Northwest University

Build Better Doors

How to Create Trust in Healthcare Through the Intentional Design of Clinical Facilities

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Table of Contents

Introduction

When you think of going to see a doctor, what pictures come to mind? Maybe a waiting room with several rows of uncomfortable chairs in precisely straight lines broken up only by the odd coffee table topped with a mix of health and designer magazines. Perhaps squeaky-clean laminate floors reflecting the blazing white of the fluorescent lights in the paneled ceiling above. Uncomfortably small exam rooms, the persistent smell of rubbing alcohol, the bulletin board overflowing with info sheets and health ads. If you grew up in western society, you probably find resonance with these descriptions. Regardless of where you go or what kind of healthcare professional you see, it is safe to say that you have likely encountered the same environment throughout your life. While such a reality is not necessarily ideal, it is what we know. However, the problem within such monochromatic design lies much deeper and addresses issues of a very impactful nature.

The reality of modern medicine is this: regardless of its brilliant ability to heal the sick and mend the broken, it is incredibly impersonal, distant, and even inhuman. Efficient, practical, and successful, yes. Warm, hopeful, and comforting, absolutely not. Western medicine is designed to be a machine, calculating and unemotional. While such an approach produces results nothing short of miraculous, it harbors an environment that is cold, even hostile. This creates a particularly acute problem within non-western collectivist communities. Communities that are focused more on healing than on medicine. Such a problem is further exacerbated when the communities in question do not have a firm foundation of trust in the greater medical community prior to healthcare facilities being constructed and put into operation. This brings us to the crux of the matter. To better maximize the cooperative relationship between modern medicine and

longstanding cultural norms throughout the world, we must build better. That is, we must begin to design and construct healthcare facilities that reflect the cultural values of the community in question, without and within.

The above conclusion was reached via a long process of personal experience, research, and study. What follows is a paper that seeks to describe to the reader the journey undertaken, the people I met along the way, and the ways in which I hope to influence, and ultimately change, the face of rural intercultural healthcare. We will begin with an analysis of my fieldwork with Washington State University's (WSU) Department of Native American Health Sciences (NAHS), where I spent the better part of three weeks observing and engaging with medical students as they went through a cultural immersion program aimed at informing and preparing them for a healthcare career within a tribal context. Then, we will look deeper at the history and present situation of my fieldwork environment: Native American communities. With such context in mind, we will explore the challenge I chose to research, namely, how we can improve the relationship between modern medicine and tribal communities. Finally, we will come full circle to the solution I have proposed and an analysis thereof.

To further inform the reader, I have two appendices. The first is an article entitled "A Proposal for the Design, Construction, and Operation of Culturally Honoring Clinical Facilities within Native American Communities" (See Appendix I). This project lays out a comprehensive timeline and roadmap for one to follow when seeking to build healthcare facilities within tribal contexts. While the project is specific to Native American communities, it is my hope and belief that it can be adapted and utilized within intercultural communities the world over.

Let us begin.

The Context

There is a great amount of weight in writing about a Native American context. Not only is there the toll that comes with the harsh history and bitter reality that these populations have, but there is also pressure as an outsider to write in such a way that is accurate, respectful, and honoring. So, rather than attempt to describe the Indigenous context from an all-encompassing, 30,000-foot view perspective, I will instead be focusing on describing the context as it relates to medicine and modern healthcare.

Currently, there are 574 federally recognized tribes in the United States. Twenty-nine of those tribes, along with five that are not federally recognized, are here in Washington state. However, when considering the entire Pacific Northwest Region (WA, OR, ID, AK, Northern CA, and Western MT), the number goes up to forty-three (1. Fieldwork Notes). Taken together, these tribes represent a cultural web of shared histories, traditions, rituals, and beliefs that have withstood the test of time for over a millennium (Sunstein 3). But just barely. The longstanding cultural values of most, if not all, tribes within the United States have been seriously damaged over the last several hundred years, thanks to the effects of European colonization. One practitioner I interacted heavily with goes so far as to say: “We have survived genocide” (6. Fieldwork Notes). Unfortunately, this has left many communities in a shattered state of affairs, barely clinging to the remnants of a once rich and powerful culture (8. Fieldwork Notes). Nowhere is this more prevalent than in healthcare.

Native American populations suffer from a variety of physical health disparities that are derived from a mix of dietary issues and a lack of physical education (4. Fieldwork Notes). Nearly half (48.1%) are diagnosed as obese; 15.1% are diabetic (Carron 28). Additionally, there are also significant mental/emotional/social disparities present. Alcohol attributed deaths sit at

98.5 per 100,000, and 19% of the population is classified as below the poverty line (2. Fieldwork notes). These disparities were highlighted by the Coronavirus Pandemic where, as of December 2020, COVID-19 cases on tribal lands in New Mexico were occurring 4.5-times more frequently than on non-tribal lands. Those same areas had higher levels of socioeconomic, household composition, and disability vulnerabilities (Yellow Horse 6). All of this is compounded by a society that is steadily growing older, with the number of Native Americans 65 years or older projected to increase 3.5-times by 2050 (Goins 285).

These factors and others have led to a society that is marked by intergenerational trauma; a phenomenon characterized by one expert here:

> "The colonized generations are the direct recipients of subjugation and loss, experiencing high rates of mortality from acute diseases, as well as depression, self-destructive behaviors, hostility, and chronic bereavement. Subsequent generations are affected by the original trauma through exposure to parents and grandparents" (Braun 118).

