

Promises, Expectations, and Obligations:  
An Examination of American Indian Health Outcomes

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## ABSTRACT

American Indian literature is replete with language that refers to broken or hollow promises the US government has made to American Indians, one of the most prominent being that the US government has not kept its promises regarding health services for American Indians/Alaska Natives (AI/AN). Some commenters refer to treaties between tribes and the US government as the origin of the promise for health services to AI/AN. Others point to the trust relationship between the sovereign nations of American Indian tribes and the US government, while still others assert that the Snyder Act of 1921 or the Indian Health Care Improvement Act (IHCIA) contained the promise for health care. While the US has provided some form of health care for AI/AN since the country was in its infancy, and continues to do so through the Indian Health Service, the promise of health services for AI/AN is not explicit.

Philosophers have articulated that a promise contains a moral obligation to fulfill it because of others' expectations created by that promise. As the US government made its first promises in early treaties with AI/AN tribes and subsequently made promises in the years since, it is morally obligated to fulfill those promises, be they lying promises or not, because of resulting expectations. Yet, the US government has historically acted to restrict the rights of AI/AN—rights that include access to health services—through assimilation, separation, or termination policies. Further, the policies of the US government have kept the AI/AN populations socioeconomically impoverished, dependent on the US government for basic needs, and susceptible to health-compromising conditions.

Using case studies, this dissertation looks not only at the policies and events that directly affected health services and health status, but also at how those policies and events contributed to health outcomes and the expectations of AI/AN. Given the history of the US government in fulfilling (or not fulfilling) its promises, this dissertation examines the expectations of AI/AN for their own future health outcomes under the policy of self-governance.

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## CHAPTER 1

### INTRODUCTION

*"My father, you have made promises to me and to my children. If the promises had been made by a person of no standing, I should not be surprised to see his promises fail. But you, who are so great in riches and power; I am astonished that I do not see your promises fulfilled!*

*"I would have been better pleased if you had never made such promises than that you should have made them and not performed them. . ." (Shinguaconse ("Little Pine"), n.d.)*

American Indian literature is replete with language that refers to broken or hollow promises the US government made to American Indians (Dixon & Roubideaux, 2001; Jalonick, 2009; U.S. Commission on Civil Rights, 2004; Westmoreland & Watson, 2006). One of the prominent claims is that promises regarding health services for American Indians/Alaska Natives (AI/AN) <sup>1</sup> have not been kept. Indian Health Service (IHS), as an US agency in the Department of Health and Human Services, provides health services for AI/AN in 567 federally recognized tribes (Indian Health Service, 2016a). In 2014, the US government allocated over 4 billion dollars to provide care to 2.2 million AI/AN (Indian Health Service, 2015c).

Despite the monies the US government and IHS have expended on behalf of AI/AN, many scholars and activists point to the persistence of health disparities as

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<sup>1</sup> Throughout this work, the terms American Indian/Alaska Native, American Indian, and AI/AN will be used interchangeably. Where other authors use the terms Native American or Indian, I have not altered the terminology that they use in the quotation.



evidence of the US government's broken promises. The 2012 National Healthcare Disparities Report (Agency for Healthcare Research and Quality, 2013) determined that AI/ANs not only had worse access to care than Whites for about 40% of the standardized access measures but also received worse care than Whites for one-third of quality measures. AI/AN have a life expectancy that is 4.1 years less than the average life expectancy of all races in the US (Indian Health Service, 2015b) and the mortality rate from diabetes mellitus and liver disease is three and five times higher respectively, than the general US population's mortality rate from those diseases (Indian Health Service, 2015b). When compared to the rest of the American population AI/AN are more likely to die of alcoholism (552%) (Indian Health Service, 2013a) and tuberculosis (500%) (Indian Health Service, 2010). Many studies of AI/AN health disparities have pointed to different, and overlapping, causes for the disparities.

Some of the causes given for the persistence of health disparities include: geographic barriers, (U.S. Census Bureau, 2006) a severe lack of adequate funding for IHS (Joe, 2003), and discrimination (Office of the General Counsel U.S. Commission on Civil Rights, 2004). Almost 30% of AI/AN do not have health insurance and therefore depend solely on IHS for their medical care, yet more than 60% of the population are located away from IHS services on the reservations and therefore have limited access to IHS (The Kaiser Family Foundation, 2013; Urban Indian Health Commission, 2007). The US Commission of Civil Rights (2004) maintains that the persistence of health disparities in the American Indian communities is a direct result of discrimination:

While some disparities result from intentional discrimination based on race or ethnicity, more frequently discrimination must be inferred from the continued

existence of a chronically underfunded, understaffed, and inadequate health care delivery system. For Native Americans, the existence of glaring disparities across a wide range of health status, outcome, and service indicators, combined with the manner in which the disparities mirror patterns of historical discrimination, makes a convincing argument that the current situation is in fact discriminatory (p. 1).

