usage of traditional healing and biomedicine (Elling 1981).

Ironically, the surge of interest in "cross-cultural communication" within the biomedical community over the past decade may actually generate some of the most potent and subversive
mechanisms for the assertion of biomedical hegemony. Though unquestionably important and often lacking in physician-patient interactions, an understanding of the culture and belief systems of patients can be used not only to foster communication, but as a subversive tool to convince and inspire the patient to comply with biomedical advice -- to "enhance the driving power of modern medicine's penetration into other cultures (Yoon 1983: 1467)."
B. The Interaction at the Systemic Level

Prior to the 1970s, the only effort to integrate traditional beliefs with modern medical care had been the Many Farms clinic, described in the introduction. In Many Farms, the basic approach had been to use anthropologists as cultural interpreters to enable physicians to present information in a culturally acceptable way. At its inception, the most pressing health problem by far had been the TB epidemic. Until that time medical care on the Reservation had been scarce, often of substandard quality, and generally insensitive to the different health care beliefs of the patients. This experiment in cross-cultural medicine focused, by necessity, on finding ways to make biomedical interventions culturally acceptable to Navajo people, thus facilitating the widespread use of screening and treatment services for TB. The Many Farms clinic had been an exception in a health care system which gained, over the decades of the 1950s and 1960s, a reputation for low-quality health care and relative cultural insensitivity. Prior to 1972, most of the medical staff on the Reservation came in through the medical draft. Young physicians came to fulfill a two-year requirement, with no prior knowledge of or experience in Native American communities, and often no particular desire to be there. These conditions led to a general atmosphere of isolation between the two cultures, and a feeling that physicians for the most part did not care about their Navajo patients (Iverson 1982: 154-156). By the time a physician had a chance to learn anything about the culture, it was usually time to leave. But in the early part of the decade, some physicians who had been on the Reservation for a longer period of time began to voice support for the role of traditional healers. Dr. Robert Bergman was perhaps the most vocal, and he became involved in the Rough Rock Demonstration’s project to train Navajo medicine men, which represented the first formal attempt by a government agency to help promote traditional healing.

Several things changed in the 1970s which helped the efforts to promote traditional healing and religion as valuable resources. The passage of the Self Determination Act in 1975 facilitated
Navajo efforts to assume much greater responsibility over their health care. And in 1977, the tribal government established the Division of Health Improvement Services (DHIS), which began to exert a powerful influence in the planning and administration of health services. One of the paramount goals of this organization was to "ensure that all agencies providing health care do so in harmony with Navajo beliefs." (Iverson 1982: 203).

The changes brought about by this new imperative for respect and promotion of traditional beliefs and healing practices occurred at a philosophical more than a practical level. The two systems still function almost completely separately, and with the exception of the school for medicine men, the financial resources directed toward health care have gone entirely to biomedical care and the community-outreach programs run by the DHIS. Nevertheless, the effects at a philosophical level have been profound. As opposed to the contentious atmosphere of prior decades, physicians coming to the Reservation now learn from the beginning that they must work respectfully alongside with traditional medicine. An informational packet sent to prospective providers begins its description of the "Area Health Care Delivery System" begins by saying

"Traditional Navajo beliefs about health contrast with western ideas about medicine....Elements from both the traditional and western medical models are required to operate in a cooperative, integrated fashion to meet the diverse health needs of the Navajo People (NAIHS informational packet for incoming providers).

Thus, most biomedical providers learn early to respect and value the other types of healing on the Reservation. Because of this new atmosphere of cooperation, many physicians come to the Reservation with the express purpose of learning about the practice of medicine in a cross-cultural setting. This, too, facilitates the cooperation and respect between the systems.

Somewhat surprisingly, given the strength of the Navajo Nation's support of traditional healing, there have been only sporadic efforts to formally coordinate the systems. One level
which has attracted significant attention is cultural orientation programs for incoming providers. The most extensive of these is given in Chinle, in the heart of the Reservation, once per year. Lasting approximately ten days, this program uses panels of Navajo speakers, healers, and other health care providers, workshops, and field trips into the community to introduce new personnel to the beliefs and healing practices of traditional Navajo culture, as well as to help new providers learn the skills they will need to work effectively with Navajo patients. However, it is not required, and has a limited number of spaces available each year. Different Service Units have various policies and programs directed toward cultural orientation. In Crown Point during my tenure there, there were two informal resources to help new physicians. Dr. KB, a Navajo physician, conducted weekly meetings in which she taught physicians about various aspects of Navajo culture and tradition. Second, one of the health educators gives a two-hour presentation for interested providers which describes the Navajo creation story, theories of disease causation and the ceremonial system, and touches on some of the more important problems frequently encountered by physicians.

Despite the proximity in which they practice, often co-managing a patient's illness, traditional healers and biomedical providers very rarely have any contact. There have been formal attempts change this situation, and give providers in the different systems a chance to meet and become familiar with each other and their respective disciplines, and to discuss problem areas involved in co-managing patients. Dr. GL described a "medicine man forum" which occurred regularly near Chinle until the around 1990. Panels of physicians or traditional healers presented information about a given topic (such as pediatric care, birthing, and more specific diseases or concerns), and then had the opportunity to discuss these issues with providers from other systems. These forums served the dual purpose of introducing physicians, nurses, and healers to each others' fields and beliefs systems, and allowing them to discuss problems which had arisen in co-managing patients in an atmosphere of cooperation and mutual respect.
Similarly, Dr. KB organized conferences of local healers to discuss problems affecting their communities. These conferences were not organized expressly for allowing physicians and healers to discuss the issues, but rather represented an effort on Dr. KB's part to facilitate and encourage traditional healing in her area through providing a forum for healers to discuss critical problems in their communities.

A major outward sign of the IHS' commitment to respecting and working alongside traditional healing has been the construction of traditional treatment rooms in some of the newer hospitals. Dr. GL described the development of one of these rooms. When plans for the hospital were being made 15 years ago, an advisory board made up primarily of community members worked to plan and develop a facility which would provide care in a culturally congruent manner. As part of this goal, the advisory board felt that the hospital should include a place where hospitalized patients could have healing ceremonies. The room was designed and built with great effort to make it as "authentic" as possible. It is round, the shape of a hogan or sweat lodge; the entrance faces east; and a tube filled with earth connects the floor of the room with the earth under the foundation of the hospital.

Despite the strong philosophical commitment to making traditional healing an important part of the Navajo health care system, very little funding has gone directly to fund traditional healing. Thus, while programs such as nutritional education and mental health and substance abuse counseling may draw on traditional philosophies, money to directly support traditional healing has been non-existent, with the exception of the Navajo Healing Arts program discussed above. Funding for traditional medicine -- for example through IHS reimbursement for traditional healer's fees -- is a controversial issue, and the lack of money directed toward this area until now does not necessarily reflect only a reluctance on the part of federal funding agencies, but also a fear on the part of the Navajo people of the danger in involving the government in
traditional Navajo culture. For example, Dr. GL worried that if the IHS began to pay for traditional healers, the lack of any standardized certification might lead to unqualified people trying to offer healing services to patients. Some tribal advocates feel so strongly that funding should be provided for traditional healing that they have advocated studies to show its efficacy to strengthen the argument (personal communication with Leon Nuvayestwa, director of Hopi Department of Health). But others feel that it is precisely the government's desire for standardized, "proven" care that might endanger the integrity of the traditional healing system. Another objection to government funding was raised by BL, a Navajo mental health worker. She said that payment for traditional medicine is a complex issue, involving not only monetary compensation, but the family and community effort required to put on the "sing," and that the efficacy of traditional ceremonies depends in some part on the sacrifice the patient and his/her family make to pay for it. One company, the Peabody Coal Company, agreed to give workers $225 for traditional therapy in its comprehensive coverage (Shepardson, M 1982: 206). This appears to be the sole exception to the lack of outside sources of reimbursement for traditional medicine.

Hence, at a systemic level, there is little organized or systematized interaction between traditional medicine and the IHS. However, the relationship between these two systems has improved over the past three decades largely due to the Tribe's insistence that the federal health care programs be designed to work harmoniously and respectfully beside traditional healing, as well as the change in the composition of the IHS from a staff comprised primarily of physicians fulfilling their military obligation to a volunteer staff which tends to be more interested in and sensitive to Navajo culture.
C. Perspectives from Navajo People

1. A Complex Relationship to Tradition.

In a study of expectant mothers, the strongest predictor of use of traditional medicine was educational level, the more highly educated Navajos tending to be more acculturated and less likely to use traditional medicine. Christian faith was a far weaker predictor. Many providers with whom I spoke told me that Navajos can be broken down into thirds: "traditional," "transitional," and "modern." According to this schema, "traditional" Navajos do not consider themselves Christian, practicing only Navajo religion; they tend to be older, live in traditional hogans often far from towns; speak little English; and have little formal education on the Reservation. "Transitional" Navajos may identify themselves as Christian, but may still take part in traditional ceremonies; they are often in their 30s-50s, and may live either in more traditional settings or in towns and government housing. "Modern" Navajos tend to be younger more educated, often having spent time in college or working away from the Reservation; they tend to identify themselves as Christian, and rarely participate in traditional religion or healing ceremonies. The Navajo people with whom I spoke during my time on the Reservation betrayed a far more complex and diverse relationship with tradition, in which these generalizations had little significance. The examples below are not meant as a "representative sample," but rather serve to highlight the complexity of personal belief systems and relationships to traditional religion. However, I believe it is significant that I found no one who completely rejected the values and belief system of traditional Navajo religion. As one author put it, "the identification of oneself as Navajo implies a certain continuing allegiance to at least some traditional beliefs. Traditional religion and knowledge are social identifiers, markers, part of that which set the Navajo people apart. Many individuals values them as such, even though they may attend church regularly." (Fransted 1982: 209-210)
Dr. KB is a Navajo physician who works on the Reservation. She fits the profile of a "modern" Navajo woman to a large extent. She was educated entirely off the Reservation, and worked in private practice in a town located near it for several years after finishing her medical training. She is a Christian, and she relies exclusively on biomedicine for her own and her family's health care. Based on these observations, she seems to have few ties with traditional religion or healing. However, despite her "modern" profile, KB feels strongly about the value and relevance of traditional medicine to Navajo communities. As mentioned in the "Interaction at the Systemic Level" she has organized gatherings of local medicine people to discuss the major health problems on the Reservation. She sits on the community board of her hospital -- a very unusual position for an IHS provider -- and has achieved a deep level of trust and mutual respect between herself and the community, including several trusted and established traditional healers. Furthermore, despite her affiliation with Christianity and her reliance on biomedicine alone for her health care, she told me that she plans to have a "Kinaalda" -- a traditional Navajo celebration of a girl's passage into womanhood -- for her daughter.