In other words, the trauma of preceding generations directly affects the physical, mental, and emotional health of following generations. This is especially hard felt on children. Paul Tough, author of Helping Children Succeed: What Works and Why, states: "Certain environmental factors, experienced over time, produce unhealth and sustained levels of stress in children, and those stressors, to an extent far greater than we previously understood, undermine healthy development, both physiological and psychological" (Tough 14).

However, despite these harsh factors, the Indigenous communities of America have a deep and rich history with regard to medicine. This comes from an underlying holistic approach to healing and healthcare. To Native Americans, health is so much more than physical. Rather, it is the collective summary of their physical, mental, and spiritual states. To them, we are spiritual beings in a physical body (6. Fieldwork Notes). This stems from the highly prevalent animistic

(the belief that everything around us possesses a soul and desires to be in harmony) belief system in Native communities (5. Fieldwork Notes). As one community elder told me: “We are firm believer in guidance we can’t see” (Elder 3).

All these factors come together to create societies that are incredibly rich, complex, and hard for outsiders to navigate. Most Native communities are highly wary of most, if not all, outside influence, and rightfully so. The state of affairs that faces most Indigenous communities finds its roots in the impact of western expansion into the Americas. This creates the primary challenge modern medicine faces within Native contexts: a severe lack of trust.

More on this later.

Fieldwork Overview

After beginning Northwest University’s Master of Arts in International Community Development (MAICD or ICD), I quickly determined that I wanted to focus my thesis work on healthcare within rural, non-western communities. Specifically, the intersections, or “friction points,” where western medicine and traditional cultures collided (Kelley 78). And there was only one place I wanted to study: Tanzania, Africa. It was a trip to Tanzania in 2018 that ignited a passion for rural healthcare in my heart and ultimately led to my applying to the ICD program. However, as I approached the summer of 2021 with an end to the global coronavirus pandemic nowhere in sight, I was faced with a choice: hedge all my bets on an international trip to Tanzania or pivot completely and choose a domestic fieldwork setting here in the United States. I chose the latter. Now, there is little doubt that in doing so, I made one of the most important decisions of my life.

Several months prior to beginning my fieldwork, I stumbled upon a magazine published by WSU Health Sciences Spokane and issued by the Department of Native American Health Sciences. Across the front cover in big, bold letters was the title, Changing the Face of Health Care. Intrigued, I began skimming through the contents until I came across an article detailing a research opportunity for first-year medical students that the department had hosted the previous summer. The article highlighted how the students were weekly exposed to a curriculum designed to teach them more about the history and current state of Native American communities with specific regard to healthcare ("Spotlight on Summer Research Opportunity"). Highly interested, I reached out to the director of NAHS to learn more. Several weeks later, I received an invitation to observe and participate in the NAHS 2021 Summer Research Opportunity (SRO).

What followed was nearly three weeks of daily Zoom meetings with six medical students, who had just completed their first year at the WSU Elson S. Floyd College of Medicine. Day in and day out, we poured over a wealth of material on Native American history, law, healthcare, and society. Additionally, we also sat in on sessions of the RISE Summer Academy, a collaborative pre-med program designed "to support and expand the number of Native American physicians in the workforce" ("Reimagine IndianS into MedicinE (RISE) Summer Academy" 8). This allowed the medical students and me to meet, interact with, and learn from Native pre-med students from across the country. In turn, they received advice and feedback from various Native and non-Native medical professionals. The combination of daily exposure to targeted readings and videos, the perspectives and experiences of the RISE students, and the knowledge of our research mentors created an environment in which each of us, be it Native or non-Native, began to identify and sympathize with a Native view of medicine.

While the zoom meetings were incredibly impactful in their own ways, by far the most formative experience of the research opportunity came on three-separate days when we were invited to meet in person on WSU's Health Science campus in downtown Spokane. These days were packed with rich and meaningful experiences, including meals, traditional ceremonies, and the dedication of WSU's Center for Native American Health ("Center for Native American Health Blessing Celebrates Native Health" 22). The most influential experience, though, came in our having the opportunity to utilize the Center's brand new Indigenous-developed simulation exam room ("Indigenous Healers Cohort Helps NAHS Thrive" 24). This space, designed to reflect cultural values inherent to Native populations of the Pacific Northwest, allowed the medical students and me to conduct simulations of patient-provider interactions from an Indigenous perspective (see Appendix II). Everything about the space was intentional; the artwork, the furniture, the lights, and even the flooring had meaning. It was in this exam room that I found the crux of my thesis. More on that later.

Coming into my fieldwork, the only experience I had with research was quantitative. With a bachelor's degree in molecular biology, I had plenty of experience putting together numerical data, but almost none with qualitative data. However, as the goal of my research became clearer, it also became obvious that I was not going to be looking for numbers; I was going to be looking for human experiences. Qualitative research focuses on understanding meaning as it is created by individuals and groups; it seeks to make sense of how people interpret their world and their experiences in that world (Merriam 15). Furthermore, the fieldwork I undertook required me to utilize skills that are specific to qualitative research, those skills being "looking, listening, collecting, questioning, and interpreting," the same skills we use

in everyday life (Sunstein 1). All-in-all, choosing to conduct my research qualitatively rather than quantitively just made sense.

