Benjamin Jacobs //

As a sophomore pre-medical student, I remember how excited I was to shadow a doctor for the first time. I set up a shadowing experience in the Intensive Care Unit (ICU) at my local hospital and was ready to see what a "day in the life" was like. I walked into an ICU room early that morning with a physician and a fourth-year medical student. In the room I saw a Native American man hooked up to a bunch of equipment with his wife by his side, holding his hand firmly.[*] I learned that the man was in a coma due to a brain bleed that stemmed from a major infection in his teeth. The physician told me this patient was from the Rosebud Indian Reservation in Rosebud, South Dakota, and that his condition was due to the poor dental care on the reservation. The wife turned to the physician and asked if she could burn sage and pray for her deathly ill husband. The physician was dismissive of her requests and told her that would not help her husband. This encounter went on for several minutes, and I could tell that everyone was uncomfortable, especially the medical student.

During lunch that day, I ate with the fourth-year medical student. I asked her about our encounter with the Native couple earlier that morning and asked her if she had ever seen a disagreement like that before. I was told that not only was this certainly not the first experience she'd had, but that she encounters it quite often. I continued and asked her about her training and if she was ever taught about Native peoples and their social and cultural values during her medical education. She said no.

American Indian and Alaska Native communities are perhaps the group that experiences the most health disparities in the United States. American Indians (AI) and Alaska Natives (AN) have a heightened mortality ratio of 1.3 deaths to every 1 death of all other US races (Indian Health Service, 2011). In addition, AI/AN are 6.6 times more likely to die of alcohol-induced deaths, 4.6 times more likely to die due to chronic liver disease and cirrhosis, and 3.2 times more likely to die due to uncontrolled diabetes compared to US populations of every other race (Indian Health Service, 2011). AI/AN born today have a life expectancy that is 5.5 years less than the US all-races population (73.0 years versus 78.5 years, respectively) (Indian Health Service, 2011).

With such overwhelming disparities, it is vital that future healthcare providers are not only aware of health inequalities, but are also actively working toward eliminating them in their community. This mission becomes increasingly important in my home state of South Dakota as it is home to the fourth highest population of American Indians and Alaska Natives by percentage in the United

States at 9.0% (United States Census, 2018). This 9.0% population of AI/AN makes up the largest minority population within the state.

My shadowing experience in the ICU opened my eyes to the differences between traditional Native approaches to heath and Western biomedical understanding of health. I was inspired by my encounters with the Native couple and the medical student to see if other medical students have had similar encounters in their training. I joined the honors program at my university and created a survey to be sent out to all medical students in South Dakota about their experiences with Native peoples and their unique health needs. After several drafts of the survey, approval from School of Medicine leadership, and IRB approval, my survey was distributed.

The survey consisted of 14 questions with 5-point Linkert scale, multiple-checkbox, and free answer question formats included. I was humbled to receive 103 responses from the 272 medical students in South Dakota (a 38% response rate). Data from Native medical students did not appear in the survey results because, while the survey was sent to all 272 medical students in South Dakota, there were no medical students in the state who identified as "Native American or Alaska Native" when asked about their race. Formal statistics about the availability or accessibility of Native providers in South Dakota have proved elusive.

In the survey I asked, "Have you ever observed barriers between traditional Native approaches to health and Western biomedical understandings of health?". This question was asked in a 5-point Linkert scale from [1] Never to [5] Very Often. The most frequently endorsed answers were [4] Often (33.3%) , [3] Somewhat Often (21.6%), and [5] Very Often (16.7%). Over 70% of medical students reported observing barriers at least "Somewhat Often" and 50% of medical students reported observing barriers at least "Often" or "Very Often".

Perhaps the most meaningful data collected from the survey came from the open-ended free response question: "If you have experienced barriers, in what ways have you experienced barriers between traditional Native approaches to health and Western biomedical understandings of health?".

Some of the most mentioned differences included differences in treatment, culture, communication, access to resources, finances, awareness, familial structure, and more. Several responses from medical students show a disconnect in vocabulary in talking about cultural differences in clinical settings (e.g., "health relics"). Physicians and student doctors should have more training in cultural sensitivity to foster shared vocabulary and foster working together with Native patients and their communities.

> ***First-Year Medical Student***: "*There is a lack of awareness regarding Native health and how to respectfully treat patients who don't have the same background*."
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> ***First-Year Medical Student***: "*Misunderstanding and miscommunication between a physician and NA patients, particularly in the discussion of treatments and background*."

> ***Third-Year Medical Student***: *"Societal customs between Native American and Caucasians (e.g., eye contact) can sometimes be a barrier to the physician-patient interaction."*
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> ***Fourth-Year Medical Student***: *"Their values and approach to medicine is such that they are reluctant to always accept treatment on first approach. This usually improves over time with the same provider, but that can change constantly with different providers at HS [health services] facilities, which can complicate continuity of care."*
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> ***Fourth-Year Medical Student***: *"There is a strong amount of distrust in some Native American patients towards Western medicine. Most providers seem to be tolerant of the differing of opinions between traditional vs. Western medicine, which I appreciate. I've seen patients in the ICU with sage (not burning, obviously) and other health relics being supported by providers."*

It is important to say that there is not just one perspective on health. Every group and every culture can have variances not only in how they classify health but also how they treat those with health conditions and ailments. My personal shadowing experience and the results of the survey demonstrate that there are differences in health perspectives between non-Native clinicians and their Native American patients and communities. Furthermore, differences in understanding of health are present among clinicians, as evident in the broad spectrum of responses to the survey. Different tribes, Native American populations, and individual patients similarly can differ in their understanding of health, as well.

To respond to these differences, medical students should be educated on how to acknowledge and appreciate those differences between their own understandings of health and wellness and those of their patients, regardless of background. Medical school curricula should include health disparity education so that the next generation of physicians are not only scientifically knowledgeable but also culturally sensitive and confident in building relationships, establishing trust, and treating those of all backgrounds fairly and equally.

As I go through my own medical education, I frequently remind myself that my mentors, colleagues, and patients may have differing understandings of what health is from my own. Medical intervention and treatment should always be a shared decision-making process. With this survey data I hope to propose integrating disparity education and cultural sensitivity training into all medical curricula.

[*] Identifying details have been changed to preserve the anonymity of the patient.

**Works Cited**

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**Author bio:** Benjamin Jacobs is a first-year MD student at Texas Christian University and UNT Health Science Center School of Medicine in Fort Worth, Texas. His research and interests are focused on Native American health and integrating cultural sensitivity curricula into medical schools.