

# Injustice in Healthcare: A Navajo Case Study

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## Abstract

Significant health inequalities exist between the Navajo tribe and the US population as a whole and are worsening over time. I argue that while these health issues are concerning, there are also larger systemic issues (i.e., the Navajo's historic and contemporary marginalization, the removal of traditional medicine from formal healthcare settings, etc.) that continually reproduce these health issues, which create an injustice. Using social justice theory, I draw on Norman Daniels and Martha Nussbaum to establish that the health inequalities on Navajo Nation are unjust. By removing the Navajo's fair equality of opportunity and capability in health choices, the US has imposed unjust healthcare and thus unjust health-related inequalities on the Navajo. I then propose why and how a hybrid healthcare model based in medical pluralism that integrates both traditional and Western medicine potentially corrects for the sources of health-related injustice within Navajo Nation by reinstating peoples' freedom to choose what they believe to be good health.

## I. Introduction

Navajo Nation is a semi-sovereign territory located in Arizona, Utah, and New Mexico and is home to over 300,000 Navajo, the second most populous tribe in the United States (US) (Henson, 2008).<sup>1</sup> Additionally, Navajo Nation is the size of West Virginia, making it the largest Native American Indian (NAI) reservation in the US. The Navajo tribe is one of many examples of the pluralism that exists in the US, as the US has peoples from many different traditions and cultural backgrounds (Carrese & Rhodes, 1995). These different backgrounds manifest in some groups in society, including the Navajo, having health-related values and practices that differ from those of Western medicine (Carrese & Rhodes, 1995).<sup>2</sup> While few have explored how these differences in health values and practices manifest on Navajo Nation, those that have have brought to light the large tension that exists between biomedical and traditional health practices, which is largely due to the enforcement of biomedicine on the reservation (Carrese & Rhodes, 1995).<sup>3</sup> While this domination of biomedicine likely contributes to many of the health issues on Navajo Nation, it may also be indicative of much larger practical and ethical issues that need to be addressed.

Significant health inequalities exist between the Navajo tribe and the US population as a whole and these inequalities are worsening over time. Through combining scholarly works, government reports, and interviews that I conducted in Navajo Nation over January 2015, I find that all actors recognize these inequalities. For example, in recent years, teachers on the reservation have seen the biggest health concern for young students transition from poor dental care to obesity and diabetes mellitus Type II, which were previously considered chronic conditions found only in adults (Noggle S., 2015).<sup>4</sup> By the time the Navajo are adults they experience diabetes mellitus Type II over four times more than the US average and about 33

percent of Navajos are obese, which is seven percent higher than the US population as a whole (Clichee, 2013; Will et al., 1997). The increasing rates of diabetes and obesity on Navajo Nation, which are now affecting youth, are but two of the many examples of the health issues and health inequalities present on Navajo Nation that go largely unaddressed.

I argue that while these health issues themselves are concerning, there are larger systemic issues (i.e., the Navajo's marginalization, the forced removal of traditional medicine from formal healthcare, etc.) that continually form and reproduce these issues, which are what create an injustice.<sup>5</sup> These systemic issues are the social determinants of health, the set of socially controllable factors that effect health (Daniels, 2008).<sup>6</sup> Thus, I claim that it is not the Navajo's high rates of diabetes and obesity that are unjust, but the reasons for the existence of these high rates of diabetes and obesity (i.e., the Navajo's marginalization, the forced removal of traditional medicine in formal healthcare, etc.) that create an injustice. In other words, it is not a lack of the Navajo's health functionings (e.g., obesity and diabetes) but a lack of peoples' health capabilities (e.g., peoples' opportunity to prevent obesity and diabetes) that are unjust.<sup>7,8</sup>

In order to better explain this injustice and the ways in which health and healthcare on Navajo Nation could become just, I do the following in this paper. First, to provide necessary context, I introduce the health inequalities on Navajo Nation ranging from physical ailments to mental and behavioral health concerns that may be indicative of an injustice. I then describe how the interaction between Western and traditional health practices and belief systems have molded both the Navajo's current health practices and the health inequalities that exist between the Navajo and the US population as a whole. The forced removal of traditional medicine from formal healthcare institutions is the systemic issue that I focus on that may be indicative of an injustice, but it is not the only systemic issue on the reservation. Others include the historic and

contemporary marginalization of the Navajo, their forced geographic isolation on the reservation, and more.

Next, I utilize social justice theory, drawing on both Norman Daniels and Martha Nussbaum, to establish that health and healthcare in Navajo Nation (which has suffered from this removal of traditional medicine and enforcement of Western medicine) is representative of an injustice.<sup>9</sup> Daniels, drawing on a Rawlsian approach, states that justice in health requires that the Navajo have fair equality of opportunity to choose what they believe to be good health and good healthcare for themselves (Daniels, 2008). Nussbaum then substantiates Daniels by claiming that health is not only a manifestation of opportunity (as we must protect peoples' opportunity), but is itself a central capability, a substantial freedom required to live a life of human dignity (Nussbaum, 2011). I then propose that the freedom for individuals to choose their own good health and healthcare (e.g., the freedom to choose Western and/or traditional medical care) is congruous with the notions of fair equality of opportunity and capability (Beauchamp & Childress, 2001).<sup>10,11</sup>

By articulating issues related to health and healthcare on Navajo Nation (e.g., the removal of traditional medicine and enforcement of Western medicine) and pairing them with social justice theory, I thus show how the Navajo do not have fair equality of opportunity or capability in their healthcare options, which are primarily enforced by the US, and how their resulting health-related inequalities are unjust. Once I outline why an injustice within healthcare exists on Navajo Nation, I propose how a hybrid healthcare model based in medical pluralism potentially corrects for the sources of health-related injustice within Navajo Nation by reinstating peoples' fair equality of opportunity and capability.<sup>12</sup>

## II. Health Inequalities

As I stated earlier, health inequalities themselves are not inherently unjust, but when they stem from a lack of capability, they become unjust (Nussbaum, 2011). So, it is important to outline the health inequalities on Navajo Nation, as they may provide insight as to how these inequalities came to be. To begin, while the Navajo originally suffered from acute health issues (i.e., heart attacks), as the US became more involved with NAI tribes, chronic health issues (i.e., diabetes) began to permeate the reservation (Henson et al., 2008).<sup>13</sup> Prior studies have linked the Navajo's worsening health to the imposition of Westernized healthcare systems (which I focus on, as mentioned in the introduction), the Navajo's unresolved historical trauma, their isolation, their poor economy and infrastructure, patient choice, and more (Heart & DeBryn, 1998; Lee, 2015; Byers; Glasses, 2015). I cannot make any causal claims here, but it is important to keep in mind that a combination of these systemic issues has likely largely contributed to the Navajo's health today.

