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From the Ground Up: Indigenizing Medical Humanities and Narrative Medicine

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From the Ground Up: Indigenizing Medical Humanities and Narrative Medicine

Cover Page Footnote

Please accept this revised draft of MS #1099

**From the Ground Up:
Indigenizing Medical Humanities and Narrative Medicine**

In our graduation photograph we are wearing our academic gowns and we are grinning at the camera. It is the winter of 2014, convocation day for the College of Public Health. We lean easily toward each other and smile, full of the emotions that students, family and those of us who teach commonly experience on graduation day – joy, pride, relief. If you look closely though, our eyes are sharing other stories, ones that will shake themselves loose, like bears waking up after winter. These stories will walk a different kind of medicine through and beyond this high-ceilinged room and its academic customs.

"That's always a good way to start a story, you know: you'll never believe what happened."

– Thomas King, *The Truth About Stories: A Native Narrative*

How do you begin a story? We traditionally begin by expressing our gratitude to the Creator, to the earth, to our ancestors, to our Nations and communities: Métis, Dakota, Cherokee and settler. All our relations. We often share greetings in our tribal languages and begin by apologizing for speaking on behalf of our ancestors and before our elders. We share our name, where we are from and who we belong to. We also begin with prayer. Does any of that unsettle you, as this appears in an academic or medical context? Welcome to our story. We mean that. Welcome. And, thank you for this opportunity to share our cultures and stories with you. Because, you'll never believe what happened.

Michele: Tansi. Hello. My name is Michele Marie Desmarais. I was raised and educated in Vancouver, Canada on the unceded traditional territories of the Coast

Salish peoples of the Musqueam, Squamish, and Tseil-Waututh Nations. I am a scholar and poet of Métis, Dakota and settler ancestry. I am an Associate Professor in Religious Studies and a teaching faculty member in the Native American Studies (NAS) program at a mid-western state university. I was also the founding director of an interdisciplinary Medical Humanities (MH) program on that campus.

You'll not likely see an academic bio that begins, "You'll never believe what happened," but that's the hidden beginning for some of us. In my case, I dropped out of high school, had a rough life for a while and still reap the physical and emotional consequences of that life in, as Arthur W. Frank terms it, a state of "perpetual interruption" (2013, p. 56). And, yet, with much support, I've also found myself in a safe place and in a profession in which I have the honor of supporting others.

I was introduced to the field of MH through the studies and doctoral work of two students: Regina Robbins and Mark Gilbert. Being Indigenous, and with a focus on non-European understandings of illness and healing practices, I was intrigued when asked to join the doctoral committees for these two scholars at the medical school that is affiliated with our campus. I was surprised to find, at a medical school, scholars and practitioners who were, and are, deeply committed to exploring the healing power of stories, art and contemplative practices. I was also surprised to find myself welcome or wanted in that place. Still.

After serving on these two MH focused doctoral committees at the medical school and co-founding a community engagement initiative on my own campus called SPHRS (Spirituality, Public Health, Religious Studies), an administrator on my campus asked me to work with a group of faculty members to put together an interdisciplinary program in MH and I agreed to take that project on.

Regina: Osiyo. Regina Emily Robbins dawadoa Tsi Tsalagi. Hello. My name is Regina Emily Robbins. I am Cherokee. I am Michele's student and colleague and friend. I'm also a scholar and indigenist who is dedicated to promoting the MH. I earned a PhD from the medical school and a graduate minor in Native American Studies from the mid-western state university where Michele works. I later became an Assistant Professor of Sociology and Anthropology and teaching faculty member in that same Native American Studies program, where I served as a core member of the executive committee that helped develop our MH program. I

am now an Assistant Professor in Health Promotion at the affiliated medical school and serve as the first affiliate member of the MH program.

I was raised in the Southwest, on the California coast and in the Arizona desert, among the peoples of dozens of tribal Nations. I am an enrolled member of the Cherokee Nation of Oklahoma and my relatives carried our medicine across the Trail of Tears so that I could someday hold and see and know and share that with others.

I am the descendent of many teachers and a family of strong Cherokee women. I am the great-granddaughter of an educator, granddaughter of an artist, and the daughter of a nurse. An understanding of and appreciation for the MH has been passed down to me from my ancestors. We create, we teach, we learn, we write, we heal. But, I never called what we do “medical humanities” until academia gave me that language and I was introduced to the work of Scottish artist and researcher, Mark Gilbert (Gilbert, 2014). Collaborations with Mark and Michele have cultivated my understanding of the MH and led to my involvement in community-based participatory research that investigated spirituality and wellness at the intersections of art, education and medicine, and inspired a rich body of work that evolved into foundational efforts in support of our new MH program.

