

Cultural Influences on Nursing Care: Native American Middle-Aged Men (Erikson's Midlife Stage)

Slide 1: Introduction – Project and Team



Cultural competence in nursing improves care quality for diverse populations.

- **Project Title:** Cultural Influences on Nursing Care – Focus: Middle-aged Native American males (ages ~45–64, Erikson's "Generativity vs. Stagnation" stage ¹).
- **Course:** NURS 320 – Adult Health II (Clinical Group Project)
- **Institution:** AdventHealth University, Dept. of Nursing
- **Team Members:** See next slide for names and roles.

Speaker Notes:

In this presentation, our group examines culturally sensitive nursing care for **middle-aged Native American men**, roughly **ages 45–64**, which corresponds to Erikson's *middle adulthood stage* of "**Generativity vs. Stagnation**" ¹. We will explore how **culture** – including history, values, and practices – influences the health behaviors and needs of this population. Our team has collaborated on this project for NURS 320: Adult Health II, under the "*Cultural Influences on Nursing Care*" assignment. Each member contributed to a specific topic area, which we'll introduce on the next slide. By understanding these cultural factors, we aim to highlight strategies for providing **culturally competent care**. (Visual: The image above illustrates a Native American nurse and a family in traditional attire, symbolizing the blend of healthcare and cultural context.)

Slide 2: Introductions – Team Members & Sections

- **AnaLucia Diao** – Health Disparities in AI/AN Midlife Men
- **Brooke Thomas** – Traditional Healing & CAM Practices
- **Chanel Campbell** – Health Beliefs & Values
- **Charlene Fana** – Family Roles & Decision-Making
- **Mathew Moslow** – Gender Considerations in Care

- **Matteo Testa** – Religious/Spiritual Influences
- **Melanie Rodriguez** – Diet and Nutrition Impacts
- **Shanique Wilson** – Special Considerations & Summary

Speaker Notes:

Our group of eight nursing students has divided the research into key areas required by the project rubric. Each member focused on how Native American culture affects a particular aspect of nursing care for **middle-aged male patients**:

- *AnaLucia* researched **health disparities**, identifying prevalent conditions and causes.
- *Brooke* explored **complementary and alternative medicine (CAM)** and traditional healing practices common in Native communities.
- *Chanel* examined Native American **health beliefs and values**, such as views of health and illness.
- *Charlene* focused on **family hierarchy and decision-making**, like the role of family and elders in care.
- *Mathew* analyzed **specific gender issues**, including male patients' communication and care preferences.
- *Matteo* investigated **religious and spiritual influences** on health and healing.
- *Melanie* looked at **diet and nutrition**, especially traditional versus modern dietary patterns.
- *Shanique* compiled **special considerations**, including communication styles, trust, and other cultural factors.

Each of us will present our findings, and together we will provide a comprehensive understanding of caring for Native American male patients in midlife. We've prepared speaker notes (as a script for voiceover) and will also provide a reference list of sources (all recent, within the last 5 years) at the end of the presentation.

Slide 3: Background & Significance – Why Culture Matters

- **Historical Context:** Native Americans faced centuries of adversity (colonization, forced removal, boarding schools) leading to **intergenerational trauma** and **mistrust of healthcare** ².
- **Need for Cultural Awareness:** Cultural beliefs (e.g. respect, holistic wellness) strongly influence patient behavior and communication. Lack of awareness can lead to misunderstandings (e.g. a quiet, non-eye-contact patient might be showing respect, not noncompliance ³).
- **Midlife Focus:** Middle-aged Native American men are in Erikson's "**Generativity**" stage, often striving to care for family and community despite health challenges ⁴. Culturally competent nursing can support their roles and improve outcomes.

Speaker Notes:

Native American populations have a unique history that heavily impacts their healthcare experiences today. **Historical trauma** – including loss of land, the Trail of Tears, forced boarding school assimilation, and other injustices – contributes to a profound **mistrust of healthcare systems** ². Many Native communities remember or have heard from elders about unethical treatments and broken promises, which understandably affect their willingness to seek care and trust providers.

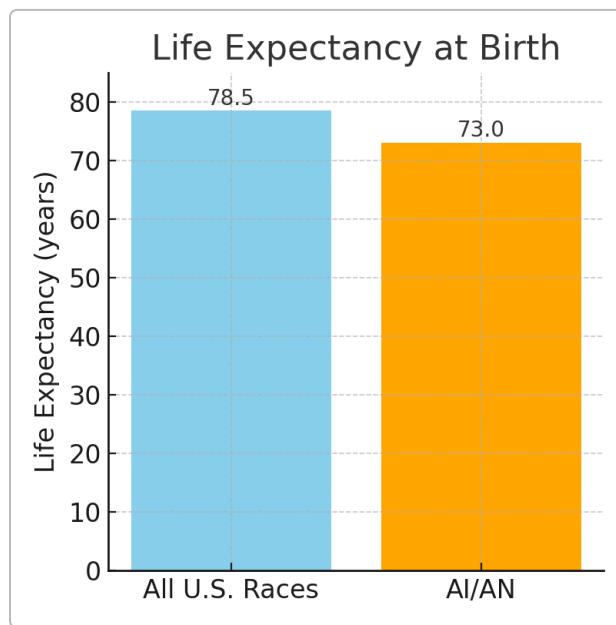
It's vital for nurses to recognize that **culture shapes health behaviors and perceptions**. For example, in some Native American cultures, a patient may remain **quiet and avoid eye contact as a sign of respect** ³. A nurse unaware of this might mistakenly view the patient as unengaged or resistant. Similarly, a Native patient who is slow to answer or uses long pauses could be processing information or translating

terms internally (perhaps from English to their Native language) – reflecting the cultural value of **silence and careful listening** ⁵. Without cultural awareness, these behaviors might be misinterpreted and lead to uncomfortable encounters (as seen in the case study of a student nurse who struggled when an American Indian elder patient was silent and looked away).

We focus on **middle-aged males** because in this life stage (Erikson's seventh stage, *Generativity vs. Stagnation*), individuals aim to “**make their life count**” by contributing to their family or community ⁴. For Native American men, this can mean being providers, elders-in-training, or culture bearers in their communities. However, health disparities and cultural barriers can hinder these roles. By understanding and respecting their cultural background – including beliefs about health, healing traditions, family dynamics, and so on – nurses can better support these patients in achieving their health goals and continuing their generative contributions to family and tribe.

Overall, this introduction sets the stage for why **culturally competent care** is not just ideal but essential. It improves communication, builds trust, and ultimately leads to safer, higher-quality care. In the following slides, we'll delve into specific cultural factors and how they affect nursing care for our chosen population.

Slide 4: Health Disparities – “Where are the Gaps?”



Life expectancy for Native Americans is about 5.5 years shorter than the U.S. average ⁶.

- **Higher Disease Burden:** Native American communities suffer **disproportionately high rates** of chronic illnesses. For example, **heart disease and cancer** are top killers ⁷ ⁸, and **type 2 diabetes** has reached epidemic levels (with an incidence about **3 times higher** than in whites) ⁹.
- **Shorter Lifespan:** Average life expectancy for American Indian/Alaska Native (AI/AN) people is **~73 years**, about **5.5 years less** than the U.S. all-races average (~78.5 years) ⁶. Many deaths are due to preventable causes, e.g. **diabetes, liver disease, suicide, accidents**, often at younger ages ¹⁰ ¹¹.
- **Contributing Factors:** Health disparities stem from socio-economic and historical factors – **poverty, limited access to care, discrimination, and education gaps** all play a role ¹² ¹³. These factors,

combined with lifestyle shifts (e.g. adoption of processed foods in place of traditional diet), have led to a higher burden of illness in midlife ¹⁴ ¹⁵.