In regards to physical health, as I stated earlier, diabetes mellitus Type II ails the Navajo over the age of 20 four times as much as the US population as a whole, which is a condition often tied to poor nutrition and low physical activity (Will et al., 1997). Navajo children, who often receive free and reduced school lunches, typically have unhealthy meals at school because the school lunch program provides unhealthy options (e.g., pizza) daily (Noggle S., 2015). Additionally, one traditional healer says that traditional meals incorporating homegrown ingredients have become far less common on the reservation and that commodity foods and fast food have quickly become the norm because they are both accessible and affordable (Jim, 2015). In Navajo Nation, over 40 percent of people have low food access (defined as living over 10 miles away from a supermarket in rural areas) while less than seven percent of all Americans do, and there a higher

concentration of fast food chains and convenience stores on the reservation than there is in the US overall (Clichee, 2013). Doctors also say that many people on the reservation are not physically active, as there is only one wellness center on the entire reservation and only four percent of people live within half a mile of a park as compared to nearly 40 percent of Americans (David, 2015; Clichee, 2013). So, there is then little incentive for people to be active or go outside.

Mental health fares poorly as well and is likely the most neglected realm of health, with many Navajo suffering from anxiety and depression. In fact, the Navajo report frequent mental distress over 20 percent more than other Americans (Henson et al., 2008). Additionally, Samantha Lee, a behavioral health counselor, says that most people that do receive behavioral health services do so through court mandated programs rather than by personal choice, and there is still a misunderstanding within the formal healthcare system as to what the role is for psychology and mental wellness in peoples' health (Lee, 2015).

Other behavioral health indicators are also worsening that are closely tied to people's physical and mental health. Domestic violence is largely tolerated on the reservation, potentially due to peoples' traditional family structures; homicides and suicides are increasing and suicide attempts in particular are starting to become common for high school kids; and alcoholism rates are increasing. All of these (save domestic violence) are starting to appear at a younger age. For example, alcohol related deaths for youth on the reservation are 17 times higher than the US average (Henson et al., 2008). So, by the time youths reach adulthood, they have already been exposed to many of the health issues plaguing Navajo Nation. Many issues related to alcoholism only worsen throughout one's life, with doctors claiming that hospitals do not do enough care for their alcoholic patients, as there are so many (David, 2015). They treat alcoholic individuals by

hydrating them in the emergency room without providing them with any longer-term treatment options or inquiring what the source of their alcoholism could be even if they frequent the emergency room often (David, 2015). For example, one doctor stated that after a man came to the emergency room multiple times for alcohol related issues, he asked the man what was causing his drunkenness and the man stated that he had prostate cancer and that alcohol was the only thing that dulled the pain (David, 2015). So, by asking a simple question, doctors were able to prescribe proper medication and curb this man's alcoholic behaviors. While the solution to alcoholism is rarely this simple, this example does indicate that it is necessary for doctors to go beyond merely treating the outward symptoms of alcoholism to actually better peoples' health.

Physical, mental, and behavioral health issues have thus all taken hold in Navajo Nation in ways that both overwhelm the healthcare system and expose the insufficiencies of this healthcare system, which is based in Westernized care. For example, it often takes up to three months for people to get appointments at behavioral health centers, thus revealing the dire need for more counseling services (e.g., the system is overwhelmed) (Glasses, 2015). However, when looking more deeply, it becomes clear that part of the reason that the waitlist is so long is that many Navajo distrust the Westernized behavioral health system, so by the time they go (often through court mandated programs), they have complex mental health issues that are difficult to treat (e.g., the Westernized system is insufficient) (Lee, 2015). By peoples' many health issues overwhelming the healthcare system and exposing Western medicine's insufficiencies for the Navajo, a tension between Westernized and traditional care comes to light.

### III. Traditional and Western Health Influences

Now that I have expanded upon the health inequalities between the Navajo and the US majority population, I must explain how these inequalities are intertwined with the Navajo's

medical influences. These influences have both Western and traditional roots that are often in conflict with traditional care being made inferior in formal healthcare settings. Exploring Western and traditional influences allows me to see, in part, how the Navajo's health inequalities came to be and potentially why they continue to exist today. Traditional medicine typically refers to indigenous health traditions while Western medicine refers to biomedicine, conventional medicine, or modern medicine (Bodeker & Kronenberg, 2002).

Most important for my analysis are the two different definitions of health set forth by these two belief systems. It is not surprising that the Navajo and the US majority populations have different conceptions of health, as health is an emergent property of social, biological, ecological, psychological, and cultural relationships (Pappas, 2007). Traditional healers see health as a balance of and harmony with the natural order (*hozho*) while Western healthcare providers often see health as biologically and culturally constructed (Carrese & Rhodes, 1995; Rickmann, 2004). So, in a traditional view, health issues often stem from a spiritual imbalance or a lack of harmony in the natural order while in a Western view, health issues are often physical and require that pathology be present in order to become a health problem (Carrese & Rhodes, 1995; Daniels, 2008).

These differing views in healthcare are best seen in action, so I now provide an example in which Western and traditional care are in opposition. Through the Patient Self-determination Act, Western medicine requires that all physicians inform patients of the potentially negative health consequences that can come from diseases that his or her patients have (e.g., pathology is present, so the doctor has diagnosed the patient with an illness) (Carrese & Rhodes, 1995). However, many Navajo find that negative speaking or thinking is inconsistent with *hozho*, so it can actually lead to a negative reality (e.g., talking about the consequences of a disease can



actually cause a disease that the Navajo did not believe to exist before) (Carrese & Rhodes, 1995).<sup>14,15</sup> Thus, while both traditional and biomedical healthcare views aim to accomplish the same end, better health for their patient, they differ in what they believe classifies health and in what they presume to be the cause of health issues (Reeve, 2000).

### *Traditional Health Influences*

In traditional Navajo belief, health is constructed by the body, mind, and spirit and is in accordance with *hozho*. So, when one of these components is out of balance, health is in jeopardy. The Navajo have traditionally received treatment from native healers, who range from those providing healing ceremonies through herbs, balms, and purgatives to those providing their ears for listening (Kim & Kwok, 1998). Tina Coleman, a traditional healer, provides all of these components, as she has an herb garden, hosts sweat lodge retreats, and counsels Navajo youth through the Adolescent Care Unit (ACU) at Fort Defiance Indian Hospital, which is located on Navajo Nation in Fort Defiance, Arizona (Coleman, 2015). By combining these traditional remedies, she is able to ensure that her patients' needs of the mind, body, and spirit are met.

