

Episode: Ethics Talk Podcast Transcript – Representation, Sovereignty, and Caring for Native American Patients

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Tim Hoff (Host): Welcome to Ethics Talk, the American Medical Association (AMA) Journal of Ethics podcast on ethics and health and health care. I'm your host, Tim Hoff.

The land that Chicago currently occupies, where many of us at the AMA live and work, is the traditional homelands of the Council of the Three Fires: the Odawa, the Ojibwe and the Potawatomi Nations. Our Washington, DC, office sits on ancestral lands of over a dozen tribes including the Anacostans and the Piscataway. With 574 federally recognized tribes in the US and hundreds more without formal recognition, the history of Native American dispossession undergirds every inch of the contemporary United States.

Yet representation of Native-Americans in many dimensions of US life, including the health professions, remains disproportionately low. In the 2019-2020 application year only 44 of 21 863 matriculants to US medical schools were Native-American. 2017 data from the Association of American Medical Colleges shows that the full-time faculty at MD-granting institutions had fewer than 0.1% American Indian/Alaskan-Native representation.

This gap is an effect of the chronic and continuing under-investment in Native American communities and a cause of inequity in health status and access to health services so pervasive for Native-Americans living in both rural and urban areas. This month's issue of the journal explores how clinicians can best care for Native-American patient and community health, and on this episode of the podcast we're joined by two experts to discuss Native representation in medicine, the historically entrenched and present day practices and policies that influence Native-American community's health, how tribal sovereignty operates to allow Native communities to protect the health status of their members and much, much more.

With us first is Dr Mary Owen, assistant professor in the department of Family Medicine and Biobehavioral Health and the director for the Center of American Indian and Minority Health at the University of Minnesota Medical School. Dr Owen is president-elect of the Association of American Indian Physicians.

Dr Owen, thank you so much for joining me today.

Mary Owen: Thank you.

HOFF: The University of Minnesota has seen an increase in Native American students. You mention in an interview late last year that there were 12 first-year Native-American medical students. For listeners who are unfamiliar with how dramatically American Indians and Native Americans are under-represented in the health professions, can you first help us understanding why efforts to increase representation are so important.

OWEN: Sure, first of all we actually got 13 we didn't realize one student had let us know about her status until afterwards. But also, let me give you a picture of how short we are. Every year we graduate about 20 000 physicians and only 40 of those are Native-American. It's quite stark. It's important because like all of us I think sometimes you take for granted if you are not a person of color walking into an office and seeing people who look like you, but we don't often get that experience. Especially if you are only graduating 40 out of 20 000 each year you can imagine how much more rare it is for Native people. But when you go and you don't have to explain everything, you don't feel like you necessarily have to explain everything is one issue. You suspect that people will have a better understanding of where you come from. Another is that standing in front of you is proof that you and the community that you come from can get to these higher level in education of western education and can accomplish the same tasks that western education gives so much merit to. And finally, there's a degree of trust that's implied by having another Native physician, or I should say, there's not that mistrust that might come from having a white person or a non-Native person serve you. The mistrust is there because of years of bad behavior on the part of the US government and institutions toward Native people. So when you get a person of color, particularly a Native person, you don't automatically have that level of concern.

HOFF: Rates of Native-Americans students in medical schools still lag far behind other racial and ethnic groups. For instance, 889 out of 91 000 total students for the 2017-2018 year were Native-American - that's less than one percent. But as you know obviously the goal is not just to get students into medical schools in the first place, but it's to keep them there and get them into the work force as well. So what should health profession schools be doing to make sure that the learning and social environments are welcoming, supporting, and nourishing for what Native-American students have to offer?

OWEN: We need to see some Native health curriculum. We need to see curriculum not just on Native health, right, but for any population, they need to see themselves and we need to see ourselves reflected in the curriculum. So for instance, when I was a medical student everybody thought it was great thing that a person was coming in to talk with us about type-1 diabetes. Well, that is cool, but I think it would've been more helpful if we had someone come in and talk about type-2 diabetes given the amount of - the number, much higher number, of people who have type-2. When students of color are taught about skin diseases, they inevitably see all white skin, right, except for a few cases. We need to see ourselves represented. Students of color want to see for instance their own skin color and what diseases look like, rashes look like on their skin as well. So we need to see ourselves in the curriculum.

