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Notes

1. Gorman C. Why do blacks die young?. *Time* 1991 Sep 16:50; Kjellstrand C. Age, sex, and race inequality in renal transplantation. *Archives of Internal Medicine* 1988;148:1305; Kjellstrand C, Logan G. Racial, sexual, and age inequalities in chronic dialysis. *Nephron* 1987;45:257; Held P, Pauly M, Bovbjerg R, et al. Access to kidney transplantation: has the United States eliminated income and racial differences? *Archives of Internal Medicine* 1988;148:2594.
2. Byrd M, Clayton L. The "slave health deficit" racism and health outcomes. *Health/PAC Bulletin* 1991;25(Summer); Schwartz E, Kofie V, Rivo M, et al. Black/white comparisons of deaths preventable by medical intervention: United States and the District of Columbia 1980–1986. *International Journal of Epidemiology* 1990;591; Byrd M. Race, biology, and healthcare: reassessing a relationship. *Journal of Healthcare for the Poor and Underserved* 1990;(Winter):278.
3. Escarce J, Epstein K, Colby D, et al. Racial differences in the elderly's use of medical procedures and diagnostic tests. *American Journal of Public Health* 1993;(July):948.

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Patient Self-Determination Act: A Native American (Navajo) Perspective Melvina McCabe

No one has found a way to avoid death, to pass around it; those old men who have met it, who have reached the place where death stands waiting, have not pointed out a way to circumvent it. Death is difficult to face!

—death song, Omaha¹

Biomedical ethics, self-determination, culture, ethnicity—these are all words that in combination stir the mind and heart of health professionals now being forced to deal daily with such issues.

These issues that deal with life-prolonging measures, such as resuscitation, intubation, and tube feedings, are difficult issues to confront even within the dominant society. When the factors of culture and ethnic identity are added to the equation, the issues become very complex. Health professionals who, in the majority of instances, have not been exposed to differing thoughts, beliefs, attitudes, and values concerning death and dying in their training years are in a quandary when confronted with these matters. As healthcare professionals respond to the goals of the Patient Self-Determination Act, the complexities of different perspectives become all the more pressing.

The American Indian culture has values, beliefs, and attitudes concerning death and dying that may vary markedly from those of the dominant society. There are approximately 500 American Indian tribes within the United States,² each tribal group having their own biomedical ethical conceptions. Besides the heterogeneity of ethical conceptions that exists between cultures, there is also the great heterogeneity that exists within the culture, which is due in part to the acculturation process and to the influence of Christianity. One particular perspective will be presented in this paper, the Navajo perspective.

The Navajo, until recently, had no reason based on their beliefs to think about end-of-life decisions. Navajos do not fear death and view death and dying as a part of life, a part and completion of the circle of life. However, the traditional Navajo approach to discussions of death and dying was one of avoidance, because of the implication of these discussions. The name of the dead person was not spoken. Family members avoided physical contact with the body. Given these beliefs, one can see how the usual Western medicine approach to death and dying would not

be acceptable to the traditional Navajo. Although the approaches to death and dying differ, the Western biomedical ethical principles of autonomy, beneficence, confidentiality, truth telling or honesty, and social justice have corollary precepts in the Navajo culture.

The Western principle of autonomy states that persons have absolute control over their bodies and minds and can therefore decide what is best for them without family/friend intervention or without external judgement of right or wrong. The Navajo people, in the traditional sense, also have a strong concept of autonomy. Navajo individuals have complete control over their possessions and actions to decide as they deem appropriate; this autonomy extends to children. The difference and irony, however, is that the individual in most instances makes no major decision without the input of the pertinent group, usually family or clan members. Two principles are in operation here: autonomy and consensus or cooperation. If a question is posed to a Navajo, this individual may refer the question to the group. The fact that the question has been referred to the group demonstrates an affirmative response by the individual. The individual is now looking for consensus. If the individual's answer is no, s/he will respond in the negative. The principle of autonomy is present in Navajo beliefs; however, this principle does not stand alone—just as important to the Navajo individual is the principle of consensus or cooperation.

The beneficence principle in Western biomedical ethics states that there exists a duty to do what is best for another. A corollary in the Navajo culture is the Navajo value of helping and aiding for the good of the culture. Navajo individuals must provide assistance in an uncalculated way. There is no expectation of reciprocity.

The principle of confidentiality states that when information is exchanged be-

tween two parties, there is an understanding that this information will not be divulged to any other person without consent. This principle protects the rights of the individual; however, in the Navajo thinking almost no major decision is made solely by one person. This approach reflects on the principle of cooperation and consensus. There is no hierarchal or vertical line of decision making; instead there is a horizontal line—all concerned individuals are involved in some form or another in a major decision.

The principle of truth telling states that all pertinent information concerning an individual be disclosed. Truth telling or honesty is a value in the Navajo culture. The differences between the Anglo and Navajo cultures are the reason why honesty is important. The Navajo values honesty because of its practical implications (the family will be looked upon with disfavor), not because of the religious implications or because it is right or wrong.

The last principle of social justice states that all persons should share equally and fairly in the benefits and burdens of the resources. The Navajo believes that no one should strive to become rich for him/herself only. If someone is materially wealthy, this wealth must be shared, supporting family and clan relations and, in the end, supporting the culture.

The biomedical ethical principles as outlined by Western society are not foreign concepts to the Navajo people. There are corresponding principles. However, these principles as understood by the Navajo people have not been used in the way Western medicine has chosen to use them in addressing biomedical ethical issues. If Western medicine can incorporate these principles, as they are understood by the traditional Navajo, into the discussion of death and dying while respecting the traditional Navajo's approach to death,

a positive and mutually agreeable outcome may result.

In conclusion, Western-trained health professionals must begin to acknowledge and accept the differing attitudes and beliefs concerning death and dying of the various cultures; not only the American Indian, but the Hispanic, the Asian American, and the African American. The imposition of the dominant society's approach and resolution of biomedical ethical issues must be mitigated when dealing with the various ethnic

groups and must then incorporate those ethnic groups' specific means and methods of dealing with death and dying.

Notes

1. Lombardi FG, Lombardi GS. Life and death, the circle is timeless. In: *Circle without End, a Sourcebook of American Indian Ethics*. *Naturegraph*, 1982:36-9.
2. Klein BT. *Reference Encyclopedia of the American Indian*. 6th ed. West Nyack, New York: Todd Publications, 1993.