The Navajo's traditional belief system is not completely opposed to Western medicine, as Western medicine emphasizes health of the body and mind and is starting to integrate these two components more. Traditional medicine most conflicts with Western medicine in regards to the spirit, as biomedicine typically does not include spirituality when speaking about health. Religions on the reservation range from peyote to Baha'i to Christianity, but most of the Navajo, regardless of their religion, hold onto components of traditional spirituality that emphasize harmony with the natural world (Levy, 1983). Not only does spirituality remain a critical component of health, but its importance changes the way in which the Navajo perceive physical and mental health. Thus, by combining spirituality with the Navajo's views of physical and

mental health, their conception of health becomes very distinctive from Westerners' conceptions of health.

### *Western Health Influences*

When the US began taking over Navajo land in the 19<sup>th</sup> century, the Navajo's traditional practices were made inferior to Westernized medicine by US federal forces (Henson, 2008). The US created the Bureau of Indian Affairs (BIA) in 1824, from which stemmed the Indian Health Service (IHS) in 1968 (Henson, 2008). The goal of the IHS was to raise the Navajo's health to the US average and to erase peoples' tribal identity (Heart & DeBruyn, 1998). By doing so, they hoped to fully assimilate and acculturate the Navajo, after which the IHS would close down (Heart & DeBruyn, 1998). However, neither of these goals have been reached. The IHS has largely begun providing healthcare for the chronic conditions I previously described and has recognized that the Navajo identity is a permanent and critical component to these peoples' lives and is not something that should be erased.

Since the creation of the IHS, the Navajo have retained more control over their healthcare system and many IHS facilities have transitioned to 638 programs, which have more autonomy than IHS facilities but still receive pressure from federal funding priorities to be Westernized (Henson, 2008). For example, the Patient Self-determination Act still applies to Navajo Nation even though the use of negative information in healthcare consultations is seen by the Navajo as harmful to their health (Carrese & Rhodes, 1995). So, while healthcare has become more localized in law, it is unclear whether or not it has in practice.

While Westernized care has been imposed on the Navajo, many have held onto their traditional beliefs and practices. Over two-thirds of NAI continue to use traditional practices today, often as a complement to Western medicine rather than as a substitute (Buchwald et al.,

2000). Dr. Kirby David, who is both Navajo and a biomedical physician's assistant, says that he knows that many patients integrate both types of care at home, which he neither supports nor opposes (David, 2015). So, many patients combine traditional and Western care in informal settings rather than choosing one or the other. Additionally, Fort Defiance Indian Hospital has integrated care on-site in a formal setting by providing a traditional Hogan where spiritual ceremonies take place, having traditional practitioners work alongside biomedical doctors, and more (Coleman, 2015; Jim, 2015). Thus, at least one facility has combined traditional and Western care in order to reflect peoples' blending of traditional and Western practices, but most facilities have not, which begs the question: should they?

#### IV. Health Inequalities As An Injustice

Now that I have contextualized the health inequalities that exist between the Navajo and the US by describing the Navajo's traditional and Western medical influences, I suspect that these health inequalities may then be largely and systemically determined by the cultural insensitivity that American society has shown the Navajo in removing traditional medicine from healthcare. This lack of sensitivity is based on and manifested in the Navajo's race, which is a social determinant of health as I described earlier. Thus, the forced acculturation that the Navajo have been subjected to as a whole is not due to their individual differences but by something much more systematic.

These systemic inequalities are what Iris Marion Young calls a structural social injustice, an injustice created by a set of contingent social processes that result in a deficit of peoples' central capabilities (i.e., health) (Young, 2006).<sup>16</sup> To reiterate, it is not peoples' functionings (e.g., health status) that are unjust, but the lack of peoples' capabilities (e.g., what creates their health status) that is unjust (Sen, 1999). However, peoples' health functionings are

manifestations of their capabilities, so these functionings do often indicate that an injustice exists (Nussbaum, 2011). For example, the Navajo's high rates of alcoholism are not unjust in and of themselves. But, these alcoholism rates likely came about because of the Navajo's lack of economic opportunity and untreated historical trauma, which are other systemic processes that the Navajo face in addition to the removal of traditional medicine. Because the Navajo's alcoholism is likely a coping mechanism for their forced acculturation and marginalization, I then suspect that their high rates of alcoholism are unjust (Lee, 2015; Heart & DeBruyn, 1998).

The entirety of the contingent social processes that Young claims constitute a structural injustice is unclear, but I suggest that the enforcement of Westernized healthcare through the IHS and the removal of traditional medicine in formal healthcare institutions are culturally insensitive and are some of the processes that have contributed largely to both the inequality and injustice that exist (Henson, 2008). Enforcing Western medicine and removing traditional medicine both inhibit peoples' capabilities and their fair equality of opportunity to choose what they believe to be good health and good healthcare, thus making these actions unjust.

To clarify, a utilitarian perspective validates that the Navajo's poor health outcomes are unjust (Daniels, 2008). Utilitarianism requires that the greatest happiness be given to the greatest number of people and because the Navajo's health and provision of healthcare does not do this, it is unjust (Bentham, 1879).<sup>17,18</sup> However, I go beyond utilitarianism by incorporating in a social justice perspective. Rawls' and Daniels' interpretation of social justice theory is, as I said before, based on fair equality of opportunity for all. In this theory, justice requires that the Navajo have choices in their healthcare (e.g., fair equality of opportunity), and are not only provided with Westernized notions of good health (Daniels, 2008).

*Social Justice Theory*

Under social justice theory, how the US healthcare system and traditional Navajo systems interact meet qualifications for being minimally just if their interaction promotes the primary social goods, defined as goods that support peoples' capabilities to function as free and equal citizens (Daniels, 2008). Opportunity, defined as the capability to lead the life we reasonably value, is a primary social good (Daniels, 2008).<sup>19</sup> By allowing opportunity to be what people reasonably value, social justice theory caters itself to each society's values, making it a culturally sensitive theory. While it does not require that everyone's individual values are met, it does require that values be set by each moral system. For example, if the Navajo value traditional healing through sweat lodges, they should have the opportunity to practice this. However, if Western society does not value using sweat lodges, then Westerners do not have to have this opportunity.