We also need to see mentors that look like us. When I was a medical student, I had one - I met one Native physician in my school, and he was the director who recruited me. It took him taking my colleagues and myself to an Association American Indian Physicians' conference before I was finally able to see lots of other Native doctors. But we do need to see ourselves to know and to have mentors who can mentor us.

And then finally, we need a safe environment. Like it or not racism is still alive and well - or whether we admit or not, I think most people are finally admitting it - it's alive and well in all of our schools. And sometimes students of color, Black students, African-American students, Indigenous students need a place to go where they don't have to explain anything or they don't have to explain why something that just happened to them was wrong and how it hurt them. I don't know that all schools recognize that.

So we need to see ourselves represented in the curriculum our communities represented in the curriculum. We need to hear about how there are other factors that impact our health that are not always obvious to everybody, particularly to doctors, like those structural determinants like why we have the housing we do, why are we are not succeeding in school at the rates of other people, why are we in prison more often or in the penal system more often. All those factors. And we need to have people that can mentors us and provide a supportive environment as well as a safe space.

HOFF: So as the next president of the Association of American Indian Physicians, which goals do you plan to prioritize and promote and how can all health professionals and health profession educators help motivate these priorities?

OWEN: Thanks for that question, it's really important for us. One of the biggest issues that we face is invisibility. People just aren't aware of our health statistics, health disparities, so it's a priority for me to educate the general public, one, about our existence, and help address some of the stereotypes that are out there about us but also help us advance in our education and address some of these health disparities.

I think a way to do that would be getting as many of us who are able to out there talking about our issues and reminding people of our statistics. For instance, while most people are aware of the disproportionate impact of COVID-19 on African Americans and many are aware of, now, of the impact on the Navaho nation, there's still a significant amount of population who isn't aware of the disproportionate impact of COVID-19 on our communities, and why that's happening. So, one good way to do that or one possible way to do that would be develop somewhat of a speaker's bureau within the Association of American Indian Physicians. Those physicians how are able to would be able to go out to their communities and help spread the word about our health issues and the problems that our communities are facing. Another issue - and that's something that other communities, it doesn't have to be only Native people doing this work, you know anybody else who's out there who knows about these statistics can help us spread the word and make sure that we're always included - this whole intentional inclusion idea, that anytime you're talking about health statistics make sure that even though we are only 2% of the population that our data is still there and included.

The next issue that I would really like address, or that I would like to work on, is growing the community of people that support our patients. As physicians we know how much education, housing, and jobs impact the lives of our patients. We can see patients think of they are okay, and then have them come back within a month with some of the same issues because we haven't addressed the root problems. So, to do that I think as an association of American Indian physicians we need to also have alliances with for instance National Indian Education Association, with other health care providers, with dentists, physician assistants, nursing. There are not many of us so we have to do the opposite of conquer, or of division, we have to come together and support our community. And that's a natural process I think for most Native people anyway, we are community oriented not individually oriented. Reaching out to those other organizations I think will be key while I am president.

Finally, I don't know that many people are aware of the difficulty we have, or the low numbers that we have of representation in as physicians. I think you gave some statistics early on, but in 2017, let me give you another view of it, in 2017 the number of physician graduates who identified as Native-American alone was only 30, or 29 to be exact, out of about 20 000 total physician graduates. So imagine that, 30 out of 20 000. But to give you a better view of the issue let me go over some statistics from Minnesota and national statistics just to put this picture together. In 2017 - well, first of all Minnesota student enrollment is about 90 000 - about 2,070 in 2017 of those were Alaskan-Native and American Indian. High school graduation rate in 2017 was 52%, 52% of that 2070 is 1076. Of that 1076, 44% in 2017 enrolled in college. So now you're down to 474 students. On average 40% according to the national center for education statistics, about 40% of Native-American students, or college students graduate within six years with a bachelor's degree so that's down to 16%. About 15% of Native-American students get standard degrees so now you are already down to 27 or about 30 Native students with STEM degrees and you don't need a STEM degree to apply and to get into medical school but we know that most of the applicants matriculants do have stem degrees. So 30 in the entire state of Minnesota with STEM degrees who could possibly apply to medical school and of course we know that most of those do not. It tells you the degree of the problem that we have and how far back this goes.

