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RK: Rohan Khazanchi, MPH

AC: Alec Calac, BS

VLC: Victor Lopez Carmen, MPH

SN: Sophie Neuner, MD, MPH

TS: Tom Sequist, MD, MPH

RK: 00:10	This is Rohan Khazanchi and welcome back to another episode of the Antiracism in Medicine Series of the Clinical Problem Solvers podcast. This episode is titled Our Land is Our Health: Confronting Anti-Indigenous Racism in Medicine. As always, our goal on this podcast is to equip our listeners, at all levels of training, with the consciousness and tools to practice antiracism in their health professions careers. I am excited to be joined today by my brothers, Victor Lopez-Carmen and Alec Calac, who are brand new members of our CPSolvers: Antiracism in Medicine team. We are just so excited to welcome them into the fold. And before we get started, I want to share a little bit about the intention behind this episode. Our series to-date has focused heavily on equipping our listeners with 1,000-foot toolkit to understand structural racism. But as we try to reimagine a more just and equitable healthcare system together, we have to hone in on how white supremacy operates in different ways to place specific minoritized groups at the margins. The movement for health equity and antiracism should leave no stone unturned, which is why some of our upcoming episodes will have a targeted focus on how particular minoritized communities are impacted by interpersonal, cultural and structural racism. November is Native American Heritage Month, but as Alec and Victor have reminded us, anti-Indigenous racism is not just a problem in November. It is pervasive, persistent and ubiquitous and harming our Indigenous communities. And we strongly believe that Indigenous peoples have been left out of antiracism conversations in healthcare. Our hope is that this conversation will motivate our listeners to learn more about the unique challenges faced by tribes in the United States. So with that framing in mind, let me introduce our fantastic hosts and new team members, Alec and Victor.
RK: 01:51	First, I'd like to introduce Alec, who is a medical student at the University of California San Diego, where he is also pursuing a PhD in the joint doctoral program in public health at the University of California San Diego's Herbert Wertheim School of Public Health and Human Longevity Science and the School of Public Health at San Diego State University. As the national president-elect of the Association of Native American Medical Students, Alec works tirelessly at the local, state and federal levels, identifying barriers and facilitators to greater inclusion of Native Americans in medicine and the allied health professions. He also works collaboratively with the Global Health Policy and Data Institute on research projects that synthesize public health, global health, social media and health technology. Victor Lopez-Carmen, also known as Waokiya Mani in his Dakota language, is an enrolled member of the Crow Creek Sioux Tribe and is also from the Yaqui Nation. He received his traditional name in baptism as a baby on

the Pascua Yaqui Reservation, attended traditional ceremonies every year of his life and remains an active member of his communities today. Currently, he is a third-year MD student at the Harvard Medical School. He also advocates for Indigenous health as elected co-chair of the UN Global Indigenous Youth Caucus, a research advisory board member at Ariadne Labs and a city-appointed member of Boston's COVID-19 Health Inequities Task Force. His research and writing focuses on adolescent mental health, human rights policy and Indigenous health delivery. And in his free time, he loves to write op-eds, salsa and Bachata dance, snowboard and hike. Alec, Victor, I'm so excited to have you guys here. Victor, you're coming to us from Scotland, attending the United Nations Conference right now. Alec, so glad you're here. So welcome to the pod. Please say hi to our listeners and please introduce our guests for this episode.

AC: 03:33 Well, thanks so much, Rohan. I can't really beat Scotland, but I do have sunny San Diego on my side. I'm going to start by introducing Dr. Tom Sequist, a family friend. Dr. Sequist is the chief patient experience and equity officer at Mass Gen Brigham, a practicing general internist at Brigham and Women's Hospital and a professor of medicine and professor of healthcare policy at Harvard Medical School. Dr. Sequist is a member of the Taos Pueblo Tribe in New Mexico and is committed to improving Native healthcare, serving as the director of the Four Directions Summer Research Program at Harvard Medical School and the medical director of the Brigham Women's Hospital Physician Outreach Program with the Indian Health Service. He is also particularly interested in health policy issues affecting Native American healthcare and has worked collaboratively with the IHS to evaluate the provision of care for this population.

VLC: 04:27 [non-English language] It's really great to be here with everyone. And Rohan, I just want to say I'm so impressed that you knew how to pronounce my Dakota name. [laughter]

RK: 04:39 I did my best. I appreciate it.

VLC: 04:43 That was amazing. I'd love to now introduce Dr. Sophie Neuner. She's an MD and an MPH. She's a proud member of the Karuk Tribe and a research associate at Johns Hopkins Center for American Indian Health. Dr. Neuner is passionate about promoting Indigenous women's health and well-being. She strives to address the needs of Native American women and families as an obstetrician, gynecologist and a public health practitioner, through approaches that are culturally congruent and honor Indigenous sovereignty. Dr. Neuner is also the director, producer and co-host of Indigenae, a community-grounded podcast dedicated to Indigenous woman's health.