Then, because health protects peoples' opportunity to lead the life they value, society must promote peoples' health (Daniels, 2008; Sen, 1999). In order to promote health, society must give people fair equality of opportunity (Daniels, 2008). For opportunity to be distributed fairly, society must then correct for the moral arbitrariness of social contingencies (Daniels, 2008).<sup>20</sup> As an example of treating social contingencies, Navajo society must correct for peoples' untreated historical trauma that contributes to their alcoholism, such as through behavioral health counseling. Once society corrects for social lotteries, the Navajo will have robust health, defined as a just distribution of the socially controllable factors affecting population health (e.g., the social determinants of health), meaning that the Navajo's health will no longer be determined by their race (a social determinant of health), which, as previously stated, is a manifestation of the cultural insensitivity that the US imposes on the Navajo (Daniels, 2008). If the Navajo have this robust health, then justice exists.

Social justice theory neither requires equality of health nor constrains peoples' choices or individual freedoms, but it does require that inequalities are not based on race, religion, sex, or ethnic origin because inequalities based on these classifications are morally arbitrary. Because health inequality among the Navajo is largely based on cultural insensitivity (i.e., removing traditional medicine in a formal healthcare setting) as seen through their race, as I previously mentioned, they do not have fair equality of opportunity. Without this fair equality of opportunity in place, there is an unfair distribution of the social determinants of health and thus an injustice. To reinstate justice we must then correct for the special social burdens that the Navajo face (Daniels, 2008; Daniels, 1985; Nussbaum, 2011).

### *Objections and Concerns*

It could be argued that we do not need to correct for the special social burdens that the Navajo face because they are sufficiently provided with Westernized healthcare. The Navajo may have fair equality of opportunity to receive biomedical treatment, which, under a narrow definition of health, may be all that justice requires. My response to this is two-fold. First, the Navajo often do not have fair equality of opportunity to access biomedicine due to their isolation, which is imposed upon them by the US due to the Navajo's forced relocation onto the reservation. Many Navajo live on dirt roads that easily become inaccessible in bad weather, many do not have cars, and many live in very rural areas (Noggle S., 2015; Lee, 2015). So, a health-related injustice may exist even when only speaking about access to biomedicine, as the Navajo have little to no choice in their current isolation that prevents them from receiving biomedical care. Secondly, as previously stated, what involves good health and good healthcare is defined by each society. So, because the Navajo's health is defined as more holistic than

Western health is, simply providing the Navajo with Westernized medical care is unjust because it removes the Navajo's ability to have what they consider to be good health.

An additional concern under social justice theory is that by allowing for each society to define health, it also allows societies to define their other necessary opportunities because opportunity is a primary social good that society must promote. The practice of religion and spirituality is an opportunity that the Navajo greatly value. So, in a just society, the Navajo must have the opportunity to practice this. However, this can present a tragic choice wherein two opportunities (e.g., health and religion), are opposed. A tragic choice involves vital personal goods wherein only one good can be fully distributed, meaning that people must choose between two conflicting manifestations (e.g., health and religion) of a primary social good (e.g., opportunity) (Berry, 1984).

For example, many Navajo practice peyote as part of their religious beliefs (Noggle I., 2015). However, regularly using peyote often makes participants sick and may be associated with poor cognitive effects (Noggle I., 2015). If health and religion are equally valued as opportunities towards what the Navajo consider to be the good life, it is not clear which one to choose. While I can in no means resolve this issue, it is important to point out that this specific tragic choice likely exists more commonly for the Navajo at large than it does for Western society when utilizing social justice theory.<sup>21</sup>

#### V. The Need to Rectify the Injustice<sup>22</sup>

I argue that one pathway to reinstating health-related justice is through healthcare.<sup>23</sup> Healthcare institutions promote health, and because health promotes opportunity (a primary social good) as previously said, healthcare itself promotes opportunity (Daniels, 2008). So, healthcare is one of the institutions that distributes the opportunity that needs to be equalized for

fair equality of opportunity to be promoted (Daniels, 1985; Nussbaum, 2011). However, as I said earlier, providing people with the opportunity to choose their own good health does not mean that healthcare institutions must reflect everyone's needs or preferences as utilitarianism requires (Daniels, 2008). Rather, a just society must give weight to peoples' needs and preferences within a moral structure (Daniels, 2008).<sup>24</sup> As previously discussed, this moral structure allows for people to have a normal opportunity range for their functioning (here, the functioning is health) that is relative to their society but not that is relative to each individual within that society (Daniels, 2008).

To preserve the Navajo's exercisable freedom to choose what good health and healthcare is for them, the majority population (e.g., the US) then cannot enforce a singular healthcare system on the Navajo (Singer, 2011). When all are given equal value in a moral system and when people are allowed to be actively involved in these systems, no entity can be culturally imperialistic towards another. Cultural imperialism assumes that the minority's choices equate those of the majority, thus not giving weight to different needs and preferences (Singer, 2011; Sen, 1999). Again, the Navajo largely consider health to be spiritual, mental, and physical, and based on cultural values and belief systems while the majority of Americans consider health to be primarily physical and mental and to be based on pathology (Rickmann et al., 2004). An example of these differences in health beliefs is that Western healthcare assumes that no cultural background values the use of a sweat lodge for their health. However, the Navajo do value this and removing the opportunity for them to partake in this practice is culturally imperialistic. Thus, we cannot generalize value systems across cultures (Sen, 1999).

Thus, I conclude that the US has been providing unjust, imperialistic healthcare on Navajo Nation through the IHS by providing only health services found important by US society



and the US government (Nussbaum, 2011; Henson et al., 2008). The IHS system does not facilitate peoples' freedom to choose good health through its paternalistic actions and is culturally insensitive. So, there is no opportunity for Navajo patients to choose the type of healthcare they want to receive (Wikler, 1978).

To make the healthcare system just, US society must then take into account different health beliefs in relation to religiosity, cultural values, and more when modeling a healthcare system (Nussbaum, 2011).<sup>25</sup> When healthcare systems are culturally relevant and give people true choice, they promote fair equality of opportunity and promote people's capabilities and freedoms. When they do this, they are just.

In sum, to promote the Navajo's freedom to choose good health and healthcare, US society must then promote a set of health-related opportunities, or substantial freedoms, which the Navajo can choose to exercise or not. So, it is then clear that Western medicine alone cannot satisfy the Navajo's healthcare needs (Nussbaum, 2011). Justice then requires that healthcare institutions be relevant to the Navajo and allow them to choose the type of care they receive.

