

Division of Diabetes Treatment and Prevention

Advancements in Diabetes

Caring for AI/AN People – A Native American Physician’s Perspective

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Dena Wilson:

I thank all of you for logging on today. I’m Dena Wilson, Cardiologist with Indian Health Service. And today I’m going to talk about caring for American Indian/Alaska Native patients and basically it’s just my experiences. My disclaimer is that I do not have a degree in cultural sensitivity or anthropology and I don’t really consider myself a subject matter expert, but I am a Native American Physician and I face challenges every day.

My presentation today is really just my story and I’m hoping that by telling it, it can help us start a discussion on ways to help better understand and treat not only our patients but also our providers of Indian Health Service.

So this presentation could have had several different titles and some of the topics mentioned could be all hour long presentations in themselves. The reason this topic came about was because Dr. Bullock, back in June, she and I were having lunch and I think I was actually just venting a little bit about some of the struggles I was facing and she asked if I would present. Initially I balked at the idea. I really didn’t understand what I had said that would be of any interest or importance. But over the past few months, I’ve kind of come to understand. I’m not sure I will be able to hit all the topics that we discussed that day but I’ll give it a try.

So, as I mentioned, this presentation is really just more of my story, my journey. I don’t have very many useful slides and I do have some pictures from back home just to give you a little scenery while I talk. I know many of you and many of us including myself are visual learners, so I’ll try to do my best to stay relevant and hopefully somewhat interesting.

The funniest part about all of this is that I’m extremely nervous today. I tend to get nervous before presentations but this is a personal presentation, so I’m a little more nervous than usual. I find the scientific topics to be much easier. Presenting evidence-based medicine, is very easy compared to talking about myself.

So the main reason I decided to give this talk is because some of the recruitment and retention problems that we have in IHS. Many of you know that on February 3rd there was a hearing regarding the Great Plains region. That didn’t just hit close to home but hit home because I’m from South Dakota. And one of the things that I focused on while listening was the lack of qualified providers. And as I was listening over the internet, I just wanted at times to speak out. I wanted to be there. But one of the questions that just wasn’t really completely answered and addressed was, why is it that we can’t get providers onto the reservation?

One of the most common questions I’m asked is not only by my patients but by my family, my community, and my friends is “Why don’t you come home?” I’m not going to answer that question but I’m telling you about my journey and why I think it’s hard to recruit providers and what I think we can do.



I was born in Pine Ridge, South Dakota, on the Pine Ridge Indian Reservation. I'm a member of the Oglala Lakota Tribe. I was raised in a single parent home with the help, of course, of a very awesome extended family or that's what referred to. I attended three schools on the Reservation. Back then, it was called OCS, Wolf Creek, and Red Cloud. I attended college at Chadron State College which is about 45 minutes from Pine Ridge. And many times, I would come home in the middle of the week just so I could see my family, and a lot of times I would also just bring my laundry or bring my laundry to my mom so she could do it.

In 1999, I left home to attend medical school at the University of Washington in Seattle. I still remember opening my acceptance letter. It was the greatest yet scariest moment in my life, because I knew at that time I was going to leave home.

After med school, I moved to Tucson, Arizona where I completed my internal medicine residency training and cardiology fellowship. As Kelli mentioned I am currently a board certified cardiologist working at the Phoenix Indian Medical Center in Phoenix, Arizona. I'm also a Commander in the United States of Public Health Service. Prior to moving to Phoenix, I was working as the Director of the Native American Cardiology Program in Flagstaff, Arizona.

During that time I would travel to Tuba City, Chinle, Kayenta, Fort Defiance, and Hopi, and sometimes Peach Springs. Most of this time the driving was alone and for those of you who don't know about these places, I would spend 4 to 6 hours in the car, seeing the 18-30 patients a day.

So last year while I was driving in a snowstorm to Chinle, I had an anxiety attack. It was pretty scary and I knew at that time that I probably needed to make a change. Deciding to move to Phoenix was one of the hardest decisions I had to make. I felt like I was letting my patients down because now I was going to be another one of those doctors who came and left.

