Indian Health Service modernizes medical care on reservations

George Bock, MD, won the 1971 Fried Bread Making Contest at the 25th Annual Navajo Tribal Fair. Ordinarily, MEDICAL NEWS does not report sports results of this sort, but this event has a unique medical significance. Dr. Bock is Navajo Area director of the Indian Health Service, and his performance in the fried bread competition neatly illustrates a number of points about his role.

Dr. Bock's part of the contest was in effect a pantomine public health lecture. Each contestant was provided with firewood, flour, baking powder, lard, salt, and the appropriate utensils—and running water was available. The other bread friers got to work with a minimum of fuss; Dr. Bock made an elaborate ritual of washing his hands after nearly every step of the process, practicing what he has long preached about kitchen cleanliness as a way to control disease.

He made his point and had the audience in stitches with his performance—while actually concocting some edible bread. But one old Navajo turned to his neighbor after Dr. Bock's tenth or twelfth wash-up and observed, "it's easy to see he didn't have to tote that water himself."

This, in miniature, is a statement of one of the major problems facing the Indian Health Service, the branch of the Public Health Service responsible for providing health care to the Indians who live on reservations. It is not enough to tell people to keep their hands and cooking tools clean; they know that and do the best they can. But if the well is three miles away. . . .

It is also fine to explain to a young mother that infant diarrhea is potentially fatal and needs prompt treatment. But she grew up with that knowledge, she's seen countless infants die; what she needs is a way to get to the clinic with her sick child—and her home may be 20 or 40 miles from the clinic. "Home," furthermore, may be a flimsy one-room shack; there is probably no running water, flush toilet, electricity, and her family income is probably among the lowest in the country.

Courtesy Indian Health Service

Against this dismal background, the Indian Health Service (IHS) has made some encouraging gains. The IHS was formed in 1955, taking over health responsibilities from the Bureau of Indian Affairs (BIA), which remains responsible for many other areas of Indian policy. The change has been generally popular. (BIA is a fighting acronym to many Indians, who say it stands for "Bossing Indians Around" or other uncomplimentary things). The key difference, according to IHS officials, is one of attitude: now Indians are encouraged to tell the physicians (non-Indian) what they want, rather than being told what they can have. At best, this results in cooperation.

(The IHS staff includes 3 of the 38 Indian physicians in the country—Lionel De Montigny, MD, a Chippewa assigned to the IHS headquarters in Rockville, Md, and two Navajos, Taylor McKenzie, MD, and Gerald L. Ignace, MD, at the hospital in Ship Rock, NM.)

Still, enormous problems remain, ranging from economic, environmental and cultural, to the purely medical.

Indians are often portrayed as being "caught between two cultures," and the statement is true as far as it goes. On the one hand, they desperately need the cash income provided by "Anglo" enter-

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The two articles in this issue of MEDICAL NEWS by associate editor Paul Sampson, who visited the Navajo Reservation and other places in the Southwest to gather information, describe Dr. Bock's role and work more fully. Three other articles about the health problems of Indians, dealing with the training of paramedical personnel for the reservations and the recruiting of Indian physicians, will appear in next week's issue.

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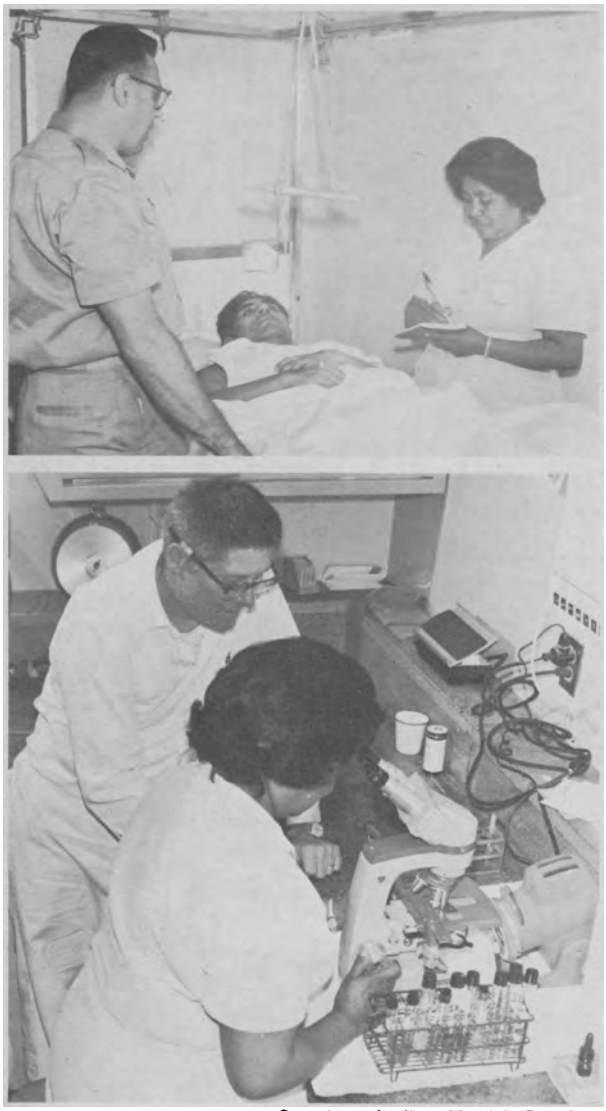