## VI. How to Rectify the Injustice

The use of non-hybrid, or monolithic, healthcare models that prevent the Navajo from having true choice must then be criticized. Providing only Western care to the Navajo imposes a concern for physical health and psychological diagnosis, while disregarding their own health concerns (i.e., spirituality). But, providing only traditional care removes the Navajo's opportunity to receive Western healthcare, which the Navajo have had for the past two centuries. In fact, the want for incorporating traditional medicine with modern care grew out of perceived shortcomings in Western medicine, so reverting back to only traditional medicine requires the Navajo to erase their past two centuries of healthcare, which is now imbedded in society

(Moghaddam, 2014; Henson et al., 2008; Wikler, 1978). For example, many Navajo with depression go to behavioral health counselors and take prescription medication alongside speaking with traditional healers about their mental health. By removing behavioral health counselors from the reservation, Navajo patients would not have the option of using these providers and accessing the type of medical care that they have had their whole lives. Thus, offering only traditional or Western medicine also does not allow the Navajo true freedom and is unjust (Moghaddam, 2014).

A model based in medical pluralism, a syncretic medico-ritual system that blends medical cultures and allows people the freedom to choose the type of healthcare they want to receive may then be just (Pappas, 2007; Capps, 1994). Medical pluralism exists when any one community has patients and providers using differentially designed and conceived medical systems that are at least minimally integrated so that there is not one ultimate principle guiding medical care (Hsu, 2008; Janzen, 1978; Reeve, 2000). In medical pluralism, individuals' treatment choices are often shaped by the type of disease, the seriousness of the illness, and whether treatment is sought for the physical symptoms causing the illness, spiritual difficulties, an imbalance with the natural order, or other purposes (Reeve, 2000). So, patients do not treat health systems as mutually exclusive, but often use them in tandem (Pappas et al., 2007).

#### *Examples of Pluralistic Healthcare Systems*

Pluralistic healthcare has become more popular throughout the world since the 1960's and has led to much collaboration between different medical beliefs so that medical systems are no longer seen as mutually exclusive (Cant & Sharma, 2000). About 50 percent of people in developed countries and 80 percent of people in developing countries use some type of pluralistic care (Bodeker & Kronenberg, 2002). This care comes in many types with some

Americans now using contemporary medicine, many Mexican-American immigrants incorporating traditional care with biomedicine, and many ethnic minorities in developing countries incorporating indigenous practices with Westernized care.

Collaboration among different types of healthcare occurs often in the US' and in the United Kingdom's (UK) majority populations between biomedicine, contemporary medicine, and folk medicine (Stevenson et al., 2003).<sup>26,27</sup> Starting around the 1960's, patients became dissatisfied with biomedicine and felt like they didn't have an active role as a patient (Stevenson et al., 2003). They also began to question the approach of and assumptions made by allopathic medicine and wanted to know more about the healthcare they were receiving (World Health Organization, 2002). So, many began to practice contemporary and folk medicine, but most do so as a supplement to biomedicine rather than as a replacement, which is similar to how the Navajo use traditional and Western medicine (Stevenson et al., 2003; Finkler, 1994). In fact, the number of general practice consultation rates has increased since people started practicing pluralistic medicine in the UK (Stevenson et al., 2003).<sup>28</sup>

This sort of pluralistic medicine occurs in the US among Mexican-American immigrants as well, who often participate in the dominant healthcare system and continue to use their own culturally appropriate healthcare practices, including *curanderismo*, *santeria*, and *espiritismo* (Gomez-Beloz & Chavez, 2001).<sup>29</sup> In these traditional practices, the provider prepares healing remedies from medicinal herbs, religious amulets, and/or other products to treat illnesses, which are often provided at a *botanica*, a store used primarily Latinos that sells these healing remedies (Gomez-Beloz & Chavez, 2001). Prior studies have found that many Mexican-American patients use traditional practices in conjunction with culturally appropriate care, specifically for people with diabetes mellitus Type II, which, as I said earlier, is highly prevalent among the Navajo

(Hunt et al., 2000). While the majority of patients going to the *botanica* are satisfied with the care that they do receive from biomedical doctors, they say that the *botanica* gives them a point of reference by which to negotiate the conventional healthcare system in a culturally appropriate manner that is familiar to them (Gomez-Beloz & Chavez, 2001). This practice may be similar to the ways in which the Navajo view traditional healers, as they often practice traditional medicine alongside Western medicine, as traditional medicine may be more familiar to them.

This collaboration among medical systems also occurs in countries with marginalized ethnic minorities such as in Ghana among the Kusasi, in the lower Amazon among the Cabocco, and in Papua New Guinea among the Ningerum (Pappas, 2007; Reeve, 2000; Welsch, 1983). For example, the Ningerum people of Papua New Guinea are a traditionally oriented society that has rapidly incorporated Western medicine as a complement to their traditional medicine (Welsch, 1983). While the motives behind each of these societies' medical pluralism is different, they are all examples of how combining the traditional practices of a marginalized minority with the more Westernized practices of a majority can be accomplished.

I propose that the US majority population's, Mexican-American's, and other marginalized ethnicities' want for medicine outside of biomedicine is similar to the Navajo's want for traditional medicine. This is because all of these groups became dissatisfied with Western medicine and its lack of opportunity for people to achieve what they thought constituted good health, so they began integrating the two. While none of these examples show a completely formalized medically pluralistic system, they do show how multiple medical cultures can work in tandem, thus suggesting that a more formalized model may be possible. When Western and traditional care are truly combined, it reinstills the patients' choice in what type of care they receive. Additionally, it allows them to choose who to see in the medical practice (e.g., the

medical doctor, the traditional medicine practitioner, or a combination) (Cant & Sharma, 2000).<sup>30</sup>

As previously stated, prior work finds that patients use the type of healthcare system that is best suited for treating a particular illness at that time and that they do not look into epistemological differences in care (Finkler, 1994). Thus, a hybrid system does allow patients to make the healthcare choice that they believe is right for them on a case-by-case basis (Finkler, 1994).

#### *Criteria for a Hybrid Healthcare System*

In order for this medically pluralistic or hybrid model to be just, it must meet multiple criteria. First, it must not be culturally imperialistic and must allow people true choice and access to care, second it must include wellbeing in medical practice, third it must be medically sound, and fourth it must actually improve peoples' health and satisfaction. I will now assess these four critiques.

