The Care of American Indian Children in North Carolina: Protecting Our Future and Our Heritage

Joseph T. Bell

Native American children face many different challenges when it comes to their health. They are predisposed to an increased rate of diseases such as diabetes and asthma. Traditional medicine is still practiced in many Native communities. As health care professionals, we must be culturally sensitive to their needs. One way to improve Native health care is to increase the number of Native physicians practicing in their communities.

Introduction

I have had the pleasure of working in Native communities for my entire 32-year career. That includes four years in the Indian Health Service in Oklahoma and 28 years in Pembroke, North Carolina. I presently serve as medical director and senior pediatrician at Children's Health Pembroke in my hometown of Pembroke, headquarters of the Lumbee Tribe. I have also worked as a contract pediatrician on the Catawba Reservation in Rock Hill, South Carolina, for the past 23 years. I am a member of the Association of American Indian Physicians and I serve on the Committee on Native Child Health for the American Academy of Pediatrics and the North Carolina American Indian Health Board. I have worked in Native communities from California to Alabama and many places in between.

Needless to say, I have become all too familiar with the many health challenges that affect Native children not only here in North Carolina, but across the country. According to the 2018 "North Carolina Health Equity Report" published by the North Carolina Department of Health and Human Services Office of Minority Health and Health Disparities, Native infants in our state are 70% more likely to die in their first year of life than non-Hispanic Whites, and Native children are 30% more likely to die before the age of 18 than their non-Hispanic White counterparts [1]. Nationally, Native youth have the highest rates of type 2 diabetes [2], a condition that has traditionally primarily affected adults. Rates of obesity, a strong risk factor for type 2 diabetes, are highest among American Indian youth compared to other racial/ethnic groups in the United States [3]. American Indian youth are 50% more likely to be diagnosed with asthma compared to non-Hispanic White youth [4]. Native children are more than twice as likely to be living in poverty in our state compared to non-Hispanic White children [5]. These sobering statistics are largely due to factors such as lack of access to quality health care, inadequate prenatal care, poverty, limited access to healthy foods and places to exercise, and other factors related to what are referred to as the social determinants of health.

Unfortunately, there are many other health conditions, like oral health and mental health issues, that affect Native children in our state for which data are not available to indicate how impactful these conditions are and what can be done to address them.

I have had my share of unique experiences during these past three decades working across the country. In Oklahoma, an 80-year-old Native elder came up to me and shook my hand and said, "Someone told me there was a Native doctor working here and I have never met one." I remember a middle-aged Native man in Oklahoma in our hospital with pneumonia who was asking for his traditional healer to be allowed to treat him. It was permitted, and I remember seeing the ceremonial smoke coming from his room. I had a mom who was treating her five-year-old son's asthma with traditional Spanish moss tell me he got worse when the specialist made her stop. I had a young man ask me once if he should use traditional medicine recommended for him by a traditional healer or the chemotherapy from Duke to treat his cancer.

This experience stays with me: I was taking care of a two-year-old Native patient in my hometown and we were struggling with an ongoing illness. At one visit, the concerned dad turned to me and said, "Dr. Bell, can we perform a smudging?" A smudging is a purification ceremony performed for generations by Native people to cleanse the body, mind, and spirit. Of course, I said yes. We stepped outside the back door of my clinic; he went to his car and got his bowl, traditional sage, and eagle feather. We stood close together as

Electronically published November 8, 2021.

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N C Med J. 2021;82(6):420-422.
0029-2559/2021/82613

he lit the sage and used the feather to wave the ceremonial smoke over me, its vapors ascending to the heavens. The whole experience only took five minutes and then we were back in the clinic working on his son. I was honored, not just to be part of this sacred ceremony, but that the family felt I would be open to their desire for me to participate in this traditional practice.

Many times, parents say they would prefer I recommend something natural for their child with ADHD instead of prescribing medications. In my clinic, we have used natural or herbal remedies for a variety of ailments, including colic, appetite suppression, reflux, and allergies. On occasion, a medical student who rotates with me will come back after seeing an infant and say, "Dr. Bell, I noticed that six-month-old child has a dime around its neck. What could that be for?" I will tell the student to follow me as we go back to speak to the mother. I say, "Mom, can you education this young student on why your baby has a dime around its neck?" Matter-of-factly, the mom will say, "To ward off teething pain." Of course, my next question is, "Does it work?" The answer is always, "Yes." (In Oklahoma, I saw mothers doing the same thing, except they used bone instead of metal).

As we step out of the room, this allows me the opportunity to talk about cultural sensitivity with the student. I remind them that we must practice medicine within the context and culture of the community in which we are working. I also remind them that traditional practices continue in communities across the country for two reasons. First, because it is an aspect of Native culture that enhances the creativity, productivity, and cooperation of the individuals in the community, and we are to respect that. And second, because it works! Traditional remedies are not passed on from generation to generation because they don't work. That would not make sense! They live on because they work.