AC: 05:28 So excited to have this conversation with all of you, from following afar to meeting everyone in person. Of course, we are a little bit distanced now with COVID-19, understandably, but to be able to have this conversation is so important. And I feel particularly in the advocacy space, Indigenous people represent about 6% of the global population, but over 15% of those in poverty. And when it comes to addressing their needs, we often get stuck on terminology and asking an Indigenous person, "What do I call you?" It surely can't be Indian or Native American. And I think Indigenous peoples have been and are still referred to, in many different ways, especially in the United States, Native American, American Indian, Indigenous, BIPOC and so many more terms. So when approaching your work in Indian country, Sophie and Tom, how do you think about defining terminology both for yourselves, your communities, as well as in academic spaces that aren't always welcome to Native people?

SN: 06:37

Thank you for the warm welcome [non-English language] Sophie Neuner. I'm a member of the Karuk Tribe. So that's a great question, Alec, and one that I get asked a lot. I'm sure Dr. Sequist does, as well as all of you. To me, I think the best terminology to use if you can and it applies to the situation is using folk's specific tribal affiliation. So there are almost 600 federally-recognized tribes in the United States and many others that are currently unrecognized. And all these tribes have their own distinct cultures, histories, languages. And to me, that diversity within Indian country is something so beautiful and so powerful. And yet it's often overlooked when we use blanket terms such as Native American and American Indians. For instance, in my community in Northern California, I will say I'm a Karuk person. And what I'm saying by that is I'm an upriver person because that is actually the direct translation of the word Karuk. So it's just my tribal affiliation can tell you a lot of who I am and where my ancestors come from. Especially in the north, we would say about someone, "Oh, she's Yurok. Oh this person's Hoopa and Karuk." And that's really how we talk about our community members. But then, of course, there are definitely contexts, especially when we get outside of local communities when we look in academia in which these blanket terms, such as Native American, Indigenous, American Indian, are really useful. So my personal preference is to use either Native or Indigenous, and I really like Indigenous because it doesn't have reference to colonial boundaries. So American Indian and Native American refer to Indigenous people living in the United States. Right? But there are lots of Indigenous people throughout Turtle Island, which is known as this continent, North America, but across the world as well. And Indigenous is a little bit more inclusive. In my community, we often use Native. Personally. I'm not a big fan of American Indian, but I will say that that term has specific legal context. So in academia, when we're writing papers, American Indian is often the official way to refer to an Indigenous person from the United States. I'd love to hear Dr. Sequist's thoughts on this.

TS: 09:09

Thanks again for having me here. And that was a really wonderful introduction. It's funny because I think the identification of Native people, we always have to remember that often we identify them based on this racial classification and we struggle with the words. But the words are so tied into the political and government history of this country in a way that many other races are not. And so you reference the use of the term American Indian, which can have some very specific implications around what we're talking about. I think it's a really complicated answer in terms of how we refer to the population as a whole. I would say, personally, it's interesting because it could be very regional. So growing up in New Mexico instead of the pueblos, it sort of run down the Rio Grande and Central New Mexico. I think the most common term was to refer to yourself and to others as Indian. But I recognize also that that's not odd to me growing up to say that I am Native American in New Mexico. I think it would have just felt awkward interpersonally. But I think it is the use of these different languages, it's changing over time. But I do encourage us to remember whether or not we're using words because we're trying to fit a political model or political use of the term or a legal use of the term versus a description of a people. I will give you an example to me that really stands out is my son who is applying to college now. If you apply to college, you click on the race field and it's labeled, I think, American Indian, Alaska Native because they're using the sort of OMB definition. But when you click on it, it's the only race when you click on it, you get a subset selection of options which say a member of a federally-recognized tribe, member of a state-recognized tribe. There was an option that actually took me a minute to figure out even what it meant. It said something along the lines of direct lineage or

something like that. Again, you sort of ask yourself, "Why are we asking these sub-setted questions of someone's identity? Certainly, we're not asking that for the cultural repercussions of how they identify. We must have a financial or a legal reason why we're asking that." And I think that's something that is often very unique to Native American populations and we sort of blur those uses of these terms. I'm not sure in many settings when you're applying to college or you're filling out any other application, why does it matter if you are a member of a federally-recognized tribe or a state-recognized tribe when you're identifying your heritage? It matters if you're a member of Congress and you're trying to allocate funds, but certainly it doesn't seem like it matters to an individual who's just telling you who they are as a person.

AC: 12:09 Now, that's so important, Dr. Sequist, because you get into the politics of recognition between federal recognition, state recognition, termination and understanding that most of the American public doesn't understand the American Indian health policy and how that has affected the health of our communities. I think even of my own tribal affiliation, a Pauma band of Luiseño Indians, that's-- Luiseño is Spanish and that reflects our encounters with the Spanish mission system and Father Junipero Serra, who in my mind certainly was no saint. And going back to who we are as a people, Payómkawichum people, we are people of the West and that underscores our relation to the people around us and what we now call Southern California. But if you use that in an application or even a data system, no one understands what that is. So it's interesting when admissions officers ask you to prove who you are, when that isn't really a burden shouldered by any other group in the country.