To begin, biomedical providers often conceptualize what good health and healthcare are for their patients, so some fear that a hybrid model may do the same. The doctor in a hybrid system may have a broader conceptualization of healthcare than strict biomedicine but still determine what this conceptualization is for the patient (Hsu, 2008).<sup>31</sup> So, pluralism can reinforce the provider's power. However, a hybrid model does not require that biomedical doctors be superior. A hybrid model can re-appropriate expert knowledge to patients, traditional healers, and others by allowing individuals to choose what type of medicine they believe to be fit. If patients are allowed to take on an active role, they then develop a shared understanding of health and illness alongside the doctor (Welsch, 1983; Green et al., 2006).<sup>32</sup> This active role then prevents cultural imperialism by ensuring that patients and providers make decisions in tandem. Thus, giving patients and traditional practitioners an active role alongside biomedical

practitioners allows patients and both types of providers to positively interact with biomedical and traditional medicine (Stevenson et al., 2003).<sup>33</sup>

A hybrid model also allows individuals to practice medical treatment and apply it to their everyday lives (Stevenson et al., 2003). For the Navajo, this can manifest in growing their own herbs, attending traditional ceremonies in Hogans, participating in sweat lodges, and more (Coleman, 2015). Finally, this model can be structured in such a way that allows patients to choose whether or not they want to incorporate family members or others in their healthcare, as the Navajo typically separate the individual from the family less so than other Americans do (Dinges et al., 1974). When patients are given a more active role, a choice in their healthcare, the ability to apply it to their life outside of a formal system, and the choice to include others in their medical care, a hybrid system is not culturally imperialistic.

Second, it could be argued that wellbeing should not be so highly valued in a medical system.<sup>34</sup> Rather, only physical and mental health should be, which some say is sufficiently addressed by biomedicine. My response to this is two-fold. First, medical pluralism itself and justice in healthcare support culturally appropriate care (Green et al., 2006). Because the Navajo define health as physical, emotional, and spiritual, their healthcare must address their patient's broad needs in order to be just, which has been validated through policy (Green et al., 2006). Both national and international policies have enacted this on a practical level. In regards to international policy, the World Health Organization's (WHO) Declaration of Alma Ata in 1978 recognized the necessity of incorporating traditional medicine with Westernized care in some societies by stating that traditional medicine should be considered in national health systems (Reeve, 2000). Additionally, national governments are addressing the complexities of establishing the guidelines for integrating traditional, contemporary, and biomedical care

(Bodeker & Kronenberg, 2002). They are aware that they need a broad public health agenda that integrates social, cultural, and political dimensions of their respective societies (Bodeker & Kronenberg, 2002). So, the provision of culturally appropriate care is not only an ethical argument but has been implemented on a practical level. Secondly, by including patient wellbeing in healthcare, providers are more easily able to extract detailed information from their patients about the nature of their illness because patients are better to understand their care and have a more vested interest in their health (Pappas, 2007). The nature of peoples' illnesses include the social determinants of their health and the patients' personal significance of their illness, which encompasses where the patient believes their illness comes from (Cant & Sharma, 2000). In sum, due to both the Navajo valuing wellbeing in health and providers being able to better assess and diagnose their patients when taking into account their overall wellbeing, it is clear that wellbeing should be prioritized in a hybrid model.

A third concern is that a hybrid model could be medically unsound or unethical. It could require that providers use non-biomedical practices to draw people into their practice as patients may see certain biomedical healthcare practices as illegitimate (Stevenson et al., 2003). For example, Fort Defiance Indian Hospital has a Hogan onsite, a structure used for traditional ceremonies. So, potential patients may be persuaded to come to the hospital because of this structure.

The response to this concern has three components. First, as I stated earlier, what is normal and what is considered medical is contextualized by each society. So, because health is culturally grounded, Hogans and other seemingly nonmedical practices and structures may become medical once medicine is contextualized to fit the Navajo's definition of health. Secondly, many traditional or alternative medical practices are becoming professionalized and

nationally recognized so that they are now legitimate in a biomedical setting. For example, Tina Coleman, a licensed traditional practitioner, and Harrison Jim, a traditional substance abuse counselor for the Navajo, both work at Fort Defiance Indian Hospital alongside biomedical doctors in both consultations and treatment (Coleman, 2015; Jim, 2015). This means that Western medicine is realizing that being medically sound may necessitate incorporating traditional care in some settings (Cant & Sharma, 2000). Thus, providers in a hybrid system may still be using medical practices to draw people in but these medical practices may be different than they are used to in a biomedical system.

Thirdly, even though some practices may remain non-medical, including non-biomedical practices allows providers to make medicine more relatable to their patients and helps patients make sense of their medical situation in ways that biomedicine alone cannot (Cant & Sharma, 2006). For example, Mexican-Americans' use of the *botanica* helps people understand the US healthcare system in a culturally appropriate way, as I previously said (Gomez-Beloz & Chavez, 2001). When patients are able to better comprehend their medical situation, pluralistic legitimation occurs. In this process patients see the validity in biomedical treatment and are more responsive to it and providers then see the validity of using non-biomedical treatment (Green et al., 2006). When patients better understand their own health, biomedicine increases in legitimacy for patients, and when providers better understand their patients, providers are better able to see the value in traditional medicine (Rogers, 1998).

Fourth and most obvious, a hybrid system must actually improve patients' health and satisfaction.<sup>35</sup> Prior research shows that medical pluralism makes people more aware of their health for three reasons. First, the emphasis on holistic care expands the healthcare needs that are addressed in a formal system. For example, a Hogan allows for spiritual health to be addressed in



a formal system in a way that a non-hybrid system does not. Second, people become more consciously aware of how their life decisions influence their health (i.e., people's spiritual concerns or beliefs may contribute to their stress levels) (Cant & Sharma, 2000). Third, patients become more satisfied at their healthcare visits, as most Mexican-American patients that used a *botanica* in addition to Western healthcare were more satisfied with their general practitioner (Gomez-Beloz & Chavez, 2001). This holistic care then demedicalizes healthcare by allowing Navajo patients to see healthcare as helping to better the *hozho* and remedicalizes life by bringing emotional and spiritual life into healthcare's focus in addition to physical life (Cant & Sharma, 2000). As a result, patients are then more likely to have more health-seeking behaviors than before and are likely to be more proactive about their health in general because they see how relevant health is to their everyday lives (Green et al., 2006).<sup>36</sup>

A hybrid model that incorporates both traditional and Western care can then be justified if it is not culturally imperialistic, includes wellbeing, is medically sound, and improves peoples' health and their satisfaction with their health. Promoting this system requires that Western and traditional medicine are offered both in combination and in isolation for patients because this then includes all of the Navajo's prior and current healthcare options and introduces a hybrid model as well. Doing so then promotes peoples' freedom to choose good health in a way that is socially relevant for the Navajo (Daniels, 2008; Daniels, 1985; Nussbaum, 2011). Thus, the hybrid model is an appropriate way to navigate the ways in which only a traditional or Western model strips people of their freedom to choose their conception of good health practices and good healthcare.