Once I had confirmed my method of research, I then decided to conduct my research through the lens of Appreciative Inquiry (AI). The big difference between AI and other forms of qualitative research boils down to how you ask questions. While traditional forms of qualitative research tend to ask, "What problems are you having?" AI takes the opposite approach, asking, "What is going right around here?" (Hammond 5). As someone who tends to approach life from a "glass-half-full" perspective, I found immediate resonance with the AI approach. In my experience, much of our work in development has historically come from the "fix what's broken" mentality. Author, consultant, and AI expert, Sue Annis Hammond, describes this mentality in her book, The Thin Book of Appreciative Inquiry:

> "We are very good at talking about what doesn't work. We have all had years of practice in the art of problem-solving and in being exhorted to be part of the solution. We have limited practice looking for what works and finding ways to do more of that. It never occurs to us that we can 'fix' an organization or even our society by doing more of what works. We are obsessed with learning from our mistakes" (7).

This sentiment is echoed by authors Emmanuelle Katongole and Chris Rice, who adamantly states: "The worst evils are committed not only in the name of evil but also in crusades in the name of fixing what is broken" (Katongole 24). While such an approach is not necessarily wrong, I do believe that it causes us to lose sight of those elements we're already getting right. That is why I chose to conduct my fieldwork through the lens of Appreciative Inquiry.

About three-quarters of the way through my fieldwork, I began to put serious thought into what kind of questions I wanted to ask the medical students in one-on-one interviews. Sticking to the core themes of the ICD program, I decided that I wanted to really hone in on how

the research opportunity had impacted the students' viewed medicine within a communal setting. Additionally, I wanted to know why they had chosen to participate, what they got out of it, and how they were going to use the experience moving forward in their careers. Here is the full list of questions I ended up using:

Student Interview Questions

1) How did you hear about the NAHS Student Research Opportunity?
2) After hearing about it, why did you choose to participate in the NAHS SRO?
3) Before it started, how did you view the role of medicine within community?
4) Before it started, what did you expect to experience from the opportunity?
    a. How were those expectations met or unmet?
5) What part of the opportunity had the greatest impact on you?
6) What did you know now that you didn't know before?
7) How has your understanding of the role medicine plays within a community changed?
8) How do you plan on using what you learned in the future?

Questions one and two were asked mostly for context purposes, as I knew how I had come to be involved in the program, but not how the medical students had come to be involved or why they had chosen to do so. Two of the six students were Native themselves and were directly influenced by this in deciding to join the program (Student 1, Student 3). The other students' answers varied, but for one thing: each of the other four students referenced a desire to address a lack of knowledge with regard to Native American populations (Student 2, Student 4, Student 5, Student 6).

Questions three and seven were directly linked, designed to give me a "before and after" snapshot of how each student saw how the role medicine plays within a community. Most of the students came in with a preconceived notion that medicine played a part in a communal setting, but the degree to which that part is played varied. However, when asked how their views had changed in light of the program, they each emphasized the importance of 1.) patient-provider relationships and 2.) a physician understanding and being a part of the community they serve.

Questions four and five were also linked and, similar to questions one and two, meant to give me context more than anything. The underlying them of the answers I received here communicated that the students expected to undergo a much more independent experience with an emphasis on reading, analyzing, and critiquing scholarly articles. By and large, they were surprised by the focus on interpersonal connections and the amount of storytelling we were exposed to. However, this unexpected experience was received as a positive twist.

Question six served a similar role to question seven, providing me with a snapshot of the knowledge each student acquired as a direct result of the research opportunity. These answers varied. One student highlighted how they were struck by the idea of considering and including feedback/influence from target populations when conducting research (Student 6). Another emphasized the "mindset shift" they had experienced to think about and listen more to voices that often go unheard (Student 4). Several of the students referenced the sheer amount of information, both historical and cultural, that they did not know before going through the program (Student 2, Student 3, Student 5).

Finally, question eight served to inform me as to the way in which the students were inspired to use the knowledge they had gained via the research opportunity. Three of the students voiced their desires to take their experience into future careers working with tribal communities,

either in healthcare or in research (Student 3, Student 4, Student 5). Another described how they wanted to take the interpersonal skills taught in the program into a career in healthcare, wherever that might be (Student 2).

Upon completing my fieldwork, I found myself in an interesting spot. While my research had been incredibly rich and impactful, I really didn't know how it was going to influence my thesis or even what my thesis would be. However, as I continued to look over my notes and analyze what I had collected, I kept coming back to one thing: the simulation exam room. Four of the six medical students who participated in the SRO described how having the opportunity to use the simulation room was one of the impactful elements of the program (Student 2, Student 4, Student 5, Student 6). But it wasn't just the training space; it was also the intentional design of the entire Center for Native American Health. The entire facility was designed to reflect cultural values. The color of the paint on the walls, the types of words used in the furniture, and the large dining table meant to invite conversation and friendship over a meal were just a few such items. There was even a small water fountain mounted on a wall directly above a research laboratory on the floor below that conducted experiments on mice. The purpose of this was to use the sacred power of flowing water to honor the sacrifice of the mice below. In every little detail, there was intention.

These elements continued to dance around in my brain until I came to the question: What if those same principles were applied to an entire facility? An entire clinic? An entire hospital? And so the seed was sown.