TS: 13:21 I think in our country, whether it's admissions offices or a variety of other spaces, where we ask race, for whatever reason, it's become reflexive when you identify as American Indian or Native American to ask this follow-up question of, "Are you tribally enrolled?" Right? And many times, if you were-- to be able to ask the folks who put those applications together, "Why are you asking that? What did you mean? What were you going to use that information for?" I think many people probably don't even understand why they're asking it other than they've seen it asked in other settings.

AC: 13:55 We have seen reports on social media in the recent weeks of Native medical school residency applicants who are being asked, "What is your blood quantum? How Indian are you?" And from a legal standpoint, we know asking about race, age, sex and national origin is illegal. But in this kind of gray area of kind of political status, it seems that people are often getting away with it. And you can imagine how harmful it is for trainees to be confronted with those questions when they're being interviewed for residency, and that's happening in the year 2021.

TS: 14:35 Well, you have to ask, Alec, why are they asking that. And I think sometimes-- I think many times people don't know why they're asking it. I think other times they don't realize the harm they're doing in asking that question. And you could say, "Do you have a CIB card? Or do you have a tribal enrollment card that has blood quantum on it?" So I have one of these cards, right, but my take on this is I don't know in the history of the world, not just America, has it ever worked out well for the group of people who are carrying around an ID card that says the amount of blood that they have that comes from a certain background heritage. I'm not sure that's ever been done to the benefit of that population [laughter] that is experiencing that. And so I just think that we, all of our institutions across the country, really need to think hard about why we are asking these questions and the harm you are doing when you're asking these questions.

VLC: 15:40

I feel like I'm learning so much, even as an Indigenous person who's already experienced some of this myself. Listening to all of you and your perspectives on terminology, blood quantum identification and I think it's so important-- and reflecting on my own experience internationally as well, it's been really interesting to hear how other Indigenous peoples around the world also identify, different Indigenous peoples in Australia and different Indigenous peoples in Canada, cross-border communities. For instance, if a political status, as Dr. Neuner said, identifies an Indigenous person within colonial boundaries, how do cross-border Indigenous peoples-- how do they approach that? And both of my tribes are cross-borders and I find that-- in the old days, our elders would introduce themselves by not just their nations, but by their Tiospayes or their clans. And that's happening less and less because I think that those introductions are less understood by the general population. So it's gotten to the point where withering down these introductions actually can lead to cultural loss, where people aren't understanding which clan they're coming from anymore. And I think that's important for you to understand those things. But going back to the international Indigenous people scene, it reminds me of the UN Declaration on the Rights of Indigenous Peoples. And that declaration, which is now endorsed by the US, explicitly states that Indigenous peoples have the right to health and education. And we know that we're not-- obviously not there yet, especially in medicine. And according to the American Medical Association, Indigenous peoples, Native Americans make up 3% of the US population, but only one half of 1% of physicians, only 9% of medical schools have more than four Native American students who identify as Native American alone, 43% have none. And Native Americans also make up one half of 1% of medical school faculty nationwide. So I want to ask this to you, Dr. Sequist, dould you speak to these issues around underrepresentation of Native Americans in medical education, medical academia? And what impact is this underrepresentation having on Indigenous health? What best practices have you seen? And what more needs to be done?

TS: 18:37

Well, I think that the notion of the importance of diversity and clinical teams, whether they be physicians, nurses, pharmacists, other members of the healthcare team, is critical regardless of whether we're talking about Native people or Black physicians or Latino physicians or anyone else. I think all of that is important. There's a ton of data, right, showing the importance of that diversity. I think as it relates to the American Indian population, there's a couple of things that I find pretty striking about the data. The one is that the sheer soft of-- the size of the disparity among the volume of trainees that we have that are that are Native. And by disparity, I mean relative to their representation in the population, how many are going on to becoming nurses and physicians and they're just dramatically underrepresented. How that reflects itself in Native health is that you-- for a substantial proportion of the population, the Native American population, that they are in more what would be considered remote communities. And in those communities, there is a dramatic shortage of clinicians, again physicians, nurses, pharmacists and others. And by dramatic, I mean 20, 30, 40 percent vacancy rates in these settings. What we know is that-- and there's a lot of reasons for that, right, that have to do with it's hard to recruit and retain clinicians to have to be in these environments when they're not from that community. There's things that relate to what are the-- because of the way that we have had institutional policies and national policies that have supported structural racism and created poverty around these communities, when you try to bring in people from outside the community to work as physicians and nurses, they also - not surprisingly, they and their families can't find economic opportunity - can't find educational opportunities

for their families, so they don't stay there, even if you do loan repayment or other programs. Right?

TS: 20:36

So there's this sort of kind of snowball effect on the inability to fill these vacancies. But what we do know is, if we say-- I don't have my fingertips on the most recent data, but let's say 0.1% of physicians in the country right now are American Indians. If you look at the Indian health service, right, like 15 to 20 percent of those physicians are American Indian. And so it's very clear, in my mind, that Native physicians are much more likely to go work in Native communities. And so it's super clear to me that one of the ways to build this shortage of clinicians in these communities is to start training more people who are from these communities because you can't have high quality care and good outcomes if there's no clinicians there to be able to provide care. So to me, there's a super direct line between the need for us to start training more and more Native physicians and the ability of the country to improve outcomes for tribal members.