## VII. Conclusions and Implications

The Navajo are currently forced to participate in a Westernized medical system that has largely devalued traditional medicine and removed it from formal healthcare structures. The health of the Navajo has not improved over time within this system and has arguably gotten worse in physical, mental, and behavioral health realms. While most studies describe how the Navajo have worse health than other US populations, few studies have explored whether or not the Navajo's healthcare treatment and options are just. Using social justice theory, specifically the notions of fair equality of opportunity and capability provided by Rawls, Daniels, and Nussbaum, I argue that healthcare provision on Navajo Nation is unjust because the Navajo do not have the freedom to choose what they believe to be good health for themselves.

I propose that this injustice can be corrected for by introducing a hybrid healthcare model that draws on medical pluralism by combining Western and traditional Navajo healthcare methods. Fort Defiance Indian Hospital has begun to implement this hybrid model by allowing biomedical and traditional practitioners to collaborate with patients and find the type of treatment that is best for each individual patient and by providing a Hogan on-site that allows patients to participate in the spiritual components of health. While I cannot provide a causal solution to the current injustice, I do suggest that the remainder of Navajo Nation building on Fort Defiance's current healthcare structure would be beneficial. If this hybrid model is expanded in such a way that caters to each specific locale within Navajo Nation, it can promote the Navajo's fair equality of opportunity and ensure that the Navajo have the capability to choose what they consider to be good health, thus making their healthcare options, and thus their resulting health, just.

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<sup>1</sup> While NAI tribes are often grouped together in analyses, it is important to clarify that they cannot be considered to be a single entity. Thus, I focus on the Navajo and their health concerns specifically, as they may not be generalizable to other NAI tribes.

<sup>2</sup> There is no consensus in the literature as to what terminology is most appropriate to use when describing medical systems. Medical practices are often labeled by their origin, so ‘Western medicine’ is commonly used in the global context when describing the healthcare system used by the US majority population (Wiseman, 2004). However, ‘modern medicine,’ ‘modern Western medicine,’ ‘allopathic medicine,’ and ‘biomedicine’ are used interchangeably in the literature, so I use these terms interchangeably as well when describing the healthcare system used by the US majority population (Wiseman, 2004).

<sup>3</sup> Traditional medicine refers to the knowledge, skills, and practices that are based on the beliefs indigenous to different societies used in maintaining health and preventing, diagnosing, improving, and treating illnesses (World Health Organization, 2015). Throughout this text I refer to the Navajo’s healthcare system and beliefs as traditional medicine.

<sup>4</sup> To be clear, dental care has not improved on the reservation, with providers claiming that access to dental care is still a large issue (Glasses, 2015). Rather, obesity and diabetes rates have increased so much that they tend to overshadow the Navajo’s lack of dental care.

<sup>5</sup> I expand on how larger systemic issues are operative in Navajo Nation later in the paper. However, I provide a short example now: the Navajo live in an isolated area without access to fresh produce, wellness centers, and more (Clichee, 2013). So, they live in an environment that limits their nutritional and exercise options, which then likely contributes to their high rates of obesity and diabetes.

<sup>6</sup> Norman Daniels states that the social determinants of health are health needs that exist in addition to adequate nutrition; sanitary, safe, unpolluted living and working conditions; exercise, rest, and important lifestyle features; preventive, curative, rehabilitative, and compensatory personal medical services; and personal and social support services (Daniels, 2008).

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<sup>7</sup> A functioning is an active realization of one or more capabilities (Nussbaum, 2011). Later, I expand on how we are often able to recognize peoples' capabilities by their functionings, as functionings are an outgrowth of these capabilities. Also, a capability is the opportunity to have a specific functioning. Thus, as I speak about fair equality of opportunity and the opportunity to choose good health, it is important to keep in mind that opportunity is a vague concept and that capability is a more specific form of opportunity.

<sup>8</sup> In parallel to the argument that the Navajo lack health capability is the notion that they may lack autonomy as well (Beauchamp & Childress, 2001). While these two concepts are similar, they are not identical. The Navajo having autonomy means that they have self-determination while the Navajo having capability means that they have the opportunity to utilize this self-determination. Because my focus is on the Navajo having a lack of opportunity, which I expand on later, I refer to the Navajo as lacking capability rather than autonomy. However, this does not mean that I claim that they always have autonomy. For further information on autonomy within health and healthcare, please see Beauchamp and Childress's *Principles of Biomedical Ethics*.

<sup>9</sup> While John Rawls first presented the theory of justice, which parallels social justice theory, Nussbaum both expands upon it and critiques it. She states that Rawls assumes that people involved in social contracts are roughly equal, so his theory does not hold up when there are deep asymmetries of power between different parties that cannot be corrected for by rearranging income and wealth, such as between the Navajo and the US majority population (Nussbaum, 2011). However, she does state that Rawls' notion of fair agreement between parties still holds true. Because of her claims, which are similar to those of Daniels', I draw most directly from her and Daniels' interpretations of social justice theory rather than from Rawls' directly.

<sup>10</sup> While it may seem that fair equality of opportunity and capability are two different entities, capability may be a more specific version of the vague notion of opportunity, as said in footnote 7. Capability is the opportunity to have certain functionings, so these two concepts are congruous with one another. Throughout the text, I thus refer to the Navajo lacking fair equality of opportunity and/or capability interchangeably.

<sup>11</sup> Once people have this freedom, the resulting inequalities are permissible (e.g., just) only if they work to make those that are the worst well off (e.g., the Navajo) as well off as possible (Daniels, 2008). This is the difference principle, which serves to ensure that the freedom that each person has is constrained by the fact that the inequalities that freedom allows must serve to make the least well off as well off as possible. However, my argument focuses on fair equality of opportunity, as I do not have time to fully delve into the difference principle as well, and because fair equality of opportunity is sufficient for my argument. Please see how the difference principle relates to health in Norman Daniels' *Just Health*.

<sup>12</sup> There is not only one fair model for healthcare, but I focus on the hybrid model. Other just models must meet the following stipulations: health systems must be revisable and have an appeals process, be relevant, be accessible, and be public in their reasons and rationales for decision-making (Daniels, 2008).

<sup>13</sup> While there is a larger argument to be made that acute conditions are merely symptoms and chronic conditions are direct causes of health issues, it is still important to separate the two because they align with the Indian Health Service's (IHS) shifting priorities from acute to chronic care. While the IHS first provided only intermittent care and operated most closely to an emergency care service, it has begun to address the Navajo's chronic, long-term conditions.

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Please see Henson (2008) for a more detailed depiction of the history of healthcare on Navajo Nation.

