The Dilemma of White Providers in Indian Country

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Abstract: The legacy of the European diaspora across North America is fraught with grim realities as it relates to the impact on Indigenous populations long-residing here. Generational trauma related to centuries of systematic cultural dismantling has ravaged tribal populations. As an RN of Scots-Irish descent practicing in western Montana among the psychiatric and corrections populations, I have had the opportunity to witness the challenges unique to the predicament of providing care to the Native population for non-Native providers. Is it possible for members of the dominant, historically oppressive culture to provide care without re-traumatizing?

***Keywords*:** Native American, generational trauma, Indigenous health

"Robert Lone Elk" (pseudonym) is a member of the Crow tribe and a patient at Montana's only state mental health facility. He was admitted for the eighth time via tribal commitment related to public intoxication and disturbing behaviors that the tiny clinic on the Crow Reservation is unable to address. His medical chart reveals a history of chronic Alcohol Use Disorder. The tribe has scant addiction services on the reservation, struggling to address the most basic medical needs of the tribal population. Twice daily he is held down by nearly a dozen non-Native hospital personnel to receive psychotropic medication injections. An Involuntary Medication Review Board composed entirely of non-Native hospital personnel assumes the paternalistic role of making the decision for him. Recent bloodwork reveals abnormally high ammonia levels along with abnormal liver values, indicating liver failure. The medical doctor suspects his confusion and steady decline in cognitive function are the result of untreated cirrhosis. When the medical doctor visits him in his room to discuss this, he disdainfully admonishes her: "Get out of my room, you white bitch." He refuses the necessary lactulose to correct ammonia levels, which would potentially resolve related cognitive and psychiatric decline. He wants nothing to do with these providers. This anti-colonialist sentiment is not uncommon among the Native population of Montana.

The ethical dilemmas related to serving the Native population in Montana are numerous and complex but could be addressed by the answering the following questions: How can non-Native clinicians of western European lineage provide effective medical care to members of a culture who have been historically oppressed, exploited, and traumatized by their forebears? If Native recipients of medical care neither trust nor wish to engage in the dominant culture's healthcare system, how is beneficent and autonomous healthcare delivered without retraumatizing the population?

Dilemma Context

Delivering effective, culturally competent medical and mental healthcare to the Indigenous population in Montana is a systemic quandary straddling the ethical ideals of autonomy, justice, and beneficence. Barriers to care include lack of Native cultural awareness among providers of

European descent, an inherent paternalism related to the trust relationship assumed by the American federal government in 1955 to provide comprehensive healthcare to Native populations, and a dearth of Native healthcare providers. Beginning in the late 19th century, colonialism decimated centuries-intact cultures and family structures. The unslakable thirst for westward expansion isolated once wide-ranging tribes to comparatively small parcels of barren land. Religious persecution and wholesale genocide of Native Americans ensued. Native children were taken from families in the era of Native boarding schools where forced assimilation took place and abuse was rampant. In short, the Indigenous population of Montana has sustained grave generational and cultural trauma at the hands of a paternalistic, white America enduring decades of oppression, exploitation, marginalization, and near extinction. Native American healthcare is marked by inequity, overseen by an inadequate federal agency, the Indian Health Service (IHS). Little opportunity for education exists on reservations, resulting in the notable dearth of Native health providers. Because Indigenous Montanans have been serially traumatized by European colonialism, white healthcare workers pose the threat of re-traumatizing an entire population due to an understandable lack of trust. "As members of federally recognized sovereign nations that exist within another country, American Indians are unique among minority groups in the United States" (Office of the Surgeon General et al., 2019, p. 79).

In light of my first undergraduate degree in Native American Studies, received from the University of Montana, I carry my own bias *toward* Native Americans with the goal of advocating for this marginalized, under-resourced population. However, this advocacy is not always welcome; my own European heritage poses a distinct barrier as the anti-colonial sentiment is justifiably rooted within the hearts of many Native people and is often viewed as a dressed-up version of paternalism. This pro-Native bias, however, positions me to be keenly attuned to the ethical dilemmas I witness daily and provides an awareness that allows me to evaluate the dilemmas from the unique perspective of witness and observer.

