Western medicine as standard practice

- The Egyptian Imhotep describes the diagnosis and treatment of 200 diseases
- Birth of Hippocrates, the Greek father of medicine begins the scientific study of medicine and prescribes a form of aspirin
- Diocles wrote the first known anatomy book
- Herophilus studies the nervous system
- Alcmaeon of Croton distinguished veins from arteries
- Birth of Galen, Greek physician to gladiators and Roman emperors
And going….

1953 James Watson and Francis Crick work on the structure of the DNA molecule
1954 Gertrude Elion patented a leukemia-fighting drug
1955 Jonas Salk develops the first polio vaccine
1956 Thomas Fogarty invented the balloon embolotomy catheter
1964 First vaccine developed for measles
1967 First vaccine developed for mumps
1965 Dr. Christian Bernard performs the first human heart transplant

Anyone notice a trend?
To the victor goes the spoils

EVIDENCE BASED PRACTICE

- Evidence-based practice (EBP) is the integration of
  - Clinical expertise/expert opinion
    - The knowledge, judgment, and critical reasoning acquired through your training and professional experiences
  - Evidence (external and internal)
    - The best available information gathered from the scientific literature (external evidence) and from data and observations collected on your individual client (internal evidence)
  - Client/patient/caregiver perspectives
    - The unique set of personal and cultural circumstances, values, priorities, and expectations identified by your client and their caregivers

American Speech-Language-Hearing Association
Retrieved on 4/26/2023 from: https://www.asha.org/research/ebp/#:~:text=Evidence%2dbased%20practice%20(EBP)%20is%20the%20integration%20of,your%20training%20and%20professional%20experiences
• Clinical expertise/expert opinion
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Traditional Medicine: Is the sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences Indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness (WHO, 2001).

The Report of the Royal Commission on Aboriginal Peoples (1996) defines traditional healing as:

- Practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western ‘scientific’ bio-medicine. When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counseling and the accumulated wisdom of elders (RCAP, 1996, Vol.3, p. 348).
Leverage
Leverage integrative medicine to advance health equity, that is, the attainment of the highest level of health for all people.

Promote
Promote an integrative medicine culture that upholds the values of diversity, equity, and inclusion.

Address
Address intrapersonal attitudes, beliefs, and behaviors that perpetuate bias and discrimination. (Ijaz N. & Boon H., 2018; Weeks, J. 2018).

Dr. Daes (1993), Report on the Protection of Heritage of Indigenous People (as cited in Battiste & Henderson, 2000) states:

Indigenous knowledge is a complete knowledge system with its own concepts of epistemology, philosophy, and scientific and logical validity...which can only be understood by means of pedagogy traditionally employed by these people themselves (p. 44).
“GOTTA KEEP THE LIGHTS ON”
Establishing medical necessity and 3rd party billing

§ 485.916 Condition of participation: Treatment team, person-centered active treatment plan, and coordination of services. (retrieved 3/29/23 from: https://www.law.cornell.edu/cfr/text/42/485.916)

Medically necessary:
Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. (retrieved on 3/29/2023 from: https://www.healthcare.gov/glossary/medically-necessary/)

How do I demonstrate medical necessity in therapy?
Generally, three things inform medical necessity: ICD-10 (DSM-V) & ASAM findings, impairments as a result of the said diagnosis, and what interventions you’re providing to alleviate symptoms and improve functioning. You can use that one sentence as your guide. (Retrieved on 3/29/2023 from: https://www.mentalyc.com/blog/medical-necessity-documentation-utilization-review-and-authorizations/)

The best way to navigate medical necessity is by having clear documentation from the very beginning or first session of treatment. It’s extremely difficult to know the nuances of what each insurer wants to see.

However, clinicians are generally successful when they use these three pillars (diagnosis, impairment, and intervention) and language around medically necessary interventions. It can be additionally helpful to document how removing or stopping your interventions will bring the risk of relapse/recidivism or worsened functioning. (retrieved on 3/23/2023 from: https://www.mentalyc.com/blog/medical-necessity-documentation-utilization-review-and-authorizations/)
Symptom: a physical or mental feature which is regarded as indicating a condition of disease, particularly such a feature that is apparent to the patient. (Oxford Dictionary)

- It is our job as the provider to determine whether a “symptom” is something that requires “treatment”
- Is the symptom intrusive? Why would our patient present/report that symptom? Is this a typical or atypical presentation?
- Is it or could it be associated with a common ailment: a sore throat may be associated with streptococcus as an example
- Frequent feelings of hypervigilance associated with PTSD
- A physical craving/headache associated with recent nicotine cessation
By definition, a therapeutic alliance is a ‘...conscious and active collaboration between the patient and therapist’. Similarly, a therapeutic relationship is ‘a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and

- The development of a strong therapeutic alliance and the subsequent production of positive client outcomes are dependent on effective communication skills, practitioner behaviour, collaboration, time and trust. (Leach, M. J. 2005)
Ways to invite information?