Looking back on my fieldwork, I am filled with a sense of honor and gratitude. I never expected that I would have to pivot away from my original fieldwork setting, let alone that I would have the tremendous opportunity to study in what has become one of the most protected

and exclusive research environments in the West. And such an opportunity did not go unwasted. My research aside, I was given a remarkable chance to meet and interact with some of the most incredible people I have ever encountered. Physicians, lawyers, politicians, and elders, each and every person brought with them a unique story and perspective that added to the richness of the overall experience in ways I could never have hoped for. Seth Holmes, the author of Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States, in reflection upon his own fieldwork, writes: "In addition to the comprehension of social suffering and strong social hierarchies, my embodied experiences led me to recognize the impossibility of separating research from human relationships" (Holmes 37). I echo this sentiment entirely. While the research I was able to conduct was incredibly meaningful and productive, it would be nothing without the relationships I was able to build throughout the journey.

However, the relational aspect of fieldwork surprised me with a complication I was warned about but didn't expect: my becoming tied to the subject matter of the content which I was studying. The more I interacted with the students and professionals involved in my fieldwork, the more I found myself having a hard time drawing a line for myself between researcher and student. This phenomenon is described by Sunstein and Chiseri-Strater: "All fieldworkers, even those who investigate local cultures and subcultures, risk projecting their own assumptions onto the groups they study. They must be ready and willing to unpack their own cultural baggage and embark on a collaborative journey with those they study" (4). This "collaborative journey" is exactly what happened to me. Rather than sit back and observe the effects of the research opportunity on the medical students, I was invited into learning with them. And it wasn't just us who were learning, but the professionals who were mentoring us along the way as well. Time after time, we were told something along the line of, "I've learned so much

from this experience" by the very people who were teaching us! This had a profound impact on how I viewed and interpreted the results of my fieldwork.

This brings me to probably the most profound effect that my experience had on me. After those three weeks were over and the dust had settled, I was confronted with the question, "what are you going to do with what you've been given?" Not in reference to my thesis, but in reference to my life, my career. Up until that point, I hadn't put much thought into the context in which I would someday practice medicine. However, after my fieldwork, it became clear to me that I want to begin my medical career working with tribal communities in the Pacific Northwest. This represents an opportunity to practice co-powerment at a domestic level before making the leap to work internationally, which is also still a hope of mine. The reality is, there are many communities here in the U.S., both Native and non-Native, that are broken and hurting. I am reminded that: "Seeking justice means choosing to do so for all," not just for those who are a world away (Clawson 182). This recognition was arguably the most impactful part of my fieldwork experience with the WSU NAHS Research Opportunity.

Now, back to the issue at hand.

The Challenge

The simple but sad reality that faces healthcare within Indigenous communities is that, by and large, it is not trusted. There are several reasons for this

The first reason has to do with history. Western medicine was at the forefront of centuries of conflict between European settlers and Indigenous communities and has been used more as a weapon than an aid. The distrust of such abuse still stands today, with many pointing to the first contact between Europeans and Natives as the beginning of the end for Indigenous communities

in the Americas (4. Fieldwork Notes). However, the use of research in medicine in more recent years has led to further distrust. Speaking on this topic, one Native practitioner remarked: "Research is probably the dirtiest word in the Indigenous world's vocabulary" (3. Fieldwork Notes). These factors have come together to create intergenerational trauma, as well as another form of trauma called betrayal trauma. According to researchers at the University of Regina: "Betrayal trauma theory emphases the interpersonal relationship between the person experiencing trauma and the perpetrator(s) of the trauma" (Klest 657). The intimate nature of the relationship between patient and provider ensures that any form of abuse by the provider will likely lead to betrayal trauma. On top of trauma, Native American communities have also been the victims of years of structural violence. This is defined by Holmes as "the violence committed by configurations of social inequalities that, in the end, has injurious effects on the body similar to the violence of a stabbing or shooting… Much of the structural violence in the United States today is organized along the fault lines of class, race, citizenship, gender, and sexuality" (43). The history of Native Americans with respect to western healthcare leaves little room to wonder why there is such prevalent distrust in Indigenous communities.

A second reason for the current state of distrust of western medicine within Native communities has to do with how medicine is practiced. The rise of modern medicine within the last century was initially led by those at the heart of healthcare: the doctors, nurses, and other practitioners. However, in recent years, the control of medicine has shifted dramatically away from the providers into the hands of major corporations. And this has not gone unnoticed by Native communities. As one tribal elder told me: "Allopathic medicine used to be controlled by physicians. Doctors are no longer in control" (Elder 4). The corporatization of modern healthcare has created a "fast-food" approach, with more emphasis being placed on how many patients a

provider can see in a day rather than on the quality of care. This puts further strain on the relationship Native Americans have with western medicine. To many Natives, the patient exam room is more than a place for "checkups"; it is a sacred space meant for healing (1. Fieldwork Notes). Additionally, contrary to the assumptions of many western healthcare providers, trust is not inherent to the patient-provider relationship, especially in Indigenous settings (Hendren 1270). It is a Native belief that every patient has a question that must be voiced (Elder 2). Thus, when that question goes unanswered and the patient-provider interaction is not given the proper degree of respect and honor, it only further compounds the distrust most Native Americans harbor.