Although the US government has provided health services to AI/AN for nearly 200 years, it is not a direct provider of health services to most of the US population. In fact, the US government provides health services directly to only three populations: AI/AN through the Indian Health Service (IHS), veterans through the Veterans Health Administration (VA) and federal inmates through the Federal Bureau of Prisons Health Services Division (BOP). There is a considerable difference in the money spent by the US Government for each of the populations. Donald Warne's (2009) analysis of the 2005 federal budget shows "per capita expenditures for IHS were \$2,130, a fraction of the federal funding for other health services programs such as Medicare (\$7,631), Veterans Administration (\$5,234), and Medicaid (\$5,010). Even the Bureau of Prisons' allocation is nearly twice that of IHS (\$3,985)" (p. 10), which begs the question of the value placed on the health of AI/AN, or at least the value for the US government to fund the health care of AI/AN. Understanding the nature of the relationship among the three groups to whom the federal government provides care may explain some of the discrepancy in funding.

The origin of health services to each of the three groups is different. The US government promised the benefit of medical care for veterans in exchange for military service, whereas the mission of the BOP is to provide "medically necessary health care to

inmates” (Federal Bureau of Prisons, 2014). Regardless of the health care provider relationship begun in the infancy of the US that continues to the present-day structure of Indian Health Service, the promise of medical care for AI/AN is less explicit. Many scholars and activists refer to treaties enacted between tribes and the US government as the origin of the promise for health services to American Indians. Others point to the trust relationship identified between the sovereign nations of American Indian tribes and the US government, while still others assert that the Snyder Act of 1921 or the Indian Health Care Improvement Act (1976) (IHCA) contained the promise for health care.

The use here of the term “promise” is deliberate, and serves to identify the higher moral obligation of a promise above law. As Thomas Scanlon (1990) states, “the wrong of breaking a promise and the wrong of making a lying promise are instances of a more general family of moral wrongs which are concerned not with social practices but rather with what we owe to other people when we have led them to form expectations about our future conduct” (p. 200). Many other philosophers argue that a promise must be based upon trust between the parties, and the renegeing of a promise damages that trust (Habib, 2008). As the US government made some of the first promises in early treaties with AI/AN tribes and made subsequent promises in the years since, it follows then that moral obligations are embodied in the debt owed because of the expectations the promise, be it a lying promise or not, generated in the recipient of the promise.

Some of the promises made in the original treaties expired after twenty or so years, but the US government repeatedly referred to its relationship with, and desire to provide health services to, AI/AN, either in a paternalistic or government-to-government manner, in a number of treaties, statutes, and executive orders. Yet, many of those same

treaties, statutes, and executive orders are broad enough that numerous court cases decided against any explicit legally enforceable promise or affirmative action to provide health services within those entities.<sup>2</sup> Whether or not the promises made to AI/AN are legally enforceable, the question remains, what are the nuances of the promises? The US government has historically acted to restrict the rights of AI/AN, rights that include access to health services, through assimilation, separation, or termination, policies. Included in those policies are eligibility, or determination of “Indian status,” in the form of blood quantum rules later adopted by tribes emulating the US government’s constitution. As recently as 2007, Dr. Charles Grim admitted at his Congressional reconfirmation hearing as Director of IHS that on a previous occasion, the George W. Bush White House:

had blocked his usual statements on the federal government's trust responsibility to the tribes. Specifically, OMB [Office of Management and Budget] had removed language referencing the 1921 Snyder Act and the amended Indian Health Care Improvement Act, which Grim had previously called the "cornerstones" of the government's responsibility to provide health services to American Indians and Alaska Natives (Rife & Dellapenna, 2009, p. 134).

