Speaking for Myself

An Indian meets the American Indians

V. K. KAPOOR

Gall bladder cancer (GBC), the commonest biliary tract cancer worldwide, is an uncommon cancer in the West. It is, however, very common in northern India. Among women in Delhi, GBC is the commonest gastrointestinal cancer and the fourth most common cancer (following breast, cervix and ovary).[1] We have observed and highlighted the fact that GBC, common in north Indians, is common in Native Americans also—in fact we call GBC an 'Indian' disease.[2]

When Christopher Columbus landed in the Bahamas in 1492 (the day of his landing 12 October is celebrated in the New World as Columbus Day—though some Native American groups decry the celebrations; in fact in South Dakota—a state with a large Native population—the day is observed as the Native American Day) he thought he was in India and the people he met were Indians. We know that he was wrong. They were Red Indians or, as they are called now, the American Indians (AIs)—the native people of the Americas.

The Natives respected their land and nature, unlike the White Europeans who considered and treated them as resources. The Natives succumbed to the diseases (such as smallpox, chickenpox and measles) brought by the Europeans and the extermination policies of the US Government in the nineteenth century (the Indian Wars) have brought down the population of the Natives from the original (estimated) 10 million to the current 3 million (just 1.1% of the total US population). Those who remained were pushed and driven to the reservations (Indian Removal Act) but education and employment is driving them back to urban areas and big cities where 70% of them now live.

The Natives have several geographical, historical, cultural and linguistic tribes and ethnic groups, and States and communities which are administratively classified into Alaska, Northern Plains, Southern Plains, Southwest, Pacific and East. Their identification/recognition as a Native is done by the Federal Government which recognizes 560 tribes (in addition, there are about 200 more non-federally recognized tribes) which are allowed to have their own tribal laws (cf. Federal and State laws).

Working hard against the forced assimilation policies of the US Government, under which they were forbidden to speak their native languages, denied the right to practise their religions and taught Christianity, they are trying their best to maintain their separate identity (proudly displaying the names of their tribes along with their names) and purity of bloodline—degree of tribal ancestry of a Native individual is measured in terms of the blood quantum. But mixing and marrying with other ethnic groups (Non-Hispanic Whites, Hispanics or Latinos, African Americans and even [Asian] Indians) has diluted the blood quantum to a great extent. Chairman of the Community Advisory Board—a Cherokee grandmother—told me that her great-grandmother had married an Irish gentleman and her own son has recently married an (Asian) Indian girl and they have named their daughter Shiva. Some of the Natives still follow their way of life including dress, hairstyle, food habits, rituals, practices and (like us Asian Indians) family bonds.

There is an apparent lack of unity among the various Native tribes and States and some of them feel that just as the early Europeans followed the policy of 'Divide and conquer', the 'Feds' are following a policy of 'Divide and rule'. Some tribes are making unsuccessful attempts to regain and exercise their sovereignty.

The Native people are poor (with lower per capita income than the national average), have poor housing facilities, lower levels of education, are more frequently uninsured/underinsured for health cover, under-served as far as healthcare is concerned—there is even an Index of Medical Under-service (IMU)—and live far from healthcare services, making it logistically difficult for them to access such services. Their social, cultural, religious and spiritual beliefs sometimes keep them away from the benefits of modern healthcare, e.g. less Natives participate in cancer screening programmes. There is a federally funded and supported Indian Health Service (IHS) which provides free primary healthcare to the federally recognized tribes. But IHS is not adequately funded—US$ 2500 per capita as opposed to US$ 5500 per capita for the rest of the population. Specialty care is purchased by the IHS from other healthcare providers but only in Contract Health Service Delivery Areas (CHSDA). For Natives living in non-CHSDA areas specialty care is difficult and unaffordable. There are several other native-specific organizations, e.g. Native American Cancer Research (NACR), Native People for Cancer Control (NPCC), Association of American Indian Physicians (AAIP), American Indian Science and Engineering Society (AISES), etc.

Though the overall cancer incidence rates in AIs and Alaska Natives (AN) are lower (relative risk 0.8) than in Non-Hispanic Whites (NHW), some cancers including those of the kidney, stomach, cervix, liver and gall bladder (relative risk 3.6), are more common in them.[3] The incidence of GBC in AI/AN women in the state of New Mexico in USA is 14.5 per 100 000 per year (cf. 1.4 in NHW women).[4] There are several hypotheses for the higher rates of some cancers in natives—food habits, non-participation in national screening programmes, infections, metabolism and genetic predisposition. Many natives still depend on farming, hunting and fishing for their food. This may result in contamination of their food with environmental pollutants; prevalence of *Helicobacter pylori* is higher in Natives than in the general population (50%–75% *v.* 27%); they are also more prone to have the metabolic syndrome. Gallstone disease (GSD) is also very common in AI/AN, especially women. The prevalence of GSD in AI/AN women is 64% (cf. 17% in NHW women).

