

Indian Health Service: Providing care to Native Americans and Alaska Natives

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In his *Bulletin* article “Rural surgical practice: A personal perspective” (2007;92(2):12-17), Tyler Hughes, MD, FACS, beautifully elucidates the challenges and joys of providing rural surgical services. My career with the Indian Health Service (IHS), which echoes much of what Dr. Hughes shares, gave me the added pleasure of experiencing a world that exists in the very heart of our own country but to most Americans is a completely unknown culture.

Above: The richness of the Indian Health Service experience. (Photos and collage courtesy of the author.)

The IHS is an agency of the U.S. Public Health Service (USPHS) that provides health care to American Indians and Alaska Natives. Many representatives of all sectors of our health care community—physicians, engineers, nurses, therapists, and pharmacists—have a common experience through their service with Indian Health. The IHS operates a comprehensive health care delivery system for approximately 1.8 million of the nation’s 3.3 million American Indians and Alaska Natives in 33 states, mainly in the western U.S. and Alaska. Facilities range in size from the smallest clinic, the Supai clinic in the bottom of the Grand Canyon, to three regional medical centers. One of these centers, the Alaska Native Medical Center in Anchorage, is the only level I trauma center in the State of Alaska.

Health care professionals are drawn to the IHS from a mixture of altruism; the adventure of visiting new regions of our country and the experience of native culture; and economics, as the IHS is an escape from the hassles of private sector health care. Some health care providers come to the IHS remembering stories about Geronimo and Sitting Bull, the pony express, Buffalo Bill Cody and his Wild West show, and General Custer. Most of the people who have worked for IHS are now aware of the other side of the story, such as the massacre at Wounded Knee and that as late as the 1950s, children were still taken from their families and placed in boarding schools, where they were punished for speaking their native language. Prejudice toward Native Americans still abounds in the communities surrounding reservations. All of this history is part of the picture that paints the Indian health experience.

Many providers become frustrated with the governmental bureaucracy, as well as with the funding restrictions that lead to issues with equipment and staffing. People tend to either burn out and leave or seek ways to work within and around the system, finding that the rewards of service exceed the frustrations encountered. I often reminded my staff that we were providing care to many people who would not otherwise have any access to care or any resources to obtain it. Many of our patients were “working poor,” whose employment did not provide health insurance.

The IHS has three major referral centers: the Alaska Native Medical Center, the Phoenix Indian Medical Center, and Gallup Indian Medical Center. Multiple smaller facilities exist throughout the U.S. and Alaska. The majority are located in the western states. Some are beautiful new hospitals, like the Crow Agency (MT) Hospital and the Fort Defiance (AZ) Hospital. The Supai facility mentioned previously is the smallest. This clinic has emergency evacuation available only during daylight hours when a helicopter can safely see to navigate its way into and out of the canyon.

Surgery services are available at 20 facilities in Oklahoma, New Mexico, Arizona, the upper plains states, and Alaska. Fifteen hospitals have full-time surgical services and five have contract surgeons who visit on a regular basis. One of the

most important factors in providing care at any of these facilities is maintaining an awareness of the capabilities of both the operating staff and the facility to handle any given case. Cases that exceed the capability of a given institution are either referred to a larger IHS facility or to a hospital in the private sector. In these communities 20 years ago, the IHS hospital was often the only facility available, but today there are many private-sector hospitals that have developed in nearby towns.

The joy of IHS surgery is the freedom to still be a general surgeon not only in the scope of operations performed but also in providing overall medical care. Within the capacity of each individual facility, an IHS worker cares for patients from neonates to elderly. There is no choice but to care for whomever comes through the door. There is always the necessity to determine whether to treat or to stabilize and transfer.

My surgical experience

In 1977, I accepted a commission in the USPHS. My career began at the Gallup Indian Medical Center, a 127-bed referral hospital serving the Navajo, Zuni, and Hopi tribes in northwestern New Mexico. I arrived at Gallup fresh out of residency and found diseases I thought were only part of my medical history books. These diseases certainly hadn't been part of my experiences in Pennsylvania or Massachusetts. A woman died of diphtheria. Patients were being treated for plague. We operated on people with echinococcal cysts. Presentations of peritoneal tuberculosis were not uncommon.

With a population of 200,000, the Navajos are the largest tribe in the U.S. The Navajo reservation, which is the home to the Navajo tribe, covers a land mass larger than the states of Massachusetts, Connecticut, and Rhode Island combined. Our patients frequently drove three or four hours to see us. In winter, they might be snowed in for days, either in their homes or with us, because there are no snow crews on the unpaved reservation roads. In the spring during mud season, they leave their homes in the early morning when the roads are frozen and can't return home until night when the roads freeze again. There are still areas of the reservation today that have no water or utilities. We often ad-

mitted patients for social reasons related to the distance they live from the facility or their lack of resources at home to care for themselves.