When we think of what has been passed down to us and consider the beginnings and early growth of our MH program, we think of the earth. **Our program was built from the ground up.** Inspired both by the needs of our students and the possibilities that open up through collaboration, a small group of passionate faculty worked together and in three years: we had dozens of faculty teaching MH courses, a minor in MH was approved, spanning four colleges and two campuses and including twenty-three departments or programs; we offered forty MH classes; and fifty-one undergraduate students enrolled.

From the ground up also has another meaning. We have learned throughout the years of high school (or high school equivalency), undergraduate studies, graduate studies, Ph.D. committees and faculty life, that we must live every day trying to show honor to our ancestors

and all of our relatives. Every culture and every person has their own unique ways of doing this.

One way that we do this is through prayer and ceremony. We make time for our feet to feel the earth and our hearts to feel gratitude, respect, humility and purpose (or at least try to). Our MH program was, therefore, also grounded in these practices. Before each MH executive committee meeting, tobacco was offered and prayers were silently made. Although other committee members were not expected to participate in our Indigenous ways and most did not even know about that start, it was part of how we quietly indigenized the process of growing a new program. Ultimately, this is how we cope with all of the "you'll never believe what happened" moments that make up a life. This is the only way we know to survive, to endure states of "perpetual interruption" and to heal, to teach, to fulfill responsibilities and to build a program.

Another way that we do this is through storytelling and story-listening. Passing down cultural understandings through stories, both visual and verbal, is part of what we believe develops many of the specific aims of MH programs, such as developing learners' understandings of personal values, empathy, narrative integrity and cultural humility. Scholars in the field recommend reading literature and engaging in reflective writing to promote narrative medicine, "the practice of medicine with empathy, reflection, professionalism, and trustworthiness" (Charon, 2001). While sharing stories through writing, reading and discussing books can help promote narrative medicine (DasGupta et al., 2006), live story telling or being in relationship with living stories in the form of a faculty and/or student body may be just as powerful, if not more so. In our experience, being and hearing diverse voices in faculty meetings, in administrative consultations and in classrooms was fundamental to the development of a MH program grounded in human rights and ethical principles that recognize not only health disparities but also opportunities to explore culture-based and community-based strengths and wellness practices.

"The truth about stories is that that's all we are."

– Thomas King, *The Truth About Stories: A Native Narrative*

From an Indigenous perspective, stories are conduits of knowledge and “alternative ways of understanding relationships, creation and the creative process itself” (Cajete, 2000, p. 44). As Smith (2013) explains, “We had to know to survive. We had to work out ways of knowing, we had to predict, to learn and reflect, we had to preserve and protect, we had to defend and attack, we had to be mobile, we had to have social systems which enabled us to do these things. We still have to do these things” (p. 13). For these reasons, we rely on our stories to make meaning.

Stories provide us all with a forum for introspection. Storytelling creates opportunities to illustrate, define, and explain. In fact, scholars in the sciences are increasingly interested in “treating narratives as an empirical source of information and in broadening the theoretical understanding from what a narrative is, to focus also on what it does” (Henriksen, Tjornhoj-Thomsen & Hansen, 2011, p. 4). Narratives, in all their forms, can welcome viewers and listeners to engage in the MH and explore, from multiple perspectives, connections between humans, cultures, medicine and allied health sciences.

According to Rita Charon, Narrative Medicine (NM), “the ability to acknowledge, absorb, interpret, and act on the stories and plights of others,” is required for effective medical practice (2001, p. 1897). Scholarship within the field of MH has assigned a privileged role to NM. Natasha L. Vos, for example, maintains that patient narrative is “at the core of Medical Humanities” (2017, p. 50). Charon succinctly defines NM as, “a medicine fortified with the knowledge of what to do with the stories of illness,” noting that the benefits of this approach include “increasing clinicians’ capacity to attend to what patients tell them, to perceive the plights of those in their care, and to affiliate with those who suffer” (2009, p. 120). From the non-clinician's side, illness or other health issues may result in a “call for stories,” both in the sense of being called upon to report what is happening as well as the possibility of telling one's story as a way

to navigate through changed life circumstances (Frank, 2013, p. 53). Indeed, such a call is likely inevitable if we, as Charon and others do, recognize the ways that place, body, clothing, stance, gestures and so much more all participate in the telling of a story. In a meta-analysis of research studies on NM approaches and patient or caregiver illness experiences, Fioretti et. al. found NM to not only be a "useful tool to assess the patients' experience of illness," but also, "a powerful instrument for decreasing pain and increasing well-being related to illness...for being more confident, active and cooperative in respect to the illness, for having a less stressful response and decreasing feelings of alienation and finally for sharing illness stories with family members" (2016, p. 7).