Courtesy Indian Health Service

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prises; but leaving the reservation for a wage-paying job is no small step. In general (and conditions vary from tribe to tribe), an Indian who moves away to earn wages takes two great risks: he disturbs the delicate fabric of traditional Indian family life in which adjacent clan-groups live cooperatively, and he may also risk losing his status as an "enrolled" Indian, entitled to the hard-won benefits that his tribe has secured by treaty and litigation with the federal government.

One answer, of course, is for Indians on the reservations to form their own companies that can pay competitive wages while producing goods that can be sold to the "outside" world. This goes far beyond the souvenir shop level. The Navajo, for instance, have had some success with the processing and sale of timber and finished lumber, and other tribes have similarly made money from leasing oil and mineral rights or other local resources. The tribe's profits go to "purchase" needed services—including education and health care to supplement what the government provides.

The building of Dr. Bock's office provides a good example of creative cooperation. The IHS personnel occupy one wing of a handsome new tribe-owned motel in Window Rock, Ariz. The tourist season is short, however, and without year-round income the motel would be a financial disaster—but the IHS office pays rent all year.

In this instance, the "cultural gap" was bridged. What happens when it isn't? Dr. Bock's answer includes a thumbnail analysis of what the IHS found when it inherited the program from the BIA in 1955:

"First of all there were only about six physicians on the whole reservation, which consists of some 25,000 square miles—larger than West Virginia, but with only about 130,000 people. Now we have 108 physicians in six hospitals, five health centers, and 18 health stations. The Navajos responded very well to the curative program, and I would guess that it was because they saw things happen—people got well as result of the 'magic' of medicine. We're talking about an era when we were first seeing the full effects of antibiotics and other chemotherapeutic agents. Patients would come in with severe pneumonia, which had been untreated previously or treated by their traditional medicine men with poor results—and they got well. So the practice spread of going to the 'Anglo' medicine man."

But IHS physicians also encountered some resistance. As far as the Navajo were concerned (and this is also true of many other Indians), the "Anglo" doctor could give only *symptomatic* relief—he had no effect on the *cause* of the disease, which could be discovered and cured only by a traditional healer. "In Navajo culture, religion and medicine are interrelated—there's no separation. The true traditional Navajo believes that any illness he encounters—physical, mental, emotional, social—is caused by some transgression by him or someone in his family, which results in a disharmony between him and the supernatural and their supernatural is a much more extended idea than ours," said Dr. Bock.

"The first thing he (the Navajo) would do was go to one of the lower echelon practitioners, the diagnostician. The diagnostician gets his abilities in some supernatural way, perhaps in a vision. They use a variety of techniques; one is hand trembling, in which the diagnostician's trembling hand passes over the body. When the hand stops trembling, he can identify the *cause*, and can tell the man what kind of sing is needed to cure the condition. The only one who can perform the sing

...and the old

is the highest level of practitioner. He's the true medicine man, or *hatathele*. Through apprenticeship to another singer, he has learned all the rituals, all the ways of curing certain kinds of illness.

"The first thing to remember about the medicine man is that he's a most intelligent man, and has learned a series of rituals that has been likened to memorizing a Wagnerian opera—not only all the dialogue, but all the music and the relations of all the players, and the *hatathele* can reiterate this. I've been to sings and they can go on for as much as nine days and nights. The interesting thing about it is that all during a sing, the other people there are telling the sick person that he's going to get well. The person himself feels deeply that he's going to get well. So in psychosomatic and psychological illnesses, there's a tremendous impact. The other thing is that there are many psychological components of even organic illnesses.

"There's another echelon in Navajo medicine—the herbalist. He can give certain herbs that produce symptomatic relief—the same as we do.