On my first night on call in Gallup, I was called to evaluate a young father who had pulled his truck off the road to avoid an oncoming drunk driver, who still managed to hit him head-on. The father had a grossly bloody peritoneal tap. When he crashed on me while I was waiting for the operating team to arrive, I had no choice but to explore him in the emergency department. He had a hepatic vein injury that I had no facility to repair and I lost him. We had no intensive care unit and minimal blood banking. The nearest big city with blood services was Albuquerque, NM, a 155-mile drive away. If a patient required mechanical ventilation, we kept him or her in a room near the nurse's station with our one ventilator. The only emergency transport available was ambulances.

The breadth and depth of my surgical experience was phenomenal. I became well-versed in biliary surgery. This was gallbladder country. Any surgeon who spends time in the IHS becomes an expert in biliary disease. Elective and acute presentations, empyemas, porcelain gallbladders, common duct stones, Mirrizzi's syndrome, and gallstone ileus were common. Sphincteroplasties and choledochoduodenostomies were our treatment of choice for patients with significant common duct disease. Pancreatic pseudocysts secondary to biliary disease or alcohol problems were common and responded very nicely to cystogastrostomy.

Gallup is in a goiter belt and we saw significant thyroid disease (see Figure 1, this page)—thyroids like I had never seen during my residency. Biliary and gastric cancers were our two most common neoplasms, followed by intestinal and breast malignancies. The majority of patients presented in advanced stages.

During my time in Gallup, I treated and cared for trauma and burn patients. I performed pulmonary resections and decortications for both disease and trauma. I repaired diaphragmatic hernias, some trauma related and some congenital. I operated on kidneys for trauma, cancer, stones, and infection.

When my career shifted to Phoenix, AZ, I gained major exposure to diabetes-related prob-



Figure 1. Patient with a massive multinodular goiter.

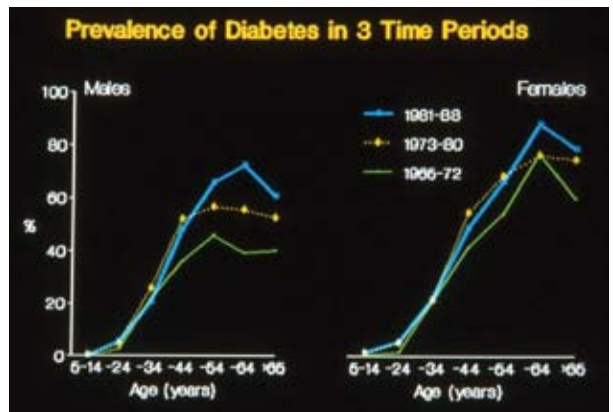


Figure 2. Diabetes prevalence in the Sacaton Indian community. (Source: Compiled from unpublished NIH data.)

lems. The National Institutes of Health (NIH), which runs a research ward on the fifth floor of the Phoenix Indian Medical Center, has been studying diabetes in the Sacaton Indian community for 40 years. NIH studies have shown an increasing prevalence of diabetes in each decade studied, with more than three-quarters of this population now developing diabetes by the time they reach 65 years of age (see Figure 2, this page).

We cared for the full gamut of diabetic foot disease—hammer toes, hallux valgus and rigidus, onchomycosis, neuropathies, calluses, and ulcers. Days, nights, and weekends were often

spent operating on people for osteomyelitis and infections resulting from ischemia and pressure-related injuries. One of the greatest blessings during my tenure in Phoenix was the development of a podiatry department. The aggressive, fastidious care of the podiatry staff actually helped to decrease the amputation rate. Our goal was and is to get patients to a state of wellness to be functional in whatever home situation they may live.

Yes, there were frustrations with equipment and staffing. The story was, and still is, that it doesn't matter who is in power in Washington. If the Democrats were in charge, our salaries, which were tied to the military, were flat but our operating and equipment budget would go up. If the Republicans were in power, our salaries would go up, but our budget, which was viewed as a social program, would be flat. We were always happy with a party change to keep us in balance.

The rewards of the system

The long-term providers in IHS find community and family throughout the system. As people move about the nation during their careers, the web of the IHS community is woven.