Speaker Notes:

Native American populations experience some of the **widest health disparities** in the United States. As the bar chart on the slide illustrates, life expectancy for American Indian/Alaska Native people is significantly lower (around **73 years**) than for the general U.S. population (about **78.5 years**) ⁶. This gap of over five years highlights an alarming inequality in health outcomes. Middle-aged Native American men often face serious health conditions **earlier and more frequently** than their non-Native peers.

Let's break down a few key disparities:

- **Cardiovascular Disease:** This is the leading cause of death among Native Americans ¹⁶. By middle age, many Native men have risk factors like hypertension and obesity that, combined with limited healthcare access, contribute to high rates of heart disease ¹⁷.
- **Diabetes:** Type 2 diabetes is extremely prevalent – some communities have among the highest rates in the world. Native Americans are **50% more likely to be diagnosed with diabetes** than non-Hispanic whites ¹⁸ ¹⁹. In fact, the mortality rate from diabetes is about **3.2 times higher** for AI/AN people than the U.S. average ²⁰. This “diabetes epidemic” is attributed in part to genetic susceptibility, but also to lifestyle changes – especially the shift from traditional diets to **processed foods** and refined sugars ¹⁴.
- **Liver Disease & Alcoholism:** Chronic liver disease and cirrhosis (often alcohol-related) are major causes of death in Native populations, occurring at **4-6 times** the rate of the general population ¹¹ ²¹. Alcohol use disorder has been linked to historical trauma and socio-economic stress. Many middle-aged Native men struggle with alcohol-related health issues, from liver damage to accidents.
- **Mental Health & Suicide:** The stressors faced by Native communities – including historical loss, marginalization, and current poverty – contribute to high rates of **depression, anxiety, and suicide**. Suicide rates for AI/AN are roughly **1.7 times higher** than the national average ²², with middle-aged men being a high-risk group. This is compounded by limited mental health services in many tribal areas.
- **Unintentional Injuries:** Injuries (e.g. car accidents) are also a leading cause of premature death, often tied to factors like rural living (long travel distances), lower seatbelt use, or alcohol. The injury mortality rate is about **2.5 times higher** for AI/AN people than for all races ²⁰.

It's important to emphasize that these disparities are **not due to inherent traits**, but largely to **social determinants of health**. Many Native American men in midlife live in **poverty or remote areas**, with limited access to quality healthcare facilities. They may not receive preventive care or early management of chronic conditions. Educational inequalities and unemployment also impact health literacy and the ability to afford healthy lifestyles. Additionally, past and present discrimination in healthcare can discourage Native patients from seeking care until illnesses are advanced ¹³ ¹¹.

In summary, middle-aged Native American men often carry a **heavy burden of chronic disease** and face a shorter lifespan. As nurses, being aware of these statistics should prompt us to assess for these conditions

proactively (e.g., routinely screen for diabetes complications or liver issues) and to advocate for resources. It also underscores why culturally competent, accessible care is critical – bridging those gaps can literally be life-saving. We will next discuss how traditional practices and beliefs intersect with these health issues and can be leveraged to improve care.

Slide 5: Complementary & Traditional Healing – “*Blending Old & New*”



Traditional healing items used in a smudging ritual – sage bundles, sweetgrass braid, tobacco, and an eagle feather ²³.

- **Medicine Men & Healers:** Many middle-aged Native men may seek guidance from a **tribal medicine man or healer**. Traditional healers use rituals, prayer, herbal remedies, and other ceremonies alongside (or sometimes in place of) Western medicine ²⁴ ²⁵. Nurses should show respect for these practices and, if appropriate, collaborate (e.g. allowing hospital visits by healers).

- **Smudging & Purification:** **Smudging** – burning sacred herbs (sage, cedar, sweetgrass) and wafting the smoke – is a common healing ritual believed to cleanse body and spirit ²³. It's used in prayer or to purify hospital rooms for Native patients. Healthcare facilities are increasingly accommodating smudging because it brings comfort and spiritual healing ²⁶ ²⁷.

- **Sweat Lodges:** A **sweat lodge** ceremony is a traditional steam bath ritual used for detoxification, prayer, and healing. Participants (often guided by an elder) spend time in a dome-shaped lodge with heated stones, experiencing intense heat that is thought to cleanse **physical and spiritual impurities** ²⁸. Middle-aged men might participate in sweats to treat ailments or seek spiritual insight.

- **Herbal Medicine:** Indigenous pharmacology includes many **herbal remedies** (e.g. cedar or willow for pain, berries for nutrition, etc.). Some Native patients may use teas or salves from traditional plants. Always ask patients about any **herbal supplements** they use, to check for interactions with prescribed meds (and to validate their importance to the patient) ²⁹ ³⁰.

Speaker Notes:

Native American healing practices are **deeply rooted in culture and spirituality**. Many patients do not see a sharp divide between “traditional medicine” and “modern medicine” – instead, they might use both in

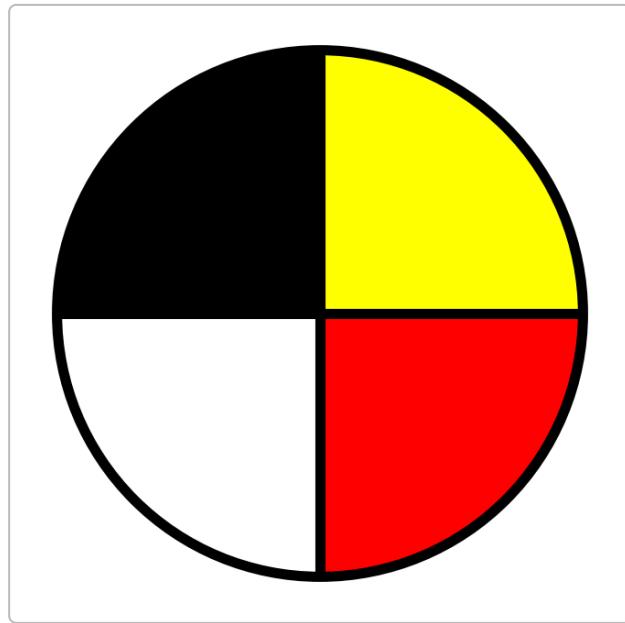
complementary ways. As nurses, recognizing and respecting these **complementary and alternative medicine (CAM)** practices can greatly improve rapport and outcomes. Let's explore a few key traditional practices:

- **Medicine Men/Women:** In numerous tribes, a medicine man or woman is the keeper of healing knowledge. Middle-aged and older men might themselves be training to be healers or might frequently consult one for guidance. For example, a patient might delay a surgery until he can consult with a medicine man or get a blessing. It's important we do not dismiss this; instead, try to **integrate cultural practices** where possible. If a patient wants a ceremony or healer's involvement, work with your healthcare team to accommodate it (ensuring safety and infection control, of course). This inclusion can build trust – the patient sees that we honor what's sacred to them ²⁵.
- **Smudging:** As shown in the image (a collection of sacred items on a table), smudging is a common ritual across many tribes. In a smudge, dried herbs like **sage**, **sweetgrass**, **tobacco**, **cedar** are burned in an abalone shell or bowl, and the smoke is fanned over the person or space with a feather ²³. Patients might smudge to **pray for healing** or to purify a hospital room from negative energy. Many hospitals (like Mayo Clinic mentioned in the source) now allow smudging in designated rooms or even at the bedside with proper precautions ²⁶. For example, a chaplain or Native liaison might assist with smudging a patient before a procedure to help them spiritually prepare. As nurses, we can facilitate this by coordinating with hospital policy (disabling smoke alarms temporarily, finding a proper space, etc.). The **benefit** is huge – patients often feel more at peace and "cared for" on a cultural level, not just physically ²⁷.
- **Sweat Lodge:** A sweat lodge ceremony is another traditional practice that some Native men may participate in regularly for wellness or recovery. In the sweat lodge (which is like a hut or tent covered with skins/blankets), water is poured over hot stones to create steam, and participants pray, sing, or sit in reflection. It's considered a **purification rite** – cleansing toxins and also cleansing one's spirit ²⁸. If a patient mentions attending a sweat or if scheduling allows, we should understand that this is akin to a therapeutic practice for them. Post-sweat, they might feel spiritually rejuvenated. However, we should also caution patients with certain medical conditions (like severe heart disease or uncontrolled hypertension) about the physical strain of sweat lodges, and perhaps find safer ways to fulfill their spiritual needs if a sweat is too risky at the time.
- **Herbal Remedies:** Indigenous knowledge includes a vast pharmacopeia of local plants. For instance, willow bark (which contains a form of salicylic acid) was traditionally used for pain relief; various roots and berries are used for stomach ailments or boosting immunity. Middle-aged and elder men might brew **herbal teas** or use ointments from healers. We should **ask about these remedies during medication reconciliation** – not to dissuade them, but to be aware of potential interactions. For example, if a patient is taking a certain root extract that thins blood, we'd need to know before giving anticoagulants. Also, showing interest ("Can you tell me about this medicine you're using?") demonstrates respect. You might learn that a certain tea helps them and perhaps incorporate it (with physician approval) rather than insisting only on pharmaceuticals.

Key point: Where possible, **blend traditional and Western treatments**. Research shows that honoring patients' cultural healing practices can improve trust and adherence. For example, one might schedule medication times around a patient's daily prayer or smudge routine, or allow family to bring traditional foods if diet allows. By doing so, we treat the *whole person*, acknowledging that for Native American

patients, healing is often as much spiritual and cultural as it is physical ³¹. Culturally competent care isn't about replacing modern medicine, but about **complementarity** – working together with the patient's cultural framework to promote healing.

Slide 6: Health Beliefs & Values – *Holistic Worldview*



The Medicine Wheel – a Native symbol – represents holistic health balance (physical, emotional, mental, spiritual) ³².

- **Holistic Definition of Health:** Native Americans traditionally view health in a **holistic** way – a balance of body, mind, spirit, and community. Illness may be seen as an imbalance or disharmony. The *Medicine Wheel* (circle divided into four quadrants) is a common metaphor for this balance ³³ ³². Nurses should approach care addressing not just the body, but also emotional and spiritual needs.
- **Spiritual Connection:** Many believe that health is closely tied to spiritual well-being and **connection to nature**. For example, some may attribute illness to a disruption in their relationship with the Earth or the Creator. Healing might involve **prayer, rituals, or reconnecting** with cultural practices, not just taking medicine.
- **Beliefs about Illness:** Certain tribes have specific beliefs (which can vary widely). Some examples: illness might be seen as **having a spiritual cause** (e.g., breaking a taboo, or a spirit intrusion), or as a test of faith/spirit. Some may believe in the power of **positive thinking and storytelling** for healing – hearing stories of others' recovery can instill hope.
- **Respect and Non-Interference:** A cultural value in many Native communities is **respect for each person's path**. Patients might be **non-confrontational** with healthcare providers, listening politely even if they disagree, because it's disrespectful to directly say "no" to authority. (E.g., a patient may nod "yes" but not intend to follow instructions, to avoid appearing rude ³⁴.) Nurses need to use techniques like "teach-back" to ensure understanding and true agreement, rather than assuming nodding equals consent.
- **Slow Pace & Silence:** Traditional communication often values **thoughtful silence**. Patients might take longer to answer questions, reflecting carefully. This isn't ignorance or avoidance – it's a cultural style of **careful communication**. Being patient and not rushing or interrupting aligns with this value ⁵.

Speaker Notes:

Understanding a patient's core **beliefs about health and illness** is crucial for effective care. Native American cultures are diverse (with 570+ federally recognized tribes ³⁵), so beliefs can vary, but there are some common themes:

- **Holism:** For many Native Americans, *health = balance*. The concept of the **Medicine Wheel** (like the image with four colored quadrants) exemplifies this. Each quadrant can represent an aspect of life – typically the physical, emotional, mental, and spiritual realms (sometimes also aligned with the four directions or four seasons) ³² . The idea is that all parts of a person and their environment are interconnected. So, a “sickness” might not be viewed purely as a pathogen invading the body; it could be a sign of something out of balance – perhaps unresolved grief (emotional), or conflict in the community (social/spiritual), or a disconnect from nature. As nurses, if we approach assessment *only* focusing on physical symptoms, we might miss what the patient perceives as the true cause. It’s helpful to ask open-ended questions like, “*Why do you think this illness has come to you?*” or “*How do you believe it should be treated?*” The answers can be insightful. A patient might say, for instance, “I think I’ve been feeling sick ever since I stopped attending our ceremonies,” revealing a spiritual need. We can then support them in fulfilling that need (perhaps facilitating a visit from a spiritual counselor or family member).
- **Connection to Land/Nature:** Many Native American men (especially those middle-aged or older who grew up on tribal lands) feel a deep tie to the **land**. Good health is often equated with being able to be outdoors, to hunt or fish, or simply to be on their ancestral land. Hospital environments can feel very alien and uncomfortable. Some patients may even believe that certain illnesses can only be cured by returning to nature or using natural remedies from their land. While we might not be able to send a patient out of the hospital, we can incorporate elements of nature – perhaps allow them to have sacred stones, cedar, or other culturally significant natural items at bedside (as long as it’s safe). I recall a patient who improved in mood after we placed a potted plant and some pine from his home area by his window – small gestures can honor that connection.
- **Spiritual Etiologies:** We should be aware that in some cultures, illnesses might be thought of in spiritual terms. For example, the Navajo traditionally might attribute illness to “**disharmony**” or actions that disrupted balance (like not honoring certain traditions). Some Plains cultures historically believed in the concept of “soul loss” or spiritual intrusion causing illness. Understanding this means if a patient or family is performing a ritual or asking for a ceremony, it might be their way of addressing what they see as the root cause. We should not belittle these beliefs. Instead, we can ask, “Is there anything spiritually or culturally we can help you do while you’re here that you feel would help your healing?” That question can open the door for them to share any needs (maybe a ceremony, prayer, or certain people to be present).
- **Non-Interference and Politeness:** Culturally, many Native communities teach **non-interference**, meaning one shouldn’t force opinions on another. So a Native patient might **politely agree** or say what they think the provider wants to hear, rather than contradict. That means a smile and nod could hide uncertainty or disagreement ³⁴ . For example, as given in our scenario, a Chinese patient nodded yes to meds but then didn’t take them – similarly, a Native patient might do that out of politeness. So, we must confirm understanding. Using a **teach-back** method is effective: after explaining a care plan, ask the patient to repeat it in their own words or ask “*What will you tell your family about your treatment?*” If they can explain it back, we know they truly understood and

presumably agree. Also, encourage questions in a gentle way ("I know some of this might be different from what you're used to; what concerns do you have?"). They might not volunteer doubts unless we create a safe space.