So, growing up on the Reservation also meant that I received my healthcare from Indian Health Service. And for as long as I can remember, I recall hearing people complain about the lack of providers and that the provider's don't care; they just come and go.

Obviously I know now that that's not true but it still hurts when I hear patients say it and I hear it a lot. Many patients don't realize or didn't realize at the time that I was an IHS doctor, so I would often get an earful during my visits. My earliest memory of IHS was not as a patient but as a daughter of a social worker. My mom was a social worker for the Indian Health Service. And being a single parent on call, there were times that she had to bring me in to work with her.

And -- sorry, I'm trying to find my picture. While I would go work with her, the doctors would entertain me and they seemed so fun and energetic. It might have been because I was young, they were young and just out of school, but either way I think that was a huge influence on me becoming a doctor.

Some of my first memories as an IHS patient include having to sign up for clinic and wait all day for a provider. I had asthma as a kid so I spent my fair share at the clinic. And I remember some days that we would wait all day and have to come back the following day because we didn't actually make it through the list. And then I also remember, there were never enough chairs in the waiting room so we had to sit on the floor or even outside.

I would hear elders complain and think to myself, "I'm going to be a doctor so that people will not have to wait." And if any of you who know me and work with me, you know that I still do not like my patients to wait to this day.

I'm pretty sure I made the decision to become a doctor when I was in about first grade. My mom kept a book regarding all the -- who I wanted to be when I grow up, and in kindergarten, I wrote that I wanted

to be a bird, so I'm pretty happy I changed to a doctor in first grade because I'm not really sure how that bird thing would have worked out for me.

Back when I was about fourth or fifth grade, one of my cousins was in a very serious car accident and she had to be flown out to Rapid City Regional Hospital which is about two hours away from Pine Ridge. I remember all of my family meeting up in the parking lot discussing who was going to ride in what car and trying to cram everybody into the vehicles to get up to Rapid City, but we all made it that night.

In my memory, there were about 50 of us in the Davies Family waiting room at the Rapid City Regional Hospital. Although I was very young, I clearly remember the disgust or frustration the staff had with the family laying all over the waiting room. We were making ourselves at home, putting together puzzles and playing games and praying, but we didn't care what they thought because we were family and my cousin's life was on the line and we needed to be there.

It wasn't until much later in life that I realized that the frustration the staff felt was not because they were mean or racist but because they didn't understand the importance of family and extended family and community. Still to this day, I hear colleagues complain because they had have a family meeting with 15 or so family members and I try to explain that this is important, this is important for the healing process, this is important for the family.

When I was 18, another cousin was diagnosed with leukemia and for 18 months she fought but lost her battle June 13, 1997. During that time we had many good experiences with medical staff but we also had a few bad ones. During her last few weeks, she was in a hospital in Denver and we wanted to have a ceremony, needed to have a ceremony, but that ceremony required that no one who was menstruating be in the room. So, we had to bring this up to the staff and again I remember feeling that disgust or frustration.

At that time, I didn't have the energy to deal with it. But it was only years later that I again realized, it's because they just didn't understand. They didn't understand that that was an important part of the healing process for us and our family.

In June of 1999, I left and went to Seattle to start medical school with my mom, my uncle, and my aunt. We drove in a van with all of my -- well, I shouldn't say, "With all of my belongings," with a few belongings. They took me to an apartment that I had rented outside of Seattle. At the time, I had no idea how big a city could actually be, so I didn't realize I was renting an apartment so far away from the school.

When I got to Seattle I realized that it was now my turn to not understand things. I faced a lot of challenges and went through culture shock when I arrived. It's funny because one of the challenges that I faced was learning how to ride a bus. I know it seems trivial, but riding a bus is a hard thing to do especially when you have to change buses three times and you're never quite sure what number to get on. But the thing is, when you grow up in a place without buses, trains, taxis and your major mode of transportation is walking or horseback, this is a daunting experience. For those of you who have ridden a bus, you know what it's like to be on a bus. There's no personal space, and a lot of times I would hear six different conversations in six different languages. I was scared. I was scared a lot of the time.