Cultural Humility Models

The Campinha-Bacote Model of cultural competency in healthcare delivery was created in 1998 (Albougami, 2016). It is described as a process of healthcare delivery rather than a consequence of any certain factors. "To achieve cultural competence, a nurse must undertake a process of developing the capacity to deliver efficient and high-quality care" (Albougami, 2016, p. 3). Of the five concepts comprising this model, three of them are central to the ethical dilemma of delivering just care to the Indigenous populations of Montana. The first concept is *cultural awareness*, referring to basic acknowledgement of one's own cultural background. This self-awareness precedent must be achieved first to avoid bias when approaching separate cultures. Cultural oppression is not unique to Native Americans. By becoming aware of one's own Irish or Italian or Romani heritage, for instance, a provider gains awareness of persecution endured by members of their own heritage, thus allowing the provider to meet Native Americans in their own reality of cultural and generational trauma. The second concept is *cultural knowledge*. This refers to the process by which healthcare providers "open their minds to understand variations in cultural and ethnic traits as they relate to attitudes toward illness and health" (Albougami, 2016, p. 3). Native Americans often view mental illness through a culturally different lens marked by

lack of distinguishment between physical and mental distress (Office of the Surgeon General et al., 2019). Non-Native mental healthcare providers' recognition of this would inform treatment and could allow the provider to prioritize inclusion of Native healers in the healthcare process. The third concept, *cultural desire*, is critical. This cultural humility model could be implemented in nursing education from coast to coast, but without the intent to learn and comprehend Native American cultural ideals and values, the educational intervention is futile. "Cultural desire … is the driving force for becoming educated, skilled, competent, and aware of culture; it also presumes a willingness to have transcultural interactions" (Albougami, 2016, p. 3). Educating nursing students who have the desire to practice among Native clients is the keystone for successful application of this healthcare delivery model.

The American Association of Critical-Care Nurses developed the Synergy Model for Patient Care in the 1990s (Kaplow, 2008). Less specific to cultural awareness than the Campinha-Bacote Model, the Synergy Model is valuable in application to the Native American population in that delivery of care is patient-centered, specific to patient values, thus necessitating the need for cultural awareness. "The core concept of the model is that the needs or characteristics of patients and families influence and drive the characteristics or competencies of nurses" (Falter, 2008, p. 260). Of the concepts central to this patient care delivery model, vulnerability, complexity, and resource availability are directly relevant to the Native American population. Vulnerability addresses physical, psychosocial, and social stratum, all relevant within the Native American population. There exists a well-established genetic vulnerability to alcoholism among Native Americans; the psychosocial vulnerability speaks to cultural and generational trauma; and social vulnerability covers issues such as geographical isolation, lack of adequate social services, and shortage of economic opportunity on reservations (Ehlers & Gizer, 2013). Addressing this vulnerability is foundational to serving the population with an awareness that is paramount to delivery of high-quality care.

As established, the healthcare needs of Native Americans are complex, fraught with challenges related to the burdens of cultural and generational trauma and tangential physical and psychiatric illnesses. Acknowledgement of the complexity inherent to the population, therefore, is of direct concern to nurses delivering competent mental healthcare to Native populations. Finally, awareness of the dire shortage of resources available to both urban Native populations and reservation populations is essential for the healthcare provider serving these populations. A common misconception of the Indian Health Service is that it provides high-quality care to all Native populations. This is not so. In the mid-1950s the federal government developed a trust agreement with all federally recognized tribes promising delivery of comprehensive healthcare in perpetuity (IHS, 2015). In reality, the IHS is short by nearly $2 billion annually to provide healthcare equal to the level and breadth of care provided to federal employees (Office of the Surgeon General et al., 2019). Further, urban Native populations fall through the care safety net in that IHS services are available predominantly on reservations. "Although the goal of the IHS is to provide health care for Native Americans, IHS clinics and hospitals are located mainly on reservations, giving only 20 percent of American Indians access to this care" (Office of the Surgeon General et al., 2019, p. 82). Recognition of the shortage of healthcare resources is necessary to effectively address healthcare needs of the Native population.

Strategizing Solutions

The ethical dilemmas of beneficence and autonomy present challenges to effective healthcare delivery to the Native population in Montana and beyond. To overcome barriers to care for this population certain strategies could be implemented. Compulsory training could take place for all IHS employees in the Campinha-Bacote model, or related models, to achieve cultural humility specific to Native Americans. "Formal opportunities to cultivate cultural awareness and investigation of racism's root causes must be robustly integrated into health professions training" (Wescott & Mittelstett, 2020, p. 859). The federal government has an obligation to actively recruit Native students into nursing programs via scholarships to incentivize participation thereby increasing the amount of "patient-clinician concordance—defined as shared identity between patients and clinicians" (Wescott & Mittelstett, 2020, p. 857). Language training for both Native and non-Native healthcare providers could be offered as "approximately 280,000 American Indians and Alaska Natives speak a language other than English at home," thus honoring tribal identity (Office of the Surgeon General et al., 2019, p. 84). Incorporation of traditional spiritual practices and inclusion of Native healers in the healthcare delivery process could add credibility to the Western healthcare model making necessary treatment possible that might otherwise be refused. Delivering healthcare to the Native population in Montana and across the United States is daunting, but it is not impossible. The implementation of systemic solutions to address systemic oppression is long overdue.

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