<sup>14</sup> Many Western healthcare providers working with the Navajo experience dilemmas when trying to adhere to medical protocols while also ensuring that their patients continue to use formal healthcare services, as some have stopped coming when doctors tell them negative information (Carrese & Rhodes, 1995). While patients' attendance is a large issue, I do not have time to sufficiently expand upon ways in which to encourage it here.

<sup>15</sup> This friction between traditional and Western healthcare exists in other societies that simultaneously provide traditional and Western healthcare, as traditional health issues stem from causes outside of pathology and Western health issues stem directly from pathology (Finkler, 1994). I expand on these other similar cases later, but it is important to keep in mind that this friction is not confined to Navajo Nation.

<sup>16</sup> Please see *Creating Capabilities* by Nussbaum for a list of the ten central capabilities, which are those capabilities that are necessary for normal functioning (Nussbaum, 2011). While many of the central capabilities are inextricably intertwined with health, the three most closely related are life, bodily health, and bodily integrity.

<sup>17</sup> Later I address the issue of satisfying the happiness or preferences of all (a utilitarian approach) versus giving weight to everyone's preferences in a moral system or society (a social justice theory approach).

<sup>18</sup> While utilitarianism is largely concerned with peoples' happiness, it is not clear that happiness should be the ultimate goal. While I do not have time to fully expand on this, it is important to note that the utilitarian measure of happiness has issues in and of itself.

<sup>19</sup> The primary social goods that Rawls spells out are as follows: basic liberties, opportunities, powers and prerogatives of office, income and wealth, and the social bases of self-respect (Daniels, 2008).

<sup>20</sup> Some claim that society must correct for both social contingencies and natural lotteries (e.g., negative attributes) for fair equality of opportunity to be upheld. While natural attributes do exist, I argue that the negative weights placed on natural attributes themselves are social contingencies and that many natural features have social histories, meaning that by correcting for social contingencies we also correct for so-called natural lotteries. For example, xeroderma pigmentosum (XP) is a genetic disorder where the person cannot repair damage caused by ultraviolet light, which is much more prevalent in Navajo Nation than the rest of the US (Stark & Lavy, 2012). While having XP is a natural attribute, its high prevalence on Navajo Nation largely came about due to the genetic bottlenecks that the Navajo experienced in the long walk, which was a social and historical event (Stark & Lavy, 2012). So, an argument for correcting social contingencies also corrects for natural lotteries. However, I do recognize that there is much debate about society attempting to correct for peoples' genetic disorders, which I cannot settle here.

<sup>21</sup> Jeremy Bentham's approach to utilitarianism claims that there is only one personal good (e.g., happiness), so society must only distribute this good to the most people (Bentham, 1879). This is another problem with his view of utilitarianism, as multiple personal or primary goods do exist in a society and sometimes create conflicts.

<sup>22</sup> When speaking about rectifying the injustice, it is important to keep in mind that correcting for the Navajo's poor health is primarily a collective responsibility rather than a responsibility

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placed in certain people. Please see Young (2013) for a larger explanation of collective responsibility, as designating responsibility for these matters is beyond the scope of this paper.

<sup>23</sup> In regards to healthcare I speak primarily about formal healthcare institutions for practical purposes and for simplicity, but healthcare encompasses much more (i.e., school nutrition programs). While I do not work through all of the ways in which healthcare should be altered on Navajo Nation, I do recognize the changing formal healthcare institutions is not a panacea.

<sup>24</sup> However, this does not mean that I ignore peoples' personal freedoms and individual conceptions of the good (Sen, 1999). People still have health related rights that are prior to their societies (Sen, 1999). But, I do argue that the weight that we give people's needs and preferences does depend on the society that they are a part of.

<sup>25</sup> While religiosity is included in this list, it is important to remember that societies may face a tragic choice between religion and health. So, while healthcare systems must take into account their patients' religious beliefs, they must also assess whether or not a tragic choice is involved.

<sup>26</sup> Contemporary medicine is defined as medicine that lies outside of the biomedical mainstream and it is most prevalent in industrialized countries (Bodeker & Kronenberg, 2002). I refer to contemporary medicine rather than alternative medicine because, as its name implies, complementary medicine complements biomedicine while alternative medicine is seen as an alternative to biomedicine, thus allowing for less collaboration with biomedicine (Wiseman, 2004).

<sup>27</sup> Folk medicine in the US includes self-medication, certain products at health food stores, herbal remedies, aromatherapy, reflexology, and more. While this is distinct from contemporary medicine, for my purposes it is not necessary to fully explain these two classifications. Rather, it is important to remember that neither is based in biomedicine.

<sup>28</sup> So, synthesizing traditional and Western care may actually be of benefit to Western providers as well by increasing the number of patients that providers see. However, I do not have time to go into depth as to how the hybrid system benefits the Western healthcare providers in addition to the Navajo.

<sup>29</sup> These three terms are all similar forms of traditional medicine, but they have their roots in different societies. *Curanderismo* is Mexican-American, *santeria* is Cuban-American, and *espiritismo* is Puerto Rican (Weaver, 1994).

<sup>30</sup> Later I expand on the professionalization of contemporary medicine practitioners and traditional healers, which allows them to practice alongside biomedical doctors.

<sup>31</sup> Additionally, this pluralism may reveal underlying social inequalities and cultural divides because pluralism is often a reaction to social inequality and suffering (i.e, the Navajo) (Broom, 2009). So, pluralism can bring to light the domination of one culture by trying to incorporate within it the health practices of what is considered to be inferior.

<sup>32</sup> Additionally, patients and traditional healers often have shared meanings of illnesses already so the hybrid model allows for this shared understanding to reach the biomedical realm as well (Reeve, 2000).

<sup>33</sup> Another concern here is that traditional and biomedical care can come to exist as mutually exclusive when trying to create a hybrid model. However, if traditional and biomedical practitioners are seen as both valid medical practitioners (which I touch on soon), this should not be the case.



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<sup>34</sup> Here, an argument for the importance of religion in health is important, which I discussed earlier, as religiosity often contributes to peoples' wellbeing. However, a tragic choice can exist between religiosity and health, which it is important to remain cognizant of.

<sup>35</sup> It is possible that a hybrid model could worsen peoples' health by allowing people to use treatments that counteract each other. For example, antiretroviral medication for HIV is made ineffective by consuming garlic, which is a traditional (Nyika, 2007).

<sup>36</sup> There is little evidence supporting improvements in physical health for hybrid systems, primarily because quantifiable improvements have not been measured. However, many report that a hybrid system does lead to patients being in harmony with the natural order, which is the basis of good health for the Navajo.