One of the other trivial challenges that I faced when I left home was the use of idioms. We would be having a conversation and all of a sudden someone say something like, "Don't count your chickens before they hatch." I had to wonder, "Why are we talking about chickens?" My favorite though, was the, "Let's pow wow." Back then, I was so homesick, so when I heard that I got really excited. I thought, "Oh, goody. We get to dance." Only to find out, it was a meeting. That was a true let down.

The one that I still don't get to this day though is, "They went off the Reservation." I am really not sure what that one means to this day, and I have to admit I kind of cringe when I hear that. I'm not sure if it's a good thing or a bad thing.

Needless to say, I was most definitely experiencing my own culture shock. When I'd have to return from a visit home, I would cry so hard because I had to go back to this place where I just didn't fit in.

Then, the years passed and somehow things changed. I would now go back home and experience culture shock all over again, but this time it was in my own hometown. I would wonder why people would sit in Whiteclay, Nebraska, drinking malt liquor all day. I couldn't understand why they just didn't leave. Go find work. I think my family also found it hard, because I tended to speak a little different and I used different words, and yes, I even started to use idioms. I remember once being asked if I thought I was too good to come home. I would cry so hard when I left, because I no longer fit in. I no longer fit into my own home.

I'm sure many of you have heard or even experienced the suicide epidemic in Pine Ridge over the past couple of years. I didn't know many of the young children, but I did lose a high school friend. He was a loving, kind, and generous man. He never used drugs or alcohol. Back in school, he made all of us laugh and brought us so much joy. When I heard the news, I couldn't believe it was true. It happened shortly after we lost another high school friend to a tragic accident. The news hit me very hard.

Here, I was hiking and biking and skiing, enjoying life, and he took his. I still have not been able to process. But it was the first time in a long time that I thought, "Maybe I should go home. Maybe I could do something." I don't know what, but maybe. And then suddenly, a familiar fear arose. See, I'm no stranger to addiction and depression. After my cousin died, I was in a dark place. Throughout my life, I had seen addiction ruin people and relationships, including my own relationship with my father.

When I think about going home, I often think, how would I handle all those challenges? How would I protect myself? I don't think that I'm too good to go home. It's more that I don't think that I'm good enough. In my search for my answers, I have come up with some ideas, not only for myself but for all providers who serve within the Indian Health Service.

This past Monday, I returned from a trip to Peru. We were out visiting my in-laws who've lived there for the past three or four years. While we were there, we went on a trip to the Amazon River and stayed at a lodge in the jungle. One day, we went out to the local village. Here I was, a tourist walking through a tribal village in the Amazon jungle. Who would have thought?

As we walked through, I felt the familiarity, but yet a heaviness in my heart. We were taken to a hut where a local dance was performed, and we were given the option to buy souvenirs made by the locals. Believe it or not, I saw dream catchers. On our way back to the lodge, we passed the local clinic and I thought to myself, "Gosh, what would it be like to practice medicine there not knowing the language or the belief systems?" That thought scared me. And then I realized, I wonder if this is what it feels like for providers who don't know about the reservations and the Tribes they are serving in IHS.

Back to the topic, caring for American Indians and Alaska Natives. The way I see it, medicine just isn't about treating an illness, it's about treating a person. In order to treat someone, you must know where they come from and what they believe, otherwise you're just forcing your belief onto them. It's really easy to prescribe insulin for a diabetic, but it's much harder to understand that that person may not have electricity to keep the insulin cold, or that the patient is taking their insulin but because of the stress of paying bills with money they don't have or worrying about – loved ones with addictions, this can lead to high cortisol levels preventing adequate glucose control. Or maybe understanding that an 82-year-old woman is caring for her great grandchildren because their parents aren't around, and she's eating what they eat, spaghettiOs and ramen noodles. See the medicine part, that's the easy part. It's the understanding of the patient that's hard.