We need to go all the way back to kindergarten with these pathways program to develop a cohort, several cohorts, of students who could apply to medical school, and not just medical school, we also need Native scientists in the biomedical sciences. There are not nearly enough of us, I think you could count on two hands the number of Native-American biomedical scientists out there. So really to bring attention to, one, our visibility and, two, the need that we have for these pathway programs to help our students overcome the barriers in school from kindergarten through medical school, but particular kindergarten through college, so that we have a significant number of students who can apply to these health profession programs to these research programs where we are so needed. And then obviously address the invisibility program and then to build this larger community of support for our patients and for our

communities by bridging to other organizations like the National Indian Education Association or tribal colleges, the national tribal colleges.

HOFF: Have you seen any efforts or indications among young either Native medical students or new physicians or perhaps people who are pre-med to... efforts to try to boast those numbers and what kind of advocacy and activism there is happening at that initial stage?

OWEN: Yeah I have seen some promising efforts. Of course it's selective right what I'm able to see and so I see the actions from our students. This past year in 2019-20 we had thirteen Native-American medical students. Let me just comment on that. That is such a great number for us . . . I think it's . . . a couple things are really important about that. One, that's thirteen students that aren't going elsewhere it's not like we increased the entire pool right. That's one. The other issue is, and I'm pretty sure if you look at those statistics I know I looked at them once and I don't think that there was a significant increase in the number of students everywhere for that year. The other issue is that or the other thing that's important to me is that the students that we selected here that I was really intent on our getting here are not just Native American on paper or not just . . . didn't just find out they're Native. We intentionally looked for those students who have been connected to their communities for a long time or are strongly . . . who are able to really demonstrate their connections to their communities somehow because we know those are the students who are more likely to develop the programs that you are talking about right now. The ones who are more likely to reach out to other Native youth to help pull them through the system, to mentor others, in the future to be those physicians who are connecting to the communities to support our Native patients, to be doing all of that work. Yes, we are starting to see that or at least I've seen that. I don't know if again if it's starting to see it, but, yes, I have seen that in our programs. We have two students who, one is a physician now and one is a fourth-year medical student, who created a program called "Rezzies in Medicine." I believe that's what it is called. It's a social media site to reach out to other Native students who might be interested in going into medicine and talking about their experiences. We have a program where we take Native medical students and STEM students down to the local high school where there's a larger number of Native students and African-American students as well to mentor there and tutor there. So we have programs like that and the more students I think that we get that are connected to their communities the more students we get who are going to be interested in doing that sort of work. That's a long answer to your question.

HOFF: Earlier this year the Cheyenne River and Oglala Sioux tribe established health and safety checkpoints for visitors to their reservation and obviously this was done to mitigate Coronavirus contagion risk for the entire tribe. This, to put it lightly, wasn't received well by the state of South Dakota, but tribal sovereignty is solidly established in federal law. Without getting too much into the specifics of this particular news story, what do you think health professionals and students should learn from it?

OWEN: I think this really points out how little people in this country understand from the history that they were taught in the US what the significance of tribal sovereignty. I doubt many people - in fact, I know because I teach medical students and residents - people don't know what tribal sovereignty is. They don't know that we are sovereign nations and that our laws supersede those of states. We are still subject to federal law, but the state of South Dakota had no right. And even though we're subject to federal law, we still have the right to govern and protect our communities, and that's what South Dakota was doing. So the best thing that health professionals and health students should learn is more about our history and more about our rights as a population. And then not only that but learn what rights we have to have health services and education, that's a trust responsibility that is based on treaties and the US Congress and Supreme Court rulings to have education and health care provided for us, so what's happening with the Navajo nation was a travesty.