VLC: 21:40

Thank you so much. That was an excellent summary of how representation ties in to our health. And going off of that, I think you could also say that culturally-sensitive healthcare would improve as well, if we see more Indigenous peoples who are from their communities going back and serving those communities.

TS: 22:02

That's like that snowball thing. But I would say, if you survey physicians, let's say, who work in the Indian health service, somewhere, I'm-- again, I'm blanking on-- I'm ashamed to say blanking on my own data, but I think it's somewhere in the range of 15% of clinical encounters are with a patient who doesn't speak English, right, speaks their Native language. You can't pick up the AT&T international translation line, right, which we often use right in a clinical setting if a Spanish interpreter is not available, or Mandarin interpreter. You can't pick that up and say, "Do you speak this dialect for this tribal community that I am with?" And so what then happen is like, "Who is the person that translates in that setting?" Well, the person who translates in that setting is the person most likely who can speak both English and the Native language. And who is that? The child. Right? And so then we end up with children translating things that they should never be translating around that the illness of their parent or grandparent. And so there is this-- again, the ability to have language concordant providers greatly increases when you train providers from that community, who are from that community.

VLC: 23:19

Yeah. Thanks for that. Alec has really taught me - and a lot of people - a lot about another issue that ties into academia as well. So I'll hand it over to Alec just continue to deepen this discussion.

AC: 23:34

Yeah. I think seeing how the Indian Health Service has this overreliance on training non-Indian healthcare professionals or at least attracting them as locum providers or through loan repayment, it's clear that we're relying on a workforce that is serving out a commitment on contract rather than a commitment to the people. And I look towards the people who are most likely to stay and help their own community and those are our own people. And that's why I'm so excited that, Dr. Neuner, you're here for this conversations. We are California Indian people. There are close to 200 tribes in California. You're up north, I'm down south, if you will. And I know as we really appreciate the impact that COVID-19 has had across Indian country, I think it's often been understated what the impact for California Indian country has been. And I know that you were involved and maybe still involved in the COVID-19 response efforts for your own tribe. What has that been like, especially thinking of infrastructure,

preparedness and really linking together different state or local state, federal entities, to really try and address this head on?

SN: 25:00

Yeah. Absolutely. That's a great question. It has looked possibly different here in my extremely, I would say, ultra remote area in rural Northern California than it has in other areas of the country. Well, to begin to answer your question, Alec, I do want to mention to our listeners that COVID-19 is not the first infectious disease threatening Indigenous lives, nor will it be a last. So I think that's important to bring up here because we've had the staggering inequity to infectious diseases really since the beginning of colonization, since settlers arrived on this land. And by and large, the conditions which affect this vulnerability remain today. And some of those are overcrowded living conditions. We've talked about lack of access to healthcare. We haven't really talked too much yet about food and water insecurity, but those are all things that are major social determinants of health and are really impacted and caused by colonialism. And we really see those issues in our communities today. For example, in my own area, I will say almost every Karuk household has multiple people with underlying health issues. And this risk is further compounded by the fact that our people tend to live in multigenerational homes. So in my area, over half of Native American households have a member with a child and over 60% of households have elders living in them. And that's a really beautiful thing. That's a really important thing for us, culturally. Our grandparents and great grandparents are typically deeply involved in child-caring activities and really revered in our culture, important for the intergenerational transmissions of songs and ceremony. And infection prevention measures that we've all had to take in this COVID-19 pandemic have often really heavily relied on separating extended family members, separating elders from children, which is something that is really deemed offensive to the Indian way of life. And then poverty is also an enormous factor. Almost half of the people in my area live below the federal poverty line and that really limits access to transportation and healthcare. Hospitals are over two hours away and driving this treacherous roads are bad. We have no cell phone service here and many, many households have no internet. Food insecurity I've mentioned before, but almost 92% of households in my area experienced some food insecurity.

SN: 27:38

So those are some of the things that we were dealing with while also confronted by a pandemic. And you can imagine all of these things are so deeply interconnected and intertwined. Now, let's take a step back and think, "Okay, how do we respond in a situation like this? How do we mount a tribal advisory board? How do we mount an intertribal COVID-19 response to this very complex pandemic?" Well, faced with the paucity of Indigenous people, of Native people who are educated in medicine and public health, that makes it extremely difficult, I think, across the nation. And this applies to all governments in all areas of leadership. We've seen an enormous political and social divide really perpetuated by social media, by misinformation and disinformation we've seen out there. And these things affect everyone, including people in leadership. So when you have leadership who doesn't necessarily fully believe or know how to execute based on the current science, then that's a problem, then that really sets you up for failure in the face of responding to a pandemic. Another issue is that the federal government - and I believe we'll talk about that more later - is obligated, constitutionally obligated, to provide aid and to provide healthcare services to our tribes and our communities. But often, the rules and regulations with regards to federal funding are so complex and manifold that accessing those services requires administrative capacities that many tribes do not have. And disproportionate

time is spent on preparing funds and basically overcoming administrative barriers. So I think those aspects that make the public health response really difficult.