Even without legal justification or requirements to fulfill the Snyder Act or IHCIA, if we all agree there is some sort of a promise what does that mean? What standard of care would meet the expectations to fulfill the promise? What is the

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<sup>2</sup> Some of the cases that specifically refuted claims for care based upon the trust responsibility, the Snyder Act, or IHCIA include: (*White v. Califano* 1977/1978), (*Lincoln v. Vigil*, 1993); (*Hammitte v. Leavitt*, 2007); (*Allred v. United States*, 1995); (*Tsosie v. United States*, 2004); and (*Quechan v. United States*, 2012).

understanding of the promise that precipitated a relationship of health care provision that has persisted for over two hundred years? What expectations for services formed from the understanding of the promise? Has the US government acted in good faith to meet the expectations of AI/AN for health services? Has the US government acted in good faith to meet its own intentions to “meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy” (Indian Health Care Improvement Act, 1976)? What should the future of health services for AI/AN hold? This project addresses questions about how policies and laws of the US government have contributed to the health status of AI/AN through the lens of case studies in different periods to measure the fulfillment of promises regarding AI/AN health services and statuses and their subsequent expectations on the part of AI/AN.

This dissertation begins by relating a brief history of the policies and events that affected American Indian health and health services provision up to the current system through the Indian Health Service. The history looks not only at the policies and events that directly affected health services and health status, but also at how those policies and events contributed to health outcomes and the expectations of AI/AN. Given the history of the US government in fulfilling (or not fulfilling) its promises, this dissertation examines the expectations of AI/AN for their own future health outcomes under the policy of self-governance.

To fully understand the genesis of the reliance by AI/AN on the provision of health services by the US government, it is useful to focus on selected case studies to probe more deeply into what is at issue in each case, and how these add to an

understanding of the system overall. The first case studies look at the effect of the removal policy on two tribes. The tribes expected to be protected not only on their passage to new lands, but also once they were on the lands reserved for them as the US promised them in the removal treaties. The removal itself proved deadly to the tribes, and the rough conditions of the trip left them weak and vulnerable to illness. The status of the Sioux as they were confined to a reservation details the effects of the reservation policy that developed soon after the removal policy. As a conquered nation of the US and dependent on the government for their basic needs, the Sioux found reservation life, and the lack of rations as causative factors in the pervasive illness throughout the community that continues to this day. The second case analysis describes the effects of the assimilation or termination policy on the health and welfare of the Menominee tribe of Wisconsin. The case of the Menominee illustrates the false promise that was the foundation of the Termination Act and how it was nearly successful in exterminating the tribe as they suffered from ill health and malnutrition following their “termination” until the government allowed them to again be a federally recognized tribe. The final case looks at expectations of care and direct benefit in the form of health improvement during the use of American Indians as clinical test subjects through the research and treatment of the Diné (Navajo People) <sup>3</sup> for TB in 1956-1962 by the Cornell Institute and its effect not

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<sup>3</sup> There is not consensus among the people whether the name Diné belongs to the past and Navajo to the future (Haederle, 1994; "Navajos Weigh Return to Old Name: Dine," 1993). Whereas Diné translates to “the people”, the name Navajo was given to the Diné from a Spanish adaptation of a Tewa Pueblo word meaning “Apaches who farm in the valley” (People of the Mesa Verde Region, 2014). In 1969, the Navajo Tribal Council adopted the name “the Navajo Nation” to refer to the land identified in the Treaty of 1868 with the US government named the Navajo Indian Reservation (Wilkins, 2013). Historical materials refer to the people as “Navajo” or “Navaho” interchangeably.

only on the Diné, but also the subsequent medical care for the Diné research subjects through Indian Health Service. The research on the Diné is contrasted to the research on the Akimel O’otham (Pima)<sup>4</sup> begun in 1963 and the actions of Indian Health Service during that study.

Finally, this dissertation examines the future of the special status of the AI/AN for access to federal services as well as the options available for tribes for health care provision in the 21<sup>st</sup> Century.

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<sup>4</sup> Spanish missionaries gave the name “Pimaria” to the region the Akimel O’otham occupied and thus called the tribe the “Pima Indians” (Gila River Indian Community, n.d.). Throughout this work, I will use the preferred name Akimel O’otham, although historical documents will refer to the Pima. The tribe lives on the Gila River Indian Community (GRIC) with the Pee Posh (Maricopa.)