HOFF: Despite having a right to health care via the Indian Health Service Native Americans' access to health care services and their overall health status in general illuminate clear health inequity. One reason for this is that the IHS like you said is woefully underfunded by the federal government. But another reason is that there are these legacies of colonial conquest and racism in the US that persists for Native America and many forms of transgenerational trauma including dispossession, food insecurity, poverty, among many other things. How should clinicians and health profession students respond now to these historical legacies that have situated the present day inequities?

OWEN: What I am teaching residents right now is to start to critically analyze the situation of each of the patients that they serve. So just like we come up with a differential diagnosis for hypertension. We need to apply that same sort of thought as to why our patients is coming and can't access medications, why they seem to have sub-standard housing, why they can't get to their appointments. We need to think outside the box. And then when we start doing that we're going to start looking at those structural inequities and how our histories contributed to those. We'll start to look at . . . look bordering schools caused generations of people not to know how to subsist - you know, follow our traditions - didn't teach them patenting skills that they really needed, so go figure that there are generations of people out there who have some dysfunction and can't teach the next generation proper skills right. I'm not saying that's the case for all Native people but certainly there is a large impact in our communities from those bordering schools and from these other forms of intergenerational trauma.

On top of that, those structural determinants have ended up with us living in areas that have food deserts and food insecurities and have resulted in us not having the same educational benefits and having less access to good jobs and therefore if you're in a job where you have less power you are less likely to be able to get out and go to your appointments take care of your health in the same way because you're trying to do just the bare minimum to survive for you and your family. There's all these different linkages that residents and physicians need to be aware of when they consider how to treat their patient for hypertension, diabetes, whatever the disease is, it's not just about the

medications, right? It's not just about the allergies to medications. It's "can this patient afford these medications," "can the patient access these medications," "can they access the follow-up for these," "if not what's in the way?" "Are their grandmothers getting taken care of so they don't have to miss appointments to go be with their grandmother" because communities are so important to Native people? It's "do they have daycare for their kids so they can get to those appointment?" It's all those factors.

Here's what I would like you to know though - is that we've existed on this north American continent and south American continents for 10 000 years, at least, and for all of that time we had our own health systems. But when Columbus came in 1492, and from then on for centuries, we had people trying to disassemble our health systems as well commit genocide against us. And so we essentially got our own ways of knowing our own way to take care of ourselves wiped out, and it's only been since 1975 when we started to own our own health care with sovereignty and the right to self-determination and taking over our own clinics that we started to turn this around. So it hasn't been very long it's only been about 50 years or so that we've started to run it ourselves. It's going to take a lot longer than that for us to get our feet back under us, but it's important to know that we are doing this and that any efforts for us have to be with us if they're going to succeed. We have to be in the driver's seat on all these issues that impact us, and I believe that's what is important for health professionals to know. Anybody who is trying to work and do good by our population, if you want to help us then get us in those leadership positions. If that means that you need to start funding pipeline programs down at kindergarten, then so be it. It's really the responsibility of the society I think to really take care of everybody. Miigwetch for listening.

HOFF: Dr. Owen is president-elect of the Association of American Indian Physicians. Dr. Owen thank you so much for joining us.

OWEN: Thank you

HOFF: Em Loerzel joins us next to discuss intimate partner and sexual violence and how tribal sovereignty influences the ways that Native communities are able to respond. Em Loerzel is a PhD student at the University of Washington where her work focuses on intimate partner and sexual violence in Native communities, sex trafficking of Native women, and integrating Indigenous ways of knowing into teaching and learning. Em, welcome and thank you for joining me.

Em Loerzel: Boozhoo, Tim, I really appreciate you having me on the podcast. I feel very honored that I can talk about some of these issues because I don't think we have good context for violence in Indian country and especially violence against Native -American women and femme-identifying folks. So, thank you.