Now, it must be said that there have been many attempts to rectify the wrongs committed against Native American communities by institutions of health. As early as 2009, medical schools in the U.S. and Canada were mandated to include "cultural competency" as a core part of their curriculum (Kumagai 782). Additionally, many have become aware that, in order to successfully work in cross-cultural settings, we must become culturally aware (Holkup 7). Western society is also beginning to realize and own up to the many ways it historically exploited other people to get us to where we are today (Moe-Lobeda 96). However, at the end of the day, apologies and better cultural education are not enough to create trust. No, in addition to our words, we must also come up with a way to offer our works in a culturally authentic, humble, and honorable way.

This brings us back to my core conclusion.

Addressing the Challenge

Picture a door. Any door. What color is it? What kind of doorknob does it have? Does it have a doorknob? When opened, does it swing away from, or towards you? Maybe instead of swinging, it slides (for you non-doorknob people). Now, what is on the other side of the door? Something fun? Something scary? Something sad? If asked to walk through your door, would you do so willingly, or would you need convincing? These questions form the general rationale for my approach to cultivating trust in healthcare within intercultural contexts, specifically within Native American communities. It all boils down to the door. Let me explain.

Doors require trust. Think about that. While most of us are probably not aware of this regularly, we are constantly exercising trust by simply choosing to walk through doorways. Doorways are an extension of walls, walls being elements of design used to *separate*. Whenever we cross through a doorway into the separated space on the other side, we effectively say, "I trust myself/this space/the person I'm with/etc. enough to move from the space I was in into the space I'm in now." Most of the time, the doors we walk through tend to be fairly inconsequential. However, think of doors that have *meaning*. Some of them probably still look like regular doors (think the door to the Oval Office); then again, many of them probably don't (such as the gates to the Buckingham Palace). My point is that there is meaning behind every door, whether we choose to see it or not. Iti is my belief that this concept can play a huge role in establishing trust in western medical facilities within intercultural contexts.

Towards the end of my fieldwork with the WSU NAHS department, I found myself constantly asking the question, "How do we get them to walk through the door?" "Them" being Native American community members, and "the door" referring to clinical facilities within Indigenous settings. Finally, I came to this conclusion: Make the door look familiar. That's

where it starts, at the door. The experience I had with the NAHS simulated exam room taught me the important role that intentional design of space can have with regard to patient-provider reactions, but the design of the exam room can only help if the patient enters the reception area. And the patient can only enter the reception area if they feel comfortable enough to walk through the front door of the clinic itself. So, in order to get the patient to walk through the front door, *we must make the door itself familiar to the patient*. That is, we must begin to design and construct healthcare facilities that reflect the cultural values of the community in question, without and within.

The strategy for this concept is threefold. We will exam each in turn.

1. **Build Key Relationships**

The first step sets the tone and ultimately determines the venture's success (or failure). When approaching an intercultural community with the desire to build a clinical facility, one must first approach the local leadership. In a Native American setting, this doesn't mean the mayor or city council; this means tribal government. These local bodies of authority oversee the well-being of their entire community and are often put in power due to the respect they have garnered from their friends, neighbors, and peers. When coming in to propose building something like a healthcare facility, it might be easy to think we're offering a service and should be treated as a generous benefactor. This is not the case within Native contexts. At the end of the day, no matter how pure your intentions are, you are still an outsider. In this case, an outsider with an agenda. In order to break down this wall, time must be invested in building a relationship with the community leadership. Research within Indigenous contexts has shown: "Factors that were especially important when initiating [partnerships] included a respect of tribal leaders and

their sovereign status; an equitable partnership involving tribal leaders, tribal organizations and tribal members" (Brockie 32). By putting in the time to build a relationship, you effectively say, "I want you to *want* what I have to offer. It's your decision, and I will respect it either way." Simon Joyaux writes: "It's human to want quick solutions and facile answers. Nonetheless, it reflects a dangerous naïveté and the lack of understanding about what is required to make change" (Joyaux 8). Relationship is simply not something we can rush.

Remember, many communities the world over, especially Indigenous communities, have all received "charity" they didn't ask for, that did nothing but harm their societies. Katie Willis, the author of *Theories and Practices of Development,* suggests: "Rather than imposing ideas of 'progress' and 'development' on individuals and communities throughout the world, people themselves should be able to choose the way they want to live without being made to feel that they are somehow 'inferior' or 'backward' by not following a pattern that has been adopted elsewhere" (Willis 125). When approaching community leadership first with an offer to build a relationship, *then* talk business, we put the ball in their court and hand them the timeline. From then on, we are no longer developers but partners.

2. Gather Feedback from the Community

Once you've taken the time, built relationships, earned the trust of community leadership, and received the go-ahead to execute your project, then comes the time to approach the greater community at large. Not to build, but to listen. This demonstrates not only a core principle of development but of true medicine. During my fieldwork, I was approached by a Native Elder who wanted to share how much my taking the time to seek out conversation with Indigenous community members meant in their culture. According to him, simply showing a desire to better

my understanding demonstrated an authentic desire to create change (Elder 1). When we take the time to simply sit and listen in order to better understand the community we wish to impact, we lay down a foundation for trust to be built upon.