Simply asking about faith or religion may not be enough, we are taught in American society that it is uncouth to discuss money, politics, and religion.

Do you smudge up at home? Do you pow wow?
Do you sweat? Medicine people?
Do you go to church? How often do you pray?
How do you pray?
Dreams and guidance? Medicine bundles?
Ceremony? Baptism? Bible study? Mission trips?
Crystals? Pilgrimages?

Poker face

How aware are you of your response to information? Tone?
Body language? Facial expressions?

(the weird, wacky, shocking, random, wild, odd....)

Regardless of our personal orientations we promote our patient’s values and customs, sometimes that can feel odd for a provider.
Universal regard

Back to diagnostics

- Where to chart? How to chart?

Example:

New patient diagnostic session (we just met this guy and no very little): Bob reports that “my grandmother comes to me in my dreams, she has warned me about things” “one time she told me not to go on the interstate and the wheel of my car fell off” “if I would have been going highway speeds I would be dead” “she came to me to keep me safe”
What to make of things?

- Therapist (Me): “whoa! Way cool”, “what do you make of that?” “what does your family think about that?” “how do you feel when she comes to you like that?”

I want to know: is this a cultural/spiritual thing or is this somehow delusional in nature. Is the self-report linear and clear or disjointed/rambling in nature?

- Are there any other “types” of auditory, visual, olfactory, etc… hallucinations present? Any substance use history that may contribute to this?

- Could be a hallucination that is commanding in nature...

- Is this disruptive to the patient’s ADLs?

How to chart symptoms vs culture

**In a diagnostic we have clear headings:**

- **Spirituality/Religious:** pt reports that his “grandmother comes to me in dreams” and in this offers guidance and support pt deems as helpful. Utilizing MI this author established that this is considered by pt to be cultural/spiritual in nature, as such this author interpreted this not as a symptom of SUD/MH.

- **Symptom:** pt reports that his “grandmother comes to me in dreams” and in this offers guidance and support pt deems as helpful. Utilizing MI this author additionally identified that pt reports a number of waking auditory and visual hallucinations, through reflective dialog pt reports that “I think it’s the meth?”, denying historical symptom presentation associated with psychotic disorders. Pt furthers denies the presence of these “dreams” as being cultural/spiritual in nature.
How to chart self-identified culture as justified intervention in p-note & treatment planning

- Let’s assume that this dream is not a symptom associated with SUD or a significant mental illness and in talking to this pt he further identifies that “I feel like I can call on her (grandmother) to help me when I need it”

- Treatment Plan: Goal 1 through MI pt will identify one or more new coping skills he can utilize across the coming week to self-sooth and/or reduce triggers to use substance

- P-note: pt was engaged utilizing MI to identify a coping skill he felt he could utilize to minimize “all these cravings and messed up thoughts”, in this pt identified a culturally relevant/spiritual worldview he felt he could utilize as a coping skill. Pt will employ the utilization of said skill to minimize symptom interference and report back to this author efficacy of its use next session.

Case study “the purple dragon”
Purple dragon

- **Child A**: 10 y/o male—mother is white, father is Salish. Father reports no connection to traditional ways. Child is seemingly unaware that he is a tribal member. Both parents struggling with addiction-CPS involvement. Child recently discharged from inpatient pediatric psych setting and is on Seroquel. Child referred to outpatient r/t increased behavioral disturbances in school and at home.

- **Child B**: 9y/o male—mother is Crow and Salish, father is Salish and Kootenai. Family pow wows, attends ceremony, generational household, grandmother smudges every morning and prepares traditional plant medicines when members are sick. Father struggling with addiction-CPS involvement. Child recently discharged from inpatient pediatric psych setting and is also on Seroquel. Child referred to outpatient r/t increased behavioral disturbances in school and at home.