DB is a 60 year old Navajo man who owns a cattle ranch. He described an incident which occurred three years previous to our meeting, when he began to note progressive shortness of breath over the course of several weeks. Despite the urging of his family, he declined to go to the hospital until his symptoms became so bad that he could not walk across a room without stopping to catch his breath. When he finally went to the hospital, he was found to have advanced coronary artery disease, and shortly thereafter underwent triple bypass surgery. He has unconditional praise for the way that the IHS handled his diagnosis and surgery. He now talks very "medically" about his problem, referring to his cholesterol level, blood pressure, and discussing his coronary angiogram results. He says he never felt any conflict between the treatment he received and his own beliefs. He now feels strongly about the need to get Navajo people involved in learning about preventive health, early warning signs of disease, and
healthful diets -- referring to the information he has learned through the IHS. But despite his unhesitating belief in and support for the IHS' approach to his case, DB later told me that he also used traditional medicine for his heart problem, and began to talk about herbal treatments he and friends have used in the past, often with seemingly miraculous results. Thus for DB, the two systems have extremely important roles, and though he believes in traditional Navajo healing, these beliefs do not conflict with his faith in and appreciation of the biomedical approach used by the IHS.

A nurse introduced me to two young Navajo women whom she knew from visits to their home, which lay several hours away from the hospital on rugged dirt roads. She told me that they never came to the hospital because they disliked and distrusted the place and the people. These young women live with their father and other family members and use traditional medicine almost exclusively. Their primary contact with the IHS until this visit had been through home visits by public health nurses.

LR is a college educated Navajo woman who works for the IHS in planning public health programs and interventions. She considers herself a devout Christian, and she gives the impression that she feels that traditional Navajo religion is somewhat in conflict with her Christianity. Unlike KB she does not place a great deal of emphasis on the importance of traditional religion and healing to the health of Navajo people. However, despite what seemed to be a fairly strong outward rejection of traditional Navajo beliefs, she too plans to celebrate the Kinaalda with her daughters. Last summer an epidemic of mysterious, sudden deaths hit LR's community. Referred to as the "unexplained acute respiratory distress syndrome (UARDS)" epidemic, these deaths caused an extremely strong reaction in the community. Many people felt, as several local medicine people suggested, that the epidemic had been facilitated by a growing imbalance between the Navajo people and the environment, and an
apathetic commitment to traditional Navajo values. One traditional healer said that prayer acts as a protective shield for the community, and that the people had been exposed to this illness because of a lack of commitment to spirituality and traditional Navajo values. As she and her community struggled through this frightening epidemic, LR also began to voice concerns about how far her community had moved away from a traditional Navajo value system. I do not believe that she was questioning her own religion or "modern" values. But, it seemed that through her cultural heritage and upbringing as a Navajo, she empathized with and even shared a certain amount of the concern felt by more traditional Navajo people.

Each of the individuals discussed above represents a unique combination of belief systems and health care practices. Though our society tends to portray Native Americans through unidimensional stereotypes and caricatures, the examples above show that -- like any other community in the U.S. -- the Navajo people have a diverse and complex relationship with traditional culture and religion. However, despite their diverse and disparate backgrounds, all of the people with whom I spoke continue to share some common connection with traditional Navajo religion and values. One explanation for the outward rejection of traditional beliefs is the prevalence in our society of racism and stereotyping against Native Americans. In order to feel respected and valued for their skills, intelligence, and abilities people may feel pressure to reject traditional values in order to avoid being inaccurately perceived as "primitive" or categorized and characterized by inaccurate and offensive stereotypes.

2. Personal Experiences with Health Care

In this section I will draw primarily on interviews with several Navajo patients, supplemented by informal conversations with Navajo people in the community and on the staff of the hospital, comments from providers, and the available literature to discuss the interaction between Navajo patients and the multiple health care systems available to them. My main
focus in the interviews was on understanding how a patient who uses more than one form of health care can rectify the entirely different explanatory models informing traditional and biomedicine, and achieve an integrated and personally meaningful understanding of his/her illness. Secondly, I wanted to understand how patients make decisions about what type of treatment or combination of treatments to use for a given illness. I hypothesized that the compatibility of the system with the patient's own belief system underlies these decisions. Thus, for example, a very traditional patient might be more likely to see a traditional healer exclusively, or at least before going to the IHS. However, many other factors, such as accessibility, the wishes of the extended family, and past experiences with health care may also influence an individual's choice of health care. Finally, I asked about the strengths and weaknesses of each system based on each patient's personal experiences with health care, and about personal successes and failures with each system; and about the cultural knowledge and sensitivity of providers in both traditional healing and biomedicine.

The vastly different explanations for and treatment of illness found in biomedicine and Navajo religion carry the potential to generate a cognitive conflict for a patient who uses a combination of both systems, as s/he attempts to understand the nature and origins of, as well as the therapeutic approach to a particular health problem. However, based on the experiences of other researchers as well as my own discussions with patients and providers, patients rarely experience such conflicts. There may be several explanations for this finding. According to several authors, many Navajo patients and traditional healers believe biomedicine operates at the level of ameliorating symptoms, whereas traditional medicine is more appropriate for curing the underlying cause of the illness (Adair et al 1988: 170). This explanatory model would help a patient rectify the different explanations of his/her illness through an understanding that the different forms of medicine act at separate levels of the problem. An alternate model suggested by several IHS physicians with whom I spoke suggests that
traditional medicine tends to be used for certain types of problems, and the IHS for others. Thus patients can avoid the challenge of trying to integrate multiple explanations for a single problem by using only one form of care for a given problem. These mechanisms are not mutually exclusive, since a patient might choose to manage some problems through a dual approach, and for others choose only one kind of health care.

In discussing his decision to seek treatment by a traditional healer after his bypass surgery, DB (see "A Complex Relationship to Tradition) told me that he did so to "cure whatever had caused his problem." Despite his enthusiastic praise for the competence of the IHS physicians and belief in the efficacy of the procedure, he understands his illness as a complex event, the roots of which lie beyond the scope of biomedicine. This resembles the suggestion that Navajo patients believe biomedicine cures symptoms and traditional medicine cures the underlying cause, but DB's model is more complex than this theory suggests. As discussed above, DB sounded very "medical" about his heart disease. He says that Navajo people, including himself until this illness, are "completely uninvolved in their health, and never go to the doctor unless they are very sick." He thinks that Navajo people need to be educated about health, which for him now includes such concepts as "low cholesterol diets" and "regular exercise." This formulation of the deficit in health education among his people is entirely based in the public health concepts he learned through his contact with the IHS. Thus, he not only accepted the ability of biomedical interventions to ameliorate his symptoms, through surgery on a damaged heart, he incorporated a working biomedical model of the etiology of his disease. Yet despite his acceptance of the biomedical explanation of both his disease and its origins, and his willing compliance with the prescription for diet and exercise to prevent further cardiac problems, DB still feels the need to consult a traditional healer for the purpose of "curing the underlying problem." He told me that he has not found that the explanations of his disease which he has
received from the various providers he sees conflict with each other, or with his personal beliefs.

Hence for DB the different explanations for his illness by biomedicine and traditional medicine have not caused internal conflict about the nature of and appropriate treatment for his illness, despite his apparent acceptance of the validity of both. A study by Csordas offers one possible explanation. In a lengthy interview with a Navajo woman in remission from breast cancer, he asked questions about traditional therapy. In response she "discussed the causal influence of lightning at some length" (Csordas 1989: 480). When, later in the same interview, he asked her what specifically she thought had caused her disease, she responded by ranking three factors -- the fact that her grandmother and an aunt had had cancer, her history of using depo-provera, and (somewhat skeptically) an auto accident in which she hit her breast on the steering wheel. Csordas then reminded her that she had mentioned lightning earlier.

"Appearing somewhat startled, she said, "in that case, I'll make lightening third and bumping against the steering wheel fourth.' " (Csordas 1989: 480). In his analysis, Csordas suggests that her initial surprise owes to the fact that the explanatory models of traditional and biomedicine are cognitively separate, and do not inspire the patient to attempt to rectify the differences between them. When challenged to juxtapose the two, his subject readily did so, suggesting that though cognitively separate, the belief systems were not incompatible.

Similarly, DB may not compare and analyze the differences between traditional and biomedical approaches to his problem, hence avoiding any potential cognitive dilemma. My interview with DB resembled Csordas' encounter, in that the questions about traditional medicine brought about an abrupt shift from his apparently "medicalized" answers to a very traditional approach to the disease, as if a door had been opened onto a different part of his problem. From talking extensively about such biomedical concepts as "cholesterol" and "blocked coronary arteries" he rather abruptly changed his frame of reference to discuss traditional
healing, herbs which friends had used for heart problems, and the loss of traditional lifestyle. Far from being unique to Navajo people, this separation of explanatory models into cognitively distinct domains probably finds a ubiquitous counterpart in Anglo cultures. Thus, for example, a Christian patient might understand his/her recovery from a serious illness as the result of biomedical interventions, but also from a spiritual perspective, without comparing the two.

However, DB's lack of conflict regarding his illness may derive not only from a cognitive separation of explanatory models, but from a broader conceptualization of health and disease. Later in our conversation, he told me that he feels Navajo people have become "dependent." He means this in an inclusive sense, saying he feels that problems with drugs and alcohol have the same origins as people's dependence on welfare and biomedical health care. He believes that the root of these problems is complex, but relates to people's movement away from traditional culture and religion. As discussed in the "Traditional Navajo Religion and Health Care" section, the core of Navajo religion and healing practices is the maintenance of harmony within an individual and between that individual and the environment. DB seems to place his illness in the context of these changes, and understands the alterations in diet and lifestyle to which biomedicine attributes his cardiac disease as resulting in turn from a loss of the protective force of traditional lifestyle and religion. Thus, for DB, traditional healing constitutes a way to reestablish the harmony which has been lost through his own and his peoples' movement away from tradition.

Several other people with whom I spoke told me that they choose between traditional healing and biomedicine based on the type of problem they have. A 60 year old Navajo police officer, FA, said "if its obvious that I have some kind of pain internally or a visible wound, I go to the hospital. Anything that's kind of a mystery, like a prolonged illness, or the Doctor. can't find
what's wrong with me, then I go to a medicine man." In this case, a patient can avoid the necessity of trying to rectify conflicting views of a particular illness by using only one type of healer for a given problem. Another Navajo police officer, CK (a 65 year old man) also said that he generally uses either one system or the other for a given problem, but also that he often decides to see a medicine man when the IHS physicians have failed to find anything wrong with him, or the prescribed biomedical treatment has been unsuccessful.