- **Value of Silence:** As mentioned, if you ask a question and the patient is silent for a while, **do not rush to fill the gap**⁵. In Western culture, silence in a clinical interview often feels awkward, but in many Indigenous cultures, silence is respectful and thoughtful. The patient may be gathering their thoughts or waiting to ensure you are finished speaking (since interrupting is considered rude). So, after asking a question, *wait*. You might be surprised that after a long pause, the patient gives a very thorough answer. If we jump in too fast, we might cut them off or derail their train of thought.

Overall, **respect** is the guiding principle. Show respect for their beliefs – even if you don't personally share them – and incorporate those beliefs into the care plan whenever possible. By doing so, you validate the patient's identity and build trust. In turn, patients are more likely to engage in the plan of care and communicate openly, which is exactly what we need for effective nursing. Cultural humility (knowing that we as providers are learning from the patient about their worldview) goes a long way in aligning our care with their values.

Slide 7: Family & Decision-Making – "It Takes a Village"



Native American family in traditional regalia - extended family often plays a central role in healthcare decisions.

- **Extended Family Involvement:** In many Native cultures, health decisions are **family affairs**. It's common for a patient to have multiple family members (parents, siblings, cousins, even tribal elders) accompany them and provide input³⁶. Nurses should welcome this support system – involve family in teaching and discharge planning if the patient desires.

- **Elders & Hierarchy:** **Elders are highly respected**, and their opinions carry great weight. In some cases, an elder (often the eldest female in matrilineal tribes) must give approval before a major procedure or treatment is undertaken³⁷. For example, a middle-aged male patient might postpone surgery until he's consulted his mother or a tribal elder. We should ask, "Would you like to discuss this decision with your

family or anyone else before proceeding?" and facilitate communication.

- **Collectivist Culture:** Native communities tend to value **collectivism** over individualism. Decisions are made in the context of "What is best for the family or tribe," not just the individual. A patient might prioritize family obligations over personal health (e.g., a man might delay his own treatment because he doesn't want to burden his family or because he needs to fulfill a community role). Understanding this can help us frame our advice in a way that aligns with their values (e.g., "Treating your diabetes will help you stay strong so you can continue supporting your family").

- **Communication Norms in Group:** When multiple family members are present, the patient might defer to a spokesperson (often an elder or a respected relative). Address **questions to the group** as appropriate, and don't be surprised if someone else answers on the patient's behalf (this can be culturally appropriate, not necessarily "speaking over" the patient). We should still ensure the patient's voice is heard, but we can engage the family by asking for their thoughts or concerns too.

- **Family as Caregivers:** Expect that family members will want to be **actively involved in care**. They may stay with the patient round-the-clock, help with ADLs, perform traditional practices (like bringing comfort foods or items). If hospital policy allows, accommodating a family's presence (flex visiting hours, providing space) demonstrates cultural sensitivity. It's often seen as *everyone's duty* to care for a sick relative, so multiple visitors or overnight stays are expressions of love and responsibility, not lack of trust in nursing care. Whenever safe, we should **embrace family participation** rather than restrict it.

Speaker Notes:

For many Native American patients, "**family**" extends well beyond the nuclear family. It can include not only blood relatives but also clan relatives or close community members considered family. In a healthcare setting, this means decision-making is often a **shared, consultative process**. Let's consider how this manifests and what we as nurses can do:

- **Involvement of Extended Family:** Imagine a scenario on a hospital unit: a 50-year-old Native American male patient is admitted, and soon the waiting room or his room is filled with relatives – his wife, children, siblings, maybe an auntie or a community elder. This is a common occurrence. Rather than viewing it as an inconvenience or a HIPAA headache, view it as a resource. These family members are there out of concern and love, and they can help ensure the patient's needs are met after discharge. In my clinical experience, when I took a moment to update a group of family about their loved one's condition and invite them to ask questions, it built trust quickly. They saw me as someone who respects them. One cultural note: sometimes families may refrain from asking questions or "pushing" too hard in front of staff because they value being respectful. So it helps if we **proactively offer information and invite input** ("*How do you feel about this plan? Is there anything you think we're missing given what you know about [patient's name]?*"). This opens the door for them to share insights (maybe the patient is stoic and hasn't told us about a symptom, but his wife knows and can tell us).
- **Role of Elders:** In many tribes, elders (grandparents, older community leaders) are considered **wisdom-keepers**. A middle-aged man might still very much defer to his father, mother, or an older uncle/aunt when making decisions. For instance, in some cases an *elder's blessing* or input might be sought for something like starting chemotherapy or deciding on hospice. One of our sources noted that often "**the consent of the family leader, often the eldest female, must be obtained**" before surgery ³⁸. So if you sense hesitation, it could be the patient wants to talk to an elder. We can respectfully ask: "*Have you had a chance to discuss this with your elders or family?*" and even arrange a conference call or meeting if needed. I've seen a case where a care team arranged a meeting

including the patient's tribal elder via speakerphone – the elder asked questions and gave his advice, after which the patient felt more at peace with the decision. This might seem unusual in Western individual-centric healthcare, but it can be the make-or-break for compliance. Once the elder said "yes, go ahead with the surgery," the patient wholeheartedly agreed.

- **Collectivism and Selflessness:** Many Native patients place **family/community needs above their own**. A man might say he's fine when he's in pain because he doesn't want family to worry. Or he might be reluctant to undergo a long treatment if he feels it will take him away from duties (e.g., caring for grandchildren or participating in tribal events). To address this, frame how treatment will enable him to **continue fulfilling his roles**. For example, "*I know providing for your family is important to you. Getting this treatment now may be hard, but it could give you many more years of strength to be there for them.*" Also, involve the family in supporting him through treatment – in a communal culture, if the family collectively says "we will manage without you for a bit, we want you well," he's more likely to agree to rest or rehab.
- **Family Meetings:** One practical tip is to hold **care conferences or family meetings**, bringing everyone together (in person or via phone/Zoom). This aligns with how Indigenous communities often make decisions – talking it out in a group, ensuring everyone (especially elders) has a voice. As a nurse, you might suggest to the doctor or social worker that such a meeting be held if big decisions (like end-of-life care) are on the table. During these meetings, it's respectful to acknowledge the family structure – greet the elder first, or ask, "*Is there someone you'd like to speak for the family?*" They might designate a spokesperson, or they may all speak but in a certain order (sometimes older first). Be observant of their cues.
- **Family as Part of Care Team:** In practical daily care, you might find a family member doing things like helping the patient eat, or performing traditional comfort measures (maybe rubbing a special ointment, or saying prayers). Unless it conflicts with medical care, **allow and encourage it**. It not only comforts the patient but empowers the family. If a certain practice isn't possible (say they want to burn something in a non-smoking area), try to find alternatives (maybe an electronic candle or allowing it in a designated space). If multiple family members want to stay overnight, see if a larger room or additional cots can be arranged. These actions show cultural sensitivity and can reduce the patient's stress (because in many cases, being alone in a hospital is deeply uncomfortable for someone used to being surrounded by family).

In summary, think of the **family as allies** in the patient's care. Embrace the proverb "It takes a village to heal" in this context. By involving and educating the family, we leverage their support for better compliance and holistic healing. When family and healthcare providers work in unison, the patient benefits from both modern medicine and the loving care of their community.

Slide 8: Gender Considerations – Men's Roles & Preferences

- **Stoicism and Emotion:** Many Native American men are culturally conditioned to be **stoic** – not openly expressing pain or emotion, as doing so may be seen as weakness ³⁹. A middle-aged male patient might under-report pain or discomfort. Nurses should **ask sensitively** about pain (and observe non-verbals) because a brief "I'm okay" could be masking significant pain. It may help to explain that managing pain will help him heal faster or be more active for his family (appealing to practical reasons rather than just "complaining about pain").