- **Child C**: 13 y/o female—mother is white and Winnebago working as a western medicine provider, father is White Clay, residing on the Ft. Belknap reservation. Parents are separated. Child reports familial sexual abuse by "older cousin". Family identifies as "Christian" and attends church regularly. Child is self-harming and reports frequent, passive suicidal ideation.

I really messed up.....

Turns out my Assiniboine Sioux ways are very different.....
Eleven states have officially recognized more than 60 tribes.

There are 567 federally recognized tribes in the United States.


In his statement before the Senate Select Committee on Indian Affairs, Mr. Barney Old Coyote of the Crow Tribe of Montana underlined the issues that continue to vex legislative, administrative, and judicial efforts to deal with matters relating to the religious practices of American Indians. The various tribal religions practiced by native peoples in the United States are almost without exception inextricably linked with what non-Indian society regards as culture. This unity of culture and religion makes American Indian forms of worship alien and difficult for the non-Indian to understand and poses difficult questions for
Seeking understanding

- Child A and B presented within a day of one another. Both reporting the same purple dragon, describe in detail and draw pictures that are essentially identical.
- Children live in very different areas of the reservation and have never met
- Child A identifies as white Child B identifies as Salish & Kootenai
- Both children have been diagnosed with a psychotic disorder via pediatric inpatient and are on Seroquel.
- Children present as inpatient referrals to outpatient as “step-down”
- During treatment planning a Kootenai colleague readily identifies what the purple dragon is. Via staff we reach out to an area Salish elder
- This purple dragon can be “resolved” with ceremony

Informing colleagues

- You cannot name the purple dragon or you will welcome “it” to you—this includes charting (hence “purple dragon”)—we will honor this world-view!
- Some staff imply that this is “made up”, a community folklore, “not real” despite Child A and B having never met, living in different parts of the reservation, and not identifying or being raised the same
- Real vs make believe—defending the sacred in practice and in policy

Engaging patient and family

- Linking into interventions. How to engage, what to expect, honoring experience
- Introducing the knowledge from the elder and offering linkages
- **Child A’s** mother was intrigued and very open to staff introducing family to cultural leaders
- **Child B’s** mother and grandmother cried, relieved that they could heal the child and stop medications, family reported knowing healers/medicine people that they would engage
• **Child C** and mother were engaged, this author shared aspects of the knowledge gained from A and B, that this “dragon” was attached to the area and came to the vulnerable. This author reaffirmed their Christian values and given that Mom was classically trained western medicine–this author explained hesitance to chart the purple dragon as a symptom (AH/VH) could we explore this first?–would mom feel comfortable engaging the families medicine people? Would dad engage the families medicine people? C is 13, what would she like to do? How could I support the inclusion of Christian values?

**HONOR Everything of value to your patient**

• Mom and C safety planned and at a follow-up appointment Mom and child reported back having engaged a bundle keeper and that the “dragon” was resolved, they also engaged their pastor and were included in the church’s prayer chain (duality is common). Both reported feeling supported and C’s suicidal ideations and self-harming behaviors were

• All 3 children reported a resolution of “purple dragon” following engagement with traditional medicine.

• Each family reported relief and happiness for the holistic approach

• I never asked what ceremonies were held/details and I told them I never would—they are welcome to share but that I would honor the sacred

• Each child continued to engage in outpatient therapy related to individual traumas but all cited utilization of culture as their “go to” coping skill
Duality

- Patient centered and self-directed
- As practitioners walking in two worlds, protectors of the sacred. Not by our own definition but by that of our patients. As healers we must promote and defend what heals our patients while also drawing continuity to our western ideologies, licensing standards, payer restrictions, and the like.

All of these sessions were reimbursable. Each session utilized an evidence-based intervention to support the patient/family utilizing/developing a coping skill (etc...) that hinged upon **self-identified value systems** to minimize intrusive symptoms.
RESTORATION OF THE CIRCLE

And as I looked and wept, I saw that there stood on the north side of the starving camp a Sacred man who was painted red all over his body, and he held a spear as he walked into the center of his people, and there he layed down and rolled. And when he got up it was a fat bison standing there, and where the bison stood a Sacred herb sprang up right where the tree had been in the center of the nation's hoop. The herb grew and bore four blossoms on a single stem while I was looking—a blue, a white, a scarlet and a yellow—and the bright rays of these flashed to the heavens. (Black Elk, quoted in Neihardt, 1959)

References:


