Bridging Worldviews

Integrating Indigenous Medicine in a Clinical Practice

A Multicultural, Multifocal Perspective

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ABSTRACT

Within the context of the World Health Organization's new Global Strategy on Traditional Medicine (2025–2034), this article employs Indigenous Research Methodologies to examine the integration of Indigenous medicine into contemporary clinical practice. Drawing on personal reflexive ethnography, the author proposes moving beyond a dualistic framework and the notion of "second sight" toward a multifocal perspective that weaves together narrative, Indigenous teachings, and scientific discourse. This approach emerges from a mixed Indigenous and multicultural identity that articulates Indigenous medical practices, integrative medicine, and Western biomedical science. The analysis includes a critical review of traditional, integrative, and complementary medicine, biomedicine, gender disparities in healthcare, and the historical role of women, with particular emphasis on Sámi traditional medicine. Finally, the article discusses clinical experiences that engage with the four objectives of the WHO strategy: evidence, safety and efficacy, integration into health systems, and community empowerment.

Keywords: Indigenous medicine (IM), clinical integration, Indigenous research methodologies, multicultural identity, multifocal thinking, traditional medicine (TM), traditional knowledge (TK), Indigenous women, Sámi traditional medicine (STM)

Ethical Statement and Acknowledgments

Rectitude

When I narrate stories from the past, relay my memories, or share Indigenous teachings, if I cause offense to anyone or to their knowledge, culture, or traditions, I offer my apology and ask for understanding. For all I can truly speak to is my own experience and the universal truths entrusted to me, which I live by and through the guidance and brilliance of my Ancestors, Elders, and Ancient Ones. I stand on the shoulders of many generations of giants. We—the reader, all other living beings, and I—stand together within the circle of life.

Gratitude

I am taught by my Ancestors, Elders, and Ancient Ones that gratitude feeds the universe, completing and welcoming the cycle of what is received. I come to you carrying many generations before me and many generations yet to follow. I would not have risen through the challenges and struggles of life, standing in my strength, without my teachers, mentors, and Elders in the physical world; my children and my grandchild; and my spiritual Ancestors, Elders, and Ancient Ones. I humbly give thanks for the web of love and life that flows through me as a result of your support.

Thank you.

Introduction

Systematic integration of Indigenous Medicine (IM) within the western clinical context requires structured frameworks that include: respect for all knowledge systems, support for self-identity, cultural safety, and the empowerment of practitioners and patients, while ensuring clinical safety and efficacy. Ideally, this occurs within sacred space, honoring universal and scientific principles, professionalism, integrity, and ethical conduct.

This discourse has been shaped over a lifetime, encompassing four decades of service. I reflect upon the ethical integration of Indigenous Medicine teachings in a clinical setting. I ponder life experience, personal mixed-blood identity, knowledge systems, community and healing systems, challenges and opportunities experienced. Journey with me, removing the 'romance', sharing life's relational complex—finding oneself, one's family stories, the 'roots' of one's personal tree. Living as uniquely designed, I stand strong in any wind, growing new branches for future generations' nourishment.

In this discourse, italicized words are words directly from my Ancestors, Elders and Ancient Ones (AEAO)—my helpers. Doing this denotes respect and honor, allowing a direct relay of their transmission, reminding all that I stand on the shoulders of many giants. I am not who I am today without all who came before me.

Personal Reflexive Statement, Acknowledgement of Lineage

> "As a woman I have no country. As a woman I want no country.
>
> As a woman, my country is the whole world." (Woolf 1938)

My name is Sandi Ayahwehwah Divine Light Bearer Abdal Sami Japdev Kaur Atl Chuatl Löytömäki. I am a helper of people, one who is one with the wind, carrying the light through the dark, a generous friend who always listens, one who whispers the name of god, becoming one with god, keeper of the sacred waters, who found a hill. My tribe is human—a woman of the whole world, essence and lineage, a global Indigenous person of mixed blood. My genetic lineage represents all colors of the human rainbow, many lands. My spiritual lineage represents multi-faceted traditions of humanity. My environmental lineage is rooted in the oldest rock of the back

of the Turtle, the Canadian Shield, mixed with universal intrusions, the land of the boreal forest. I live now where the trees are standing in the water, in the Great Lakes forest region.

My paternal ancestry descends from the Sámi people through Finnish territory, a people resettled, living a physical life, experiencing the death of cultural life, and having previously migrated *from the Ural and Himalayan mountains*. My maternal ancestry is mixed blood through northern Italian territory, previous the vast expanse of *'silk road' territory*. Here, blood from several continents is mixed. I am a product of human migration—Ancestors seeking peace, experiencing displacement, the aggressors, the oppressed, seeking a better life in the 'New World'. I am a descendant, a product of cultural trauma, religious conversion, conditioning, inter-generational trauma, societal rejection and colonization. I am a survivor of sexual, physical, mental and emotional abuse. I am *sisu*[1]. I thrive. I am resilience. Born in Canada to 1st generation immigrants, I am a settler in Canada. My heart is nomadic, my caribou herd in spirit (joining me after the Canadian government culled a herd in the northern territories). I walk, wander and travel, studying our human nature. I live in a culturally diverse urban center, witnessing the depravity and beauty of humanity daily. As 'edge-walker,' my spirit resides in the bush or mountains, while the Ancestors have me serve in the urban jungle, fully connected nature asserting herself in the cracks of the sidewalk.

I am Mama, a single mother of two beautiful children (and many more through our house). Now, Ahku-Mummu, grandmother. Called by many titles in the various traditions, in my clinical practice, I use Indigenous and Integrative Medicine Practitioner and Osteopathic Manual Therapy Practitioner (OMPT). My foundation is not recognized by any Canadian government or insurance system. My osteopathic hands are bound by the Canadian Medical system, as they 'legally own' the terms Osteopath and Osteopathy. I strongly refute the application of the title shaman—a historical, anthropological, patriarchal term, an abstraction of one Indigenous word for one type of medicine person, applied to many without context, in the early days of its inception, excluding Indigenous medicine women (Krippner 2002; Löytömäki 2005). I stand in the fullness of the teachings belonging to my ancestral origins, belonging to humanity.

Once there was a time when we all walked together—the men, the women, the children together. Then, the men stepped ahead of the others, leaving the women and the children behind. Then, the women stepped ahead of the others, leaving the children behind – the men walked in front, behind were the women and behind them were the children, on their own, raising themselves. At some point in the journey, some women remembered. They stepped ahead of the men, and began to remind all to walk together. They brought some of the children with them, some refused to move. They brought some of the men with them, some refused to move. Now—as humans—we have some men, women

[1] Sisu is a Finnish cultural concept referring to sustained inner resilience and determination in the face of prolonged adversity.

and children walking alone. We have some women and children walking together. We have some men and children walking together. We have some men, women and children walking together. One day, we will walk together once again.

Literature Review

Integrating Indigenous Medicine Systems into Clinical Settings

Indigenous Medicine systems have existed since the dawn of time, informing current therapeutic and medical practices. The language of traditional medicine, colloquially and in research, uses a diverse array of terminology in reference to Indigenous Medicine ways of knowing. Recognizing the limitation and evolution of the English language, I choose to use Indigenous Medicine (IM) upon the guidance of my AEAO and my training with the Center for Traditional Medicine/Center for World Indigenous Studies (CTM/CWIS). I do this in recognition of: the shoulders I stand on, vast cultural influence, my lineage and ancestry, processes and principles allowing knowledge systems to adapt as the world and all her people shift, change, grow and evolve.

Human history of oppression includes an impact on Indigenous Medicine practices. Medicine people were tortured, murdered, knowledge went into hiding or became 'secretly' protected, residential schools (Waldram, Herring, and Young 2006), and similar institutions converted people to the oppressive nation state. Indigenous practices were obscured or discredited by linear patriarchal, religious, and scientific actions. Over time, many Indigenous Medicine practices fell silent and changed; they were given other names, for example, Osteopathy from 'lightning bonesetting' (Hildreth 1938; Lewis 2012; Still 1908) or integrated into other therapies, modalities (Grossinger 1995a, 1995b) or religions, for example, the Christianization of Sámi traditions (Kuokkanen 2000, 2007; Helander-Renvall and Markkula 2017; Jacobsson, Ouma, and Liu-Helmersson 2021). Thus, protocols and processes at times disappeared, were adapted and changed. Any evidence of variations or remnants, historically discredited through the socio-political history of biomedicine, their quest to dominate other medicine ways, relegating them to current complementary and alternative approaches (Grossinger 1995a, 1995b). This translates into a systematic exclusion of Indigenous medicine traditions from mainstream healthcare. People-driven use of Indigenous Medicine ways (TM, T&CM, TCIM) is facilitating a global resurgence and recognition of these practices. Although oppressors of Indigenous cultures worked hard to extinguish people, what they failed to understand is that the knowledge of Indigenous cultures belongs to human universal knowledge and is never ´lost'. Thus, it will always make its return, eventually.

Integrating Indigenous Medicine ways into clinical settings has become a global health priority. Culturally grounded partnership with Indigenous and Traditional Medicine people is essential, especially when healing traditionally is considered relational, spiritual, physical, mental, emotional, land-informed and embedded in individual and community

practice. Successful programs are emerging in various countries and across circumpolar nations, both privately and within organizations and institutions, encouraging respect for epistemic differences while providing usable data for clinicians and policymakers. Collaborative care models recognize the importance of including Indigenous Medicine people (healers) alongside regulated health professionals to improve access, acceptability, and patient health outcomes. This also requires explicit protocols to navigate confidentiality, consent and scope of practice.

World Health Organization (WHO) Global Traditional Medicine (TM) Strategy

The WHO compiled 2 Global Traditional Medicine Strategies beginning in 2014. Each strategy's vision was developed through extensive global and regional consultations with Member States, partners and representatives of Indigenous Peoples. The initial strategy laying the foundation (2014-2023) for exploration and discussions of TM, the current strategy (2025-2035) replaces and builds upon the first.

The strategies for 2019-2023 and 2025-2035 share common goals:

- Improve regulation for safety, effectiveness and quality
- Integration of TM within health systems to move toward of equitable healthcare worldwide
- Develop rigorous scientific research, bridging the gap between TM and biomedicine methodology
- Building competency across biomedicine and TM health sectors

Each strategy reflects the evolution of global healthcare needs, evolving attitudes toward TM and advances in scientific research. A closer review of both strategies reveals differences in terms of their focus areas and approaches (World Health Organization 2013, 2025).

The first strategy (2019-2023) was designed as a short-term framework, while the second (2025-2035) extends the timeframe and shifts focus to long-term goals such as: ensuring sustainability, fostering international collaboration and strengthening research infrastructure with an enhanced approach to TM as a legitimate component of global health systems. There is recognition of the need for cross-border collaboration, such as knowledge sharing between governments, TM practitioners, academic institutions and international organizations. While the initial strategy called for international cooperation, the current strategy frames collaboration as a central theme.

One of the key innovations of the current strategy is the recognition of land and ecology concerns in TM, demonstrating a growing comprehension of TM. It places a stronger focus on sustainability, especially in relation to the conservation of medicinal plants and the responsible sourcing of traditional medicine products. This recognizes concerns of biodiversity loss and overharvesting of medicinal plants.

Technology and data governance are ever-growing phenomena with great potential for use

and misuse. The current strategy introduces a focus on the role of digital health technologies in the promotion, monitoring and integration of multiple modes of medicine, as digital platforms are exploding and providing improved access. Policy framework is also expanded to address broader global health challenges, including the need for TM to contribute to primary healthcare, universal health coverage and emergency preparedness.

A welcome addition in the 2025-2035 strategy is the broader conceptualization of health. This current strategy recognizes that TM is often rooted in comprehensive health systems, which view health in preventative, promotional and integrative contexts.

Another benefit of the 2025-2035 strategy is that it upholds the rights of Indigenous Peoples while promoting their knowledge and practices related to TM. This is with the forward glance of achievement of the highest attainable standard of health and well-being for everyone through access to safe, effective and people-centered TCIM.

The Importance of Women within Indigenous Medicine

> "Woman is the First Environment. In pregnancy, our bodies sustain life. At the breast of women, the generations are nourished. From the bodies of women flows the relationship of those generations, both to society and the natural world. In this way, the earth is our mother, the old people said. In this way, we as women are earth." (Cook 2016)

For millennia, Indigenous women have occupied central roles in medicine traditions serving in a variety of medicine ways, including (and not limited to): healers, midwives (birth and death), custodians of plant wisdom, spiritual wisdom, primary caregivers, counsellors, ritualists and ceremonialists. Resistance to colonial suppression is a historical and current reality. Indigenous medicine people adapt to life, sustaining cultural medicine amid global and biomedical pressures. A 2025 publication from the Center for World Indigenous Studies (CWIS) highlights how Indigenous women, despite systemic violence, continue to resist erasure by carrying forward healing traditions rooted in the land and community. (CWIS Editor 2025) Grandmothers and Elder women serve as profound bridges between past and present, safeguarding ecological and medicinal knowledge, fostering relational worlds, and mentoring younger generations in kinship and land stewardship (Helander-Renvall and Markkula 2017; Jacobsson, Ouma, and Liu-Helmersson 2021; Struthers 2003).

Sámi traditional medicine (STM)

> I was 10 years old, sitting on the bed, playing with my cousin Helena, a decade older than me. She was visiting from Finland. I remember everyone saying she was crazy, labeled 'schizophrenic, ' the first and not the last time I heard that word. She seemed normal to me—sad, and normal. Through the years of letters back and forth, changes in her handwriting would reveal a coming hospitalization. Helena told me

> stories. Stories of how we were 'reindeer' people – how we had to move – how the reindeer still sometimes come to visit the original family farmhouse. It would be many years later that I would align geopolitical resettlement with our name change. Years following, I would 'come out of the closet', honor our *Noaidi* lineage, and take back our Finnish resettlement name (the Canadian government had cut our name in half upon my Grandfather's arrival). And still, many years passed before I had the physical proof of what I already knew and felt inside. Through genetic testing, proof was real and true. My spiritual side led me to know my full physical roots.

Sámi traditional medicine (STM) encompasses an integrative worldview combining spiritual, physical, mental, emotional and environmental dimensions of health, rooted in the cultural practices of the Sámi people across vast Sapmi territory (Norway, Sweden, Finland and Russia). Cultural expression is rooted in the relation of people with their land; thus, as there are variations in the land, there are similarities and differences within language, culture and tradition across Sámi regions. Religious influence amplyfies this.

Finnish Sámi healing systems (*noaidi vuohta*) are embedded in kinship, land-based subsistence, Lutheran Christian-Indigenous encounters and resettlement. Predating and alongside Christianization, healing practices were mediated by ritual specialists (*noaiddit*), household caregivers, and midwives. Practices often combined prayer, song/sound (examples: *joik*, drumming), touch, and a vast oral materia medica of reindeer, plants and minerals. While missionary, anthropological and legal sources long emphasized male healers ('shaman'), historical records and oral histories also attest to women ritualists and the essential role of women as caregivers, midwives and transmitters of *arbediehtu* (ancestral knowledge) (Helander-Renvall 2005; Sexton and Buljo Stabbursvik 2010).

Colonial and state institutions have historically marginalized STM. In Finland, residential schools ensured the homogenization of Sámi children into the Finnish state, as in other circumpolar states (Waldram, Herring, and Young 2006). Colonial assimilation and Lutheran missions criminalized or stigmatized Sámi ritual specialists. This contributed to secrecy, selective transmission and the partial masculinization of the historical record. As Sámi women establish their voice, stand in their identity, they lead a new way in identifying and preserving traditional knowledge (TK), traditional ecological knowledge (TEK) and traditional medicine ways (Helander-Renvall and Markkula 2017). Contemporary studies indicate that healing persists as a living adaptive practice, often negotiated by women within families and between parallel systems (parish, clinic, healer). Women have historically played a pivotal role in the transmission and practice of STM, despite facing challenges and gender bias. Sámi women have maintained and adapted their healing practices, ensuring survival and relevance in contemporary society (Helander-Renvall and Markkula 2017; Kailo 1993, 1998).

Elina Helander-Renvall, a Sámi woman, healer and prominent scholar, has extensively studied the transmission of Sámi traditional knowledge (STK). She emphasizes the importance of recognizing and respecting the gendered dimensions of knowledge transfer within Sámi communities. Her work indicates the need for inclusive research methodologies that honor the contributions of women in preserving and revitalizing STK and STM (Helander-Renvall 2005; Helander-Renvall and Markkula 2017). The SAMINOR surveys (Kristoffersen et al. 2017) indicate a higher prevalence of traditional medicine use among Sámi populations than among their Norwegian counterparts, highlighting the enduring value placed on STM practices. The marginalization of STM by mainstream healthcare systems, coupled with forced migration, erosion of Indigenous languages and cultural practices, threatens the continuity of these healing traditions. Efforts to integrate STM into formal healthcare settings face obstacles related to standardization, validation and cultural sensitivity. The fire is not extinguished. STM represents a rich tapestry of knowledge and practices that reflect the extensive connection of the Sámi people and their environment.

Disparities in Healthcare

Health disparities among women globally and in North America are a significant public health concern, characterized by differences in health outcomes and access to care influenced by factors such as race, socioeconomic status, accessibility to regular care, geography and systemic bias. Indigenous women encounter a unique intersection of gender, racial discrimination and marginalization within healthcare systems.

Indigenous women in Canada and throughout North America face health disparities rooted in the legacy of genocide, colonization, systemic racism, cultural dislocation and controlled resource allocation. The imposition of European norms and values through systematic conversion significantly disrupted Indigenous social structures, particularly those that empowered women. Structural determinants, including poverty, inadequate housing, and limited access to education and employment, further compound health challenges. Indigenous women are more likely to experience racism and sexism from healthcare providers, leading to mistrust and reluctance to seek care. The mental health of Indigenous women is adversely affected by historical trauma, including ongoing experiences of discrimination. The discrimination not only affects their access to healthcare but also the quality of care received.

Multicultural Indigenous Identity and Indigenous Research Methodologies

Multicultural Indigenous identity intersects in complex ways within healthcare research and practice, demanding culturally attuned approaches and methodologies, ethical engagement and epistemic justice. Western linear paradigms impose external definitions of health, data governance and the ‘Indian quantum’—how much Indian blood makes an Indian (Thornton 1996). This type of linear approach often ignores the rich epistemologies, diverse identities and sovereignty over knowledge. There is an ethical need to allow a specific culture to define its identity (Kailo 1993; Kovach 2021; Tuhiwai Smith 2022; Waziyatawin and Yellow Bird 2012). And

what of the displaced person, or their future generations? Do we ignore and negate them because they are a product of human oppression, having or choosing to live or belong to another culture? If we, as humans, as researchers, inadvertently apply linear colonial concepts with singular cultures, how then do we approach multicultural identity within one person, one family, multiple communities? Humans have been migrating and inter-marrying across cultures for centuries, often for the benefit of health and evolution.

Indigenous Research Methodologies (IRM) embed cultural values, such as respect, responsibility, reciprocity, relevance and relationality, into every stage of research, driven by self-determination (Alfred 2009; Cajete 2006; Kovach 2021; Tuhiwai Smith 2022). Such methodologies, in best practice, prioritize relational accountability, the integration of Indigenous worldviews and community protocols. Indigenous worldview, fundamental to Native Science, must be considered during research (Cajete 2006; Kovach 2021; Tuhiwai Smith 2022). Healthcare research and practice must reflect the fullness of the practitioners' and the patients' identity to appreciate cultural competency and avoid cultural bias.

The definition of health and healthcare services can vary in biomedical, Indigenous Medicine, complementary and integrative models, as well as from culture to culture and with literacy and fluency of language, often with health equating to "feeling better" (personal clinical experience). Ensuring language is comprehensive and understood is foundational to a beneficial outcome. Recognizing multicultural Indigenous identities also requires attention to data governance, including how health and cultural information is collected, used and shared.