The main reason we want to be culturally sensitive, especially in medicine, is so we can establish rapport. Rapport is critical to the trust that must be established to help us provide the very best care we can to our patients. I tell my students that if they cannot establish rapport, then they could memorize the *Nelson Textbook of Pediatrics* from front to back and still not be a great provider, because without trust and rapport, any patient education will go in one ear and out the other.

A Native friend who was a family physician in Seattle told me once that he was consulted on a 20-year-old Native woman who kept showing up in the emergency room with critically low blood sugars. Her regular physician just could not figure out why. The medical staff had worked her up for all types of causes of hypoglycemia, including insulin-producing tumors and other hormonal diseases, but had not found anything. My friend had the idea to bring in a traditional healer to talk to the woman. It did not take many visits before the truth came out. The woman was seeing her Western-trained physician, who was prescribing her an oral hypoglycemic medication for her diabetes, but she was also seeing her own traditional healer, who was recommending a natural hypoglycemic. She did not feel she could tell her provider that she was taking both. The lack of trust and rapport almost cost this patient her life!

One way we can improve the delivery of culturally sensitive care in Native communities is by educating and then recruiting more Native providers back to these communities. We can do this by working to increase the number of Native students going to medical school. At present, only 0.4% of all active physicians in the United States identify as Native American, and the percentage of Native Americans entering medical school is decreasing [6]. To help remedy this, there has recently been a collaboration between the Oklahoma School of Osteopathic Medicine and the Cherokee Nation of Oklahoma to set up a medical school whose main goal is to recruit and educate Native students who will go back to their communities of practice. In the first-year class, 22% were Native [6]. In March of this past year, the University of North Carolina School of Medicine and the Brody School of Medicine at ECU put on a joint virtual pre-admissions workshop for Native students in our state interested in going to medical school. These are efforts leading us in the right direction, and I hope they will bear fruit soon.

I must say that I am very proud of the Native providers who have served or are presently serving Native communities across Indian Country. We are fortunate in North Carolina that we already have a good number of Native providers, many of whom are practicing in their home communities. There are many in Family Medicine, but also in specialties like Pediatrics, OB/GYN, Surgery, Cardiology, Cardiothoracic Surgery, Emergency Medicine, Pulmonology, Psychiatry, Podiatry, and others. I just hope these numbers do not start diminishing.

I keep a portrait of Lakota Holy Man Sitting Bull hanging in my office. The words inscribed below read, "Let us put our minds together and see what kind of future we can make for our children." I am hopeful for the future of our Native children and look forward to seeing the next generation of Native providers who can provide culturally competent care in our communities. NCMJ

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Acknowledgments

Disclosure of interests. No interests were disclosed.

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The NCMJ is published bi-monthly by the North Carolina Institute of Medicine and The Duke Endowment. General business offices of the publisher are located at 630 Davis Dr, Ste 100, Morrisville, NC 27560. Co-Publishers: Kathleen Colville, MSPH, MSW, Morrisville, NC, and Rhett N. Mabry, MHA, Charlotte, NC. Editor in Chief: Peter J. Morris, MD, MPH, MDiv, Morrisville, NC. Managing Editor: Kaitlin Phillips, MS, Morrisville, NC. Owners: North Carolina Institute of Medicine, 630 Davis Dr, Ste 100, Morrisville, NC 27560, and The Duke Endowment, 800 E Morehead St, Charlotte, NC 28202. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of the total amount of bonds, mortgages, or other securities: None.

The average number of copies of each issue during the preceding 12 months are: a. Total number of copies printed: 2,646. b. Paid and/or requested circulation: 0. Paid/requested outside-county mail subscriptions stated on Form 3541: 2,191. 2. Paid in-county subscriptions: 0. 3. Sales through dealers and carriers, street vendors, counter sales, and other non-USPS paid distribution: 202. 4. Other classes mailed through the USPS: 0. c. Total paid and/or requested circulation: 2,393. d. Free distribution by mail. 0. Free outside-county copies: 0. 2. Free in-county copies: 0. 3. Free mailed at other classes through USPS: 0. 4. Free distribution outside the mail: 0. e. Total free distribution: 0. f. Total distribution: 2,393. g. Copies not distributed: 253. h. Total: 2,646. i. Percent paid: 100.

The actual number of copies of a single issue published nearest to the filing date (September/October 2021) are: a. Total number of copies printed: 2,757. b. Paid and/or requested circulation. 1. Paid/requested outside-county mail subscriptions stated on Form 3541: 2,171. 2. Paid in-county subscriptions: 0. 3. Sales through dealers and carriers, street vendors, counter sales, and other non-USPS paid distribution: 256. 4. Other classes mailed through the USPS: 0. c. Total paid and/or requested circulation: 2,427. d. Free distribution by mail. 0. Free outside-county copies: 0. 2. Free in-county copies: 0. 3. Free mailed at other classes through USPS: 0. 4. Free distribution outside the mail: 0. e. Total free distribution: 0. f. Total distribution: 2,427. g. Copies not distributed: 330. h. Total: 2,757. i. Percent paid: 100.

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