Spirit of Eagles (Education, Advocacy, Grants, Leadership,

Department of Surgical Gastroenterology, Sanjay Gandhi Post-Graduate Institute of Medical Sciences, Rae Bareli Road, Lucknow 226014, Uttar Pradesh, India; *vkkapoor.india@gmail.com*

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Elders and Scholarships) is an AI/AN leadership initiative on cancer—a community network programme funded by the National Cancer Institute (NCI) for comprehensive tribal cancer control. Its partners include Alaska Native Tribal Health Consortium, NACR and the Oregon Health and Science University (OHSU). It is led by Judith Salmon Kaur—a medical oncologist of Native origin at the Mayo Clinic, Rochester, Minnesota. During my recent visit to the USA on a Fulbright Fellowship, I was keen to visit areas with Native populations and interact with Native people and scientists. So I jumped to accept an invitation to attend the Network for Cancer Control Research among AI and AN Populations (NETWORK) Meeting at Rochester, Minnesota (10–11 September 2008). In my presentation on 'Gall bladder cancer—Epidemiology and direction' at the meeting, I almost committed a *faux pas* by floating a hypothesis that AIs and Asian Indians have a common origin from Central Asia and proposing to conduct collaborative genetic studies in patients with GBC in the two populations (AI/AN and Asian Indians). Strong beliefs about their origins, sensitivities to giving away body parts and exploitation by previous researchers have forced the Natives against genetic studies. The tribal leaders would like to know how these studies will benefit their people and whether the findings could be used against them, e.g. discrimination by insurers or other third parties. Tribes have their own Institutional Review Boards (IRBs) to vet research projects involving Natives and to allow Natives to participate in genetic studies. I was advised to be cautious and go slow and try to partner with a Native scientist who is acceptable to and respected by the community so as to be socially and culturally correct. Even the National Institutes of Health (NIH) advises researchers to obtain a community consultation before planning genetic research involving Natives. I, therefore, shifted gears and have now proposed a questionnaire-based study among north Indian and AI patients with GBC including parameters such as diet and activity, hormonal history and metabolic syndrome (body mass index, waist/hip ratio, blood pressure, blood sugar and cholesterol). Patients with GSD in these populations and those with GBC in low GBC-incidence populations (south Indians and NHWs) will be the controls. The results of this study may throw some light on why GBC is common in north Indians and AIs.

With a history of defeat and displacement, and centuries of prejudice and discrimination against them, it is not surprising that the Natives have developed a general feeling of mistrust and paranoia towards anyone and everyone who wants to 'study' them. The need of the hour is to build bridges of faith and confidence between Asian Indians and AIs (cf. the Bering land bridge which existed between the Asian and American continental landmasses during the ice ages).

ACKNOWLEDGEMENT

This write up is based on my experiences during a visit to the USA on a Fulbright Fellowship in 2008. Those who are interested in knowing more about cancers in Native Americans should read: Espey DK, Wingo PA (eds). An update on cancer in American Indians and Alaska Natives, 1994–2004. *Cancer* 2008;**113** (5 Suppl)**:**1113–273.

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3 Wiggins CL, Espey DK, Wingo PA, Kaur JS, Wilson RT, Swan J, *et al*. Cancer among American Indians and Alaska Natives in the United States, 1999–2004. *Cancer* 2008;**113** (5 Suppl):1142–52.
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ANNOUNCEMENT

Sri Aurobindo Ashram, Delhi Branch will organize the 3rd Study Camp on **'Mind–Body Medicine and Beyond'** for doctors, medical students and other health professionals at its **Nainital Centre (Van Nivas)** from 9 to 16 June 2010. The camp, consisting of lectures, practice, and participatory and experiential sessions, will help participants get better, feel better, and bring elements of mind–body medicine into their practice. The camp will be conducted by Professor Ramesh Bijlani, MD, former Professor, AIIMS, founder of a mind–body medicine clinic at AIIMS, and author of *Back to Health through Yoga.* For more details, contact the Ashram reception in Delhi (011-2656-7863) or e-mail Dr Bijlani (rambij@gmail.com).