SN: 29:37 In my own community, I saw how all of these factors can impact a pandemic response. But on top of that, I do want to say that our communities also have so many community strengths. So what I noted in our tribal public health responses that there were so many community members who really wanted to step up to the plate, who wanted to figure out, "How can we solve these issues in a way that feels good to us?" So one example is Tribal Leader [inaudible] who helped start a community garden. And with the Karuk incident command team, we figured out how to distribute food box systems to all of our tribal members. So I think there are also many examples of how tribes are really creatively trying to respond to that pandemic based on inherent community strengths.

AC: 30:37 Certainly, Dr Neuner. I think, as a doctoral student, I consider myself to have a bias in that. For many of us in Indian country, we see peoples who are living and resisting and still here rather than those in the media and non-Indian people who just see poverty and addiction and all these negative factors that were thrust onto our communities when we think about relocation, boarding schools, the mission system, for example. And I have a few quick followups before we turn back to you, Victor, to kind of talk about this context that you alluded to. First, if I remember correctly, was it your tribe in Northern California who was getting broadband for the first time ever, motivated by COVID-19?

SN: 31:29 Some areas I know have had the expansion of our broadband programs. We got broadband, I think, five years ago. So yeah, not a long time ago. I would say many households still don't have broadband. My parents don't have access to broadband, they can't get broadband because of technical difficulties, allegedly. So this is still a thing. Now, it's winter, we have power outages every week. And then the WiFi's up, no cell phone service. What are you going to do? So communication issues are definitely still a thing up here.

AC: 32:02 Definitely. And something that you brought up is just how inadequate the Indian health system is in responding to the pandemic. But also the previous administration, we saw defective PPE sent to tribes, we saw body bags instead of PPE sent up to our relatives in Seattle. And I know the Urban Indian Health Institute, led by Abigail Echo-Hawk, has brought attention to this idea or concept of data genocide. And that when you don't have data systems that properly capture race and ethnicity but also track American Indian health outcomes, how do you act on something when you don't have the data, first of all? And second, when you don't have access to it, because we saw tribes in California who were being denied their own data or being told you need a public health officer, yet we don't need that because we have the sovereignty to access that. Is that an issue that you've seen in California or elsewhere in the country?

SN: 33:10 Yes and no. I think, at least in my tribal community, it's almost more complex than that. We do have access to our own data, but we don't have people to collect that data. And you've alluded to some of the political issues that have made obtaining and tracking that data more difficult. And we've seen that in our tribal health administration systems as well. So sometimes it's that tribes don't have the capacity to track their own data as is, don't have the training, don't have the funding. So I think the issue is certainly very complex and I think looks different from region to region and from tribe to tribe specifically.

AC: 33:53 Yeah. I think, just on data and sometimes the data doesn't even make it back to the tribe to actually implement and to use for their own people. And that's happened a lot

of times throughout history. And just speaking to this, just the other day to get to Scotland, I take my COVID test and what do I see? No Native Americans on the race list. It's other. And that's a huge issue as well. We know we've seen that around the country. There's so much injustice around data that I think it also leads to a lot of mistrust in these systems as well. And that mistrust has deep roots, it's dignified mistrust in many instances. And Dr. Neuner, you mentioned colonization and there's so much injustice that has occurred towards Indigenous peoples since the beginning of colonization. And we know that our history doesn't start when colonization started. It goes way beyond that. But I want to ask to both of you, maybe starting with Dr. Sequist, what are some of the aspects of our history, whether it be the positive things or the aspects of colonization, the injustices, the policies, that you see are still impacting the health of Native Americans today?

TS: 35:33

There's a lot that we could certainly go over related to that. I mean, maybe I'll just like list off a bunch of them and we could have conversations about them. I think the active attempts in the 1800s to remove cultural identity have had long and lasting impacts on health among these communities. And it's really important to emphasize these were active attempts to remove folks' cultural identity through forced relocation and boarding school and prohibiting use of language and dance and other features of folks' or people's culture. There is also obviously forced relocation to parts of the country with limited resources, intentional policies to limit the development in these areas. Broadband is the latest incarnation of that. But you can start with clean water and electricity is still limited resources in many of these communities. So I think those decisions have had historic impact on health outcomes, but continue to have impacts. All of these things then bundle up and lead to poverty. Poverty then leads to its own set of health consequences, whether it be mental health related or other chronic medical illness related. And then I would say the active choice to continue to underfund the Indian Health Service. And when you underfunded the main agency that is to meet the needs of a large chunk-- not the entire population, but a large chunk of its population, you are making an active choice to limit access to care and to limit quality of care, which is going to worsen health outcomes. So that's sort of a-- that's a miniature list of a few of the, I think, high-level kind of important topics that have limited the health status of American Indians.