On top of building trust, we approach the community at large to gather cultural feedback for the design of that we hope to build. In the end, whatever we build is not for us, the practitioners, but for the people we hope to serve. So, they should have the biggest say in what gets built. As Brenda Salter McNeil so eloquently writes: “It’s not enough to build a model for individual change if we ignore the groups that shape them and the communities in which they live” (McNeil 35). Additionally, stay away from focus groups and committees. Too often, such bodies are made up of primarily like-minded people. Instead, lean on town halls, community events, and other gatherings likely to draw in more people from varying backgrounds. We’re not looking for a single lens, but many. One lens can’t see more than it was designed to see and thus, can’t be expected to bring the whole picture into focus (Lederach 10). No, in order to ensure that we create something that is truly honoring the entire community, we must try to touch as many community members as possible.

Some of you may be wondering, what kind of feedback are we supposed to gather? I’m glad you asked! The short answer is: “All of it!” What kind of wood should be incorporated into the architectural design? What colors reflect cultural values of peace, healing, hope, etc.? What are the plants, animals, and other natural elements associated with medicine within this particular culture? Every single element of what is built should reflect the community it was made to serve, no matter how big or small.

3. Be About the Community

The third and final portion of this strategy comes only after construction is complete. Once the dust settles and you begin to give back to the community, you must also do this one crucial thing: Never stop finding new ways to serve. The intention behind building a healthcare facility that is culturally honoring should not cease with construction. Instead, it should only grow out from there. At the heart of medicine is a desire to go out and heal. While it is crucial to have a place where the sick can come to us, we should not stop there. If it is culturally honoring, develop a home-visit program, or mobile units. Continue to invest back into the community through events, sponsorships, scholarships, etc. Not for the sake of publicity, but simply for the sake of wanting to. The people you serve will be able to tell the difference.

The proposal laid out in Appendix I illustrates a more specific route to take when building healthcare facilities within Native American contexts which, in theory, could be used as a guidance tool for professionals in the field currently. The proposal lays out a roadmap for practitioners to use which include two of the three steps listed above (it does not include step three, as that is more specific to long-term community development initiatives). Present within the proposal are the principles of co-ownership and shared design, both critical to Native American communities (Lowe 3).

It is my hope that one day this becomes a legitimate tool within the fields of healthcare and community development. Our cultures are far too important to be exclusive. Rather than using the model that is most popular, we should always seek to engage the communities we serve in ways that garner trust and foster relationship. To do this, we must begin to construct facilities that are culturally honoring and reflective of the community at large. We must begin to build better doors.

Conclusion

We live in a world where one person can determine the fate of millions. That is not speculation, but fact. Never in human history has there been greater potential for widespread harm. However, there is also a tremendous opportunity to create positive change. Thomas Friedman, the author of *Thank You for Being Late: An Optimist's Guide to Thriving in the Age of Accelerations,* writes:

> "On the positive side of the ledger, we are approaching a world where, acting together, we could sustainably feed, clothe, and shelter every person, as well as cure virtually every disease, increase the free time of virtually every person, educate virtually every child, and enable virtually everyone to realize their full potential" (Friedman 373).

This should be a cause for hope and celebration! However, the key part of Friedman's assertion lies within the phrase, "acting together." It is in this sentiment that I write this thesis. I believe in the capacity for humankind to act together, to create a better world. That's the core piece of development, the seeking of a better human future (Myers 55). However, in order to do so, we in the western world must learn to lay down our stubborn pride and ask, "how can I better serve you?" Not for the sake of service, but for the sake of being *human*. As the French anthropologist and ethnographer once said, "Humankind ceases at the border of the tribe" (Beck 102). To be better, and thus more human, we must build better. Better communities, better relationships, and better doors.

Appendix I - C

Introduction

Since the onset of the twentieth century, indigenous communities throughout North America have seen a dramatic negative reversal of population health as chronic issues such as diabetes, arthritis, and obesity have skyrocketed in tribal communities. This trend draws on multiple sources, one of the most significant being a general distrust of western medicine held by many Native Americans. This distrust, coupled with a highly dysfunctional and ineffective federal healthcare program, has led to the dramatic disparities within the realm of medicine we see today in Indigenous communities. If we wish to combat better the gross health inequities we see within Native populations, we must take a serious look into how we can change the face of western medicine within such communities. This can be done through a more intentional approach to the design and construction of clinical facilities, which incorporate elements of Native voice, vision, and culture.

The following proposal outlines a path to follow to successfully realize the proposed intervention stated above, beginning with an extended reiteration of the need to be met and the proposed intervention itself. The resources needed, implementation plan, and projected timeline follows as supporting elements.

The Need

> "The problem of hunger in the world is *not* the earth's inability to produce food for seven billion people; it's the inequitable distribution of food."
>
> - David Livermore, *Serving with Eyes Wide Open*

From the dawn of time immemorial, humanity has endured broken relationships. Nearly all of the world's great creation myths involve a fracturing of relations, be it human-from-human, human-from-deity/deities, or some other connection. In the early twenty-first century, this reality has never been more prominent than now, as we bear witness to the creation of innumerable factions born from the strife of racial prejudice worldwide. While such phenomena are by no means new, they pose a perplexing problem to a global society that is supposed to be, in theory, more connected than it has ever been before.