NM recognizes and reveals the power of stories. However, as Angela Woods explains, "scholars and practitioners working with narrative in the field of medicine frequently overlook the cultural and historical dimensions of narrative form" (2011, p 3). If the field of NM is not regularly acknowledging the fact that **Indigenous peoples' stories don't always fit into linear form** or represent transcultural or transhistorical truths of the human experience, we question: what comes from the power of NM?

Other NM researchers and practitioners also reflect on the formation and influence of dominant narratives within the field, such as the issues related to "triumph narratives" (Reiffenrath, 2016; Robillard, 2014), or "life-as-normal narratives" (Frank, 2013). Any beneficial effects of such narratives on a case-by-case basis notwithstanding, an issue with such dominant narrative tropes or scripts is that they can "silence, flout, and suppress the manifold voices who may (need to) tell a different story and instead force them to align the portrayals of their experiences with dominant scripts" (Reiffenrath, 2016, p. 41). Furthermore, Amy E. Robillard's work on narrative collapse "challenges cultural scripts" and argues that there is an "obligation to provide narrative resources for others to draw upon as they make sense of the lives they're living" (2014, p. 7).

What is surprising in the field of MH though, considering such research, as well as the strong, longstanding and rich traditions of NM in

Indigenous communities, is the lack of Indigenous voices. It is indeed what Robillard would term, a significant and disheartening "gap in the conversation" (2014, p. 1). MH focused journals publish on cultural studies, sociology and anthropology and cultures of medicine. MH focused courses include a breadth of disciplines, with the intention of introducing students to cultural diversity. And, yet, both courses and publications related to Indigenous studies specifically within the field of MH are few and far between. "If we cannot hear, if we refuse to hear," Robillard asks, "what happens to the narrative?" (2014, p. 12). In this context, what happens to all the people, all our relatives, whether clinician, patient, survivor, Indigenous or settler, if silence remains the dominant narrative related to Indigenous peoples? Here, on Turtle Island (North America), we share some stories with the hope that personal examples of faculty accounts will reinforce the possibility of including underrepresented voices and diverse perspectives in the process of building a MH program.

Regina: Udohiyu kanohelovsgi, we say in Cherokee, true story. The way my truth was taught to me was through stories. My relatives, including the plants and rocks and water are alive with true stories. When my relatives speak they often end or begin with, "true story".

The way it was taught to me, art speaks. My grandmother taught me true stories through art. She introduced me to my culture and my ways of being and knowing and doing through jewelry, clothing, sculptures, pottery, paintings, beadwork, dolls, dance, song, drum, poetry and prayer. We didn't have our language to explain things, but through the arts, I was able to understand life and engage with my culture everyday.

Michele: The way it was taught to me, we are the youngest beings on this planet, and that is why we need language.

"The way it was taught to me." We've heard many stories, teachings and practices begun with these words. The way it was taught to me, is not necessarily the way it was taught to you or to others. Jeannette C.

Armstrong, Syilx/Okanagan Nation author, explains the connections between language and land for the peoples of her Nation in a similar way: "As I understand it from my Okanagan ancestors, language was given to us by the land we live within....I have heard elders explain that the language changed as we moved and spread over the land through time. My own father told me that it was the land that changed the language because there is special knowledge in each different place. All my elders say that it is land that holds all knowledge of life and death and is a constant teacher" (1998, p. 176). By preceding statements with "I have heard elders," and "My own father told me," Armstrong shares what and how she was taught along with the authority of the teachings. In addition, diversity is gently acknowledged explicitly and implicitly as a valuable part of teaching and learning. Phrases such as, "the way it was taught to me," "I have heard from elders," also reveal – despite differences in place, ancestors, teachings and many other aspects – the awareness that we, as humans, always have much to learn.

In her acclaimed book, *Braiding Sweetgrass: Indigenous Wisdom, Scientific Knowledge, And The Teachings Of Plants*, Potawatomi citizen and botanist Robin Wall Kimmerer makes a related point, "In the Western tradition there is a recognized hierarchy of beings, with, of course, the human being on top – the pinnacle of evolution, the darling of Creation – and the plants at the bottom. But in Native ways of knowing, human people are often referred to as "the younger brothers of Creation." We say that humans have the least experience with how to live and thus the most to learn" (2013, p. 9). Therefore, we need to walk humbly and listen deeply to others, to be aware of different ways of knowing, being and doing, and to be willing to learn and hear the stories of others – human and other-than-human persons alike.