- **Gender of Provider:** While not universal, some Native patients have **preferences for same-gender providers for intimate care**. Traditional modesty can be strong – e.g., a man might be uncomfortable with a female nurse performing certain exams or vice versa ²⁹. If a male patient seems uneasy during a sensitive procedure (catheterization, bathing), consider offering a male staff member if available. Always ask permission and explain what you're doing to maintain dignity.
- **Male Role in Family:** Middle-aged Native men often see themselves as **providers and protectors**. Illness can threaten their role identity. They might feel embarrassment or guilt for being “taken care of.” Acknowledge this: for instance, involve them in decision-making (so they feel control) and perhaps assign them a role in their own care (“You’ll be in charge of tracking your sugar since you’re the head of the household – we’ll teach you how”). This empowerment respects his role.
- **Communication Style:** Some men may prefer a **direct, factual communication style**, while others might open up more slowly. It can be useful to engage in a bit of “*social talk*” about something neutral (like weather, or a common interest such as horses, ranching, sports) to build rapport before diving into personal health questions – this is especially true if discussing sensitive topics (sexual health, mental health). Trust needs to be established first; male patients might not readily discuss topics they find private or unmanly (like depression or impotence) until they trust you.
- **Cultural Gender Norms:** Traditional norms might designate certain topics or tasks as women’s or men’s domain. For example, among some tribes, women might handle herbal remedies for certain ailments, whereas men handle others. Also, men might be less accustomed to being physically cared for (in some cultures, women often care for sick family). As nurses, we should be mindful – a male patient might initially resist help with personal care due to pride. Explaining procedures in a matter-of-fact way and preserving modesty can alleviate some discomfort. For instance, draping appropriately during a bath and explaining that needing assistance is temporary and part of recovery can help maintain dignity.

Speaker Notes:

Gender plays a role in healthcare interactions, and for **Native American male patients**, there are a few nuances worth highlighting for culturally competent care:

- **Stoicism in Pain and Suffering:** From a young age, many boys in traditional Indigenous families are taught by example to be **brave and stoic**. The image of the “Stoic Indian” (while a stereotype when misused) does have roots in cultural expectations – it was often honorable to endure hardship quietly. In modern healthcare, this means a Native man might downplay pain levels or “tough out” symptoms longer than others. There’s evidence that Native Americans, in general, report that **expressing pain is a sign of weakness** and they were taught by elders to hide pain ³⁹ ⁴⁰. As a nurse, I once had a Navajo patient who kept saying he was fine post-op, yet he was pale and his vitals indicated pain. Only after gentle probing did he admit the pain was severe. We should frequently assess pain and consider using objective measures or asking in different ways (e.g., *“If 10 warriors had this same surgery, how many do you think would be in more pain than you right now?”* – sometimes reframing helps them feel okay to rate pain). It’s also useful to reassure them that accepting pain relief is not a weakness; it’s a way to heal faster or stay strong for their family.
- **Male-Female Interaction:** Culturally, some Native communities had strict gender roles historically. For instance, certain healing ceremonies were gender-specific. Today, a patient might not overtly refuse a provider of the opposite gender, but could feel discomfort. I recall a male patient who was very quiet during an exam by a female provider but later opened up about symptoms when a male provider spoke with him. We should pick up on cues – body language of discomfort or terse answers could indicate modesty issues. When possible, **offer choices:** *“Would you feel more comfortable if I*

found a male nurse to assist with this? It's entirely up to you." This respects their preference without assuming. If it's not possible to accommodate, at least acknowledging it ("I understand this might be a bit uncomfortable, but I'll be professional and quick") can help. Importantly, **privacy** is key – ensure doors/curtains are closed, only necessary staff present, and explain each step to reduce anxiety.

- **Role of Men in Family:** Traditionally, men might be hunters, warriors, or leaders – roles that emphasize strength and independence. Being ill and in a dependent position can threaten their sense of masculinity. They might feel they are burdening their family, which can lead to reluctance in asking for help or adhering to prolonged treatments. I had a patient who wanted to leave AMA (against medical advice) because he felt "useless" in the hospital while his family needed him at home. What worked was involving his adult son and framing the hospital stay as a short-term strategy to ensure he'd be there long-term for the family. The son said, "Dad, we need you to get well so you can teach the grandkids to fish next summer," which resonated with him. So involving family support to reinforce that taking care of *himself* is in service of the family can reduce that guilt.
- **Communication with Male Patients:** Communication styles can vary, but some men may communicate in a more indirect or storytelling manner rather than answering point-blank questions. It can help to ask open-ended questions and patiently listen. Sometimes, talking while doing an activity (like during a walk in the hall, or while looking at something like a brochure or pictures) can make a man more comfortable to share – as opposed to a face-to-face intense conversation which might feel confrontational. Also, showing respect (addressing him as "Mr. [LastName]" unless he invites first-name use) and not talking down is essential. Native American men, especially elders, often appreciate being treated with formality and respect initially. Use a firm handshake if appropriate (keeping in mind some tribes traditionally didn't shake hands firmly, but nowadays many do in a Western context – follow the patient's lead).
- **Men's Health Topics:** Be aware that discussing certain topics like sexual function, prostate issues, or mental health (like depression) might be sensitive. They might be embarrassed to bring these up. As a nurse, you might need to gently initiate: "*Some men with your condition experience [ED, low mood, etc.]; if that ever happens, let us know – it's common and we have ways to help.*" By normalizing and bringing it up first, you give them permission to talk about it. If they still don't want to discuss in depth, respect that and maybe provide written info or a private opportunity later.

In essence, **gender considerations** remind us to tailor our approach: Provide care in a way that maintains a male patient's dignity and aligns with his sense of identity. Encourage expression of needs (knowing he might be reluctant), and adapt to any gender-based preferences he shows. By doing so, we foster a trusting environment where he doesn't feel his manhood is diminished by being a patient, but rather that he is an equal partner in his care. This can lead to better cooperation and openness from the patient.

Slide 9: Religion & Spirituality – “Healing the Spirit”



A Native American spiritual leader conducting a sweat lodge purification ceremony, an important ritual to cleanse body and spirit ²⁸.

- **Syncretism:** Native Americans may practice a blend of **traditional spiritual beliefs and Christianity**. For example, some are devout Christians *and* also attend sweat lodges or powwows. Don't assume they adhere only to Western religion or only to Native practices – many incorporate both. Always ask about spiritual preferences: "Do you have any spiritual or religious practices you follow that we should be aware of?"
- **Ceremonies for Healing:** **Prayer and ceremony** are central. Patients or families might request to perform rituals at the bedside – e.g., **praying with a sacred pipe, singing healing songs, drumming, or anointing with sacred water**. These rituals invoke spiritual healing and comfort. When possible, accommodate these requests (coordinate with hospital chaplain services or administration if needed). Such ceremonies can be as important as medical treatment for the patient's recovery.
- **Religious Items:** Many Native patients carry or wear **sacred items** (medicine bags, sacred herbs, feathers, turquoise, etc.). These items have spiritual significance and are believed to protect or heal. *Do not remove or disturb* these without permission. If the patient needs surgery, respectfully ask if a medicine bag can be kept nearby (e.g., with a family member or under the pillow) and ensure its safe return. Removing it without consent could cause great distress.
- **Taboos and Beliefs:** Some tribes have specific spiritual considerations – for instance, **Navajo patients traditionally may avoid discussion of death or negative outcomes** as it's believed to invite bad spirits or bad luck ². Be mindful when formulating education: instead of emphasizing "if you don't do this you could die," focus on positive framing ("doing this will help you live healthier longer"). Also, some may prefer certain end-of-life rituals (like having a spiritual healer present, or not wanting their hair cut – hair can be sacred). It's crucial to inquire about any such beliefs, especially in palliative care situations.
- **Resources:** Utilize resources like **hospital chaplains or local Native spiritual leaders**. Many hospitals serving Native populations have arrangements with tribal spiritual advisers. For example, Mayo Clinic has a dedicated smudging room and training for chaplains in Native practices ²⁶ ²⁷. If your patient is far from home, perhaps a local Native community representative can visit. Providing access to these spiritual

resources can significantly reduce anxiety and promote spiritual well-being, which in turn can positively affect physical healing (mind-body connection).