HOFF: Absolutely. Your article in this month's issue of the journal which I encourage all of our listeners to go read explores sexual violence against Native-American and femme-identifying individuals. Can you first help our listeners understand the nature and scope of this violence in both rural and urban context and then next help our listeners

understand which strengths Native communities tend to draw upon when they craft responses?

LOERZEL: Yeah, I think that question of rural versus urban context is really important because a high percentage of Native-Americans individuals and communities actually live off of tribal lands. So it's important to know how urban communities have gotten there. So back in the 1950s through actually the 70s there's something called the Indian Relocation Act, and so that incentivized Native families and individuals to move from their rural communities and reservations into urban communities such as Seattle, Chicago, Minneapolis, and other areas. Unfortunately, as we've seen kind of throughout history, the US government failed to provide many of the promised resources such as access to education, job training, and housing, that was promised to individuals who relocated into urban communities. Now the motivating force for that was, if you have individuals who are no longer occupying their reservation communities, the government actually went in and took that land and dismantled many reservations during that period. So we had a lot of tribal communities lose their land and lose their federally recognized statuses. So that's actually when you see a lot of urban communities rally around the lack of resources and create things like American-American centers, urban Indian health services, and things like that.

In terms of rural communities, I think we have to think about a lot of lack of care access, so you know if you have one community, they might have to share another IHS which - I'm short-handing Indian Health Services facilities into IHS for this interview. You know they might have to drive two three hours to an IHS hospital and that IHS hospital may not have folks who are trained in taking sexual assault kits or providing just good and knowledgeable trauma-informed care to survivors of violence. There's also a legal implication for that too because a lot of times where you have Native folks residing in urban spaces, I think of my home community like Chicago, a lot of Native folks are deemed invisible because we don't have any federally recognized reservations or communities in the state of Illinois. So then that becomes how do we create culturally informed and sensitive legal services and resources for survivors of violence? And on the flipside for our rural communities, who's responsibility is it?

So in terms of understanding what strengths Native communities have to draw upon their responses: our Native communities are so amazingly strong and resourceful. You know we have managed to survive and thrive through 500 plus years of oppression and genocide, right? So that in itself I think is truly an amazing response and also we have so many grassroots community initiatives that are happening throughout the country to respond to violence in our communities where maybe we haven't been able to have outside support or resources come into communities. So you know I think this is a really hard topic to talk about, but I also really want to frame this interview, that, you know, I am just one person kind of doing this work, there's so many other amazing people amazing communities that are doing work with families and other individuals and communities that really focus on re-centering Indigenous ways of being and knowing in our relationships and relationalities in order to kind of decolonize those relationships

and to strengthen our communities to kind of push out settler and kind of colonized violence in our communities.

HOFF: When people on rural reservations experience violence how does local tribal law enforcement respond and how do law enforcement personnel - either local tribal law enforcement or surrounding state law enforcement - work with clinicians either on tribal land or beyond to try to help survivors of this violence?

LOERZEL: This is a really big question. I think we have to acknowledge that many survivors of violence do not want to go to law enforcement because either they feel that they're not taken seriously, they're afraid because they might face retaliation from the community for reporting violence. Unfortunately, and I think this is with really any community, we've seen that some people in power will abuse that power and will also abuse other people. So there could be serious ramifications for the survivor or either their family if they did report it or there might not even be the resource there to report. Another thing is fear of confidentiality. In tribal communities we often see . . . you might have a cousin or family member who is working at the local tribal office, right? Or it's a really small community so you feel that if you go and report this thing it's going to get out to the community – lack of confidentiality. So you know those are just kind of some barriers to reporting. In terms of local tribal law enforcement response we have some - and again this is a big question, and I can really only focus on a midwestern context where I'm familiar with tribal communities, and, you know, I don't want to monolith and collapse our whole you know 560 plus and that's only federally recognized communities you know that's not even including state and folks who are fighting for recognition, right? That becomes really nuanced. You know some tribal law enforcement they're very proactive and others they don't have the resources they don't have the funding to investigate or, you know, their hands are tied and they can't do anything. So It's tricky because you've had this gradient scale of law enforcement and specifically tribal law enforcement and how they interact with survivors.