I remember when my mom first told me about historical trauma. I listened, but I can't say at the time I was a believer because it just didn't seem to apply to me and to people I knew. Of course, I was only around 18 or 19 at the time. But since then, I've had a new understanding. It does affect many, yet we don't discuss it and we don't treat it.

I had an encounter that caught me off guard. A patient came to see me for palpitations, and I gave her the whole explanation. I showed her the model of the heart and the possible causes for palpitations and what we could do to test her. After we were finished, she asked me if she could see another doctor. I said, "Did I do something to upset you?" She said, "No." She just doesn't want to be seen by a Native physician. I wasn't at all prepared for that.

That night, it really bothered me. I felt horrible. My cousin kept telling me, it was no big deal. He said, "Dena, I've patients who don't want to see me, too." The thing is, is that I never had a patient who didn't want to see me because I was a Native.

Then, I thought about historical trauma. It was the first time in a long time that I really, really thought about it. Historical trauma in my opinion plays a huge role in chronic disease and mental health of our patient population. Studies have shown that repeat stressors during development affect the amygdala and the hypothalamus, thereby affecting the stress response. So basically from conception, there's a predisposition to stress and stress response. That scares me because of the amount of stress that people deal with on the Reservation, especially the amount of death. It seems like it's an everyday occurrence. The grief is just so constant. There's never time for recovery.

I don't know how many of you have heard of historical trauma or have had training in it. I imagine it's mostly the social workers. I have to admit, if my mom wasn't a social worker, I probably wouldn't know about it.

But I would love to see IHS orientation include a lecture on historical trauma. I'd love to see orientation include community visits, just like when I visited the Amazon jungle and even possibly some home visits. I remember growing up and there was one of the docs that used to attend all the rodeos and basketball games. He was really a part of the community. I still see that on occasion, but it's just not as often as we should. I think after all, it is a community we care for. We should be a part of it.

I've been through a few orientations since becoming a doctor, one with IHS and two with outside facilities treating Native patients. I have to say that all three covered cultural sensitivity, but none mentioned historical trauma. The one thing that is always a major focus in cultural sensitivity is the topic of death. No matter what Tribe or even without a Tribe, this is an extremely sensitive subject. I can't say that there's a right way to approach it, but I have noticed that when physicians are warned, it becomes taboo to talk about and sometimes they just choose not to or they choose to gloss over it. In my opinion, that's not good care. Patients need and deserve the truth of risks, and if their cultural beliefs prevent them from having specific western medical care, then that should be respected. But we should not take the opportunity away from them because we're afraid to talk to them.

I've heard that there are a few tricks in discussing risks of death, and I actually have my own experience with it. I've been told that you shouldn't refer directly to the patient, but maybe refer to others, generalize.

A few years back, my grandma had atrial fibrillation and she was going to have a cardioversion. So the doc comes in and he starts explaining the risks and benefits and he was using the trick. He was saying, "Well, some people could develop a fatal heart rhythm and some people could have a stroke, and some people might need a pacemaker." I watched my grandma listen intently, but she sort of had this glazed look on her face. And then when he left the room, she leaned over and with a very confused look, she said, "Dee, who is he talking about?" I couldn't help but giggle. My grandma tends

to be silly, so I wasn't sure if she was serious. I told her, "He's talking about you. You're the one going to have the procedure." She snapped her eyes and said, "Well, I don't know why he's talking about other people." That story still makes me laugh when I think about it.

Basically, the point is that caring for American Indians and Alaska Natives requires an understanding beyond basic science knowledge. Being able to sustain, as a provider, requires more than basic science knowledge. I can't say that I have that knowledge. I'm not really sure where we start, but I'm hoping that by sharing this story, we can start thinking about ways to address underlying issues that lead to chronic disease so that we can better treat our patients and that we can better treat our providers. Also by involving the Tribes and communities, maybe we can make the environment a more welcoming place for physicians to want to stay on. Maybe by understanding the culture, we can provide more support for patients and providers to help build stronger relationships even if they are there for only a short while.