EJ is a 45 year old Navajo man who has worked for the IHS as a medical technician for many years. He said "When I get stomach pain...something that started off real quick, I would go to see a medical doctor first. I might get medicine just to ease the pain, and find out if something is wrong physically, and then I would go to see a medicine man." EJ's wife had uterine cancer years ago. Initially, her symptoms were vague and generalized. Early in her disease she went to a physician in the IHS, who was unable to find a cause for her malaise. She then decided to see a traditional healer, but the treatment did not relieve her symptoms. Several months later she returned to the IHS, at which point she was diagnosed with uterine cancer, and underwent a hysterectomy. EJ said that he and his wife did not consider seeing a medicine man after the procedure because they felt that "it was a medical problem."

Several of the IHS physicians interviewed said that fairly commonly their patients have gone to traditional healers because an older, more traditional relative wishes it. In the examples the providers gave, these situations tended to engender more conflict for patients, who feel truly divided between the two systems. Dr. RF, a family practice physician, gave the example of a 14-year-old pregnant girl whose baby was found by ultrasound to have "hydro-anencephaly," a condition incompatible with life, at 16 weeks gestation. The young woman decided to terminate the pregnancy, following the recommendation given her by the IHS physicians. However, her grandmother decided that she should have a healing ceremony, and said that she
should keep the baby. Eventually the young woman decided to follow her grandmother's wishes, and went on to deliver the child. Dr. RF said that for a long time her patient had been very torn because she believed both the physicians and the traditional perspectives voiced by her grandmother and the traditional healer. When she made her decision, however, Dr. RF felt that she had done so with tremendous maturity, and for reasons about which she felt positive.

For many patients, the cognitive conflict that might be generated through the use of dualistic models of health and illness probably never simply occurs because the patient does not think about it. While my questions were aimed at trying to understand and explain issues of how people choose, and how they rectify the different belief systems, for many people these questions are immaterial, or address processes which are largely subconscious. Choices between health care systems may be made reflexively, based on a history of a similar pattern of use; or patients may choose based on what is most convenient or available. Similarly, conflict over the disparate concepts of illness expressed by the different healing systems may be displaced by other concerns, such as worries about the illness itself. Indeed, perhaps the most significant result from my interviews and discussions with patients was the remarkable lack of deep conflict regarding the conflicting belief systems of biomedicine and traditional religion.

Thus far I have discussed the internal processes which drive patients' interactions with and choices between health care systems. Numerous other factors, such as past successes and failures with one type of care, cost, availability, and cultural sensitivity might also impact on the choice of health care. Hence, I asked patients a set of questions to determine what other parameters might be important to consider in understanding how patients choose between systems.
Each of the five patients with whom I spoke believed that in general the IHS provides valuable
services, and each had had positive experiences with biomedical health care, most of which
have been discussed above. However, several of these patients have also had significant
therapeutic failures with the IHS, and in each case found relief with traditional medicine. DB
did not say specifically what types of problems he has seen a medicine man for, but said that
he has used ceremonies and herbs on several occasions for problems other than his cardiac
disease. EJ was diagnosed with arthritis several years ago by a physician. He was told that
there was no cure for the condition, and that he would have to take pain medication for the rest
of his life. For the next year he suffered agonizing pain which was relieved only partially by
the medication. Upon the advice of his mother, he decided to seek help from a traditional
healer. He saw both a singer and an herbalist, and several months later his symptoms
disappeared, and he has had no problems for at least one year. Because of this success, he
now frequently uses traditional healers for both himself and his family. CK related two
instances in which the IHS had been unsuccessful in treating his symptoms, but he had found
relief through traditional medicine. In the first case he had been experiencing frequent
cramping in his face when he went to sleep, which caused him so much pain that he would
"jump out of bed." An IHS physician prescribed a medication, which failed to resolve the
problem. He went to a diagnostician who suggested that he needed a squaw dance. His
problem resolved after he had this ceremony. In another episode he began to experience severe
heartburn "all of the time." When an IHS physician was unable to determine the cause, he
again sought help from a medicine man. Of this episode CK said "he (the healer) could tell
that lightening had struck a tree near a building I worked in; he went and got medicine from
the tree and I drank it and he washed me with it;" the problem resolved after this treatment.
Finally, CJ's wife had an abnormal pap smear and was told by the physician that it was
probably cancer, and she might need surgery. She had a ceremony done for her by an NAC
healer, and four days later when she went to the hospital for a follow up visit, she had no
evidence of cancer. EJ’s wife was the only patient who experienced a significant failure of an attempted treatment by a traditional healer.

Another group of factors which I hypothesized might effect patient’s decisions as to the type of care they seek were issues of access. The IHS provides free health care, whereas traditional ceremonies are generally not offered free of charge, and can be very expensive of money, time, and family effort. Furthermore, traditional healers who are well-known and trusted in the community have become more scarce as fewer people are choosing the arduous path to learn traditional ceremonies. The IHS services are readily available at any of the IHS hospitals, as well as from satellite clinics and home visits by public health nurses. Furthermore, in the case of multi-day ceremonies, the time constraints on both the patient and his/her extended family may be prohibitive. EJ said that before his mother suggested a traditional healer for his arthritis, he felt that "we get free health care from the IHS, so why would you go see a medicine man where you have to pay for the services?" However, because of his experience with the healer, he now feels that this is not a consideration when he or his family are sick. He also said that it is very hard to find a qualified and respected traditional healer, and that many of those are very busy and require long waits before a ceremony can be performed. The other patients interviewed felt that time, distance, payment, or scarcity of providers were not significant issues in deciding what type of care they seek.

Patients raised several specific problems regarding IHS services. Every patient with whom I spoke complained about length of the wait to see a provider, as well as for other services such as x-rays, lab tests, and prescriptions. FA said that he and other people he knows have had to wait most of the day just to get a prescription. One public health nurse said that she feels her patients would feel much better about waiting if the provider would take a moment to come out to the waiting room and acknowledge the problem and explain the delay. According to several
providers, many Navajo people also find the hospital an objectionable place for other reasons. Because people often go to the hospital with serious illnesses, it may be perceived as a place where people die. Furthermore, since one hospital serves a given community, most people in the community probably know someone who has died there. Also, Dr. KB said that pregnant women -- a population which has traditionally been considered to be at high risk from contact with a dead person, disease, or other "breaches of taboo" -- are often very resistant to coming to the hospital for prenatal visits because of fear of contact with disease or death. Interestingly, however, none of the patients interviewed expressed such fears, referring to the wait as the major problem. A survey done by the public health nursing department also suggested that the problem of waiting far outweighs other concerns. It is possible that patients are somewhat reluctant to express fears of contact with death and illness for fear of being misinterpreted as superstitious or "backwards." However, the vehemence with which patients have expressed their resent and dislike of waiting so long suggests that this is the primary problem that most people have with going to the hospital.

The last topic which I discussed with patients was the issue of cultural sensitivity of health care providers. I asked whether the patients felt that providers understand and respect their belief systems. While I asked these questions in regard to experiences with both biomedical and traditional providers, none of the patients with whom I spoke noted any problems with traditional healers in regard to their interpersonal interaction with them. This likely stems from the fact that despite the large variety of beliefs and relationships with traditional religion among Navajo patients, the traditional healers share a certain degree of common ground with most people who have grown up in the culture. However, the uniform consensus among the patients I spoke with was that IHS physicians also had respected their beliefs, and seemed to understand enough about Navajo tradition; none of the patients had ever had a physician say something culturally offensive, or something which contradicted their beliefs.
My questions regarding cultural sensitivity did, however, lead several patients to discuss problems in their interpersonal relationships with physicians, which were not specifically related to cultural acumen. CJ told me that he felt the physician had been far too harsh and matter of fact when discussing the possibility that his wife had cancer, leaving her feeling very frightened, and quite mistrustful of the physician. CJ feels that in a situation where the physician is going to be discussing something very upsetting and serious with the patient, s/he should try to go very slowly, gently, and to include a family member for support and to ask questions and make sure that the information presented is clear to the patient. He also feels that physicians tend to get frustrated with patients who are not proficient in English, and may have a difficult time understanding the explanation of a disease process or following a treatment regimen. A public health nurse (JW) echoed this sentiment, saying that physicians tend to respond to problems which might actually stem from cultural barriers by "tightening the rope, labeling the patient as non-compliant, and writing them off as not caring about their health." DB told me of a different problem he had with his care. While he believes that he needs to make the dietary changes he has made, and to get regular exercise in order to lower his cholesterol and blood pressure, and prevent future vascular problems, he feels that the IHS approach to teaching him how to do this has been deficient in two regards. First, the changes in lifestyle are presented as an "all-or-nothing" modifications. He was told that he must cut out all red meat and fried food, and in their place add foreign-seeming foods, such as yogurt and pasta, which he has never eaten before. Despite his enthusiastic acceptance of the need for these changes, he feels that because the changes required will drive him to lead such a foreign lifestyle, he sometimes "fails," which in turn leads him to feel that he can not do what is required of him. He suggests that the lifestyle modifications should be based more on achieving a balance, and that they would be far more effective if they drew on traditional
cultural values, such as traditional foods and the morning running which was an integral part of Navajo culture years ago.
E. Provider Perspectives

The diversity of belief systems and health care practices, as well as social, cultural, and educational backgrounds in the Navajo nation present providers with a complex challenge in providing culturally appropriate and effective health care for each individual patient. To understand how physicians, nurses, and healers address the difficulties in caring for the needs of a diverse population I concentrated on three broad areas of inquiry in the interviews. First, I asked the providers about their feelings toward and relationships with healers from the other systems, and how they perceive their respective roles in caring for patients. Second, I asked how the culture and beliefs of Navajo people impact on the interactions between provider and patient, and about specific cross-cultural techniques which have proven useful. Finally, I asked about how providers overcome situations where their desire to give the best possible care, based on their own belief systems, necessitates contradicting a patients' belief system or cultural values.

For two reasons this section will focus on biomedical providers. First, most of the issues raised in the interviews relate to providing care in a culture with different beliefs than the provider's. Certainly, many Navajo people do not see health and illness from the same perspective as a traditional healer, but the cultural heritage Navajo patients and traditional healers share make it likely that the differences will be less striking. Also, few modern Navajo patients choose to see traditional healers, and according to the healers with whom I spoke, people who truly disagree with the healer's perspective will frequently be referred to the IHS. Conversely, many traditional Navajos go to the IHS, where there is a higher probability that culture and beliefs will differ from their providers. Second, only two Navajo healers were interviewed, one man who is primarily an herbalist but does some ceremonies as well, and one NAC "roadman." The interview with the traditional healer was complicated by the need to use
a translator; because of the abstract nature of some of the questions, many details were lost in translation. Therefore comments from the perspective of the healers will primarily be used to highlight the discussion of cross-cultural medicine.