Such cultural values resonate strongly with Sayantani Dasgupta's concept of narrative humility: "Narrative humility acknowledges that our patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with....Also, by thinking about it as narrative humility (and not just cultural humility), we recognise that this is a perspective we take with all the stories with which

we engage" (2008, p. 981). For Dasgupta, narrative humility provides a "point of entry" into patients' stories, allowing us to "reconfigure our own relationships to the work of doctoring, to the Other before us, and to the Self within" (2008, p. 981). Narrative humility can address the "hierarchical imbalance of the clinical relationship" (2008, p. 981). And, like others, Dasgupta too is also aware of the "larger forces that enable the telling of certain sorts of stories and silence other stories" (2008, p. 981). For us, narrative humility is part of creating space for stories, listening and sharing. It is the way we have always been taught to behave toward all beings, including stories.

Michele: The way it was taught to me, stories can be medicine. They are not the only bringers of medicine, I was taught that bears, dreams and other beings sometimes bring medicine too.

Ceremony is also medicine. Recovery of our languages and the ceremonies that so many of our families and Nations lost in the Indian residential/boarding schools, is medicine too.

Regina: The way it was taught to me, prayer can be medicine. Prayer is alive and practiced in many forms, in songs, in dance, in silence, in crying, in laughing, in working and playing. Prayers are embodied in the life force of a drumbeat or a heartbeat, in the breath and in the mind. Prayers are made in the contemplative act of beading, or weaving, or throwing a pot or writing a poem or painting a picture. The way it was taught to me, the arts are medicine.

In their paper on "Native American Healing Traditions," Portman and Garrett (2006) further explain the concepts of medicine from Native American perspectives:

Medicine is in every tree, plant, rock, animal, and person. It is in the light, the soil, the water, and the wind...Medicine is something that happened 10 years ago that still makes a person's smile when thinking about it. Medicine could be that old friend who telephones unexpectedly just because he or she wanted to do so. There is Medicine in watching a small

child play. Medicine is in the reassuring smile of an elder. Native Americans also believe that there is Medicine in every event, memory, place, person, and movement. Medicine could be an "empty space" if one knows how to use it. And there can be powerful Medicine in painful or hurtful experiences. Even such experiences offer the opportunity to see more clearly the way things connect and disconnect in the greater flow of this stream called Life (p. 459).

The healing arts are medicine, embodied in the complex relationships that shape the processes involved in Indigenous NM and storytelling.

Stories can be medicine. They can also kill. The well-known Cherokee writer and scholar, Thomas King, reminds us that "you have to be careful with the stories you tell. And you have to watch out for the stories that you are told" (2003, p. 10).

Michele: I felt ill at ease walking into a medical school's College of Public Health to be on doctoral committees. I questioned each day how I could lead a MH program, even as I daily reaffirmed the answer: We need change. I come from a place and peoples who were experimented upon in the name of science and knowledge (MacDonald et. al. 2014, p. 64). Children in Indian residential schools died at astonishing rates, up to 40%, in the name of progress, civilization, education and anything else the colonizers wanted to call it. We lost so much. We lost so many relatives. Children. Because of this, I still sometimes have difficulties being enthusiastic about STEM fields, even as I celebrate with wonder and great pride the accomplishments of people like Regina, our MH program, our students and faculty, and all the MH initiatives that have taken place. Those accomplishments are necessary and much needed. As is an inclusive, respectful field of MH. Part of my body though will always hold our histories. I still dread going to see any medical professional other than my regular physician with whom I've built a trusting relationship over these past years. Years. And it still holds the story of a doctor some thirty years ago who, looking at me, said, "I have a nice, white, middle class practice. I don't usually see problems like you."

Regina: It is hard to understand a story that does not fit into your story. Sometimes, we need help translating our story to reach our audience. As a

graduate student studying spirituality at a medical school, I often felt that the importance of my work (and the MH in general) was under-recognized, I can't imagine ever having earned a doctoral degree in the field of MH without having Michele's support. She did not value biomedical or clinical sciences above the humanities or social sciences nor did she honor Western academia's hierarchical understandings of her position of authority. She focused on the ways that we are related and treated all subjects with equal respect. When no one else understood me, Michele did and she was able to translate my ideas and perspectives into the language understood by fellow faculty.