Disparities, in any form, are directly caused by the "persistent social disadvantages for groups that have limited access to power, wealth, or privilege" (Canales 895). One such group that has endured "persistent social disadvantages" for nearly 500 continual years is the American Indian. The indigenous inhabitants of North America for millennia, Native Americans have suffered under the trifecta of European colonization, American territorial expansion, and now, western globalization since Columbus made his fateful voyage in 1492. Of the many disparities this group has faced, one of the most prominent has been in healthcare. Indian Health Services (IHS), the federally run healthcare program for tribal communities, provides service for 2.2 million people from 567 federally recognized tribes in the U.S. (Harding 460). However, even with such coverage, Native Americans have some of the worst health statistics for any American demographic. As of 2011, American Indians and Alaska Natives (AI/AN) were killed at higher rates than all other U.S. race categories by nearly every major mortality category there is, from heart disease to pneumonia to suicide ("Disparities: Fact Sheets"). While much progress has been made in the area of health equity, there is still much to be done.

Part of the issue that sustains health disparities within Native American populations is a general distrust of western medicine perpetuated by many. This makes perfect sense, as years of

systemic abuse and trauma naturally lead to mistrust and wariness, if not downright hostility. One Canadian First-Nation elder put it this way: "Just as [Indigenous] people seldom interact with the justice system unless 'they're dragged in' by criminal or child welfare proceedings, they also avoid the medical system, which has historically been a tool of their oppressors" (Vogel E9). It is herein that we find our need. In order to combat the health disparities that have existed within AI/AN communities for years, we must begin by winning their trust.

However, creating trust from mistrust is a task much easier said than done. As one researcher notes: "Health and wellness… are areas where trust is especially critical because of the unique vulnerability and unequal power dynamics present when people are seeking to meet their healthcare needs… Understood in this way, health systems interface with the most vulnerable dynamics present within human interactions" (Adam 2). The innate vulnerability present within healthcare makes the abuse of such dynamics much more damaging and difficult to reverse. This is exacerbated by a significant "lack of understanding" that is found in western healthcare providers within indigenous communities specifically (Student 1). Even so, it can be done when those with power (in this case, healthcare providers) intentionally seek ways to honor and respect the culture of the oppressed. "There is no simple way for a provider— especially an outsider who may be reminiscent of the perpetrators of historical injustices—to repair broken trust *except* to prove themselves in the daily practice of humble, patient-centered medicine that respects each patient's and each population's unique and nuanced cultural heritage" (Harding 460, emphasis added). One medical student interested in the dynamics present between western healthcare providers and Native American communities observed:

> "If done well, then medicine is an integral part of the community. And it goes hand in hand with things that are health related, but not technically medicine, like… good public

> hygiene measures and good public health measures and hand washing and clean air and that sort of thing. And if there is… a good relationship and good trust, then… there will be people who can advise the general public on… good things to do for their health, like getting vaccinated and exercising and good nutrition and things like that" (Student 2).

Thus, to meet the need of dismantling longstanding distrust of western medicine within AI/AN communities, an effort must be made to intentionally pay homage to and respect the cultural heritage of the target population.

Proposed Intervention

"Medicine is everything you can use to be well."

- Native Elder

The proposed intervention for this need is the design and construction of clinical facilities intentionally built around themes that are culturally honoring and thus create trust. This is inspired by the recent creation of a Native American simulation exam room by a prominent American university (Fieldwork 22 July 2021). The design of said exam room was meant to reflect multiple themes familiar to AI/AN cultures. Red-wood paneled flooring, wall paintings by Native artists, and a small corner table housing small bundles of dried sage all represented elements of culture that go far beyond what the average American patient could understand. The reason behind building such a space was twofold: on the one hand, it provides an excellent simulation environment for medical students interested in working in AI/AN communities, and on the other, it opens the door to new possibilities for clinical construction and design within tribal contexts.

We find the inspiration behind this proposed intervention on the second train of thought. The following sections will outline the resources needed, implementation plan, and projected timeline for designing and constructing clinical facilities that are culturally honoring to AI/AN communities.

I. Resources

As with any major construction project, such an undertaking as the one proposed needs many resources to see it to completion. However, as this proposal is more about intentional design than physical construction, the following resource list focuses and expands upon the elements most important to projecting honor for AI/AN culture(s). This list includes Tribal Leadership, Cultural and Medical Insight, Funding, Contracted Specialists, and Physical Materials.

A. Tribal Leadership

All tribes in the U.S. have leadership bodies that oversee tribal governance. A vital part of this project would be to ensure that from the top-down, tribal authorities have the most influence over the design and construction of the proposed facilities and the level to which their constituency is involved. Funding, hiring workers, and the purchase of physical materials should all be approved, if not chosen by Tribal Leadership.

B. Cultural Insight

Of all of the resources listed herein, Cultural Insight is the most important. This is because Cultural Insight provides the mission and vision for what the end result will be. For this project to be successful in building trust, it must find the entirety of its inspiration and facilitation from within the host community (Christopher 1400). Staying on this theme, when asked how

healthcare providers can better utilize their profession in Native communities, one medical student answered: “Take it back to the people” (Student 6). That is exactly what Cultural Insight is all about, taking the power and privilege inherent to western medicine and giving it back to the people it is meant to serve.

From a practical standpoint, gathering Cultural Insight should encompass a significant portion of the total project timeline (a full twelve months is suggested). How this is done can be determined by the project management; however, some suggestions include: community-wide surveys, open art exhibitions, and informational town halls focused more on gathering input than giving information.