1. The Relationship Between Providers

Frequently biomedical providers dismiss traditional healing systems as antiquated and based on superstition and over simplistic empirical reasoning. In general, the IHS physicians and nurses I interviewed had very different sentiments, and most expressed respect for traditional healers and their role in the community. Dr. GS, a physician who has spent 15 years working on the Navajo Reservation, said that he has found that most providers become very sensitive to and respectful of different belief systems after spending some time there. However, despite their regard for traditional medicine, the biomedical providers with whom I spoke had very little knowledge about the subject. Patients are generally reserved about discussing traditional healing in depth, usually simply acknowledging that they have seen a healer for the problem. Nevertheless, each of the biomedical providers with whom I spoke had formed her/his own explanatory models for the reasons that patients use traditional medicine, the conditions for which it is applicable, and the mechanisms by which it works.

Dr. GS said he might suggest traditional medicine for a vaguely defined medical problem which is

nothing you could really pinpoint in a textbook. It's not a life or death situation, but its certainly significant for the patient. I think mostly they relate to depression, kind of obscure, vague mental health issues; things that in a western situation getting a boost emotionally would help cure.

He also said that he does not believe ceremonies make any physical difference, but that “by bringing in the community and having a sing, where the whole community gets together and prepares a huge meal, and there's just a real positive environmental feel” traditional medicine
can have a positive effect on a patient's illness. Hence, from Dr. GS' perspective, the benefits of traditional medicine have to offer derive from its psychological effects, and the social support generated by having a ceremony.

Dr. HA said

Where I see it most often, or recommend it to people is as an adjunct to help deal with the spiritual ailments that go along with illness. Somebody doesn't feel whole...my interpretation of how ceremonies work is that its a way of contacting a group or community...it's a way of bringing family support to focus on an issue or problem and give that person in a real religious experience kind of way a chance to feel more whole spiritually.

Based on his interpretation of the mechanism and the indications for seeing a traditional healer, he occasionally ("way less than once per month") recommends subtly that his patient might consider traditional therapy "to try to help deal with the same things that perhaps a psychiatrist or a clergyman would try to address."

Dr. HA's responses throughout the interview showed that he takes a supportive stance toward traditional medicine. He also recognizes that biomedical diseases, such as cancer, engender complex responses from patients and their families, rather than existing as purely physical problems. Following Kleinman's "disease-illness" dichotomy, he assigns the role of managing the psychosocial aspects of disease to the traditional healer, while he treats the "physical" ailment biomedically. Dr. HA's understanding of traditional medicine allows him to advocate a holistic approach to disease, but he avoids the need to question or reinterpret the Cartesian foundations of his own belief system.

Dr. HA's reinterpretation of Navajo medicine through a Cartesian framework exemplifies the most prevalent view among both biomedical providers and anthropologists who have worked on the Navajo Reservation. For example, with regard to Navajo medicine, Reichard states
"Whether any of the measures believed to be curative has actual therapeutic value is doubtful. Those that seem to be have a psychological rather than a physical effect..." (Reichard 1990: 119). She cites no evidence to support her conclusion that traditional medicine functions on a psychological axis. Many physicians, including the others with whom I spoke, echo the underlying assumption that since no biomedical explanation can be found for these therapies, their results (if any) depend upon their psychological effects. This view contrasts with the emic perspective described in the "Traditional Navajo Medicine and Healing" section, which explains the efficacy of traditional medicine in terms of Navajo cosmology. Furthermore, it focuses on the effect of traditional healing on the individual patient. Thus, the psychological explanation mirrors the narrow biomedical focus on internal, individual pathophysiological processes and neglects the larger ecological relationships -- political, economic, social, and environmental -- which bear on each illness and on the community as a whole. The conclusion that Navajo medicine works on a psychological axis seems more of an assumption -- based, as Foucault described, in the historically-shaped reality of what we can "see" and "prove" in our time -- than a scientific conclusion.

Notwithstanding these challenges to Dr. HA's model, patients often use traditional ceremonies for problems similar to those which Dr. HA describes. But the spectrum of problems treated by traditional healers is broader than that which Dr. HA's schema allows for, and includes both physical ailments which have been diagnosed in biomedical categories, chronic and poorly defined conditions, and diseases classified by etiology, for which there are no counterparts in biomedicine. According to DL, a Navajo singer and herbalist, ceremonies both restore harmony and protect against future problems through "stabilizing" the relationship between the patient and the environment. He believes a loss of interest in tradition predisposes patients to illness in general. Simultaneously, the reinterpretation of traditional medicine through the belief system of biomedicine may have untoward consequences. By recommending traditional
healing for a certain subset of patients, clinicians may inadvertently teach patients their own view of its appropriate uses, and thereby influence the scope of problems for which patients seek traditional help, as well as changing Navajo peoples' understandings of the role of traditional medicine in maintaining and restoring health. Kunitz points out that "despite the fact that Navajos make use of modern medicine ... there has been remarkably little incorporation of these foreign ideas into the traditional belief system." (Kunitz 1989: 129). Hence, it is not the religion itself which is likely to be influenced by well-meaning physicians like Dr. HA, but people's relationship with it. There are some indications that this may already have occurred. For example, several patients made reference to the suitability of traditional medicine for "psychological problems," a term which reflects a distinctly non-Navajo, biomedical separation of "psychology" from "physiology."

A public health nurse, TY, also sees the efficacy of traditional medicine from a psychological perspective. She said "I mean, when I think of how it would feel to have thirty or forty friends and family members sing over me four nine days and nights while someone painted a beautiful sand painting, I think I would get better too!" Unlike the physicians with whom I spoke, however, TY believes in a "mind-body connection" such that therapy which exerts its effects on a psychological axis can have physical results. This allows her to conceive of a broader spectrum of health problems for which traditional medicine can be used. She does not, however, carry this to the extreme by suggesting that traditional medicine is as effective as biomedicine for any health problem, and she values that biomedical interventions which the IHS provides. The public health nurses spend much of their time visiting patients at home. Because they have the opportunity to know patients in the context of their families and home environments, the relationships between nurses and their patients often become more comfortable and open than would be possible in a clinic setting. Hence, TY has had the
chance to discuss traditional healing somewhat more openly with her patients, which also facilitates her broader understanding of traditional medicine's role.

Dr. BN is a family practice physician who had been on the Navajo Reservation for one and a half years when I spoke with her. She came because the hospital has "a big volume of high risk obstetrics" and she wanted to gain experience before entering private practice. She gave the impression that she was less interested in "cross-cultural medicine" than the other physicians interviewed, and she had not formed close ties with the community, as many of the other physicians had. She made several references to cultural stereotypes such as "witching" people, and her notion that Navajo people think they develop visual problems from "seeing something they shouldn't see." Asked about her perception of traditional medicine's role, she said

I actually think it's what they believe. If they believe my medicines are going to work, then they're going to take them, and hopefully they work. I don't understand their belief system well enough, but I think that if they think it's going to work...I don't have to believe in it: if it works for you, great! ... I'm sure there are things Navajo people heal better than we do...

Things that are so everyday and commonplace, I don't address it, but things like miscarriages, things like a very sick baby...when people come in with a baby with meningitis, then I would say to them 'what are your traditional beliefs? Did you want a medicine man?'

Here, BN states a belief that all therapy depends on belief for efficacy. Her interpretation is less clearly defined and structured than Dr. HA's, and she emphasized her lack of significant knowledge of Navajo medicine. In the first paragraph she invokes the rationale of the placebo effect, applying it to both biomedicine and traditional healing as an explanation for why they work.

Interestingly, Dr. BN's acknowledgment of her unfamiliarity with the culture has kept her from reinterpreting traditional healing as a therapy which works purely "psychologically" and
is best applied to psychological problems. She does imply one specific use for traditional medicine, as a form of family support for patients and their families suffering from a severe illness such as meningitis. But because she applies a less rigid framework in trying to understand the role of traditional medicine, she may be less likely to bias patients toward viewing its role and uses from a biomedical perspective.

Most of the IHS providers said that they occasionally recommend traditional treatment for their patients. In general, however, the providers were satisfied to let the two systems function autonomously, because they felt that patients would not welcome an intrusion of biomedicine into this personal area, and reserved their recommendations for rare cases. None of the providers had ever discussed a patient with his/her healer, and few had spoken to healers at all. Despite the relative isolation of these two systems, the providers gave me several examples of how they can work together cooperatively.

Dr. HA had a patient in the emergency room in a coma:

While we were waiting to transport the man to the university the family went out and got a medicine man to come in and perform a ceremony. At that time the patient was stabilized from my standpoint, and they were able just to pull the curtain across, and I just stepped out of the way and let him do his thing, and he wasn’t even in the way. Had they wanted to do that at the time I was putting the endotracheal tube in or starting an IV line or administering a medication, I would have been more forceful about saying 'no, this is not an appropriate time, you'll have to wait'

Dr. HA expresses his willingness to work in parallel with the medicine man, but makes it clear that he would limit this interaction to what he deems medically appropriate. As above, where he discussed his views on what types of problems traditional medicine is appropriate for, he stays entirely within his biomedical framework, without questioning its validity. But in this situation, he is only attempting to control his own practice, whereas in his earlier remarks he was suggesting guidelines for the use of traditional therapy.
WA, a public health nurse, told of a patient with an ulcer on her great toe secondary to long-standing diabetes mellitus. The ulcer became infected, and the physician in charge of her case decided to admit her to the hospital for intravenous antibiotics. The patient declined, saying that she intended to have a sing before obtaining any medical treatment. The physician felt quite adamant because she feared that the infection would disseminate and the toe become gangrenous. Knowing the patient well from home visits, WA suspected that to push medical treatment would only alienate her, and that she would not come in for therapy. Therefore, she suggested that the patient be allowed to go to the sing with a public health nurse who would administer IV antibiotics during the ceremony. The physician and the patient agreed, and the plan was carried out successfully.

When I interviewed Dr. RF, she was taking care of a "very frail, elderly woman with TB" in the hospital. She related the following story about this woman's treatment:

She got bad hepatitis as soon as we started the medication, and became extremely malnourished and debilitated and lost a ton of weight. Her daughter and family didn't want her to come back to the hospital, but then she had this healing ceremony and the healer convinced her daughter that it was OK for us to restart the medication once she started feeling better. Well, the healer made the patient strong enough and get well so that we could again treat the TB."