"So the usual sequence is that a sick person goes to the diagnostician, who tells him what kind of sing he needs. Well, it might not be the right time of year for that sing, so there's a waiting period. During that time the herbalist gives him symptomatic relief until the sing can take place.

"There's a tremendous relationship that can be developed between our medicine and the native medicine. In fact we allow medicine men to come into our hospitals to perform a sing, or patients to go home and have a sing as part of the therapy that we're giving them. We've also found that patients who need surgery and are very tense and anxious have a better preoperative and postoperative course if they can see the medicine man prior to surgery. In the last five years, in our mental health program, we have found our relationship with the medicine man very productive. We have some on our consulting staff, who are a great help with some of the complicated Navajo psychiatric problems."

Since the traditional Navajo family—matrilinear, extended, organized in clans—is quite different from that of white Americans, Dr. Bock was asked whether "Anglo" psychiatrists had difficulty with Indian patients. He told this story:

"Five years ago, when Robert Bergman, MD, came here from the University of Chicago as chief of our mental health program, he began by going back over records from our hospitals. At Tuba City, he came upon the chart of a relatively young woman who had been been diagnosed as a severe schizophrenic and had to be hospitalized repeatedly. Not much benefit had accrued (and this was typical of our results when Indians had to be hospitalized far from home). And there the record ended.

Aloysius First Sound, a medicine man on the Assiniboine-Sioux Reservation in Montana, performs a healing ritual. Some of the objects employed in similar rituals (Courtesy of the National Library of Medicine) were the Tlingit rattle from Alaska (right) and the Pomo medicine bag, which contains 12 small bags filled with roots, herbs, bones and other items used for healing.

"He asked around, and some of the Navajo people in the hospital knew her. They said she was fine—she was taking care of her children, taking care of the traditional chores in the life of a Navajo woman. This really intrigued him—what had happened?

"He got an expert interpreter and went out to visit the woman, and sure enough, she was functioning fine, no evidence of having any psychiatric problem at all. Then he *really* wondered, and asked her what had happened. She said she had seen a vary famous old medicine man who was well known for handling this kind of problem. So Bergman said, 'My God, I have to meet this fellow!' and he arranged to do so.

"This was about five years ago, when the medicine man was in his late 80's. His name is Large Whiskers. Dr. Bergman explained that he was a doctor of the mind, as he understood the old man was, and they exchanged some thoughts. During the course of the conversation (which was all through an interpreter), Large Whiskers asked Bergman, 'Doctor, when you were learning your

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Courtesy Indian Health Service

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medicine, did they ever tell you something that my grandfather taught me when I was apprenticed to him?' Bergman asked him what that was. He said, 'Well, my grandfather taught me that there were two minds in the body—one that we had control over, and one that we had no control over.' And then Bergman quickly calculated that the grandfather knew of the conscious and the subconscious before Freud ever wrote his thesis. . . .

"So Dr. Bergman was very impressed with the wealth of knowledge these men had about the emotional and psychiatric needs of their people. He's developed Indian mental health workers in his new program, and teaches them to collect excellent histories and also to give the kind of responsive therapy necessary, and to bring this to the psychiatrist, who could give them the kind of parameters to help with the problem. So at the present time we send practically no Navajo patients, even patients with severe psychiatric illness, off the reservation—they're being helped locally."

The interface of "Anglo" and Indian cultures also shows up in the way decisions are made.