Method

Being mixed-blood, carrying multiple Indigenous lineages within, academically trained, I approach this research not as an outside observer, but rather as someone who has navigated the complexities of multicultural global Indigenous and Euro-centric settler identity, while combining Indigenous medicine practices within a variety of western contemporary clinical settings.

I have chosen adherence to current best practice Indigenous Research Methodologies (IRM). The use of a feminist reflexive ethnographic perspective, within this context, serves many benefits, allowing for:

- full discussion of intersecting issues, maintaining cultural respect
- maintenance of responsibility of myself, the practitioner as dictated by the Ancestors, Elders and Ancient Ones, and to all others
- share who I am, how I live, my experience in the world (my unique cultural and tradition adaptations) – without cultural or tradition appropriation
- recognition of similarity which exists in human experience, yielding multicultural adaptation, while also recognizing differences and uniqueness
- a bridge for demonstrating a living example of spiralist Indigenous thought to co-exist within a dominating linear framework.

Along with this approach, I enact *Etuaptmumk* – Two-Eyed Seeing, the ability to see with one eye the western approach and to see with the other eye, the Indigenous approach. Kailo also refers to a similar experience as Sámi second sight:

> "...the Sámi women do have a sort of second sight that distinguishes their struggle from that of mainstream non-Indigenous 'feminists' oppression. They are force to "see double" – their own and the colonizing culture as two circles that criss-cross and separate in separate and different ways depending on the onlooker". (Kailo 1998)

Marrying these concepts, it is also necessary for me to take this approach from the linear (two), into the quantum. To sacred geometry, creation, multiple circles intersecting, moving multiple circles (spirals) and enact a multifocal lens. In this way, I am able to fully account for all my lineages, the physical and spiritual reality I live daily, my Indigenous Medicine ways, my Integrative Medicine ways, along with my Eurocentric Western ideology, scientific, therapeutic and biomedical approach. Every time I add a new modality or learn from a new cultural tradition, I add another circle. I am grateful we as human beings are hard-wired and soft-wired for this.

I also enact an affirmative practice in all my research activities, as I hold this in my clinical practice and daily life. By this, I mean the application of affirmative care (Mendoza et al. 2020). Through affirmative care, I validate and support the self-identity of those I serve. I honor and celebrate self-identity and simultaneously validate oppression experienced and felt, previous and current.

Maintaining this perspective allows me to share my history, cultural context and lived experiences, while also sharing research of others' history, cultural context and lived experience; knowing those reading this discourse also have history, cultural context and lived experience which will resonate. This helps me maintain the sacred space and ceremony of research.

To this end, throughout this paper, I maintain the ethics and teachings of my Ancestors, Elders and Ancient Ones. I strive to achieve current best practice for informed research in choosing the methodology and creating a comprehensive (although limited) literature review. Throughout the narrative, I maintain the confidentiality of all people involved, sharing specifics only with express permission. As well, I share universal principles of Indigenous medicine principles, without sharing knowledge that requires instruction, training and demonstrating a level of mastery before implementing in service to self or others.

Theoretical Framework

The questions I began asking were taken with inspiration from Murray Sinclair (Bailey 2024):

- Where am I from?
- Where am I going?
- Why am I here?
- Who am I?

Then, first without words, following words emerging from the wind:

> How does a woman, identifying as mixed blood, multicultural global Indigenous, earth-centric, Eurocentric settler heritage,

navigate the integration of multiple Indigenous medicine lineages, traditional teachings, integrity and ethics, western scientific academic training, multiple complementary modalities within all clinical healthcare settings experienced, with the best level of practice?

These questions inform all research, all my researcher positionality and reflexivity statements.

Results

Discussion includes researcher positionality and reflexivity while attending to the 4 aims of the WHO Global Traditional Medicine Strategy 2025-2035. These four aims are to: strengthen the evidence base for TCIM; support safe and effective TCIM through regulatory mechanisms; integrate safe and effective TCIM into health systems; and empower communities, optimizing TCIM's cross-sector power.

Researcher Positionality and Reflexivity I

Beginning this process, recognition emerged from the cocoon I had wrapped myself in for the past 14 years. That cocoon was my 'spiritual sabbatical' and advanced learning in human form. Meaning, recovery to original essence from full multisystem organ failure, requiring regenerating tissue, relearning skills and returning to full active service. This death journey (fighting for survival, surrendering to death, returning to a severely damaged body, regenerating all tissues), every moment of every day, tested and used all the teachings I had formerly received, and, as needed, added new teachings from the AEAO. This is another story. I am on the edge of the cliff, in the final stages of full resolution of, at times, intractable searing chronic pain - the moth burning in the fire, the butterfly emerging out of the primordial ooze of the cocoon, drying their wings in full vulnerability. My days of rest in the sacred space of my spiritual sabbatical, coming to their cyclical moment of end, consequent with this beginning, action in the next level.

My ethical positioning is fully rooted in my relationships with: AEAO, the CTM/CWIS, mentors, teachers and Indigenous Elders; a variety of rural and urban Indigenous communities, multiple religious, spiritual and cultural communities. Academically (western linear), my ethical positioning is fully rooted in WHO and NIH international gold-standard clinical and human-subject research standards, and in the laws of the lands I live in and serve.