I had a grossly diseased gallbladder in my twenties and before it was removed, it had affected my pancreas and I was diagnosed with chronic pancreatitis. I lived in pain and waited for months to have my gallbladder removed. Why? Because, it took close to a year for my doctors to figure out what my problem was. My doctors at Student Health didn't expect a diseased gallbladder in a patient that they saw as a nice, white, middle class, college student and my doctor at the Indian Health Services clinic, didn't expect that from me because as he said, I was "the healthiest patient he had." I was told that those with gallbladder disease were fat, flatulent, forty and fertile and I was none of the above. I didn't fit anyone's storyline but, that didn't mean that my story wasn't valid.

Our physicians were influenced by stories they heard and told themselves. The same can be said for the many scholars who have historically used false-reasoning and pseudoscientific methods to support abusive research studies and medical practices that ignore, negate or disregard our stories, our lived experiences, our tribal and cultural knowledge. Research and practices and programs conducted without consent from, consultation with, or collaboration among, those they intend to serve produce stories that are not applicable, not useful and even harmful. Including diverse perspectives, and particularly Indigenous perspectives and narratives in MH program development and curriculum is our way of healing some of those wounds and bringing medicine to future generations. In our experience, diverse faculty and their communities are the most vital way to expose MH programs to stories that humanize the medical sciences.

Stories are powerful; as Indigenous peoples we live our stories, sometimes we share them and, with humbleness, recognize too that stories also have their own lives.

Our relationship with stories, with narrative medicine, as academia calls it, thus moves well beyond doctor-patient relationships, clinical settings, accounts of illness or recovery, and even socio-political or cultural considerations. Ponder for example, what Armstrong can teach us about NM: "It is said in Okanagan that the land constantly speaks. It is constantly communicating. Not to learn its language is to die. We survived and thrived by listening intently to its teachings – to its language – and then inventing human words to retell its stories to our succeeding generations" (1998, p. 176). With this perspective, we can see not only the cultural value of narrative but also the intellectual value of listening intently, respecting and learning from human and other-than-human persons. Listening to the elders who are our plant and animal relatives, is a life and death matter for us all. On any day, the public health issues connected to environmental desecration should provide plenty of examples for what happens when we do not listen.

This brings us again to the importance of stories and Indigenous NM. Michif (Métis) author, historian, activist and artist Dylan A. T. Miner writes, "I am...drawn to the powerful way that telling one's own story enables both the storyteller and the listener/reader to migrate through a variety of constructed situations in a way that empowers the storyteller to possess their community's history and to construct its parameters in an ethical and healing fashion" (2013, p. 320-321). Miner explains that autobiographic stories demonstrate medicinal qualities through the art of storytelling. In her essay, "Breaking the Silence: Writing as 'Witness,'" Gloria Bird, poet, scholar and enrolled member of the Spokane Tribe of Washington State, also reflects on the place and purpose of being a Native writer and of telling one's own story: "I see my personal story as bearing witness to colonization and my writing as a testimony aimed at undoing those processes that attempt to keep us in the grips of the colonizer's mental bondage" (1998, p. 30). Even here, a story is recognized as not merely individual in nature. While some unfamiliar with our stories and

histories, may not connect this statement with any form of healing or medicine, Bird makes the connection explicit, "The benefits to be gained from this type of work include the weakening of the burden of inherited shame, loss, dispossession, and disconnectedness.... Through writing we can undo the damaging stereotypes that are continually perpetuated about Native peoples" (1998, p. 30)

Our personal stories bear witness to our generation's experience of colonization. Including diverse faculty testimonies and illustrations of health disparities when developing MH programs is critical. Health-related outcomes correlated with colonization and the "burden of inherited shame, loss, dispossession, and disconnectedness" include a lack of access to healthcare and health disparities that result in unsettling reports of "higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease" and a life expectancy that is 5.5 years less than other Americans (Indian Health Services, 2018). The Indian Health Services note "inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences" as factors contributing to the disproportionate burden of disease (Indian Health Services, 2018). If this is not part of your story, it is easy to read through these lists without any understanding of what this looks like in real life. Indigenous faculty are bodies of knowledge that bring to life the stories behind, within and around these statistics and findings.