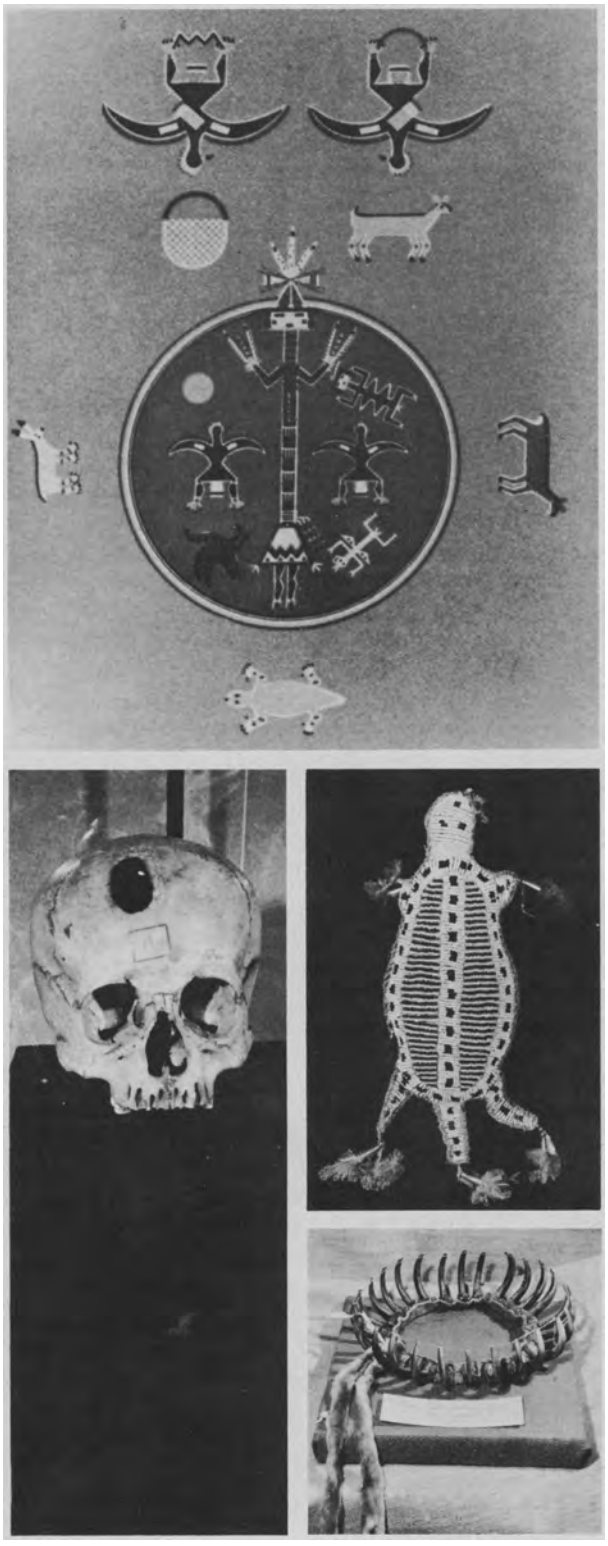
"A mother might bring a child to one of our clinics with a running ear (otitis media is a major problem among Indians). The physician says 'We have to treat the ear, and when it's finally stopped running and the infection is gone, the child will need surgery—a tympanoplasty. The mother might say, 'all right, treat my child,' but when the time comes for the surgery, she might say (if she's a truly traditional person), 'I have to discuss this with my mother or grandmother!'

"Now, if we understand the tradition, we'll say 'Fine, we'd love to have your mother come in and talk about it,' and then, through an interpreter, we can help the mother to understand the situation and make a good decision. But if the physician gets defensive and says 'Hell, I'm the doctor, I know what I'm doing—forget all that nonsense about asking your grandmother'—he loses that case. The same happens to the physician who regards medicine men as a bunch of witch doctors, who doesn't understand that we're not in competition with them—we work together, and he (the medicine man) ultimately gets anyone we see, even after surgery. A Navajo still has to take care of the cause, you see, so he goes back to the medicine men. In fact, some medicine men are now coming to us for symptomatic relief."

Dr. Bock went on to praise the young physicians who are entering the IHS these days, saying that they now are much more willing to accept the culture as they find it and work within it. Further, with increased Indian involvement in health services, more Indians are seeking medical help from IHS. There is also a beneficial spin-off from such programs as Head Start. Children who might have dropped from the sight of physicians until they started school are being seen a year or two earlier.

This creates a problem of its own, of course. The empirical successes of the IHS—in spite of the tremendous problems that remain—have created a demand for more service from facilities that were overtaxed when they were less popular.

Again, says Dr. Bock, the only solution is to let the Indians in on the decision-making. In one case, where the lines in the clinic grew too long, a change of hours helped. And then, the tribe needed a new nursing home for long-term care. No Navajo wanted to live in an "institutional" style building, so each patient room has irregularly shaped walls resembling those of the traditional *hogan,* and most of the rooms have four beds, because a Navajo would seldom be alone in his *hogan.* The door faces east, and there is no patient room in the northwest corner of the building, repeating the traditional pattern. Even the visitors' areas are broken up into small rooms that allow a family some privacy.