I've never believed that IHS providers don't care. Now that I am an IHS provider, I know that IHS providers care more than most. It takes true dedication and I truly respect and appreciate all those who choose IHS. I also respect all those who must go, because I know it's not easy leaving.

I hope I didn't ramble too much, and I know I'm very, very early. I apologize because I'm extremely nervous and I just whipped through that. Before I take any questions, I just want to flip through my slides because I know I didn't do a good job with that.

When I had talked earlier about recruitment and retention, a question, "Why can't we get qualified providers?" One of the things is that medical school is hard and you're broke for a really long time, and you look forward to enjoying some of life afterwards, going out to dinners and movies and games and operas, or whatever you're into. But when you're living on the Reservation, it's pretty hard to get to anything since some reservations are more remote than others.

There's also lack of housing. A lot of people envision a nice, big house. But that's really not possible. Then, there's the school systems. I think we should have the opportunity to travel abroad or be part of these other schools that have so much to offer. I just never had that opportunity. I'm not saying that I didn't receive a good education on the Reservation, but the opportunity was lacking compared to in the cities. And then the salaries, the salaries are low compared to what one would make living in a city. And then again, the minimal support system. It's kind of lonely being out in the middle of nowhere. It's lonely for me just being a cardiologist because I'm the only one. There's a lot that we can do to increase support with our physicians in IHS.

I just wanted to flip through. This is the house I grew up and this is my grandma's house. Yes, she's currently living with my mom, but she does still live there. If I'm not mistaken, she's still been paying rent on this house. Grandma could probably have had a semi mansion. This is my great grandmother's home. This picture is taken shortly after it was permanently closed up. This is my grandpa's home. You can't see it its way back there. This is my mom's backyard. This is a beautiful picture. This is our old hospital. This is where I was born. This is supposed to be our new hospital, but it didn't come up.

Anyway, I see that there are some questions. I will be happy to take them.

Kelli Begay:

Thank you, Dr. Wilson for sharing your experience and story and the journey that you had becoming a Native physician. I know a lot of us could really connect to your journey. So, thank you for sharing in the way that you did.

Dena Wilson:

Yeah. You're welcome. For some reason, I can't see the entire questions.

Kelli Begay:

Okay. I'm going to move them over.

Dena Wilson:

There you go. I can see it better now.

Kelli Begay:

Okay.

Dena Wilson:

Okay. Question one, Theresa Jones. "What about the cadaver lab and eye contact on your slide?"

Eye contact was one thing that we all hear, well Natives don't like eye contact. I think there is some truth to that and I know when I went to medical school. The story I was actually going to tell there was that I didn't want to be perceived, I didn't want to fall into that category that I can't make eye contact when I went to med school, I'm like, "Okay, I'm going to look at people. I'm going to look at people." But there is just like staring that would take place. I'm like, "Ugh, I can't do it. I'm going to look down." I think for us, it's a sign of respect and you wouldn't stare down your elder. That's not how you're raised. But in the Western society, when you're looking down, you're perceived as being weak. So, eye contact for me has been very difficult and still to this day, I find it uncomfortable.

As for the cadaver lab, this is always an issue. I know different Tribes have different ceremonies to deal with that. Sometimes you take a protection ceremony that will give you a spirit rock for protection or different things. Myself, my curiosity with the body in medicine, personally, it didn't affect me that much. I learned very early on to separate out science from my personal beliefs. So, that wasn't as scary for me. But I've had other friends who had a lot of issues with the cadaver labs.

There were two comments. Sarah Patt says I hit the nail on the head. Thank you.

Jane says that, "Here on Navajo, we used to use our language. Some things are said better in Navajo and we like to laugh when talking. Apparently, we have some providers that feel offended when we talk to each other in Navajo at the nurse's station and around patient care. Any opinion on this?"