I do not facilitate ceremonies or rituals that are not mine or are a singular culture's tradition. Rather, my specialty is helping others create multicultural, multi-spiritual ritual and ceremony, and assisting them when asked. Thus, my ongoing obligations and responsibilities are to all of life and all its stages. I have a personal commitment and responsibility to reciprocity across all cultures and all life. I am dedicated to the preservation and protection of sacred traditional knowledge. My understanding is that traditional Indigenous Elders share knowledge when one has shown proficiency in learning and acting on the previous instruction. The 'secrecy' or withholding of information is a recognition that when humans, in general, have knowledge

that is beyond their current 'ability to respond' (responsibility)—they have the potential to misuse it, which can create harm. I witness this reality every day in my clinical practice and life. Thus, I speak to the universal principles I can, that create, maintain and sustain balance.

Walking the Multifocal Path – Multicultural Identity as a Strength in Healthcare Integration

Multicultural identity is a multifocal path merging several cultures, traditions and ways of being. This can serve as a bridge between communities. Unique insights can be gained from moving around all circles, viewing life from different vantage points, and implementing a multifocal lens. Fluency of language is required to serve this multifocal path. Without multiple languages, adapting English as necessary to meet 'my people' where they are at. Flexibility and fluency allow conversing with the world's leading scientists and physicians, as easily as speaking to the homeless person who has stopped me on the street, "you look like someone I can ask this question to". This fluency developed as I needed to synthesize many knowledge systems, take complex subjects and make them understandable to engage people. I choose to educate, to explain why it is important for them to consider and act on suggestions. Relating their experience directly is a way of building understanding, self-awareness and motivation. After all, my Ancestors taught me: *knowledge for the sake of knowledge is meaningless. It becomes wisdom when it is taken into action on a daily basis*. If I am to help people make permanent change (the directive I am charged with), then I must do what is needed to assist them in making their change.

Carrying Multiple Medicines – The Complexity of Multicultural Indigenous and Integrative Medicine Practice

My Ancestors describe me as an 'all-purpose' Indigenous Medicine person – meaning, in my lifetime, I must learn all the ways of medicine. I must master the art of altered states of consciousness (ASC), to receive the information necessary to assist those I serve. Travelling in all realms, serving all people, also means mastering the art of internal and external communication (in Western words, intuition).

Carrying multiple medicines means I have a responsibility to service – to master each service, respond and provide appropriate service at the appropriate time. This means I must practice and prove my efficiency and effectiveness to my AEAO, mentors and teachers. When I am learning a new service, I create case studies, with full informed consent, followed by self-analysis. This marries Western standards for case studies and human subjects research, with old-style 'apprenticeship'.

In this responsibility to service and safety for patients, with decades of experience, recognizing all cycles of life, I use tools of the trade so that the person will be able to fully integrate the service. A few examples regularly present in my practice include: not providing plant medicines or bodywork until the person is hydrating consistently – ensuring they will be able to process the detoxification that will occur;

not providing advanced breathing exercises if they are not using their lungs properly while breathing – ensuring there will not be a cascade of physiological challenges. It is my responsibility to know all functional anatomy (physical and energetic, BMSE) and be able to track all that is happening within and surround the individual while I am working with them. One does not know how to track energies until one can track a red fox moving across the Canadian shield.

Carrying multiple medicines, which are inclusive to Earth and all cycles, means I have a responsibility to the Earth in all service. To this end, my ability to respond includes helping people recognize their body is their Earth, the relations of their body and the Earth, and join their mind and body in a new way. In this way, I am a 'quiet eco-warrior'. Meaning, one of my contributions to restoring balance to the Earth from human actions is to help people understand how their Earth functions, so they can better understand how the Earth, herself, functions. In this way, as they take better care of their Earth, they naturally begin to take better care of the Earth that surrounds them.

Walking in Many Worlds – Beyond Second Sight and Two-Eyed Seeing

For me, second sight, or two-eyed seeing, is definitely a step forward. It moves from the linear into a Venn diagram, using two intersecting circles. In the reality of an interconnected universe, there are more than two intersecting circles. Thus, I suggest the multifocal move into many intersecting Venn diagrams.

As we engage the moving spiral (in expansion or contraction) and add another factor beyond the two circles, we move from the linear to the exponential. As we continue this, the exponential grows, known as the Fibonacci spiral. Perhaps this is why the number 3 is considered a number of creation in many cultures and traditions? As we add another factor, the exponential gains begin to increase. I will use these teachings to help people understand the power they have at hand when they take solid, consistent actions. Depending upon their orientation, I can walk the mathematical or geometric world, the visual world, or the sacred world of disciplines from traditions in my Ancestral lineage.

Universal principles unite all my knowledge systems. I discover beauty in universal principles on a daily basis. First, that they can be applied across all levels of existence and remain true. Second, the initial understanding remains constant, while over time the depth grows and evolves. Third, they are often present long before being 'proven' in science.