AC: 37:24

Yeah. I mean, I think we could probably go off on that list for a few weeks if we can extend the Zoom call here. When I think about our history and how it intersects with the interests of settlers and those with kind of commercial economic interests, I always think back to an act that no one really connects with Indian country, which is the Morrill Act of 1862, when the federal government donated, in quotes, "10.7 million" acres of land from across the country to states so that they could establish 52 land grant universities, and these being the University of California. Cornell, University of Arizona, Texas A&M, the list goes on. But the top line, thanks to remarkable work I will say from High Country News, is 52 universities receiving land from 245 tribes that they trace those connections from each individual acre and they found that those land allotments drove half a billion dollars in university endowments, while those universities maintain an aggregate enrollment of less than one half of 1% of American Indian and Alaskan Native students. So you see how our land was used and you see how we don't even have access to this kind of foundational system of higher education. So it's hard to even be in the position to address many of these issues if you can't even get in the room. And that's difficult. I mean, I think for Dr. Neuner in California, 32 different states got land from California for their universities. I mean, I

don't know if you have thoughts here, but what obligation should these universities have to California Indian people? What does that look like in policy and practice?

SN: 39:34

Thanks for that question, Alec. Yes, looking at the numbers, reading the article, learning about this is particularly jarring as a California Native person. But I think as an Indigenous person everywhere, because we're all too familiar with this history of land grab and also the fact that a lot of our institutions are just-- I mean, all of our federal institutions and academic institutions are still profiting from that today. So the question is like, "Okay, all right, we know that these institutions are still profiting off stolen land. What are they going to do about it?" And of course, I want to highlight that nothing rights the wrongs of having stolen land. But one could think that Indigenous sovereignty movements could be a priority for support for universities. One could think that universities could support tribal issues, especially privileging tribes whose lands they are occupying and tribes that they have either historic or ongoing research partnerships with. Universities could support tribes on climate issues, for example, or really build up capacity to engage in community-based participatory research practices that are respected and uplift tribal communities rather than being extracted. I think a big thing universities should do is provide free education to Native students. There is this huge educational gap for Native peoples and we've talked about it and it gets larger and larger with higher education. And there are so many barriers keeping it that way. So often, academic institutions are typically places where Indigenous peoples and students feel included. There are often financial barriers, there are educational barriers. And I think some universities, such as South Dakota State University, have figured out how to sort of right the wrongs by providing scholarships to Native students. So what South Dakota State University did was match the estimated income generated from the 160,000 acres taken from local tribes and that money was used to develop scholarships and programs aimed to support tribal members and for financing an American Indian student center. So I think those types of initiatives are steps universities can take towards restorative justice that move beyond a performative apology recitation of the land acknowledgment, etc. But Alec, I'd really love to hear your thoughts on this question. I know that you've done extensive research on this topic and have been a really strong advocate for reconciliation at the University of San Diego.

AC: 42:34

Yeah. It's interesting. It's a very loaded question. Right? It's how do you reconcile the expropriation of Indigenous land and educational inequity that exists for Native students. Because I think in academic medicine, you try and address the underrepresentation at that stage and then you hear deans and faculty members saying, "Well, it's a pipeline issue. It's a pipeline issue, like go back to K-12 and focus there." And you can have both. Right? You can focus on the medical school stage, but you can also focus on K-12. And when we look at pathways because-- pathways, not pipelines. That's certainly not a metaphor I like. Look at California, Native boys and girls are anywhere from five to 15 times more likely to be expelled and suspended right now, this year in California. So people are starting school, but we kick them out of school and we think about how that can exacerbate the health issues that we see in the adolescent population. And I think what I really took away from what you said, Dr. Neuner, is the land acknowledgment is the bare minimum. So the question is, "How do we go beyond the land acknowledgement?" And as Rohan might say, "How do you go beyond declarative advocacy?" So I think also kind of looping in, you, Dr. Sequist, as an early to mid-career physician, what would you say? I mean, how does academic medicine go beyond a land acknowledgement? How do we hold institutions more accountable? Because I look at the consequences of the underrepresentation of

Native trainees and see how comfortable residents, fellows, attendants are and using things like, "Let's have a pow-wow. There are too many Indians, not enough chiefs in the exam room," or, "This issue is low on the totem pole." So when you don't have our own people in these settings, it's often okay to say these things which are kind of subtly racist.

TS: 45:00 Yeah. I mean, I think that-- so I wasn't expecting that last turn of your comments, but I have a little collection of those phrases that I send out to people. I mean, there's individual advocacy. You can call people out, right, when they are-- and you should, when people use phrases like, "Off the reservation." And help people understand, "Do you know what that phrase means and where that came from, and who was actually off the reservation? And what did they do to Native people who were caught hunting off their reservation?" I think people don't understand the actual ideology of some of those phrases and what they mean. Some of them may depict violence like that and others are, you're sort of demeaning people's culture. Right? But again, I think what you're asking also is sort of more systemically. I mean, I think academic medicine, one of our biggest challenges with recruiting more, let's say, medical students in particular - if we just use one example of a trainee group - is that you-- I don't remember the exact data and maybe someone here on this call knows it, but let's say half of US medical schools don't have any Native students. I'm ballparking that. I don't know exactly what it is, but it's somewhere around there, more than half. Yeah. And it's some large chunk of the Native students in the country are at five medical schools across the country, right, like Oklahoma, New Mexico, Minnesota. So why is that important? It's important because you can never establish a foundational group of colleagues. And so you will-- what I've heard from Native students for the past 25 or 30 years is, "I can't survive the isolation that I feel when I go to these academic medical complexes." So even if you identify there's one other student at the school, how are you going to see that one other person? Right? And is that really enough for you to feel like you have a peer group? So what we have to be able to do is to be in an academic medical school. If you're going to try to increase the pathway of students to start successful careers as physicians, let's say, you have to take a much more proactive and aggressive approach to having these students feel like they are not isolated, that you are doing everything you can to support them, and that you are actually not providing a hostile environment to their culture. It's sort of like what you were getting at, Alec, with your last examples about smoke signals and totem poles and whatever other [crosstalk] expressions.