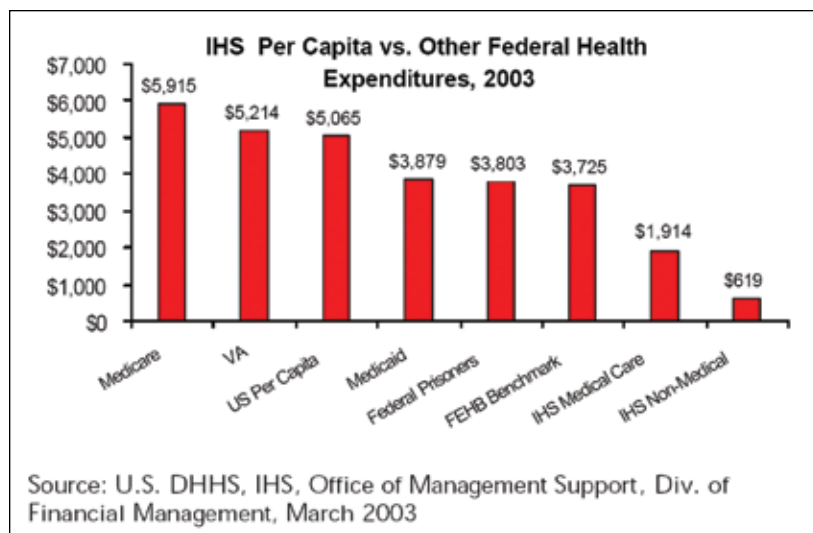


Figure 3: Per capita health care expenditures of the IHS

For providers who remain long term, no matter what facility they may visit, they find someone they know or someone who has a connection to them. A common bond develops—a bond of service, a bond of learning how to take advantage of how the system works or doesn't work.

And there is the joy of watching people grow and flourish, whether it may be coworkers, or medical schools students or residents. A full career allows one the opportunity to witness laboratory technicians and nursing assistants obtaining training to become successful clinicians and administrators. Many facilities have relationships with medical schools and residencies. The Phoenix Indian Medical Center was a founding member of what is now the Phoenix Integrated Surgical Residency. Many surgical residents who experienced surgical rotations at IHS facilities returned to become IHS surgeons.

Aside from the vast surgical exposure, the richness of the IHS experience is getting to know the people and learning their culture. Gallup afforded me the opportunity to experience the richness of the Navajo, Zuni, and Hopi cultures. The Phoenix facility serves 45 tribes in Arizona, Nevada, and Utah. I met the Native artists—the potters, weavers, painters, and carvers—in person and even

visited them in their homes. I experienced parades and festivals that are unique to Indian country. I experienced, as one of a handful of outsiders, the native dances and ceremonies that are for the people, not for the tourists. I attended rug auctions, smelled and tasted bread freshly baked from a horno, enjoyed the biliary stimulation of eating fry bread freshly cooked in hot oil, and smelled burning pinon wood on a cold winter night.

Our continuing challenges

Much remains to be accomplished in Indian country. The Native American mortality rate from tuberculosis is six times the national average. Motor vehicle accidents, deaths

resulting from accidental injury, and suicide plague the youth and young adults with a death rate almost three times the national average.

A great deal of what we do is based on our creativity and ingenuity in working in a system that provides one-half to one-third of the health care expenditure for our patients as it does for others (see Figure 3, page 15).^{*} Our challenges today relate to maintaining our infrastructure while continuing to provide quality care with budgets that squeeze resources and manpower in the face of growing tribal populations. Our federal appropriations are significantly affected by budget deficits and war expenditures.

Another continual struggle is patient compliance issues related to the socioeconomic barriers. This could relate to drug or alcohol issues for the patient or their caregiver. It could be transportation problems. It could be lack of adequate home facilities. We struggle with the ethical dilemma of allocating limited resources for transplant procedures or expensive medications versus programs to treat many such as alcohol rehabilitation or suicide prevention.

Listening to their wisdom

The joy of working with the Native Americans and Alaska Natives is coming to realize that they are vibrant peoples who adjust to what life brings them. We celebrate the wisdom of their relationship with the universe. They were and are in touch with Earth, with nature, with spirit. They were offering us guidance and warnings a century ago.

Chief Luther Standing Bear of the Lakota Sioux said, "The elders were wise. They knew that man's heart, away from nature, becomes hard; they knew that lack of respect for growing, living things, soon led to lack of respect for humans, too."[†]

Fools Crow, Ceremonial Chief of the Teton Sioux, said, "The survival of the world depends upon our sharing what we have and working

together. If we don't, the whole world will die. First the planet, and next the people."[†]

Our so-called advanced culture was not ready to hear them and we spent a century destroying Earth and one another. In the ecological crisis we have created, we need the wisdom of these leaders now more than ever. An ancient Indian proverb says, "Treat the earth well: It was not given to you by your parents, it was loaned to you by your children. We do not inherit the Earth from our ancestors, we borrow it from our children."[†] My joy in my years of service with Indian Health was the wealth of wisdom I received not only from my surgical peers and mentors, but also the richness of wisdom that is exemplified by these quotes. Ω

The opinions expressed in this paper are those of the author and do not necessarily reflect the views of the Indian Health Service.

^{*}National Congress of American Indians. 2005 Budget Recommendations. Available at: http://www.ncai.org/ncai/advocacy/otherissue/docs/2005_budget_recommendations.pdf. Accessed March 26, 2007.

[†]National Institute of Environmental Health Sciences Web site. Available at: <http://www.niehs.gov/kids/quotes/qtamind.htm>. Accessed April 24, 2007.

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