Speaker Notes:

Spirituality in Native American culture is often inseparable from concepts of health. For many, **healing is a sacred act** that involves not just the individual but also their ancestors, their community, and their Creator (or spiritual universe). Here's how we can incorporate and honor spirituality:

- **Blend of Beliefs:** You might meet a patient named Joseph who goes to church every Sunday *and* visits the Sundance ceremony each summer. Or a patient who prays with a rosary and also keeps a medicine bundle. This blending (*syncretism*) is common. So when assessing spiritual needs, **don't pigeonhole** – ask open questions rather than assuming. For instance, instead of “What church do you attend?” one might ask, “Tell me about your spiritual or religious practice – whatever is important to you.” This gives them room to talk about a Native faith practice, a Christian faith, or both. Some may identify with the Native American Church (which uses practices like the peyote ceremony) – that’s something to know because, for example, peyote (a cactus with psychoactive properties) is used sacramentally by some, and while it’s not usually an issue in a hospital, it’s part of their spiritual life story. The key is to **listen without judgment**.
- **Healing Ceremonies in Hospital:** The presence of ceremonies like drumming, chanting, or smudging can initially be foreign in a clinical setting, but these are powerful *medicine* for Native patients. For example, a patient might request a **drum circle** or singing of a healing song in their room. If it’s not disruptive to others (maybe do it at a reasonable hour or in a private room), try to facilitate it. It can have an uplifting effect on the patient’s spirit. Another common practice: some tribes do a **“blessing way” or prayer circle** around the patient. I’ve seen families form a circle and hold hands to pray or even gently touch the patient and say traditional prayers. Giving them a few minutes of privacy for such activities can mean a lot. Always communicate and coordinate – for instance, let them know to inform you or staff when they plan to light anything (for smudging), so that alarms can be managed. Or find an alternate location like an outdoor area if open flame/smoke isn’t allowed indoors.
- **Respect Sacred Items:** Many Native patients carry a **medicine bag or pouch** – often a small leather pouch worn around the neck or kept on their person containing herbs, stones, or other sacred symbols. This is extremely personal – like a cross or a holy relic would be for others, but even more so, because often only that person (or a medicine person) should handle it. If you see a cord around the neck or a pouch, *ask before removing during procedures*. Say, “*This looks like a medicine bag – would you like to keep it with you? We can tape it so it doesn’t fall off in surgery,*” etc. In many cases, surgical teams allow such items secured to the patient’s body as long as they don’t interfere (or they hand it to family with a promise to return it immediately after). Same for **eagle feathers** or other items – these can be as significant as any part of the treatment from the patient’s perspective. One patient told me his feather was his “protection” in the hospital – removing it would have made him feel extremely vulnerable. We must respect that. If an item absolutely must be removed (say, metal jewelry and we have no choice due to MRI or cautery risk in surgery), explain why, handle it with gloves if it’s culturally required (or let the family handle it), and keep it safe to return.
- **Cultural Taboos:** Awareness of some spiritual/cultural taboos can prevent unintentional disrespect. For example, **avoiding talk of death** in certain tribes: Instead of asking “If you die, who makes

decisions?" one might frame it as "If things took a bad turn, who would you want to speak for you?" Or simply ask if they have a *living will* or someone designated to help with decisions – without repeatedly using direct "death" language if they seem uncomfortable. Another example: some tribes (like certain Pueblo cultures) may avoid *direct eye contact with elders* as a sign of respect (which could be a consideration if an elder provider is interacting with a younger patient; the patient may look down out of respect, not disinterest). Also, after a death, some tribes have specific practices like not wanting the person's name spoken for a time, or needing certain cleansing ceremonies – which might not directly apply in hospital care but are good to know if you're helping a family through end-of-life. For palliative care, maybe consult with a cultural liaison about any rituals (like a family might want to burn sage in the room after a loved one passes to help their spirit on its journey). Whenever possible, facilitating these practices is part of **culturally competent, compassionate care**.

- **Chaplains and Spiritual Care:** If your hospital has chaplain services, inform them of the patient's background. Many chaplains are trained or can reach out to appropriate spiritual leaders. For instance, I've seen a chaplain coordinate with a local Native healer to come in and pray or perform a ceremony for a patient who was far from his reservation. It meant a lot to the patient. If no chaplain, perhaps contact the tribe's health department or cultural center – they often have contacts for spiritual support in hospitals. It might seem beyond typical nursing duties, but remember, per our holistic care model, **spiritual health is part of patient health**. When we address it, we treat the patient more completely.

In essence, **spirituality is a pillar** of health for many Native American patients. Embracing their religious and spiritual needs – whether it's facilitating a sweat lodge before chemo (some hospitals have constructed small sweat lodges on campus!) or simply letting them keep a sacred medicine bundle at the bedside – can significantly enhance their trust in us and their overall healing experience. It shows we care about *them as a whole person*, not just their disease. This can transform a clinical encounter into a truly healing experience.

Slide 10: Diet & Nutrition – "You Are What You Eat"



Examples of indigenous foods: dried mushrooms and varieties of native corn – traditional diets were rich in natural, unprocessed foods ⁴¹.

- **Traditional Diet vs. Modern Diet:** Historically, Native diets were **high in lean proteins (game, fish, vegetables, fruits, nuts, corn, beans, and squash)**, with minimal processed sugars or grains ⁴². This diet was *low-glycemic, high-fiber, and nutrient-dense* – contributing to lower rates of diabetes and obesity in the past. Modern disruptions (commodity foods, store-bought processed foods) introduced high sugar, refined flour, and unhealthy fats, leading to a spike in chronic diseases (the “nutrition transition” is a major factor in the diabetes epidemic ¹⁴). Educating patients about a “*return to tradition*” in diet – using more traditional foods – can resonate culturally and improve health.

- **Common Health Issues: Obesity and diabetes** are prevalent in middle-aged Native men partly due to changes in diet and sedentary lifestyle. Many patients have grown up on government-issued commodity foods (like white flour, lard, canned meats) which replaced traditional staples. Emphasize culturally relevant nutrition: e.g., *“Frybread is delicious but it’s an occasional treat. Let’s incorporate more roasted corn, wild greens, bison or fish if available – like your ancestors did.”* Framing nutrition advice in a cultural context can be motivating.

- **Food as Medicine:** Indigenous cultures often view food itself as medicine. *“Let food be thy medicine”* is a concept understood traditionally – e.g., **berries** (rich in antioxidants) for immunity, or **herbal teas** for various ailments. Encourage patients who use traditional foods or remedies, as long as they’re safe (for instance, many tribes use juniper ash to add calcium to foods, or cedar tea for colds – these can complement medical care).