AC: 47:37 And it can be uncomfortable, especially as a trainee, to confront that language, acknowledging the inherent power dynamics that are in medicine. And I always think that it's hard to feel like you fit in if you're told to constantly shrink who you are or leave your culture at the door when you put on that white coat on the wards. And I thought back to something that you said very early on, which was you were having trouble remembering your own data and I laughed to myself because I feel like we often can't find the data that we want, so then we collected ourselves. And I did a survey with one of my Native medical school friends, and we surveyed about 40 Native medical students about the issues affecting them and their training. And about 20% of them said that distance from family and loss of culture were two factors affecting their successful advancement in medical school. And it's hard to kind of drag on if your school or at least the learning environment isn't culturally responsive to who you are as a person.

TS: 48:51 Agreed.

VLC: 48:51 Yeah, I agree with that, Alec.

TS: 48:52 I mean, I think that's the very specific issue with American Indian students going into college or medical school. You see that time and time again when you survey students, it's isolation, this feeling of isolation that I'm alone and I'm going down this road alone.

VLC: 49:10 Yeah. I just want to say a lot of Native American students coming from their communities or coming from urban places, there's culture everywhere. It's in the families, it's in the home. And I think a lot of people don't know that as Indigenous peoples, we have a right to not have to choose between our culture and education. And a lot of our elders have worked incredibly hard to make sure that we have this right, given the history of boarding schools. And from what I hear from both of you, is that medical schools doing more is not a donation. It's a responsibility, it's a reparation, it's restorative justice. And just this year as a medical student myself, I had birthright ceremonies and I had to go through a process to get the medical school to be able to recognize that these ceremonies, the culture, the language, the time I'm spending with my elders, is integral to my health. And not only that, it's a right. And I think it's important for the audience to sort of understand this connection, "Why is our culture, why is our language, why is that health for Indigenous peoples, why does that make us healthier?" And I think as Indigenous youth all around the world, you see a trajectory of the communities that are losing their languages often have higher suicide rates and mental health is a huge aspect of this. And maybe Dr. Neuner can speak to this, but what impacts-- in terms of language and culture, what impacts and what's the relationship between those two things with Indigenous mental health?

SN: 51:13 Yeah. Absolutely. I appreciate you bringing up-- that's a very complex but very important topic. And I think what's important for listeners to understand is that Native peoples were inherently connected to the land and our environment essentially. And that ties into language. Right? Like when you express-- I'm learning Karuk currently. I'm not a fluent Karuk speaker. I actually was raised in part in Germany. My father is German. So I actually experienced that separation from culture a lot growing up. And then throughout my medical training, as well as my public health training, that was just the case also. So I think now being back in my tribal community, I'm understanding more and more how Indigenous knowledge is, not just beneficial to my own mental health but how Indigenous knowledge is something that really can provide solutions to some of our most important and threatening problems of today, meaning climate change, for example, the lack of interpersonal connectedness. I'd like to provide an example to sort of really illustrate what I mean from my own tribal community. So our people are known as fire people and we have used cultural burning practices. So low level managed, low intensity burns to manage our landscape and manage our landscape not just because that helps promote better acorn harvests, not just because that promotes the growth of fibers that are culturally important, but because it protects our communities and our plant and animal relations from the effects of catastrophic wildfire.

SN: 53:02 When the US government took over our lands, those practices were burned and we've seen the US Forest Service practice this radical fire exclusion. And that, in addition to climate change, which, by the way, is also a cause of colonialism, is what contributes to these catastrophic wildfires that we're seeing in California today and throughout the whole Pacific Northwest. I mean, these wildfires are something that really, really harm people's health and well-being in many different ways. And more and more, western science is sort of catching up to Indigenous knowledge and understanding

that these prescribed burning practices are something that is actually very important, not just to the environment but to health, right, the health of our peoples. So I think examples like that can really show how Indigenous knowledge and Indigenous knowledge that is really explained through language, explained through our cultural practices, deeply interwoven with all of those things. It's something that is really important, not just for the survival and thrivance of Indigenous peoples, but people all across the country and the globe.