In terms of clinicians interacting with law enforcement - I come from this from a social work point of view. So if you have something like a sexual assault response team, SART, as they are sometimes called, sometimes you do have this integrated care approach where if somebody goes and has a rape kit or has documentation of abuse and violence that they or their family has been facing often times you can see collaboration of law enforcement. Unfortunately when we are talking about folks who have to bring in the Feds, I believe only a third of assault cases are investigated by the federal government because often times you know there's different levels of prosecution that can happen on a tribal lands. Again I am not a lawyer I'm not a legal professional I'm a social worker and researcher, so it gets tricky because if you have states that are not public law to any states and the tribe has jurisdiction over their own lands, what happens is up through the major crimes act any sort of federal things like felonies of that sort have to be investigated by the federal government specifically the Bureau of Indian Affairs. And that's a whole backlog . That could take forever to have somebody come out and take a look at that case.

So it's hard because our work as clinicians and health care professionals, we're often focused on the patients, on our client. Sometimes we aren't able to see immediate action taken to protect and help survivors of violence because there's such a delay in prosecution. And I'm just going to reiterate the lack of resources that our IHS clinicians have to face and the lack of resources our tribal law enforcement have to face really do play a role in how we can care for survivors who come to us. You have folks who you know hear stories that their auntie, or their cousin, or their sister, or brother, or whoever, their relative went to go and report, and they were turned away or nothing happened. And that gets really discouraging, and that really you know misplaces . . . it just destroys the trust. Or they'll go to a health care professional and they're totally traumatized by the interaction because that health care professional might not be familiar with working with Native communities and that interaction can be, if you're not trauma-informed if you are not culturally humble in approaching folks who are outside of your community especially in terms of caring for them, that can be a very traumatizing interaction in itself.

HOFF: In your article, you talk about the Violence Against Women Reauthorization Act, and it addresses, among many other things that it does, a gap in policy that prevents tribal prosecution of violence perpetrated by non-Native people on Native people. Can you talk a little bit more on how this legislation augments tribal sovereignty?

LOERZEL: It's a double-edged sword. Because in one sense, tribal entities can finally . . . there's this 30-40 year gap where tribes could not prosecute non-Native parties, even if it happened on tribal grounds and even if it involved Native people in the context of, how they put it, dating and domestic violence. So it puts people at a risk because perpetrators of violence knew that they could get away with harming our communities. So it's this 40-year gap of this gray area where folks who go on tribal lands they can perpetrate violence and nothing usually would happen. So in one sense it goes give back a semblance of sovereignty because finally our courts are able to go in and prosecute non-Native parties who do perpetuate these things.

However, this comes with caveats meaning you actually have to have a tribal constitution that mimics the federal constitution - right to a trial, right to an impartial jury. So in terms of that sense what you are actually doing is forcing tribes to adopt colonizer and settler ways of governance. So that's why I say it's a double-edged sword because for in one sense it does augment tribal sovereignty because it finally allows us to protect folks, but in another sense, it forces us to kind of bring on colonizer code. So it's tricky . . . even, you know, I'm happy we have VAWA13, it needs a lot of work. It doesn't protect children, it doesn't protect survivors of human trafficking or sex trafficking, and another thing is the non-Native party has to have sufficient ties to the reservation, meaning they have to live or work on there. Now you know with sexual violence and domestic violence, in terms of sexual violence, what happens when that person is a stranger or acquaintance who might not have ties to the reservation? So it's a start. But it's a start that we need to keep pushing to make it more comprehensive and also to allow tribes to continue their ways of knowing and governance for that community.

HOFF: Have there been tribes who, I don't know really what the functional way that this would happen, but tribes that I guess don't opt into the Violence Against Women Reauthorization Act, and by that I mean don't adopted these principles into their own constitutions because they you know haven't wanted to change their way of governance, or has it been . . . how has the response to that particular issue been, generally?