- **Sociocultural Challenges:** Acknowledge challenges like **food insecurity** on reservations or rural areas – access to fresh produce can be limited. Work with dietitians or social services to connect patients with resources (e.g., Special Diabetes Program for Indians, community gardens, food distribution programs that are incorporating traditional foods). Also, consider family in diet planning: in communal cultures, one person’s diet change often involves the whole family’s participation. Inviting family to nutrition counseling sessions can help ensure support at home.

- **Respecting Preferences:** Some Native men may have unique preferences or avoidances tied to culture or personal taste (for example, not liking milk due to lactose intolerance common in Indigenous populations, or avoiding certain animals for spiritual reasons). Always ask about dietary preferences or restrictions beyond the usual. Show respect by trying, if feasible, to provide familiar foods during hospital stays – even something like offering hominy stew or blue cornmeal mush if available can make a patient feel more at home.

Speaker Notes:

Diet is an area where cultural practices have a direct impact on health, especially regarding chronic disease. For Native American midlife men, understanding their dietary context can guide effective nutritional counseling:

• **Traditional vs. Western Diet:** Traditionally, Native diets varied by region (for example, Plains diets included bison, berries, prairie turnips; Southwestern diets had corn, beans, squash, chiles; Coastal diets had salmon and seaweed, etc.), but generally they were **natural, seasonal, and unprocessed**. There was a harmony with the land – eating what was available during each season, preserving foods by drying or smoking for winter. This meant lower intake of refined sugars and flours. The body handled these natural foods well – for instance, wild rice or corn have a lower glycemic impact than white bread. However, with colonization and especially the 20th century reservation era, many Native communities were given **commodity rations** (white flour, sugar, canned goods) as staples. This was a drastic dietary shift leading to malnutrition in nutrients but overconsumption of calories.

As one source noted, replacing traditional foods with processed ones has contributed significantly to the “*diabetic epidemic*” ¹⁴. So when counseling, one approach is to **encourage incorporating traditional foods** again. I often frame it like, “Your ancestors ate xyz which kept them strong – let’s see how we can bring some of those foods into your meals.” This can be more motivating than saying “don’t eat fast food.” For example, suggest grilled fish instead of fried, corn tortillas or native grains instead of white bread, using natural sweeteners like fruit or a bit of maple syrup instead of lots of refined sugar, etc. Some communities have started “**return to tradition**” diabetes programs that promote traditional cooking as diabetes management – these have had success because they tie healthy eating to cultural pride.

- **Obstacles to Healthy Eating:** It’s important to **acknowledge the reality**: On many reservations or in inner-city Native communities, access to fresh produce or traditional foods can be limited. Many rural reservations are “food deserts.” Additionally, economic constraints mean families rely on cheaper high-carb foods. So telling a patient “eat fresh salad and lean meat” might be unrealistic if groceries are far and expensive. Instead, work on small changes within their context: e.g., if they rely on canned veggies, rinse off the salt; if they have only powdered milk from commodity programs, maybe use water in some recipes and get calcium elsewhere, etc. Also, portion control and timing can be discussed (like not loading up on starches all at once). Involving a **Registered Dietitian (RD)** who is familiar with Native diets (or providing culturally adapted meal plans) can be very beneficial. Some Indian Health Service clinics have RDs that incorporate local food examples in their teaching. If your patient is going home to a reservation, connect them with the local **Special Diabetes Program for Indians (SDPI)** or similar – these programs often provide education, cooking classes, and even food supplies oriented towards healthier traditional eating.
- **Food and Family:** Eating is often communal. A male patient might not be the one who cooks at home (maybe his wife or mother does), but he likely has a say in what traditional foods are kept. Encourage him to involve family in his dietary changes – e.g., “Maybe your wife has some traditional recipes that are healthy; could you both meet with our nutritionist?” I recall a case where a patient’s wife came in and we talked about modifying a beloved stew recipe to add more veggies and reduce fat. They both were more on board after that conversation. The diet changes won’t stick if the family at home doesn’t buy in, especially in close-knit families that eat together.
- **Lactose Intolerance and Other Considerations:** Many Native Americans are lactose intolerant to some degree (since dairy wasn’t a traditional part of most tribes’ diets). If a meal plan prescribes a lot of milk or cheese, the patient may quietly not follow it due to GI discomfort. So ask – “Do dairy products bother you? What happens if you drink milk?” If yes, plan for alternatives (there’s often acceptance of that among dietitians now, but it’s worth pointing out). Also, ask if they avoid any foods for cultural reasons. Some tribes or individuals have avoidances (e.g., some Navajo might not eat fish historically, some Plains tribes avoid bear, etc.). It might not be common for a hospital tray, but if nutritional supplements contain something culturally off-putting, they might refuse without explaining why. Getting that info helps tailor suggestions they’ll actually follow.
- **Emotional Aspect of Food:** For many, foods like **frybread** or certain stews are comfort and tied to identity. We shouldn’t demonize these foods. Frybread, for instance, came from hardship (made from ration ingredients) but became a pan-Indian staple. We can say “frybread is okay once in a while, but it’s heavy – for everyday bread, perhaps blue corn mush or whole grain bannock might be better.” Show respect for their cuisine while guiding moderation. Also, promote what’s good: **wild**

game (if they have access) is very lean; traditional corn and bean combos are high in fiber and protein; wild rice is excellent nutritionally, etc. If they hunt or fish, encourage continuing that (safe preparation, of course) because it's exercise and yields healthy food.

In summary, **nutrition advice should be culturally relevant and realistic**. By encouraging a return to healthier traditional foods and acknowledging current barriers, we empower patients to make changes without feeling like they're abandoning their culture or being asked for the impossible. A culturally sensitive approach might turn a lecture on "diet and exercise" into a collaborative discussion about **heritage and health**, which is far more engaging for the patient.

Slide 11: Special Considerations – Trust, Communication & Access



Building trust through culturally concordant care – having Native nurses and staff can help Native patients feel understood and respected ⁴³ ³⁴.

- **Historical Mistrust:** Due to a long history of abuse (e.g., unethical research, forced sterilizations, segregation in healthcare), many Native patients harbor **mistrust** toward medical institutions ² ⁴⁴. They might be skeptical of recommended treatments or fear discrimination. It's crucial to be **honest, patient, and consistent** to build trust. Apologize if trust was broken in the past (even by the system) – acknowledge their feelings ("I know the healthcare system has not always been fair to Native people, but I am here to support you").

- **Communication Nuances:** Aside from silence and eye contact which we discussed, note that some Native patients may **soften criticism or bad news** out of politeness. If a patient seems to agree but does not follow through (e.g., no-show to follow-ups), it might indicate they were uncomfortable voicing disagreement. Provide **multiple avenues** to communicate (in person, phone calls, involving a community health representative) and **check for true agreement** with the plan. Use phrases like "It's okay to tell me if something isn't working for you; I want to find something that will work." This invites honesty.

- **Language and Literacy:** While most middle-aged Native Americans speak English, some (especially if from very rural or if English is second language) may prefer information in **simpler language** or even some phrases in their Native language. Also, health literacy might be an issue if education access was limited.

Avoid medical jargon; use visual aids if possible. If the patient speaks a Native language and is more comfortable that way, involve an **interpreter** (perhaps a family member or certified interpreter if available) – even hearing a few healthcare terms in their language can improve comprehension and comfort.