VLC: 54:23 Yes. Absolutely. Indigenous knowledge is good for Mother Earth, it's good for the Earth and that's good for everyone. And we know that 80% of the biodiversity left on planet Earth is situated in Indigenous territories. And we know the impacts of climate change on health and it's terrible. And Indigenous peoples are the best at preserving what we have and taking care of Unci Maka, Mother Earth. And I think it's a really beautiful point and it speaks very deeply to me, because during our ceremonies in South Dakota, we were outside this summer quite a lot. You're outside for multiple days and the smoke that came to South Dakota from the California wildfires, it made the ceremony really difficult. And a lot of people with asthma, a lot of our people with COPD, with respiratory illnesses, chronic disease, they had a terrible time doing the ceremony and many of them weren't able to practice their culture because of the direct impact of these wildfires, which, as you explained, is exacerbated by the loss of this traditional burning practices.

SN: 55:46 Yeah. Absolutely. COVID-19 is another thing that has been proven to be exacerbated by wildfire smoke, so I think that's a kind of another interesting connection. But really, one point I'd like to make is that uplifting Indigenous voices, truly supporting Indigenous students is something that universities aren't just obligated to do, it would benefit them. It would benefit them greatly to have us at the table.

AC: 56:16 Yeah, that's so powerful from everyone. I always think that the meeting room is locked, or if we do get into the room, there's no chair for us to sit at the table. But for Pauma people, we bring a folding chair. We will always find a way, and wanting to continue this conversation and make more of these connections because, again, they're just incredibly powerful. A big part of the Antiracism in Medicine Series is giving our listeners something that they can take away and shoulder some of that from the speakers. So for our listeners taking their headphones off and heading back to the world, what's one key takeaway, Dr. Neuner and Dr. Sequist, that they can implement tomorrow in their lives?

TS: 57:10 So I'm going to inject a little bit of humor and maybe reveal my age, but there was this movie called City Slickers. Have you guys ever seen that? And so there's this joke in it where he goes, "There's just one thing that you have to know," and he holds up his finger but then he dies before he tells them what the one thing is. So I guess what I would say is, to me, across the country and individuals, I really think that one really important positive step that everyone can take that I don't think is a lot of effort, but it would be really meaningful, is wherever you live, to learn about the Indigenous people whose land you're living on, to learn about their culture, to learn about what existed there, what exists now in and around you, to look at the names of the streets that you're driving up and down, or the mountains that are around you and understand where those names came from, what they mean and who the people are. That will go a long way toward you recognizing that there is a living, vibrant culture all around you that has been, in many cases, displaced and is now suffering in many ways. But I don't think we, as a nation, take enough time to step back and recognize that and recognize the beauty of these cultures that are around you, but recognize

what has happened over time as well. I would say that we often don't achieve enough of a balance between-- when we think about American Indian cultures in the US, in particular, a balance between let's learn about the beauty of these cultures, the long-standing history of these cultures and then, also, let's learn about the pretty bad things that have happened and been done, perpetrated to these cultures. We often just get one side or the other as we learn about the history. But I think that we should-- again, going back to your one thing, I think the one thing you should do is take the effort to just learn, in your immediate surrounding, the cultures that are around you.

VLC: 59:12 Yeah. We can hold multiple truths at the same time. And Massachusetts is a good example. Minnesota, there are so many out there that are right in plain sight. Yeah, Dr. Neuner, same question over to you.

SN: 59:28 Absolutely, I love your answer, Dr. Sequist. And one resource that I'd like to mention to listeners is actually a website which is native/land.ca. And that's just an interactive map. You can type in your ZIP code, you can type in your address, whatever you want and find out who the tribal nations are, who are the owners of the land, or who were on the land, past, present and future. So I think that's a great resource. And I think, Dr Sequist, your suggestion can't be stated enough, is that it's really important for people to connect locally and find ways to support tribal communities in their immediate area. I think when we're looking in the field of medicine and public health, I think it's also really important for folks not to exclude Native peoples from your research narratives. And that means centering stories about Indigenous communities. That means finding the data about health inequities, yes, and about cultural strengths in whatever field that you work in. Right? I think these health inequities really are applicable to literally any field of medicine and public health. So if you do a little bit of digging, you'll find something. And if in your research you find that you don't have enough access to data, you're not finding the data, then acknowledge that as a limitation. But do not other us, do not put us in an other category and do not exclude us from the narratives. And finally, when you are looking at that data, recognize that you are talking about human stories, these are human lives. So telling those stories not for a community, but rather letting the community tell you those stories is something that you can do in order to provide anti-racist medical care.

AC: 01:01:29 Wonderful.

VLC: 01:01:30 [non-English language] to both of you. Thank you so much for everything you've shared. As Indigenous youth in the medical field, the example that you set, I think, is going to go so far, not just for Alec and I who can see ourselves in you, but for future generations as well. So before I hand it back to Alec, I just wanted to thank you very much for all the knowledge that you've shared today and the time that you've taken for this podcast. I think it's going to really benefit a lot of people. And hopefully, some more people will become-- be with us in this movement and we'll see a lot more people in medicine talking about colonization, about language and maybe even land back, we'll see.

AC: 01:02:25 Thanks, Victor. I think we asked for one key takeaway and we got five. We are certainly blessed. And Tom has been blessing me with knowledge and love for 27 years now, ever since I was in diapers. So to our listeners, thank you. Please go get your coffee and drink your water and be well.