No. I worked out in Navajo for the last five years and I much prefer that Navajo be spoken because, it's like you said, things are said better. I would also tell my patients, "If you prefer Navajo, let me know. I'll bring an interpreter." I don't think providers should feel offended. As part of the cultural sensitivity training is that they need to know that this is an important thing. Culture and language is so important, and it's not against them. It's not hiding something from them or talking behind their backs. This is just life. That's my opinion on that.

Lana says, "How the mobile clinic is used?" This is the Pine Ridge mobile clinic. To tell you the truth, I just found this picture interesting, but I'm not sure exactly which areas they would take it to. Somebody from Pine Ridge probably has a better answer. Pine Ridge is where the main hospital is but then there's smaller communities, Wamblee. I'm trying to remember where they would take this. But basically, it's just a mobile clinic for physicals and different things. They're actually used in several different Area IHS's, I believe.

Kelli Begay:

Great. Thank you. It looks like we have some people typing in the chat. I want to give the opportunity to Dr. Bullock if she would like to offer any comments or anything.

Ann Bullock:

Thank you, Kelli and Dr. Wilson. I'm really glad we had lunch that day because your words have touched -- I speak for myself, have touched me deeply and I know many others are looking at what people are typing.

Experience of being a Native person both as a physician and as a patient, you have a perspective and a profound and deep way of talking that is incredibly meaningful. We, at the Division of Diabetes completely agree with you that we'd love to see more conversation around what can we do to support providers, what can we do to help people understand about the concepts around historical trauma and the things that lead to so many problems in so many of our communities, because of the problems that have happened in the past. So, your words have touched many in a way that a lecture on some things could never do. But we are going to have some future sessions on things like historical trauma and others. We'd love to hear people's ideas about how to support providers.

One story that I tell often, because it was very profound for me is a few years ago when we had the Advances in Indian Health Conference, Barbara Mora, who is this amazing Paiute woman, who has written the book, "Using Our Wit and Wisdom to Live Well with Diabetes". She is a deep soul. She gave a talk at this conference that had 600 clinicians and providers from around Indian country, both non-Native and Native people in the audience.

So often, we hear the hard things and how we providers don't always do a good job and don't always listen, and all of the things we're not. At the end of her talk, she stood up and she had us all stand, and she gave us a blessing. She blessed all the providers and thanked them for what they did. It was one of the most profound things I've ever experienced, especially at a conference. How can we do more of those things where we bless each other and we help each other to be the very best we can be in interacting with our patients whether we're from a given community or not. How do we connect on the human level as well as the professional level?

It's an ongoing question that we will all always strive to come up with better answers for. But, words like yours Dr. Wilson help us to understand and we look forward to having your help with us in the Division of Diabetes as we try to address some of the very questions you raised today. With that, I see there are some other comments and I want people to be able to interact with you again. I want to thank you again, Dr. Wilson. Thank you.

Dena Wilson:

Thank you, Dr. Bullock.

Rhidonna from Ute Mountain says that, "One of the problems on her Reservation is that it's hard for the elders who speak Ute to understand the medications. There are CHR reps who speak the language and they come in and translate what the medications are used for. Can you share any further on addressing medications with elders in Native communities?"

One of the things that I try very hard to do is make sure that I use lay language, so that I'm not being completely technical. "This medicine is for your heart. This medicine is for your blood pressure." Sometimes it's the same thing. Even if it's a written language to write it down as a reminder or sometimes -- in Navajo, we would write like a heart or a kidney on the bottle, so that they can help

identify what their medication is used for. Sometimes we'll bring in -- like I said earlier, I'm a visual person, so I like pictures. I will bring in pictures and point where it's working, where the medicine's working. And that's the thing, I think it's very important that patients understand why they're taking their medicines, because otherwise they won't take them. It's again, one of those things where it does take a little more time, a little more effort. But if we want compliance to increase, we need to make sure our patients understand what they're doing.