Progress report: some gains, but a lot remains to be done

Officials of the Indian Health Service are quick to point out the progress the agency has made since it took over the primary responsibility for treating Indians on federal reservations in 1955. Some improvements:

- Infant (up to 11 months of age) death rates dropped from 62.5 per thousand in 1955 to 32.2 per thousand live births in 1967, and the trend is continuing.
- Deaths caused by influenza and pneumonia declined from 89.8 to 53.5 per 100,000 in the same period.
- Deaths caused by tuberculosis declined from 55.1 to 16.3 per 100,000 population.
- Deaths resulting from gastroenteric disease declined from 36.0 to 14.5 per 100,000 population. The Indians' death rate due to cancer and heart disease has been slowly rising since the 1950s, but remains less than half of that of other Americans.

One reason for the improvement is a vast increase in services:

- The number of physicians assigned to the program increased from 125 to more than 400, the number of dentists rose from 40 to 129, and there are now more than 1,000 nurses, compared with 780.
- Hospital admissions soared, from 50,000 to

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Sand paintings (top) which were prepared by the medicine man for each healing ceremony, play an important part in traditional Navajo medicine and are still sometimes used today. Trephination (center, left) was practiced by Indians in the United States and Canada, as well as those of Peru, perhaps to decompress skull fractures —or possibly to release evil spirits causing pain. The Sioux used beaded charms (center, right) in some of their healing ceremonies, while the Tsimshian medicine man in British Columbia sometimes wore a headdress of grizzly bear claws. Courtesy National Library of Medicine.

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92,000 a year, and outpatient visits soared—from 455,000 to 17,786,920 a year.

• The percentage of Indian babies born in hospitals also increased from 88.2% to 98%.

Yet the morbidity and mortality rates in various disease categories remain "about 20 to 25 years behind those of the general population," according to the Public Health Service, and some diseases rarely seen elsewhere—like otitis media—are discouragingly common among Indians. Why?

Asking why further progress in Indian health is so difficult seems to be a chicken-and-egg question. At a meeting in the offices of Charles McCammon, MD, Phoenix (Ariz) Area director of Indian Health, several physicians and other health professionals explained the nature of the vicious cycle:

First, from the clinician's point of view, the problem is still the same as it was in 1955: crisis intervention care must come first. There are simply too many sick Indians to divert skilled health manpower from clinical medicine to community health projects.

But until there are massive gains in community health—everything from safer wells, improved waste disposal, better transportation, and insect control to health education—the clinicians will be swamped by the critically ill, and won't be able to help guide efforts to improve the conditions that created the medical problems in the first place.

Naturally, enough money might enable the IHS to cope with both problems at once. This year's budget is bigger than last year's, but it's not really new money. Instead, it's a reallocation of funds already authorized for various other Indian programs. In effect, Peter is being robbed to pay Paul, according to the people who will be spending the money, and the original problems remain.

At Dr. McCammon's meeting, MEDICAL NEWS was allowed to eavesdrop on a discussion that preceded the grim business at hand—splitting up the proposed budget. Some salient quotes, from both clinicians and community health officers (who asked not to be quoted by name):

"Indian health is a special problem because it's organized along racial rather than class lines—instead of being based on poverty, it's based on inheritance. This causes some problems in areas like mine where there are lots of poor groups, not just Indians. In some respects this promotes racism . . . IHS probably offers the best health care in the area, and we can't supply it to anyone but Indians except in acute emergencies . . . In my opinion, thest things should be organized along class lines, available to poor people in general. . . ."

"It's similar in my community—the IHS has the only community hospital, and I think this creates some resentment among all groups . . . I've had to turn away people I felt needed help . . . other poor people may have to drive 60 miles to be hospitalized. . . ."

"Yes, but in Fort Duchesne, Utah, we have a combined community hospital; we participated in