As we brought our Indigenous values, perspectives, histories, stories into the rooms where we met to form a MH program, we were keenly aware of these realities and our responsibilities to our communities and Nations. We were aware of the damage caused by colonization, displacement and the Indian residential/boarding schools and of the damage caused by stereotypes and continuing human rights violations. And of the damage caused by institutions of higher learning and medicine. All of this was relevant to our work in the MH and all of this spoke to the potential for the arts to heal rather than harm. It did not discourage us. In fact, you'll never believe what happened.

"There is a story I know. It's about the earth and how it floats in space on the back of a turtle. I've heard this story many times, and each time someone tells the story, it changes. Sometimes the change is simply in the voice of the storyteller. Sometimes the change is in the details. Sometimes in the order of events. Other times it's the dialogue or the response of the audience. But in all the tellings of all the tellers, the world never leaves the turtle's back. And the turtle never swims away."

– Thomas King, *The Truth About Stories: A Native Narrative*

In the graduation photograph, we wear stoles from the Native American Studies program in which we learn and teach. Approved by the NAS program's campus administrators, they are handmade stoles that graduates and faculty can wear over academic regalia. We wear these with pride. They are symbols, not only of honoring and accomplishment, but also of bringing our Indigenous ways of knowing, being and doing into an academic context. They are a statement: Take notice. We are here. We have done more than survive.

We look more closely at the photograph, now knowing the stories it contains. Regina's smile seems joyous yet strained. Michele's eyes glow with pride, but already show a weariness, which will grow.

If we view the field of MH not as an abstract thing, or an academic field, but rather as its own being, its own story, then it too will have a "self-telling body," it too will live to be told in many tellings. **But, who will be the storyteller, what stories will be told and who will listen?** Such a view necessitates a shift in perspective, a decolonization of how the dominant culture views things such as fields or programs. And, yet we regularly speak of a "body of knowledge," so perhaps the distance to travel is not so great after all. As part of the self-telling body that is the field of MH and NM, we tell our stories, not to cast blame or to share triumph, but because, like the parts of a body or the individual strands in a sweetgrass braid, our stories are connected to yours, irrevocably connected. Otsalanvli, we say in Cherokee, we are all brothers and sisters, not just the humans, and we recognize how we are all related.

Mitakuye oyasin, we say on the Plains in the Lakota language, All are related. This understanding of our story is relevant to the development of our program.

Native people are under-represented in academia and often times in the MH. Among the total 569 full time faculty in the institution where we developed our MH program, only ten are documented as American Indian (less than 2%). Our leadership recently distributed diversity goals for each academic department and one large department (which has only one full-time Native American faculty member and a strong level of representation in our MH program) reportedly received the goal of increasing Native American faculty by "0%". Although we aimed in our MH program to be inclusive and respectful of diverse cultures, that was not necessarily facilitated through any quantitative measure or top-down administrative delivery of goals.

Diversity and multi-cultural perspectives nevertheless permeated our program from the start, from the ground up. The form of the program came from a recognition of the interdisciplinary nature of MH itself and an inclusion of the following departments: Anthropology, Art, Biology, Black Studies, Communications, English, Environmental Studies, Gerontology, Health Education, Health Promotion, History, Music, Native American Studies, Philosophy, Psychology, Public Health, Religious Studies, Sociology, and Women's & Gender Studies in course development. The breadth of our curriculum therefore inspired and necessitated work across disciplines, sectors, campuses and cultures. We found the faculty on the MH executive committee, like us, embraced values of inclusivity, of diversity, of respecting other cultures' ways of knowing, being and doing, and of healing. MH faculty and students made and developed lasting relationships as departments and disciplines discovered intersections and colleges and campuses came together around shared interests. In so doing, we built trust along with a program. NM became an emphasis, so too did courses that moved beyond stereotyping people to share not only the difficult, deadly parts of stories, but also rich traditions, like those of Indigenous peoples in healing, wellness and resilience.

Our Indigenous ways of being, organically, became a tacit and integral part of the MH program because of the people and projects that inspired our work. We never forced our ways on others; we didn't pray or smudge in the room where we held MH meetings (although we did do that at home, in private). Acutely aware that this was not Native American Studies and that we were representing a secular program made up of multiple departments and diverse peoples, we worked to recognize this and honor the ways in which a person in need of care is more than a patient, diagnosis, subject or problem. We worked, along with other MH faculty and students, to acknowledge that people embody histories, cultures, stories, identities, hopes, fears and all the complexities that are part of human life and experience.