- **Geographic Barriers:** Recognize that many patients live in **remote areas**. Attending frequent appointments or accessing specialty care can be very challenging (distance, lack of transportation) ⁴⁵ ⁴⁶. When planning care, consider **consolidating appointments** or utilizing **telehealth** (if internet/phone is available) for follow-ups. Ask about their ability to travel. Work with Indian Health Service (IHS) or tribal clinics – sometimes they can do local follow-ups and share info. If prescribing a regimen, ensure it's feasible (e.g., refrigerated meds might be hard if they lack electricity consistently; daily therapy might not be realistic if it's 200 miles away). Creativity and flexibility here will improve adherence.

- **Financial and Access Issues:** Many middle-aged Native patients are uninsured or underinsured, though IHS provides some coverage. Still, **medication costs** or lack of pharmacy nearby can hinder adherence. Connect them with resources: patient assistance programs, IHS pharmacy (if eligible), or programs like Medicaid (if not already enrolled). Also, consider **social determinants**: if a patient has unstable housing or income, prioritize interventions – involve social work or case management to assist with applications for benefits or community support. A patient who's worried about feeding his family is not going to prioritize his meds unless we help address those basics.

- **Community Liaison:** Whenever possible, involve a **Native patient navigator or community health representative (CHR)**. These are often members of the community trained to help patients navigate the system. They can bridge cultural gaps, provide follow-up in home communities, and reinforce education in a culturally tailored way. They also often speak the local language/dialect and can ensure instructions make sense in context. Studies show that involving Indigenous health workers can improve outcomes because patients feel "**they understand me**".

Speaker Notes:

This slide collects **miscellaneous but crucial considerations** that don't fit neatly into one category but significantly affect care: trust-building, communication finesse, and systemic barriers. Let's go through them:

- **Trust Building:** As we've echoed throughout, trust is the foundation for working with any patient, but especially for communities who have historical reasons to be wary. The U.S. government and medical establishment have done things in the past (and sometimes present) that broke trust – from the dissemination of smallpox in blankets centuries ago, to more modern issues like underfunded IHS facilities and even specific unethical incidents (e.g., the Navajo uranium miners not informed of risks, sterilizations of Native women in the 1970s without proper consent, etc.). A savvy patient might remember or have heard of these. I find that being **transparent** and **humble** helps. For instance, if a patient asks, "Is this experimental? Am I a guinea pig?", don't dismiss it; directly clarify what the treatment is, why it's standard, and affirm their right to refuse or seek a second opinion. If a mistake happens, own up immediately – that honesty actually *increases* trust. Sometimes simply acknowledging, "I understand why you might feel cautious given how the system has treated Native people. I want you to know I will do everything I can to treat you with respect and honesty," can be powerful. It signals you see them as an individual and you respect their perspective. Over time, keeping small promises (like "I'll check on that and get back to you at 2pm" – then do it) also accumulates trust "credit."

- **Communication Nuances Revisited:** We talked about silence and indirect communication. I'll add: **storytelling** is a common mode of Native communication. A patient might answer a health question

with a story – “When I was young, my grandfather used to... and that’s why I think this pain started.” Listen for the message in the story. Often, it’s not off-topic; it’s their way of contextualizing their experience. Also, humor – Native patients might use dry humor or teasing as a way to lighten an uncomfortable situation. If a patient jokes, laugh with them (as appropriate). Humor is a huge coping mechanism in many Native communities. Regarding nodding or saying yes: one clinician in a study on cultural care noted that “*yes doesn’t always mean yes*” with some Native patients – it could mean “I hear you” but not necessarily “I will do it.” That’s why we use teach-back or follow-up questions to gauge actual agreement. And giving *permission to disagree* explicitly can be helpful: e.g., “I want to make sure this plan works for you. If there’s anything you don’t like or want to change, it’s really okay to tell me – I won’t be offended.” Sometimes they need to hear that to feel comfortable speaking up.

- **Language & Literacy:** English fluency varies – some middle-aged folks on remote reservations grew up with their Native language first. They might have an accent or search for English words. If they prefer their language and an interpreter is available (perhaps an employee or phone service), use it, even if just to clarify key points. If not, speak in **plain language** and confirm understanding frequently. Also, consider **visuals or models** – e.g., use the “teach-back” method with a pillbox or draw a quick sketch of anatomy rather than a complex pamphlet. Many tribes have health education materials translated into their language or culturally adapted (with Native imagery). If you can procure those, it can help. Even the act of offering a brochure featuring Native art or people can make the patient feel the info is meant for them.
- **Geographical & Logistical Barriers:** We must tailor plans to the reality that some of our patients come from very far. For example, a man might have driven 3 hours to the urban hospital, missing work. If we tell him “come back twice a week,” that might be untenable. Instead, coordinate with local clinics – perhaps he can do lab checks or wound care at the small IHS clinic near home and they fax results to you. Telehealth (phone calls or video) can save travel – but ensure they have a working phone or internet; if not, the CHR (Community Health Representative) can sometimes visit the home. Also, help schedule multiple appointments on the same day if he needs multiple specialties (to avoid multiple long trips). If overnight lodging is an issue, some hospitals have patient housing or can arrange discount rates – social services can assist. Recognizing these hardships and helping to mitigate them not only improves adherence but also shows empathy. Patients often deeply appreciate when providers acknowledge the **sacrifice and effort** they make to get care. One might say, “I know it’s a long trip for you each time – let’s see how we can reduce how often you need to come in.”
- **Financial Issues:** Many Native American patients rely on the Indian Health Service (which is funded but often underfunded). If referred outside IHS, costs can be a concern unless covered by a specific program (Contract Health Services). Check if the patient has IHS eligibility and coordinate documentation because IHS needs notification for payment (some patients end up with bills because a notification wasn’t done within e.g. 72 hours for ER visits). As a nurse, involve case managers who know these processes. If uninsured, see if they qualify for Medicaid (a lot do but might not be enrolled). Be aware of programs like **638 clinics** (tribally run clinics that may have funding to cover referrals) ⁴⁷. Essentially, we become a bit of a navigator or advocate to ensure access. For medications, if we prescribe something expensive not on IHS formulary, they might not get it after discharge. So consult with an IHS pharmacist if possible to choose something covered. Little steps like that prevent gaps in treatment.

- **Community Health Reps (CHRs) and Navigators:** Many reservations employ CHRs who do home visits, check vitals, ensure patients take meds, etc., acting as a bridge between hospital instructions and home reality. If your patient is from such an area, get a referral to the CHR program. The CHR can relay if the patient is struggling at home and help them follow through. Similarly, some hospitals have **Native patient navigators** who specialize in helping Native patients through the system. They can address cultural needs, coordinate spiritual care, and help with discharge planning that's culturally appropriate. Using these resources can dramatically improve outcomes because they provide continuity and cultural context beyond the hospital.
- **Mortalities and Sensitive Issues:** Another consideration – in some tribes, after someone passes, the family may need certain practices (like immediately opening a window for the spirit, or not wanting the deceased's belongings touched by outsiders). If working in an area with a significant Native population, it's wise to learn these practices and incorporate them into end-of-life care protocols. For example, I learned that among some tribes in my area, it's important to **allow family time alone with the body and possibly a spiritual leader to perform rites** right after death. We arranged that with security and it made a huge difference to the family's grieving process.

In conclusion, these “special considerations” underscore that culturally competent care goes beyond knowing facts – it’s about anticipating and addressing **the context of the patient’s life**: historical context, communication context, and socio-economic context. When we take these into account, we demonstrate true patient-centered care, which for Native American patients is also *culturally-centered* care. This ultimately leads to better trust, better adherence, and better health outcomes.

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