Yona McKinley. "In your travels, have you seen a role for traditional healing as the medicine people in ceremonies as part of patient's treatment plan?"

Yes, absolutely. In Chinle, actually I don't know if anybody's on from Chinle, but they have a Native Healer on staff and you can actually put a consult in. They have a specific area set aside for ceremony. I believe that Rapid City Regional in South Dakota now has an area as well for ceremony. So I do think that it's becoming more and more part of patients' treatment plans and is being more accepted. I do think that's an important part. So, it's nice to see that.

I have my pictures popped up, so I've shaded a couple more things. This is one of the homes from back home, and as you can see it, it's a trailer that has more built on it. Again, going back to what we talk about with challenges that patients face, housing is a huge challenge.

This one says, "What are your thoughts about fasting as a cure for diabetes?" No. Dr. Bullock, if she's still on, she's going to be a much better person to answer this question. But the biggest goal is to have stable blood sugars and fasting prevents that, actually. You go into this starvation mode and you're breaking down other types of sugars to use in your body.

Now, that being said, we have a traditional ceremony, the Sun Dance, in which the men and women fast for four days. Over the past couple of years, we've had a lot of our dancers struggle because of underlying diabetes. I don't know how to address that, to tell you the truth, so that's a very good question.

Jane says, "A lot of traditional people like analogy stories to understand and correlate the treatment." Absolutely. That is a great comment. I definitely couldn't agree more.

When we describe the heart, sometimes we talk about it as a house with electricity and plumbing and you got four rooms and a long hallway to the rest of the body. It does seem to help a lot in terms of understanding disease and treatment. There's one more question coming in.

Kelli Begay:

Right. We had a lot of people just sharing their connection and how you're an inspiration for sharing your story and being so transparent. Again, kudos to you for being able to do that. I know that's hard.

Dena Wilson:

It was definitely one of the hardest presentations I've ever given. I feel like I could sleep for 12 hours now.

One of the questions is, "What would help make new providers stay longer? Any tips?" Well, that's the conversation I want to start because, like I said, I think it's more than just one -- We can't just say, "Okay. If we pay them well, they'll stay." That's just not what it's about, and I don't know what it's about. I said, I think one of my ideas is that bringing them into the community and making them feel at home, as a part of something, to me, is going to help providers stay longer. Like I said, Dr. Mulder who used to be in Pine Ridge, he was part of our community and he stayed there for a very long time.

“How can we break doctors who spend all of their patient time looking into their computer and not at the patient, and also seem not truly listen to what the patient has to say?”

That is very hard and that is something that I think the training nowadays, the way students are trained, the amount of buttons that we have to click to make sure that we’re meeting our CMS guidelines and meeting our quality measures. It’s hard to put that balance together. I’m a specialist, so I get to just address cardiology. I’m lucky because I can go into a room and I usually tell patients what I’m going to do and say, “Okay. I’m going to ask you some basic history questions, and then we’ll talk about you, and then we’ll talk about our treatment plan.” I explain to them, “While I’m asking your past medical history, I’m going to be typing if that’s okay?” I’ll type that stuff and I’ll get it out the way.

When it comes down to hearing their story, I’d stop, I turn, and I look at them and I listen. But it also helps in looking at them when they’re trying to tell me about chest pain that they can’t really describe, because I can see their face. Are they scared or is it something that doesn’t really bother them too much? Facial expressions give a lot of that information. So, I do like to stop there.

After I’m done, I tell them, “I need to take a few minutes to write that down. My memory is not that good to remember all of this.” And then I’ll switch over and write it down, and then again come up with my assessment plan, speak to the patient, and then again I’ll tell them, “I need to write this down” because you can’t expect the doctor to go in and see a patient, get all that history and not write it down. That’s a big expectation of any physician.

Like I said, what I like to do is break it into pieces. The patients seem to be pretty happy about that. Yeah, it means they have to sit there for a few minutes quietly, but that also gives them time to think about questions that they might want to ask me.