Not only did the providers find a mutually acceptable strategy for managing this patient, but the traditional healer played an essential role in the patient's biomedical care by allaying the family's fears and encouraging them to trust the IHS. Dr. RF did not define how she believes the healer was able to make the patient stronger, but her statement of this example strongly affirms her belief that traditional medicine can have significant benefits.
The physicians also gave several examples where they felt that traditional medicine had interfered, sometimes disastrously, with a patient's care. For example, Dr. HA saw a child in the emergency room who was having a seizure:

When the patient started seizing, the family grabbed the kid and went and saw a medicine man, and the medicine man performed a ceremony, and then told them to bring the patient to the ER. During that time the patient was seizing -- was in status epilepticus--and I felt real strongly that the delay in care resulted in this child seizing for many, many minutes longer than he should have, even though I was told that it was a short ceremony, but this kid was covered head to toe with ashes, so it had taken the individual some period of time to cover the kid with ashes, and then say go to the ER right away, and had delayed the care. I felt that the kid needed dilantin, not ashes, and I saw that as a time when the medicine man's practice and inability to recognize status epilepticus could have resulted in permanent damage to the kid's brain, and I was really upset. So there are times when I feel like they make appropriate referrals, and there are times when I have seen care delayed or approaching care delayed because someone else was out there dinking around in an area where they shouldn't have been.

Dr. HA believes that there is no ideal solution to this situation, because to truly solve it would require that medicine men and physicians each have extensive training the other's field. He feels that the situation could be ameliorated in part if medicine men and physicians entered into some kind of exchange whereby they could teach each other about the types of conditions they treat. However, this problem may have a fairly simple solution. For example, seizures, in particular, are likely to be an area of conflict between traditional and biomedical practitioners, because, according to Kunitz,

Navajo tradition gives a prominent position to (a) the signs of grand mal seizure, said to be caused by sibling incest; (b) the signs of psychomotor seizure or any bout of irrational behavior that culminates with the patient falling to the ground and losing consciousness, attributed to a form of witchcraft; (c) unilateral convulsions, shaking, or trembling, thought to indicate the gift of "hand trembling." (Kunitz 1989: 133)

Traditional healers may be far more likely to consider a seizure as falling within their purview than many other biomedical diseases. Because certain biomedical diseases have symptoms which overlap, as in this example, with traditional categories of disease, it is likely that an
exchange of information limited in its scope to address primarily these few areas might significantly decrease the potential for misdiagnosis and inappropriate therapy.

Dr. BN related a case of a medicine man who has very bad congestive heart failure.

Every time he goes and has a ceremony he believes he's cured, and he stops all his cardiac medications. And he comes in (to the hospital) in florid congestive heart failure, rapid atrial fibrillation, and almost dead. That's where traditional medicine, it's certainly not helping us at all. But this man's belief system is deeply rooted in traditional medicine, he's a medicine man. And he believes that too many people are envious of him, and that's why he's sick.

This case illustrates the difficulty of working in a dualistic system where there is no contact between providers. DB's case (in the "Patient Perspectives" section) demonstrates that traditional and biomedicine can work at different levels of the same problem, and hence need not be viewed as mutually exclusive, as seems to be the case here. Although it would be poor reasoning to expect that DB's view should be applied to everyone, his case illustrates the potential that the two therapies do not necessarily conflict and can be used concurrently. In this case, the problem might have been handled better by a public health nurse, mental health worker, or another Navajo person with experience in both biomedical and traditional thinking, to negotiate a mutual understanding and plan for the patient's care.

Finally, Dr. GL related the case of a child with bacterial meningitis:

...one of the most serious cases I had, a kid was brought to the ER some 12-13 hours after the family knew the kid was sick. But instead of going directly to the ER they had gone to one or two medicine men, and by the time the child arrived he was essentially dead, from Hemophilus B Influenza meningitis. This is an exception....occasionally, this kind of thing will happen.

All of the biomedical providers I interviewed felt that these problems, though sometimes very serious, were rare. No one used these examples to argue that traditional medicine is not valuable, or should be regulated or standardized in some way. In view of the lack of
communication between traditional healers and biomedical providers, the scarcity of problems seems somewhat surprising. The explanation may lie in the pattern of usage which most patients who choose to use both systems follow. As illustrated in the "Patient Perspectives" section many people first go to the IHS because of its ready availability. For those who sometimes visit a healer first, many employ a system for choosing similar to EJ’s (see "Patient Perspectives") wherein they still go to the IHS when they experience obviously physical and acute symptoms. If these patterns of usage reflect the community accurately, then the IHS functions as a screen whereby patients with urgent biomedical problems will be treated before, or as in the case of the diabetic woman with an infected toe, concurrently with, traditional therapy.

2. Cross-Cultural Communication

An effective therapeutic alliance between provider and patient depends in part on the providers' ability to explain a disease process or a proposed intervention in a way which is accessible and credible to the patient. This task is complicated by the differences and variations in belief systems, cultural and social backgrounds, and language and modes of expression, as well as by the mistrust generated by the centuries-long history of duplicitous Anglo involvement in Navajo affairs.

In discussing how his patients' belief systems affect the way he gives care, Dr. GL told me that he does not think it is important for him to know specific details about "whether a particular patient has this belief or that belief" but that "a general appreciation for the culture is extremely important." Dr. RF expressed a similar view:

I think it's intrinsic to medicine that you have to assume that you are working with people with different beliefs, so I'm not sure that it really makes my approach to medicine that different. My particular approach to each individual patient is based on what my best guess is at what their belief system is and what I can do to communicate
things in such a way that they can understand it, and about how their belief system is impacting on what I’m asking...

Rather than asking directly about a patient’s beliefs, Dr. RF assesses how receptive the patient is to the information being presented, and how well the patient understands her explanations. For RF, the importance of belief systems to her interaction with a patient lies in how those beliefs color the patient’s belief in, perception, and understanding of the biomedical explanations for an illness or therapeutic approach. She relies on "visual clues, like are they smiling and respectful and comfortable and relaxed with you, or are they angry or tense about something." When she senses tension or anger she tries to "dig into it" to find out if she has said something the patient does not understand or which conflicts with her/his beliefs about the illness. The language difference also makes it particularly important for her to pay attention to how well her patient is understanding her questions and explanations. She "tries to say things in three different ways" to ensure that her patients understand her. Indications that her patients understand and feel comfortable with what she is telling them, such as a patient being able to explain back to her, for example by "being able to tell you how many pills they should take, and which one, and at what time of day..." help her assess how well she is communicating with the patient and avoiding conflict with his/her belief system.

The providers had different ways of coping with patients' skepticism or conflict engendered by their own belief system. For example, Dr. HA said "it takes a lot of extra time to get through to people if they have some other beliefs about, for example, why their child is sick or about prenatal care." He gave an example of a woman who had been told that her child was getting recurrent ear infections because someone was "picking on him." He felt that she had implied some doubt about this explanation, and was coming to him for an alternate viewpoint. Consequently, he told her that from his perspective being picked on could not cause her child’s problem. He then devoted extra time to help her understand his perspective on recurrent ear infections:
"I drew her a big picture, and I explained how ear infections function, and this is why we treat with antibiotics. I like to have them look at the child's eardrum with me; and explain to her that this is what I know about ear infections," and go ahead and explain to her the medical options as I see them."

In this example, Dr. HA used his knowledge of his patient's feelings towards traditional medicine as well as his impression of how trustful she felt of him to decide to what extent he would validate her cultural beliefs, or impose his own. Sometimes, when he feels that he is not "getting through to a patient" he asks him/her "How traditional are you? Do you believe someone is witching you? Do you believe someone is out to get you? Have you considered going to a native healer?" Thus, Dr. HA's strategy seems to be to assess how accepting the patient is of biomedical ideas, and if he feels it is appropriate, he will try to explain in detail to help his patient understand what might be very foreign concepts. In cases where he feels that he may be interfering too much with a person's beliefs, he also suggested that he would consider referring the patient to the mental health department, which is staffed by Navajo people, or to a traditional healer.

In discussing how a patient's beliefs impact on her way of explaining things, Dr. BN said

I pretty much just stick with my medical belief system; I might try to talk about how the family will react -- to deal with some of the issues they're going to have to deal with at home. But if I'm just telling someone about hypertension and how it effects the blood vessels, and what kind of problems they're going to have from prolonged hypertension, I would describe that just like I would to anyone else. I don't have enough knowledge to describe it from their perspective.

Like the other providers I interviewed, she felt that she could not adequately explain a biomedical disease process in terms which would make it more culturally "palatable" or believable; all of the physicians indicated that because they are biomedical providers, and patients have come to them seeking biomedical information, they have an obligation to provide that information honestly and completely.
I also asked providers if they had found specific skills or modes of communication which help them work with Navajo people. The most often mentioned point referred to a fear held by many of their patients which relates to the power of language. According to the providers, their patients fear that predicting or discussing the possibility of a negative outcome has the power to cause it to occur. Thus, for example, telling a patient that an abnormal pap smear may mean there is a cancerous lesion developing might be interpreted by a patient as having the power to cause the cancer to occur. The providers generally agreed that the solution to this problem was to phrase such comments in the third person, therefore avoiding the direct implication of the patient in the prediction. Dr. BN gave the following examples:

You don’t say, you know, ‘you have six months to live,’ you say ‘some people with ovarian cancer like yours will go on to die in six months’; you say ‘many people who are in septic shock will not live through the night’ -- you don’t say ‘your father is probably going to die tonight’ because then if he does, it wasn’t the overwhelming sepsis that did it, it was you, no matter what.

Another point was raised by Dr. HA, who said that he does not “force eye contact with people who don’t want it.” Interestingly, this is somewhat different than Dr. RF’s impression that when patients look away it is a cue that they are somehow dissatisfied with the interaction. Dr. HA also said that he tries to leave more time than usual when he is done asking questions because he feels that Navajo patients often feel more reserved about bringing up concerns and questions. Dr. KB told me that more traditional patients have trouble understanding why physicians ask so many questions, in particular about physical symptoms, and also why so many tests are necessary for a physician to arrive at a diagnosis. This derives in part from the use of a system which classifies disease primarily by etiology instead of symptoms; Navajo diagnosticians do not generally ask as many questions about symptoms. None of the other physicians interviewed noticed this problem.

3. Managing Cultural Conflicts
This section focuses on what happens when the provider feels forced into a conflict between respecting a patient's beliefs and cultural values and providing care which is consistent with the biomedical belief system and training. Dr. RF defined the problem in this way: "It's a fine line between respecting and working along side with their alternative beliefs about healing, and not providing adequate patient information and giving them my best opinion from a modern medical perspective." As well as providing insight into constructive ways to manage difficult cross-cultural interactions, the solutions providers find to these dilemmas illuminate their own perceptions of biomedicine's role in maintaining the health of the Navajo people.