Perspective and perception are fundamental in the way we see the world and the way we interact with the world. Also fundamental in the way we are able to be a pure observer or bring in bias and judgment. Being able to walk in many different worlds at the same time, helps me navigate many realms in a clinic setting, including: different patient expectations, different ages and gender of patients, different belief systems, cultures and traditions of patients and/or their families, clinic expectations, community expectations, inter-professional

expectations and unique root causes of 'similar' medically diagnosed illnesses. I am also able to switch through different physical clinic settings for service, including urban health clinics, home settings, hospice, rural clinics, community gatherings, serving indoors or outdoors. Hospitals in Canada have been a challenge; however, I have been warmly accepted in international hospitals that recognize traditional Indigenous Medicine. All experience helps me develop the skill and proficiency to hold true to my multi-cultural integrity, ethics and responsibilities.

Sacred Space – Physical and Spiritual Environment

Within a Western, Eurocentric, linear perspective, a safe space is primarily considered physical. In the past few decades, there has been recognition that this extends to the mental and emotional realms. Within the multiple Indigenous teachings I walk with, safe space is sacred space, and is considered in all internal and external aspects of one's being. Meaning, sacred space must be created and maintained across body, mind, spirit and emotion (BMSE) in physical, social, environmental, financial and energetic realities.

Different therapeutic and medical modalities have regulating bodies that dictate conduct and protocol for practitioners, including ethical considerations. As countries become more aware of cultural competency and abusive situations, measures are also being put in place in some clinics and hospitals to ensure that all patients, practitioners and staff are in a safe environment, often described as patient-centered or family-centered care. Sometimes, over-regulation can lead to a feeling of adjudication and stressful interactions. Many complementary and alternative therapies and modalities lack regulatory bodies. Sometimes ethics teachings are included, sometimes not. Our fast-paced, quick-fix, bio-hack coaching programs are growing in popularity, as a general acceptance of speed learning occurs. I am often reminded of the process of mastery, and how it perfectly aligns with what science is discovering about neuroplasticity. CEUs are beneficial for promoting ongoing learning in a culture that struggles with its value. And, challenges can arise when complex topics are being taught in a shortened timeframe, limit relational ability, or practitioners are not fully aware of the ethical responsibility of informed consent, making patients aware of their new skills. Regulation and continuing education, ideally, can facilitate growth, evolution and sacred space at all levels for individuals.

Sacred space is also important in relation to the physical space. Within all my Indigenous Medicine traditions, there are processes for the creation and maintenance of appropriate physical healing spaces, including appropriate energy in healing spaces. This is adhered to, independent of the type of space I am in. There are times in hospitals, in contemporary clinic settings, in 'closed air buildings', where it is challenging to express traditional healing tools and rituals. I must then adapt to the environment, create ways where the energy can move, as it would move if I were using the same tools directly. As an Indigenous Medicine practitioner, it is not my

place to restrict what is necessary and needed for someone's benefit. Rather, I must adapt and provide the best of the best service to the best outcome for the individual. Approaching each session with a patient as a sacred and solemn act, filled with honor and respect, is a way to maintain sacred space at all levels. Ensuring both the physical space and the spiritual or energetic space is cleaned, physically and energetically, between patients creates a safe, sacred space for the next patient. At a biomedical level, this includes following best practice public health standards.

If, for any reason, I am not able to create and sustain a sacred space for those I serve, then I must, on direction of the Ancestors, remove myself from service. This may mean taking time off if I need restoration. Or, it may mean leaving the office space I am in and finding a new space, or adapting a space to my needs. Thus, physical and spiritual considerations are always being negotiated to create, maintain and sustain sacred space.

Weaving Sacred Protocols – navigating multiple Indigenous Ethics

I sit in prayer for many hours every few weeks, weaving 3 different prayers into my braids. It requires a whole week, several hours a night, to braid all the braids extending from my scalp. As I do this, I am reminded that each individual strand is stronger when woven with the others. Being multicultural, in order to acknowledge all aspects of myself, I have had to create inclusive individual rituals translating to daily habits, and inclusive ceremonial practices—assisting my balance and development, marking significant life events, transitions, or passages. This assists me in being my authentic self while maintaining authenticity to my full lineage. Through this, I continually create a new perspective on self, along with stable processes and protocols that are well practiced, a way of living. The repetition and practice allow for full adaptability.

Having to weave multiple ways of knowing, at first, required an un-learning (like unravelling a braid) – I needed to remove the shackles of conditioning that bound my unconscious and conscious mind. To be comfortable in myself, in the way I saw and experienced the world, in the current state of human depravity and the true state of human potential, it was instrumental for me to understand multiple perspectives, to carry multiple sets of responsibilities, to stay true to my spiralist Indigenous style of thought. The universal teachings are my foundation. As life continues, my comprehension and ability to act with universal teachings continue to expand. I am able to maintain a balance between my Indigenous Medicine teachings and all other practices.

With learning new ways and integrating the best of all ways, I am able to witness a single point, a line between two points, a relation to all interconnectedness, within and around. The mastery I was directed to attain in my Indigenous teachings carried over as a way of being to all scientific training, often to the dismay of others. Despite their responses, I continue to apply what I know to any new learning and situations. When I bring my medicines to people in a clinical setting, I am the tightly woven braid of many complex strands, living the ethics and integrity

of my Ancestors. I bring all I am, then outwardly express that which is needed in that moment for their unique nature to flourish.