C. Medical Insight

This resource is the only one that focuses less on cultural representation and more on practical design. Although this project aims to create clinical facilities that are unique in their portrayal of Indigenous values, it would be a waste of time to undergo such an effort if healthcare professionals were not given a seat at the table to provide feedback and input. What good would a clinic be if it was culturally honoring but could not fulfill its primary purpose to provide a place for the sick and broken to come and be made well? Seeking and gathering medical insight provides reasonable assurance that the marriage of cultural design and practical efficiency does not result in multiple conflict points.

D. Funding

No project of this scale can be accomplished without substantial financial backing, no matter how just the cause. As Kevin Lynch and Julius Walls write in their book, *Mission, Inc.,* “*No money, no mission* – it is that simple” (Lynch 65). In keeping with the tone set by

gathering cultural insight, this project is best served if it is paid for by the people it will serve. The fingerprints of the tribal community must be left all over the project so that it can be said that it belongs to no one else but the tribe itself. This means that the topic of funding must be brought up to the Tribal Leadership immediately after interest is shown.

E. Contracted Specialists

Once funding is acquired, contracted professionals must be hired to pull the project together. Following the set theme, the priority here should be to hire from within the target populous. If this cannot be done in full, the decision to hire from the outside should be left to the tribal leadership. However, there should be an emphasis here to hire professionals who buy into the mission and vision of the project.

F. Physical Materials

Finally, once contractors are hired, the last step before beginning construction would be to acquire the physical materials for the project. Ideally, the resources should come from Native suppliers and businesses. However, if this cannot be done in full, an effort should be made to seek out suppliers who will provide quality materials at fair prices. The Tribal Leadership should ultimately make this decision. Additionally, the input gathered by the initial community outreach should be used here to purchase materials that hold value for the community. Most Native communities place significant value on certain natural materials. For example, the tribes of the Pacific Northwest find sacred value in cedar trees and incorporate them into anything they can (Fieldwork 23 July 2021). Thus, if this project were to be attempted for a Pacific Northwest Tribe, the final product should include significant amounts of cedarwood into its design/architecture.

II. Implementation Plan

i. Approach and Engage Tribal Leadership

ii. Gather Cultural Insight

   a. See “Cultural Insight” under “Resources.”

iii. Gather Medical Insight from Professionals

   a. See “Medical Insight” under “Resources.”

iv. Consult with and hire Building Contractors

   a. See “Contracted Specialists” under “Resources.”

v. Submit Project Proposal to Tribal Leadership

   a. See “Cultural Insight” under “Resources.”

vi. Acquire adequate Funding

   a. See “Funding” under “Resources.”

vii. Acquire Physical Materials

   a. See “Physical Materials” under Resources

viii. Begin Construction

   a. At this point, most, if not all, of the project’s governance will have been transferred over to the community.

III. Projected Timeline

i. Approach and Engage Tribal Leadership

   a. Six Months

ii. Gathering Cultural Insight from the Community

a. Twelve Months

iii. Gathering Medical Insight from Professionals

a. Six Months

iv. Submit Project Proposal to Tribal Leadership

a. Three Months

v. Acquiring Adequate Funding

a. Three Months

vi. Consulting with and Hiring Building Contractors

a. Six Months

vii. Acquiring Physical Materials

a. Three Months

viii. Beginning-Ending of Construction

a. Fifteen Months

Total Time – 4.5 Years

Conclusion

"We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things work this way. Instead, success requires making a hundred small steps go right – one after the other, no slipups, no goofs, everyone pitching in."

- Atul Gawande, *Better*

In a world where the consequences of broken relationships are constantly on display for all to see, the modern leader's responsibility is to step into the fractured divide and bring peace where strife has been allowed to prevail. Such a task can be accomplished when we consciously seek out those elements that define communal relationships and thus form their borders. Charles Vogl, the author of, *The Art of Community: Seven Principles for Belonging*, writes: "Understanding the shared values that attract and keep members in a community is important for leaders. For continued success, leaders must both clearly share and personally represent the values so others can recognize what they want to join" (Vogl 13). From the context of western medicine within AI/AN tribal communities, this means taking a serious look into how we can create trust in western medicine where distrust has been allowed to grow and thrive. This can be done through a more intentional approach to the design and construction of clinical facilities, which incorporate elements of Native voice, vision, and culture. The medical community has held indigenous populations hostage for too long, trapped within a grossly unfair power dynamic. This can only be undone when healthcare providers make a tangible effort to deeply understand the indigenous populations they work in (Student 4). It is high time that healthcare providers and facilities flipped the script and began to practice medicine with the purpose of making broken things whole again.

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Appendix II – Images of Washington State University's Center for Native American Health

Indigenous Clinical Simulation Room

Image A:

Image provided by Washington State University's Center for Native American Health Indigenous Clinical Simulation, Director Naomi M. Bender, Ph.D.

Image B:

Image provided by Washington State University's Center for Native American Health Indigenous Clinical Simulation, Director Naomi M. Bender, Ph.D.

Image C:

Image provided by Washington State University's Center for Native American Health Indigenous Clinical Simulation, Director Naomi M. Bender, Ph.D.

Image D:

Image provided by Washington State University's Center for Native American Health Indigenous Clinical Simulation, Director Naomi M. Bender, Ph.D.

Image E:

Image provided by Washington State University's Center for Native American Health Indigenous Clinical Simulation, Director Naomi M. Bender, Ph.D.

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