Dr. RF feels that because of her desire to respect and support people's traditional culture, she has often not been "emphatic enough about the need for a procedure or [hospital] admission." However, she also said that there is a limit to how much she can push for something a patient does not want: "If these things are explained to them, they have every right to refuse." Dr. GL said that he has had to "fight very hard to convince the family" of the need for a spinal tap if he suspects that an infant may have bacterial meningitis. He believes in pushing hard in such cases, particularly after his experience with the patient who died of meningitis after receiving traditional therapy before coming to the hospital. However, he says that even in the hardest cases, when the parents or grandparents are absolutely against the procedure, he will not directly challenge what they believe about the cause.

Dr. GL suggests that sometimes much of what might be interpreted as resistance to a procedure because of a clash between biomedicine and traditional beliefs actually stems from the normal fear that a parent feels about a spinal tap, perhaps compounded by a certain amount of mistrust of Anglo physicians, and complicated by the involvement of many family members in these decisions. He also resorts to the "back up" of Navajo personnel, who he has found can often help with "cultural interpretation." Thus, for GL, in the case of urgent medical necessity he
pushes very hard for the parents to accept his intervention, but tries not to contradict their own beliefs.

Two of the public health nurses felt that many of the conflicts which arise when physicians are trying to convince patients of the need for a procedure stem from the physician's attitude toward the patient. Of situations where patients express reluctance to agree to a particular course of therapy, WA said "physicians often respond by tightening the rope, labeling patients as "non-compliant," and writing them off as not caring about their health." TY suggested that physicians could improve these situations by "maintaining respect and being supportive, but never contradicting the patient's belief system; you should treat a non-compliant patient like an honored guest." She felt that physicians should also focus more on creating an atmosphere of cooperation between the patient and him/herself, instead of saying "I am going to do this or that to make you better."

Dr. RF said that often the challenge of rectifying the differences between belief systems falls on the patient. "It's the patient's challenge more than the practitioner's. I mean, the traditional healer is going to give them their view, and we're going to give them ours, and they know that." She discussed the example of the 14-year-old girl who was 16 weeks pregnant when the fetus was diagnosed with "hydro-anencephaly" (see "Patient Perspectives"). Dr. RF developed a very open relationship with the girl and her family, and the girl was very torn because she believed both the biomedical system and her grandmother. Even though the girl followed the traditional recommendations instead of her own, she feels that she did her patient good by being honest with her:

You have no choice but to be completely honest, or you're not providing them with anything. In terms of 'do I think we did this girl any good by telling her about it ahead of time, I think we did. She matured tremendously -- was forced into a state of maturity and motherhood and had to deal with it, and I think she did; and the grandmother even told me that she understood exactly what I was saying and that she appreciated what we were doing for her.
Dr. BN justified a similar perspective through reasoning that "people have made a choice; they've made a choice who to come to for their healing. They have options; they can go to a traditional healer, or they can come to me. When they come to me they aren’t coming to someone for traditional advice...My feeling is that they are coming to me for my expertise in my field of medicine." Her argument that patients come to the IHS by free choice, and hence should hold all responsibility for rectifying conflicting information, fails to take into account the many factors which bias the choice of health care. As shown in the "Patient Perspectives" section, patients may sometimes chose the IHS by necessity, because of numerous factors such as cost, time required, and ease of access.

Sometimes a patient's beliefs evoke strong feelings in the providers because they conflict with very deeply held convictions about the nature of health, illness, and healing. For example, Dr. BN said:

one thing I find real impressive is the beliefs centered around miscarriage, or with having any kind of illness, is that somehow you brought it on yourself; that the reason you're having this is because you did something wrong.

Blaming oneself for an illness or miscarriage is the antithesis of the biomedical model, which explains most diseases as natural phenomena which occur without relation to an individual's behavior or emotions. Indeed, even for conditions with major behavioral components such as alcoholism, biomedicine applies the "disease model" which defines the problem as a disease for which the individual is not responsible. Viewed from this perspective, a patient who has a miscarriage and feels that she must have done something "wrong" is responding in an inappropriate and self-destructive way. However, within the context of the Navajo worldview, it actually represents a normative grieving process. Dr. BN said that she "would probably try to convince them that it's not their fault" when a patient expresses such self-blame, but she also said that she might ask if the patient wanted to see a traditional healer. Thus, while she recognizes that this may represent normative grieving within Navajo culture,
she can not restrain the impulse she has to console the patient based on her own cultural norms.

Dr. GL told me about a very different situation, which inspired in him a similarly strong sentiment:

For instance, a medicine man will sometimes go to a person, I'm not sure what the ceremony is, but they'll take out a stone from the person's gall bladder; I forget now whether the patient will actually show this stone, or not. But it's fairly common for the patient to at least say that the medicine man took out this stone. And I know that it can't be true, it's against everything that I can imagine, and it seems like a quack kind of a thing. I still haven't really gotten to grips with that situation. But it angers me to think about it, but when I hear that from a patient, I'm sensitive enough not to argue with the patient. I won't encourage it, but I at least will keep my anger to myself.

In this instance, the patient's understanding of a therapeutic process is incomprehensible to Dr. GL within the confines of his biomedical belief system. He extrapolates from his own belief that this kind of stone removal cannot happen to the conclusion that the healer is therefore disingenuous. The emic explanation for the "sucking cure" stems from the common assertion that "like cures like." It is common for a healer to place a stone, stick, or other object in his/her mouth prior to the ceremony, as Dr. GL describes. However, the rationale is not deceive the patient, but instead to "catch" the spirit of a similar object lodged inside the patient's body. Often, the healer makes no effort to hide the object from the patient prior to the procedure. Misinterpretations such as Dr. GL's could be avoided in two ways. The first would be for providers to pursue a more thorough knowledge of theories of traditional healing. Alternatively, they could attempt to actively challenge their own assumptions, and recognize the presumptive basis of biomedical conclusions. Thus, when confronted with a situation in which a healer is doing something "impossible" from a biomedical perspective, the provider would assume that perhaps his/her own explanatory model is insufficient to explain the healer's actions. Dr. GL thinks that because he does not express his anger outwardly, that his feelings do not impact on his interaction with the patient. However, it is possible that the anger he
feels is transmitted non-verbally to the patient, and by withholding encouragement he may also convey a tacit disapproval.

Dr. RF discussed the impact that these cultural conflicts have both on the individual patient and the culture. She gave the hypothetical example of a patient who was diagnosed on ultrasound with gallstones; he went to a traditional healer and had came back saying "the stones are gone: he sucked them out." Dr. RF said "you can't just say 'oh, that's nice, I'm glad you're better,' " and indicated that she would find a way to give the patient her biomedical perspective without being "too antagonistic." She suggested that she would show him the stones on ultrasound to convince him that he still needed biomedical treatment. She said that she believes that "if he wants to believe still in his traditional healer, he will ... these people, their beliefs are so strong, they'll find a way to sustain it" but she also acknowledged that she feels that

we are slowly chipping away at what's left of a very strong culture and belief system and religious system that people have held for eons, and it's a tough one. But on the other hand ... I still believe that if there's going to be trust ... if we're going to do them a good turn we have to be honest.

Here Dr. RF betrays her own conflict between providing what she feels to be the best care and contributing to the erosion of a culture by forcing people into cognitive conflict regarding their beliefs. For Dr. RF, the resolution to this dilemma comes from looking at "the big picture, and what the result of all the interactions you have will be. And perhaps we are chipping away at the culture, but at the same time if we can help people learn to take care of themselves and their blood pressure so they don't get kidney failure, and taking care of their diabetes so they don't get kidney failure and taking ... you can't lie to one person just for the sake of not damaging their cultural integrity."
F. Uniting the Viewpoints: Analysis and Conclusion

1. Therapeutic Efficacy and "The Big Picture"

As conceived of in the field of biomedicine, therapeutic efficacy is the ability of a specific therapy to ameliorate symptoms or cure a particular biomedically defined disease, as judged by a set of objective biological criteria, with the "double-blinded placebo-controlled" design representing the "gold-standard" for such studies. The most common approach to studying the efficacy and mechanisms of other systems of healing is to attempt to apply the same criteria -- thus focusing on objective, reproducible effects of a given procedure or substance on a disease process in the individual. Indeed, in an effort to accomplish this goal, the NIH recently introduced a major new department (the Office for the Study of Unconventional Medical Practices) to ascertain the efficacy -- as judged by biomedical standards -- of a broad range of traditional and "alternative" therapies. The biomedical approach to understanding other forms of healing is also evident in the words and actions of individual physicians, including the IHS physicians whom I interviewed, who seem to share the underlying assumption that other forms of healing may be judged through gauging the objectively tangible effects on an individual patient. But this definition of efficacy may provide an inadequate framework for explaining and evaluating the role and effects of traditional healing. As an intricately interwoven component of the fabric of Navajo religion and culture, the effects of traditional Navajo medicine extend far beyond the ability to cure a specific disease in a given individual. Rather, traditional healing functions as one of the primary forces in maintaining and actively renewing the protective strengths of Navajo culture.

None of the IHS physicians interviewed explicitly discussed the topic of efficacy, but in sometimes subtle ways most expressed an underlying concordance with the biomedical perspective. For example, when I asked providers to give me a broad perspective of the
importance of Navajo culture and traditional medicine in maintaining the health of Navajo people, they often responded by discussing specific applications for which they believed traditional medicine is valuable. Similarly, Dr. HN explained his concern that the IHS should not pay for therapies such as traditional healing which have not been "proven effective" in curing individual, pathophysiological disease states. Dr. RF reflected on what she hopes will be the cumulative effects of her interactions with individual patients:

... you have to look at the big picture, and what the result of all the interactions you have will be. And perhaps we are chipping away at the culture but at the same time, if we can help people learn to take care of themselves and learn about their bodies and preventative health and taking care of their health and their blood pressure so they don't get kidney failure, and taking care of their diabetes so they don't get kidney failure. ... You can't lie to people, that's the bottom line. You can't lie to that one person just for the sake of not damaging their cultural integrity. The end doesn't justify the means. It's a hard one, but I do think that as a system the IHS is contributing to chipping away at their belief system.

For Dr. RF, specific interventions such as patient education, dietary modification, and medications to control diabetes and hypertension in individual patients represent the optimal solution for these problems. She believes that the "big picture" -- the goal of improving the health of the Navajo population -- can best be met through this kind of individualized and specific intervention. Furthermore, in speculating about the possibility of weakening the traditional culture and beliefs, she concludes that this is peripheral to the primary goal of reducing biomedical diseases.

As I discussed in the "Changing Health" section, the major health problems facing Navajo people have complex roots in the changes in social structure, economic forces, and culture. Though the roots of the rise in accidents, injuries and violence, diabetes, and hypertension are incompletely understood, they parallel dramatic changes in Navajo life. Thus far, IHS efforts have proven unsuccessful in dealing with the contemporary health problems. The incidence of diabetes and hypertension, for example, seem to have undergone the most rapid increase since
the inception of the IHS. The complications of these diseases, such as kidney disease, CAD, and peripheral vascular disease, are rising as well. In the area of accidents, alcoholism, and domestic violence, the IHS primary involvement has been in treating the consequences, with efforts directed to prevention being implemented only recently and on a small scale, and they too have risen. As described above, the majority of resources in the IHS are directed toward caring for problems once they have occurred. These efforts involve strategies of early intervention, such as the means outlined by Dr. RF in the passage above. But given the complex cultural, social, and economic conditions which have led to the current health problems, it seems unlikely that Dr. RF's goal of improving the peoples' overall health through her interactions with individual patients will be realized: the best she can do is to tread water, treating new cases as they come in. Only a much more detailed and committed analysis of the societal dynamics which have engendered the contemporary health problems will lead to effective strategies of prevention.

It is within the context of these societal forces that the role, or "efficacy," of traditional medicine must be evaluated. From this perspective the value of traditional medicine may extend far beyond its role in curing illnesses in the individual. As discussed in "Traditional Religion and Health Care," Navajo religion plays a vital role in every aspect of Navajo life, as a world view which shapes an individual's emotional and spiritual self, perceptions of the world, and relationship with the community and the environment. To some extent, the role that tradition plays in people's lives has changed as Anglo culture and values have begun to pervade the Navajo world. Nevertheless, the world view of Navajo religion continues to play an important role in shaping the perceptions and values of a majority of Navajo people, including many who live "modern" lifestyles and are affiliated with Christianity. Thus, as the primary mode of transmitting and reaffirming traditional values, culture, and lifestyle,
traditional healing may have untapped potential in addressing the contemporary challenges to Navajo health.

It is difficult to predict the precise nature of the benefits which could be derived by placing more emphasis on traditional medicine. However, through promoting and strengthening the integrity of the culture, traditional medicine might help people begin to identify with and rely on aspects of a traditional lifestyle which maintained health in the past. For example, as the patient DB suggested, a recognition and promotion of the value of a traditional diet, which relied on squash and corn as mainstays, might hold far more appeal than an Anglo diet based on unfamiliar and culturally foreign foods. Furthermore, while an Anglo diet which relies primarily on convenience shopping is completely disassociated from the recommendations for "regular exercise" which constitute part of the biomedical intervention strategy, the traditional Navajo diet depended on cultivation and physical activity. Also, many Navajos involved in the health care field have suggested that drawing on the Navajo tradition of running in the morning might be much more appealing than, for example, an "aerobics class." Furthermore, the spiritual values of Navajo religion may strike far deeper into such problems as drinking and driving, and domestic violence than the organized biomedical system could ever hope to.

However, even stating these potential benefits in terms of effects on individual problems recalls a basic flaw of biomedicine, by focusing too narrowly, on individual effects. The true benefit of tradition may far exceed what can be conceptualized on a case-by-case basis.

Clearly, the use of traditional medicine in the ways described above is not an "intervention" (in the biomedical sense), which may be prescribed or applied to the Navajo people to achieve a "cure." Nor, obviously, should an attempt be made to prescribe for Navajo people what their values should be. Indeed, this would only recreate the racist Anglo stereotypes which have always, and continue to, attempt to restrict Native Americans to an endless string of inaccurate
and anachronistic caricature. Instead, it would be more valuable to examine the ways in which the imposition of biomedicine's viewpoint may interfere with people's use of traditional medicine and change their relationship with and understanding of traditional roles and values.

In the "Provider Perspectives" section, I suggested that one of the dangers of physicians recommending traditional healing to their patients for a specific subset of problems is that over time physicians will teach people a different understanding of their own healing tradition, and thus change both their understandings of its place in their culture, and their reasons for using it. A similar example of this subtle type of inadvertent re-education is found in preventive health programs. The field of preventive medicine addresses health care from the broadest perspective of any biomedical field. Rather than trying to cure or ameliorate diseases in individuals once they have developed, preventive strategies identify the etiological nature of a specific problem, and design an intervention to interrupt the progression to disease. Thus, for example, by understanding the potential complications of uncontrolled diabetes mellitus, we can design interventions, such as tight control of blood sugar, to prevent them from occurring. Similarly, the knowledge that hypertension is an almost ubiquitous precursor of coronary artery disease allows us to intervene by treating the hypertension and thereby lessening the chance that coronary artery disease will develop. The pattern exemplified by these situations characterizes the majority of preventive health efforts: a specific disease or outcome is defined, and based on our knowledge of how it develops, a strategy to prevent it is designed.

Resembling the philosophy of preventive medicine, the concept of harmony in Navajo tradition is also responsible for protecting people from illness, or, more accurately, it is the absence of illness. But the similarity between these concepts is limited, as harmony is a more generalized and all-encompassing concept which takes into account ...."skills and cultural institutions -- knowledge of hunting and agriculture, marriage, clan organization, cooperation with tribal and
extra-tribal individuals, language," (Reichard 1990: 148-149) as well as a person's relationship with the supernatural, nature, and the universe. Healing ceremonies coordinate these interrelationships, both for the purpose of restoring health and to prevent other illnesses. As with the case of physicians inadvertently asserting a biomedical perspective on the efficacy of traditional medicine, the use of the biomedical concept of prevention as a means of maintaining health can undermine the more traditional Navajo view of harmony. For example, preventive interventions -- such as teaching people to exercise and eat a low cholesterol diet for the purpose of preventing heart disease, or counseling people about the connection between diet and the complications of diabetes -- teaches people to think of health in terms of discrete, compartmentalized interventions to prevent specific disease states. A traditional lifestyle included many elements -- such as morning running, cultivation and a diet high in corn, squash, and melons, and the central role of prayer and spirituality in everyday life -- a holistic, balanced lifestyle which maintained the people in a "harmonious" state, and naturally protected against the diseases which are now so prevalent. Hence, preventive biomedical care, while it may help some patients eat less fat, or encourage someone to take blood pressure medication regularly, conditions people to segregate out and modify a particular "high-risk behavior" and not to view health as the synthesis of one's lifestyle and spiritual commitment.

In the "Theoretical Framework" section, I suggested that biomedicine's focus on individual pathophysiology tends to keep people from understanding the origins of many diseases as consequences of societal inequities. Each of the providers I interviewed expressed their commitment to giving patients an honest evaluation, from a medical standpoint. In describing what this means, the physicians focused on the pathophysiological events within the individual. Dr. RF's earlier quote about "the big picture," for example, indicated that she thinks primarily in-terms of pathophysiological disease states which can be prevented or ameliorated through individual interventions. Despite the growing recognition of the importance of such diverse
societal factors as educational level, poverty, and discrimination as etiological factors for many diseases, for Dr. RF an "honest" evaluation still focuses on individual pathophysiology. Dr. BN described her approach to discussing hypertension with a newly diagnosed patient, in which she focuses on the pathophysiology of the disease and its long-term consequences. "I pretty much stick with my medical belief system...if I'm just telling someone about hypertension and how it affects the blood vessels, and what kind of problems they're going to have from prolonged hypertension, I would describe it just like I would to anyone else," again echoing the focus on internal physiological processes. One problem with this narrow focus is that it prevents patients from understanding the roots of their disease process within the complexity of societal problems. For example, without understanding the roots of historical dietary changes which led to the tremendously high prevalence of diabetes among the Navajo people, it is less likely that a patient will be able to modify his/her diet as recommended by the physician. Furthermore, the narrow focus on biological processes tends to conceal the influence of societal inequities on the Navajo people behind the cover of individual pathophysiology. Dr. RF gave me a striking description of an encounter with a newly diagnosed hypertensive, in which she seemed on the verge of including the broader context of the disease in her comments, but then deflects the conversation to avoid discussing the social roots of his disease:

I explained to him about high blood pressure and cholesterol, and he says 'that's a white man's diet.' That was interesting because I think fry bread and mutton are a white man's diet that they didn't eat until our culture sort of overtook them... So he told me we were coming up with hypertension -- that it was just one of the things that the medical system was doing to manipulate the native population more -- just coming up with this and making them take medications...We went way back, and started talking about how Navajos used to live and they had no problems with high blood pressure, but no one even took blood pressures so no one knew; and the white people had high blood pressure too and didn't know it either. I just tried to show him that it was more of a historical change in the amount of information available....humans have evolved into a sedentary population, and its not just Navajos who are now plagued with hypertension.
This is a rather complex passage, in which it appears at the outset that Dr. RF is going to discuss the changes in Navajo health which a "white man's diet" have brought about. However, as she continues, she implies instead that hypertension is an equitably-distributed disorder, which has come to be recognized as a problem now, following increases in screening. She then concludes by telling her patient that the incidence of hypertension has increased due to a universal change in lifestyle, but again implies that the distribution is equitable -- a natural consequence of our societal "evolution." Thus, perhaps inadvertently, she deflects the discussion from a consideration of the dramatic increases both in hypertension and coronary artery disease in the Navajo people -- paralleling changes in lifestyle and social structure -- to appeasing her patient by pointing out the prevalence of the problem in white populations. It is undoubtedly very rare for a patient to be so forthright in expressing his/her skepticism, so it is likely that most discussions of hypertension never proceed past the discussion of the pathophysiology. Consequently, as suggested in the "Theoretical Framework" section, the net result is to shift the focus away from the ways in which the inequities, power struggles, and the cultural fragmentation brought about by Anglo culture has impacted on the health of Navajo people. This ability to disguise social problems by focusing on individual pathophysiology helps keep inequities in society from becoming foci for organization and dissent. Despite the benign intentions of individual providers, at a deeper level the IHS is thus helping to protect the oppressive social structure which has restricted Native American freedom for centuries.

2. What is "Cultural Sensitivity"?

There may be two explanations for why patients expressed no complaints about the cultural sensitivity of IHS physicians. It is possible that the physicians, through such "methods" as "phrasing things in the third person" and "not forcing eye contact," have avoided culturally offensive behavior. But given the tremendous diversity of personal belief systems and
individual relationships with tradition among this population, it seems unlikely that such a concise set of "tactics" would enable a physician to communicate effectively with every patient. Furthermore, physicians are on the Reservation for such a short time that it would be difficult to learn enough about the culture to become truly "culturally competent." Hence it is more likely that patients are not particularly concerned or troubled by the cultural differences between themselves and their providers. Instead, some of the comments made by patients and providers suggest that a more general atmosphere of respect, trust, and caring may be far more important than the physician's cultural acumen.

The contrast between Dr. HA's discussion of "avoiding direct eye contact" and Dr. RF's opinion that she can judge how a patient feels toward her in part through the patient's willingness to make eye contact highlights the differences between these interpretations. For Dr. HA, the knowledge that Navajo patients, in particular, tend not to make as much eye contact as other cultural groups leads him to interpret a patient's failure to do so as a cultural norm. For Dr. RF, on the other hand, this type of non-verbal communication gives her information about whether she is forming a respectful, trusting, and cooperative relationship with the patient. Thus, Dr. HA may fail to detect a problem in his relationship with the patient because he interprets the patient's behavior through a cultural screen. The argument could be made, on the other hand, that Dr. RF misinterprets a cultural norm -- avoiding eye contact -- as a problem. However, when she feels that there may be a problem between herself and her patient, she asks if the patient is comfortable, or if something is wrong. In contrast, Dr. HA's interpretation of lack of eye contact merely leads him to make an assumption, which may or may not be a correct, about his patient, without leading to further discussion or analysis. Furthermore, Dr. RF said that the most important thing she does to facilitate her communication with Navajo or any other patients is to evaluate each interaction individually, without applying any cultural screens to interpret characteristic behaviors. Dr. HA, on the
other hand, tended to refer more to cultural generalities in explaining the ways in which he interacts with Navajo patients, suggesting that he may be somewhat less sensitive to individual variations. Another example is found in Dr. KB's assertion that Navajo patients may feel doubtful about a physician's competence because they are accustomed to hand tremblers, who diagnose problems without asking so many questions and performing elaborate tests. This undoubtedly expresses a truth about many traditional Navajo patients. However, patients from all cultures commonly complain that physicians explain their decisions and recommendations inadequately; indeed, this type of miscommunication all too often characterizes the physician-patient interaction. Thus, much of the trouble from a Navajo patient's point of view may be that the physician simply has not taken enough time or effort to explain the complexities of his/her disease process or treatment options clearly and with empathy for the patient's concerns and fears. But a physician who "knows" an isolated cultural generality about Navajo peoples' tendency to regard physician's diagnostic efforts with skepticism may be more likely to interpret patient dissatisfaction as arising from a cultural difference than from a deficit in his/her communication with the patient.

Finally, the issue of predictions possessing the power to produce events -- the most frequent cultural characteristic cited by the providers -- undoubtedly reflects a truth about a traditional Navajo belief in the power of words. However, when physicians focus on this concern, they risk avoiding the inherent complexity and discomfort always involved in discussing a serious disease or the possibility of death, and hence, they deny the essence of the patient's or family's pain. Dr BN's comments about the necessity of phrasing things in the third person (also cited in the "Cross-Cultural Communication" section) illustrate this problem:

You say 'some people who have ovarian cancer like yours will go on to die in six months.' You don't say, you know, 'you have six months.' You say 'many people who are in septic shock will not live through the night;' you don't say 'your father's going to die tonight,' because if he does, it was you who did it, no matter what.
The predictions she makes in these cases carry extraordinarily frightening, inherently upsetting information. Regardless of whether she phrases them in the third person, these statements are very likely to leave her patients stricken with grief, sadness, and fear. But Dr. BN identified the most important issue in telling her patients such devastating news as her failure to use the third person. Her focus on this problem appears to have led her to avoid the deeper and more complex issue of how to provide effective support and empathetic care for patients and their families during times of crisis. Furthermore, her predictions seem to convey a somewhat fatalistic attitude toward her patients' conditions, which might lead her patients to worry that she has "given up" on them. A recent conversation with an Anglo patient, RE, illustrates this problem. RE was diagnosed with breast cancer after a biopsy of a large tumor. In telling RE that she had cancer, the physician said "well, it's a very big tumor, but sometimes we can even cure tumors this big." Upon hearing this, RE felt concerned that her physician lacked the faith and self-confidence to provide a maximal effort in trying to cure her, because she seemed to feel that RE's case was hopeless. Thus, because of the physician's attitude and choice of words, this Anglo woman, who holds no belief that words have the power to produce events, felt fearful because of the way in which her physician phrased her predictions. It is possible that physicians working with Navajo patients may interpret similar non culturally-based fears as the cultural trait "fear of first-person predictions."

The few problems which patients mentioned regarding their interactions with IHS physicians were not related to culture. For example CJ's wife felt that her provider had been too blunt, and somewhat insensitive to the upsetting and frightening nature of telling her that she might have cervical cancer. Furthermore, she felt that the physician should have tried to include CJ or someone else to support her when she received such upsetting news. Another common problem mentioned by patients was the long wait to see a provider when they come to the hospital. Though several providers mentioned that "patients don't like the hospital because it's
a place where people die" -- referring to a cultural fear of contact with dead people -- the patients I spoke with denied that this was a problem, always referring instead to the long wait. A public health nurse said that many of her patients have told her they would feel much better about waiting if they felt their providers would acknowledge or apologize for the inconvenience. DB's concerns about the IHS' prescriptions for diet and lifestyle changes are based partially in his cultural background; he feels that these modifications in lifestyle might be accomplished more effectively if the IHS took Navajo culture and tradition into account. But DB's suggestions for improvement did not reflect a desire that his providers should be better-versed in Navajo culture. Instead, the problem he experienced stemmed from his providers' failure to consider the context of his illness -- for example, the availability of refrigeration, his family support and dietary habits, the availability of land which could be cultivated, the distance to the nearest store, and the foods and types of exercise which might be most acceptable based on his culture and background. Thus, instead of trying to generalize based on a stereotype of traditional culture, DB's providers could have tried to individualize his care based on a consideration of his lifestyle and his belief system, and through discussing his own concerns about the necessary lifestyle changes with him.

The above examples have shown that often, the use of cultural stereotypes may inadvertently lead to a misinterpretation of problems which occuring at a more fundamental level provider-patient interaction as stemming from cultural differences. Another liability of what might be called a "culturalist" approach to working with patients of diverse backgrounds is the tremendous likelihood that individuals within the culture will not fit into the cultural generalizations which guide this type of cross-cultural communication. Even in a population such as the Navajo Tribe, where there is only one major ethnic group, there is tremendous individual variation in religious affiliation, cultural background, educational status, and degree of acculturation. And in a population as diverse as a major city, where instead of one culture
there are dozens, and within each are many different levels of acculturation, this approach seems destined for failure.

Thus, instead of building more assumptions and stereotypes into the provider-patient relationship, a more effective approach to cross-cultural medicine would involve the provider in reexamining his/her own assumptions and biases, in order to facilitate his/her ability to create an open and non-judgmental forum for discussion. Because this approach does not involve a specific "technique," it is difficult to avoid generalities. Nevertheless, the interviews with patients and providers showed that many problems might be avoided if physicians took the time to listen well, without preconceptions about their patients; if they welcomed patients' questions, emotions, and even frustrations about the care they are receiving into the interaction; and if they encouraged patients to participate in making decisions and developing strategies for their own care.

4. Conclusion

The arguments above suggest that the current approaches taken by the IHS may prove inadequate to address the main challenges to Navajo health today. As a source of strength and renewal of traditional Navajo culture and values, Navajo healing may have a great deal to offer where the IHS falls short. Furthermore, the IHS may actually impede the benefits which traditional medicine could offer by reorienting Navajo peoples' conceptualization of health and illness.

It would be foolish to argue based on these hypotheses that the services which the IHS provides are unnecessary or of little value. In controlling the infectious diseases which were previously such a terrible problem, and in treating the consequences of the more recent behavioral and man-made problems, the IHS serves essential functions. As Angell says in her
recent article on the connection between socio-economic status and health, "The fact that some illness has a socioeconomic basis does not diminish the need for treatment or palliation."

(Angell 1993: 127). Instead, the discussion above suggests that traditional medicine may have become a neglected resource, and furthermore that physicians may actually impede the natural relationship between Navajo patients and the traditional healing system. How can these problems be avoided?

The "Cross-Cultural Communication" section above argues for the need of a less presumptive model of medical practice. Rather than learning characteristics of a culture, and then attempting to apply them -- filtered through the provider's own belief system -- to clinical practice, physicians might better cope with the diversity of their patients by trying to remove their own biases and assumptions from the clinical interaction. Thus, rather than assuming that traditional medicine cures a specific subset of problems through psychological mechanisms, a physician would accept at face value the patient's own explanatory model, without trying to re-explain it from her/his own perspective. This would not prevent the physician from giving a medical opinion "honestly," but would simply keep him/her from reinterpreting a system of which they have little knowledge and even less understanding through a biomedical belief system. Cross-Cultural orientation programs should focus on trying to teach physicians more about questioning the presumptive basis of biomedicine, and less on "cultural compatibility."

Then rather than assuming that the individual-centered biomedical approach can solve all health care problems, physicians would begin to look at a larger picture, and pay more attention to the ways in which societal dynamics impact on health and illness. In-turn, an "honest" medical opinion would take into consideration the larger scope of challenges which impact on each patients' disease. Within this context, physicians could begin to view the role of biomedicine as comprising only one piece of a very complex solution, which includes traditional healers and Navajo culture, other health care professionals, and changes at the societal level.

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In this thesis, I have focused on the protective benefits which traditional culture can offer against the contemporary health problems on the Navajo Reservation. Biomedicine undoubtedly exerts a powerful influence over Navajo people's relationship with their culture and traditions, and future programs should be conceived of in such a way as to strengthen, not subversively weaken, this relationship. But unfortunately, the same societal forces which led to the present epidemic levels of degenerative and man-made diseases also shape the culture and peoples' relationship to it. In the "Brief Introduction to the Navajo People," I outlined the complex and often troubled evolution of the Navajo Nation -- including the depletion of the grazing and farm lands and water supply; the shift from a self-sufficient to a wage and welfare-based economy which is heavily dependent on federal funds; the acculturating effects of education and wage work; and the movement of families from widely dispersed farms to crowded communities -- as well as the repeated challenges to the spiritual integrity and health of the people -- from Stock Reduction and the Long Walk as well as through the more covert and omnipresent influences of racism and cultural stereotyping -- which frames the context of Navajo health. This history has affected not only the peoples' health, but also their relationship with traditional religion and healing. It is therefore uncertain how effective an effort to draw on traditional ways to improve the people's health status will be without concomitant improvements in the complex societal problems which now face the Tribe.
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