Healer, Healing - Healing Historical Divisions

> *The cosmology I live with includes the understanding that all life is living, sentient and able to communicate with one another. Humans, being the youngest kingdom of the Earth, are still in the process of learning and living this reality. They are currently the only kingdom which systematically destroys themselves, all other life and the Earth they live upon which provides, nourishes and sustains them.*

We do not have to look far to see this as a truth. Western linear thought is endemic with short-term thinking, exclusion, cultural and hierarchical bias. This has maintained divisions in all aspects of life for millennia, being reflected in the internal divisions many humans experience. This creates a lack of balance in the individual and the world. The Indigenous thought I live with is inclusive, including long-term thinking, with the concept of the many generations before, the current time, and the many generations that follow. For me, this is an ideology based on the concept of *creating, maintaining and sustaining balance, necessary for sustaining life*.

The word heal derives from a 13th-century usage meaning the restoration of wholeness. When the human body and human being are in wholeness, it is a dynamic, interconnected unit of being at all levels, fully resilient, in its abilities to regulate, adapt and rebalance itself. Thus, the colloquial use of the word healer, is in relation to someone who assists with the rebalance. Healing, fundamental to Indigenous Medicine traditions and all world healthcare traditions, is an individual act of rebalance in a dynamically integrated world, affecting the rebalance of the world. Once again, emphasizing that the individual and the world are not separate from one another. As I enact my ability to create, restore, maintain and sustain balance within myself, I am better able to enact my ability to assist others to create, restore, maintain and sustain balance within themselves. Each individual act of balance serves to balance the larger web of life we all exist in.

In this way, historical divisions humans have experienced within themselves, between them and their kind, between them and other living beings of Earth, between them and their relation with Earth, between them and their relation with universal realities, also return to balance, restoring wholeness to all. When I act on this in my walk of life, I make the way easier for all those who come along, having already blazed a trail.

Sacred Relations – Trust, Relationship, Co-Creative Partnerships

When speaking about sacred relations, I am using the word sacred in its older meaning, the sense of being entitled to respect or reverence. Given the understanding that all is alive and interconnected, the consequent step is that

all that is alive is worthy of respect. This is the foundation of sacred relations within my life and within my clinical practice.

I arrive at practice with the understanding that I do not heal or cure anyone. Rather, I have some training and skills, translating to current-day expertise, which allows me to be a guide and share the wisdom I have gained with others. I facilitate my patients to activate their internal ability to self-heal.

Trust, relationship and co-creative partnership are instrumental within the Indigenous Medicine paradigm I walk with. They first begin within the practitioner–trust, relation and co-creation with one's teachers, mentors, Ancestors, Elders and Ancient Ones. Also, trust, relation and co-creation with respect to all aspects of self is fundamental. As proficiency is demonstrated at these two levels, then and only then, the practitioner can begin their journey with serving others—exercising relation and trust with those they serve, knowing the healing (rebalance) process is a co-creative endeavor.

Building sacred relation requires process, time and relating to a person as a whole being (internal and external). Sacred relation is challenging to create in 5 to 15-minute sessions addressing one issue only, being told to book a second appointment for another issue, a common linear medical and therapeutic perspective. If wanting to treat root causes in place of symptoms, sessions need be inclusive of reality. Relationship building is a foundation to a successful outcome. Thus, in the process of co-creation, the individual builds a better relationship with all aspects of their self. Sacred relation, as a universal principle, exists on all levels, replicating the true functional integrated universal reality. In relation to all, I recognize it is an honor and a privilege to serve.

Conclusion

Throughout this research, I found myself constantly translating between different Indigenous worldviews, each carrying similarities in universal principles and distinct cultural protocols for Indigenous Medicine practice. I also found myself constantly translating between Indigenous (spiralist) thought, Western Indigenous research and Indigenous research written by Indigenous people, Western scientific linear thought and protocols, quantum reality and an integrative discourse. I held true to all questions within the theoretical framework, ensuring they were answered in narrative, teachings and discourse. All emergent themes also align with the WHO Global Traditional Medicine Strategy (2025-2034) objectives.

In my quest for self-identity, bringing the universal principles of the Ancestor's teachings into action in my daily life, living up to the task placed in me upon my return to this world, re-establishing my practice after my spiritual sabbatical,and returning to research and sharing information outside a clinical practice, I anchor in my multicultural ways. The multifocal reality I am is the bridge, which affords me to interact respectfully, with honor, in different Indigenous communities with different physical and spiritual world Indigenous Elders. This reality is a bridge

that affords me to interact respectfully, with honor for a variety of patients – men and women, non-gender individuals – with age, culture, religion, personal life choice and tradition variance. This reality allows me to share a unique lifetime experience, from claiming one's identity to living one's true nature. In sharing there is hope, that we, as humane humans, might learn from each other so we may enhance one another, enhance healthcare for all and in the process enhance clinical integration programs.

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This article may be cited as:
Löytömäki, Sandi. 2026. "Bridging Worldviews: Integrating Indigenous Medicine in a Clinical Practice." *Fourth World Journal* 25 (2): 01–23.

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