LOERZEL: There's some tribes that don't even have constitutions.

HOFF: Right, that was going to be my next question.

LOERZEL: Right, so it gets tricky because if you don't have a constitution you know you can't enact VAWA13. And some tribes they just don't have the resources to you know put together legal council, not all tribes even have legal council, especially you know tribes who maybe that just got federal recognition and you know they might not even have access to health care. So again it's this gradient scale where we have some folks who, you know, their communities were the pilot communities for VAWA13 and then we have other groups who don't even have a constitution yet. So I don't think it's a matter of opting in or out for some and many communities. I think it's a matter of having the resources to even assemble a task force and a legal team to put together code and constitution that would allow for VAWA13 to be able to be enacted on that specific tribal land.

HOFF: Tribal sovereignty seems "relatively" - and they're pretty strong quotes around relatively here - straight forward in rural environments where Native-American communities can live exclusively on legally Native land. Obviously our discussion just now address some of the gaps in that. But how do tribes exercise their rights to protect the health of their members in urban environments where these environments are not so easily recognized as tribal, there's no federally recognized tribal land around perhaps even in the state, can you help our listeners understand how tribal sovereignty applies in health matters relating to tribe members that live in urban areas?

LOERZEL: Sure. It's very tricky it depends on the state you are in. I know folks from Chicago, who maybe they go up to Milwaukee to their IHS, and they get dental work done in Indiana. So if you have a car great, but if you don't you're at a loss. In terms of you know exercising and protect health, I think it starts with education. I mean obviously the people who are listening to this podcast and this interview, that's where they're starting, and I think that's absolutely wonderful. Sovereignty and the protection of sovereignty, I would argue, starts with the clinician and starts with cultural humility. I don't think we are going to get everything right in an interaction, but if we can even try, people are going to see that. So in just even recognizing that your interacting with somebody who is a tribal member or even, when I say tribal member I'm not focusing on blood quantum, I'm focusing on they have kinship and their community recognizes them as a member of the community and they recognize themselves as a part of that community. So I think it really has to start with the clinician because they might not be going to an IHS facility and sometimes you might be interacting with a non-Native

clinician at an IHS facility if you're a Native person. So again it just really really starts with the clinician.

HOFF: That's really I really like that idea of the clinician kind of manifesting respect for tribal sovereignty in their interaction with their patient regardless of sort of federal designation or, you know, legal status or anything like that just allowing this patient-clinician relationship to be an expression of their respect for the autonomy that this person has as an individual, as member of a Native community, as a member of this or that tribe.

LOERZEL: I think it's important to do that too because many people in the United States are guests here. I'm Ojibwe, but I'm in Seattle: I'm a guest on this land. Respecting people's autonomy and sovereignty especially if they're Indigenous to that region. It's so important because that's like the ultimate respect, right? And also in that interaction you can rebuild some of that trust that might have been lost from other interactions in the past.

HOFF: We were speaking a little bit earlier about the invisibility of some Native people especially when it comes to care in urban environments. Given that invisibility we might reasonably assume that there's even less visibility for Native-American victims of things like human trafficking or organ trafficking. What should we know about how trafficking effects Native-American communities and what strength Native-American communities draw on to respond to that particular issue?

Loerze: So trafficking in terms of Native communities, it's insidious and it's everywhere. There was a study done in Minnesota that found that . . . it was specifically looking at a Native-American-serving domestic violence organizations. Twenty five percent of people who came to them for services indicated that they would meet the state definition for human trafficking. So there's a huge overlap in violence and often times victims and survivors of, and I speak specifically on sex trafficking, won't recognize that they're being trafficked because their trafficker is somebody they identify as their boyfriend or a family member and things like that. So not everyone who gets trafficked will recognize that they are being trafficked. They might consider their boyfriend to be bad – I have a bad boyfriend – you know, he calls me names and hits me. That of course is a gross understatement of what happens to victims and survivors.