Although ethnic studies is generally included among MH programs' areas of discipline, Native American or Indigenous studies are often absent from the coursework, the material, the faculty and the student population. At our institution, this was not the case. Two of the original executive committee members are Native American. From the start, Native American and Indigenous-related courses were included in our offerings: Shamanism; First Nations, Métis and Inuit: Spirit in Cultures, Fine Arts and Healing; Native American Religions and Native American Health and Wellness. From the beginning, students minoring in MH were given the option to have a broad focus or to concentrate on a particular area within the field, such as Native American Health. We built a minor in which all requirements could be fulfilled, for those who choose, by Native American/Indigenous-related courses.

The MH program, as a whole, became a growing vibrant community of students, educators, practitioners, artists and community partners, whose fields encompass the Humanities, Social Sciences and the Arts in ways that complement the Health Sciences. The program includes topics related to practices, healing and ethics across cultures, health and illness, the nature of suffering, the interactions between health practices and conceptions of personhood, gender, and community and models of wellness. Our students responded to this form of a MH program. Within three years: fifty-one students had enrolled in the minor; a graduate in our

first cohort was accepted into medical school; and we made and deepened connections with our university's medical school, collaborating on projects and grants. Two of our Native American students who were interested in science were placed in paid research internships at the medical school.

Amongst other activities and events, the MH program also co-sponsored an exhibition, INDIGENIST, which included art works, prayers and performances exploring the woven narratives of Native women advocating for education, health and wellness. Ten inter-tribal, inter-generational women shared their stories through the arts and later conducted an arts-based research study that developed an indigenist theory of health advocacy. Together, this circle of artists-researchers identified and illuminated ways of knowing, being and doing that ground and inform a deeper understanding of Indigenous health advocacy. The exhibition ran for over one month and engaged community in NM and MH through Native American Studies. Beyond locally, Princeton University's MH working group, Bodies of Knowledge, invited Regina out to present our work on their campus and we are hopeful that this circle continues to grow. MH projects, such as INDIGENIST, can serve to bridge existing knowledge of Indigenous theories with medical understandings that can be applied and utilized in real life.

Our MH program also contributed as a partner in a grant proposal to the National Cancer Institute which funded the YES! (Youth Enjoy Science) program to support, motivate, involve, educate, and mentor Native American students and their communities in cancer prevention, treatment and research. This partnership between Native American communities of the Great Plains and our medical school's local Cancer Center strengthened relationships and offered students laboratory, healing arts and other research experiences in culturally appropriate ways. YES! scholars are now conducting arts-based research studies in NM and sharing stories, both visually and verbally, of Indigenous patients who are living with cancer to raise awareness and increase community knowledge specific to cancer.

So, as you can see, it was a good beginning over those three years, even one of those "you'll never believe what happened" beginnings.

Convocation 2014. We are still here, in the photo. Smiling. Wearing our Native American Studies stoles, carrying our histories and each other. We go into the fields of MH and NM, of academia, with eyes wide open. Committed to it all, because of and despite the challenges. Because, as Thomas King says, "in all the tellings of all the tellers, the world never leaves the turtle's back. And the turtle never swims away."

Regina: When I graduated with my PhD, the Native American Studies program honored me with a beautiful stole, which displayed sacred Indigenous colors associated with the region (red, yellow, black and white). I wore this to my graduation ceremony at the medical center, where I was told, "you can't wear that." I kept wearing it until I was told over and over, "put that away" and "you need to go give that to your family." I reluctantly, took off the stole and tucked it in my pocket. I felt tormented by all of the reasons that I could think of to both put the stole back on and to keep it tucked away. But, when my name was called to cross the stage and receive my diploma, trembling, I pulled the stole out of my pocket and placed it on in such a frantic hurry that one side hung blank, back-side-front. My official graduation photos show a student smiling with half of a stole, brilliant in color and design and the other half, blank and pasty white. It is a picture that speaks to our story and the need to create space to bring color to and indigenize our programs and processes.

Michele: Recently, a non-Indigenous relative of mine commented on a picture of me in my academic gown. "Look how nice it looks," she said, "without all that stuff hanging around your neck." By "all that stuff," she meant the Native American Studies stole and the Métis sash I wear at convocations. In Regina's graduation photo.

In the graduation photograph....that one picture, on graduation day, represents more than one moment or two people. It is a picture from the ground up, from our ancestors onward. That's why we're here. Sharing our stories.

The MH program at our university is set for new growth. Under its interim Director, community liaison and academic advisor, along with the continued work of dedicated faculty, it aims to expand into a major. Students continue to join the program and many projects, scholarly and creative, have taken place or are planned. The values of inclusivity,

diversity, respect and humility that we brought in from the ground up as Native American/Indigenous faculty members, are still strongly represented by the faculty and students who uphold similar values and, in so doing, continue to braid their stories into ours.