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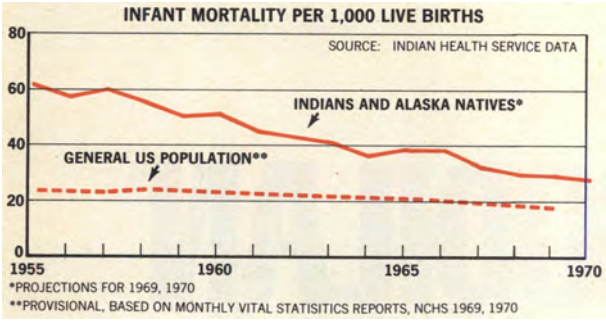
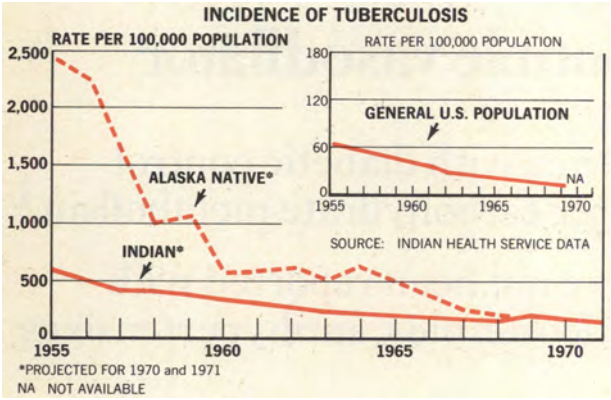
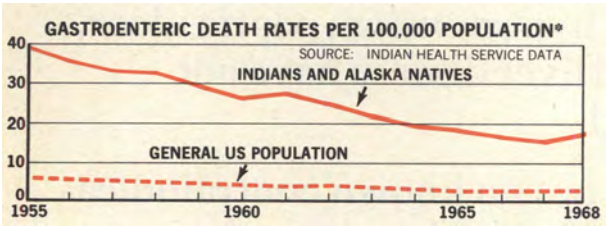
INCIDENCE OF LEADING NOTIFIABLE DISEASES PER 100,000 POPULATION (1968)

	INDIANS AND ALASKA NATIVES	GENERAL U.S. POPULATION
Otitis media	9,115.2	*
Gastroenteritis	6,031.2	*
Streptococcus infection	3,742.8	217.6
Pneumonia (except in newborn)	3,665.8	*
Influenza	3,318.7	*
Gonorrhea	912.5	232.4
Trachoma	871.0	*
Chickenpox	413.1	80.0**
Mumps	376.2	76.1
Dystentery (amebic and bacillary)	217.7	7.5
Hepatitis	174.0	25.3
Syphilis	158.0	48.1
Tuberculosis	145.0	21.3
Rubeola	79.0	11.1

*Not reported **Only 43 states reporting
Source: Indian Health Trends and Services, PHS publication No.2092







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financing the building. Part of the plant is a health center that we staff for the Indians, but local physicians are also on the staff . . . this is a unique setup where the area has a small number of Indians and more non-Indians."

"One unique problem is that of Indians perpetuating Indian culture while being assimilated into the maintream enough to survive decently . . . a lot of people believe the only hope is not to promote race nationalism but to make it possible for people to maintain their identity, yet be part of a whole and contribute to each other."

"People talk about national health care—the IHS can be a model. I think we give excellent care, free, in a large-scale setup in central hospitals with community participation . . . the care we deliver is better than what the general population—even the upper middle class—can afford."

"The program is a model from another standpoint, in that it tries to provide both curative and preventive care. . . ."

"One problem—and this is not a gripe—is the lack of continuity of care. The same might be true of any larger system. The Indians have a hard time seeing us as family physicians, with the result that those who can afford it (and some who can't) go over to town so they can feel they have a one-to-one relationship with a doctor for 20 years . . . this has to be faced in the future. An IHS doctor might want to stay on for 20 years as a general medical officer, but he can't . . . of course this is true of university settings too—they end up being teaching centers, referral centers, and the big hospital to which people come for primary care, and people feel they're being followed by an *entity* rather than a person. It can be argued that this provides better care, but people seem to want a family doctor. . . ."

"I must dissent from the idea that we're a model system. In my area we're still fighting acute problems like diarrheal diseases in infants, malnutrition, kwashiorkor, trachoma, TB—we haven't the time, staff, or money to do anything but keep our heads above water . . . We feel the problem is political; IHS is a government agency and distribution of funds is largely political—the tribe that screams the loudest gets the most."

"Granted we need preventive programs but money should still be oriented to acute care—when and if that problem is solved we can build a preventive program behind it."

"Yeah, we're jumping into the future while we're still being haunted by problems out of the past."

"We're at a plateau—we have to look at *tribal* programs in preventive medicine. They're funded by a lot of agencies, some of which aren't coordinated. . . ."

"Some of us feel that only by getting involved in community development can we get anything done."

The physicians and health officers were still having their say as Dr. McCammon started passing out pages of budget statistics. The room became silent. The young physicians—many of them recently out of training and working by themselves in Service Units at remote locations—started to mark the sheets, plotting how to get an extra nurse, an additional Community Health Representative, or even a second physician. As Dr. McCammon told MEDICAL NEWS: "One of our tasks is to take these young men and teach them to be managers. Inexperienced managers may make mistakes, but paradoxically they may be more creative and courageous than we; they haven't had time to beat their heads against the wall and become discouraged."