What we do know is rural communities, and urban communities too, but rural communities are very much at risk and a lot of it actually ties into exploitation of Indigenous lands. So we see an increase in women who go missing when we have things like oil lines being built in, mines, things like that. Because what's happening is you have a large amount of usually white men in their 20s, 30s, and 40s set-up camp, and traffickers know that these guys are in the middle of nowhere and they have a lot of money traffickers know they can target Native people and traffic them to those man camps. So I mean if you think about a community who - they struggle for things like food, shelter - it might start off as survival-sex or it might start off as, "I've gotten into a relationship with this person because you know they said that they'll pay my rent they

said that they'll help me get food," and it turns into trafficking. And that can happen in urban and rural communities. Trafficking, people think that you know they have to be pushed in a white van and moved from state to state, well that can happen, but people can also be trafficked out of their own homes.

HOFF: So in instances like that where it's sort of an outside influence coming into the community, what are ways that some communities have traditionally responded or what are current efforts to address that particular kind of trafficking?

LOERZEL: I'll will frame it in health care because we are talking for health care professionals. If you suspect abuse, and it might seem like maybe it's domestic violence, it could also be trafficking. And I think it's really, really important to start recognizing that. But a lot of people, if you straight-up call it trafficking or "Are you being trafficked," some people might not understand the implications of that or some people might get completely turned off. And some people might not want to expose their trafficker because they view them as their partner. There's fear the trafficker will hurt people that they love or even themselves. So that's one thing.

In terms of strengths, we have some many amazing people in our communities. I think of work that's going on in Wisconsin. There's folks who are assembling a task force around missing and murdered Indigenous women. It's Native-led and they're doing amazing work. I think of urban centers who are starting programs that are specifically meant and geared towards Native survivors of human trafficking. You know there is a response, and we have to be really loud because often times people don't think of trafficking in Native communities. But it's there, it's prevalent, it's invisible. And truly, as professionals who interact with people and families and who're responsible for their care, it's our duty to educate ourselves and watch for signs that this might be more than it appears to be at first glance.

HOFF: You do some interesting and important work on integrating Native-American ways of being and knowing into education. Can you talk a little bit how this can help mitigate health inequity and motivate Native-American health?

Loerze: Yeah, so, I think in terms of applying Indigenous ways of knowing into the classroom, it does a few things. First, it centers Indigenous ways of knowing in the curriculum where academia is very traditionally western. We can decolonize that syllabus and include more Native voices. And that might be the first expose that some of our non-Native students might have. The second thing it does is, if you have Native students in the classroom that is going to be such a powerful experience for them. What we know is, we don't have enough of Native-American health care providers. And a lot of people feel very, very alienated in academia because they may not have any Indigenous professors or classmates and that can really be isolating and that can really impact the health of our Native students. And it might discontinue their education and discourage their education. So mentorship of Native students by other Native teachers is huge. And that's one of the reasons why you know I decided to pursue a PhD not only to further my research skills but to show other Indigenous people that if you want to you

can, it's not easy but you can. And you know to be kind of a point of contact for connection. And that's the hope, right, is if we can create a community of success and welcome around our Native students, that's going to help them so much.

HOFF: Em, thank you so much for taking the time to share your expertise with us.

Loerze: Tim, thanks so much for having me.

HOFF: That's Em Loerzel, a PhD student at the University of Washington where her work focuses on intimate partner and sexual violence in Native communities, sex trafficking of Native women, and integrating Indigenous ways of knowing into teaching and learning. That's all for this month. Thanks to Dr. Mary Owen and Em Loerzel for joining us. Music was by the Blue Dot Sessions. Be sure to rate, review, and share this podcast and if you would like to learn about caring for Native-American patients, visit JournalofEthics.org to read our October issue. Follow us on [Twitter @journalofethics](https://twitter.com/journalofethics) for all of our latest news and updates. And we'll be back next month with an episode exploring risk management ethics. Talk to you then.