In the photograph, arms encircled, in academic and Indigenous regalia, we smile. People have tried to erase our Indigenous Nations, to assimilate us, to shame us, to remove or refuse to acknowledge the Indigenous ways we have of knowing, being, and doing. But we are here, still. We are living our stories, knowing always that since the beginning we have been part of the land's story, part of our ancestors' stories and that we are part of the stories for seven generations to come. We know that these stories, so often unheard or ignored, are central, are the original narrative medicine of Turtle Island. In the photograph we are looking not just at the camera, but at all our relations; we are celebrating their survival and our survival. We are exhausted, stressed, humble and proud. We will go on from this very place to pray, to offer tobacco, to teach, write, create, suffer, research, found and support new programs because these are the seeds and stories that will help all our relatives thrive: minerals, plants, earth, animals – our relatives who are human and other-than-human persons. Because this is how we have been taught to honor all that we have been given. Because, this is good medicine.

In the photograph, arms encircled, in academic and Indigenous regalia, we smile. We look forward to what will grow from this moment and to the stories that we will share with others. Even the stories that will eventually begin with, "You'll never believe what happened."

Our stories reflect the importance of developing MH programs that recognize the critical role that diverse faculty play in achieving the objectives of the MH. The Association of American Medical Colleges suggests that “reflective practice, professional identity formation, empathy, cultural humility, tolerance of ambiguity, critical thinking skills, literature and medicine, the history of medicine and narrative writing are standard items in a medical humanities curriculum” yet, “offerings may vary by institution given faculty strengths and mission specific goals” (Todd, 2016). MH programs draw on the creative, intuitive and intellectual strengths of faculty grounded in cultural-based and

community-based experience. As Todd explains, “the real power of an undergraduate program in Medical Humanities will always be its focus on patients and physicians as people.” We argue that the real power of MH programs is demonstrated in the people that make up the faculty body. We told our stories to demonstrate how MH programs’ inclusion of faculty from diverse backgrounds is just as critical as their inclusion of faculty from diverse departments. Our stories serve as data that corroborate the following recommendations for building a successful and sustainable MH program:

- First, work from the ground up. Get to know your MH faculty. Invite diverse faculty to share their stories and create space for their voices to be heard and ways for their ancestors to be honored in your MH programming.
- Second, be open to many forms of truth. Encourage MH faculty to recognize empirical as well as experiential evidence, technical as well as traditional knowledge, science as well as art, statistics as well as stories and the humanities as well as medicine. Ensure the values of inclusivity, of diversity, of respecting other cultures' ways of knowing, being and doing, and of healing.
- Third, keep mindful of the impact of the collective story that you tell. Imagine the MH as its own being, its own story, and ask MH faculty: who will be the storyteller, what stories will be told and who will listen?
- Fourth, aim to promote social justice and human rights. Encourage MH faculty to be aware of the realities of not only health disparities but also health equities and the program’s responsibilities to address both strengths and areas to strengthen within your communities.

Neither the academy nor our health system are solely responsible for the reasons why health inequities exist, but both can play a part in reversing historic inequalities and promoting social justice. Faculty in the field of MH shoulder this responsibility in preparing future health care professionals to teach diverse students in ways that we have not yet done. We do not question what, why or even when, but rather *who* will compel

us to assume our responsibility? We hope our stories inspire a growing MH faculty body encouraged to assume this responsibility.

We elucidated the importance of including faculty from diverse backgrounds in MH programming, gave examples of how we did this in our program and shared recommendations, based on a synthesis of our experiences, for others building MH programs. Academics from all disciplines and backgrounds can reference our stories as data in support of infusing more inclusion and diversity in MH program development. Although our stories centered on instilling Indigenous ways of knowing and being and doing in our MH program, our focus on culture-based core values and a community-based approach can be transferable to any program and any culture. Moreover, the general recommendations that surfaced from our experience have broad relevance and application to building and sustaining other successful MH programs.

We have shared our stories and perspectives here as part of the "self-telling body" that is the field of MH, with the knowledge that narrative medicine is as powerful a part of our cultures as it is of yours. Perhaps this reflective essay will even, like a bear or a powerful story, bring some medicine. And we hope that, in the end, you too, will braid your stories with ours in a respectful and healing way. That would be a good ending to our stories here.

"Just don't say in the years to come you would have lived your life differently if only you had heard this story. You've heard it now."

– Thomas King, *The Truth About Stories: A Native Narrative*

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