## CHAPTER 2

### HISTORICAL CONTEXT

Promises and policies for American Indian health services have followed a tortuous path to arrive at the current system of providing care. Following that path through its history contributes insight into the reliability of the promises made by the US government, and the expectations generated from those promises. Since 1988 the Indian Health Service (IHS) has been an agency of the Public Health Service in the Department of Health and Human Services of the US Government. However, IHS evolved from the federal government's first attempts to maintain peace with the American Indians at the beginning of the Revolutionary War. The development of health services for American Indians was not driven by the single motivation of keeping the American Indians healthy. Instead, the provision of health services to AI/AN was intertwined with the policies and motivations of the administration at each development, many of which were attempts to assimilate, separate, or exterminate American Indians. A chronology of policies and laws is incomplete without understanding the motivation for each action, and how it jeopardized the fulfillment of the promise and expectations of health services for AI/AN.

The First Continental Congress created an Indian Affairs Committee in 1774, in an effort to stabilize relationships with tribes so the focus could be on fighting the British during the Revolutionary War. At the end of the Revolutionary War in 1783, the United States and England signed the Treaty of Paris, in which the two parties “agreed that



Indians will be under the supervision of the United States” (Fixico, 2012, p. xv).<sup>5</sup> George Washington influenced the Continental Congress to establish a policy for the westward movement of the new US citizens to prohibit the “steady encroachment of white settlers on the Indian lands” (V. Deloria & DeMallie, 1999, p. 3) by making the US government the only entity entitled to purchase or settle Indian land. In Washington’s view, a purchase of the land was advisable because “there was nothing to be obtained by an Indian War but the Soil they live on and this can be had by purchase at less expense” (V. Deloria & DeMallie, 1999, p. 2). In part because of the policy of purchasing the land from AI/AN, AI/AN settled around military outposts, making their ill health conspicuous and potentially deadly to the military.

Indian Affairs was relegated to the Department of War from 1789 to 1849, therefore it was most likely the military that provided medical treatment to AI/AN living around the outposts in order to prevent the spread of infectious diseases such as smallpox (Dejong, 2008; Walke, Updated June, 2008). As early as 1801 President Jefferson did provide smallpox vaccinations to the delegations of AI/AN that travelled to Washington, DC for treaty discussions, but in general, medical care to AI/AN during that time was

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<sup>5</sup> There is no language in the Treaty of Paris that expressly mentions American Indians, perhaps other than references to the full return of property, but subsequent court cases regarding the rights of American Indians referenced the doctrine of discovery and the doctrine of conquest to assert the rights of the US over American Indians (Dixon & Roubideaux, 2001). V. Deloria and DeMallie (1999) state that the Treaty of Paris “created a nebulous political status for Indian nations living between the watershed of the Appalachians and the British possessions in Canada. In theory, and for a while in practice, this territory was owned and controlled by a confederacy of Indian nations” (p. 109).

scattered and inconsistent (Dejong, 2008). By 1819, the US government sought to make medical care more consistent to AI/AN.

Tangential to an effort to assimilate AI/AN once they were properly civilized, some money was allocated for American Indian health. The 1819 Civilization Act was ostensibly for “the purpose of providing against the further decline and final extinction of the Indian Tribes” (Civilization Act, 1819, p. 516) through education and Christianization, but in the Act Congress appropriated some funds to missionary societies that provided some “rudimentary nursing and medical services” (Raup, 1959, p. 1) to AI/AN along with their missions to educate and convert them to Christianity.

Just over a decade later, efforts to civilize through education or assimilate AI/AN were abandoned when President Andrew Jackson endorsed a new approach, namely containment and separation. The Indian Removal Act of 1830 (Indian Removal Act, 1830), endorsed by President Andrew Jackson, “authorized the president the power to exchange lands in the West for those held by Indian tribes in any state or territory” (V. Deloria & DeMallie, 1999, p. 52). Numerous treaties and westward movement of tribes occurred under Andrew Jackson’s presidency, and contributed to the near extinction of AI/AN when they were uprooted from their native lands and hunting grounds to make room for the White populations. In 1838, over 8,000 Cherokee (or as many as 50 percent) died on the “Trail of Tears” because of disease and the arduous conditions that brought on exposure and malnutrition (Stiffarm & Lane, 1992, p. 33). This event involved the forced removal and march of Cherokees from their lands in the Southeast to Oklahoma territory. Other tribes, such as the Creeks, Seminoles, Chickasaw, and Choctaws, had also suffered decimating losses in the forced march westward that began in 1831.

It wasn't until 1832 that the first recorded appropriation of funds strictly for Indian health care occurred with the Act of May 5 (Vaccination Act, 1832). The Act authorized \$12,000 for the purchase and administration of smallpox vaccine to American Indians (Dixon & Roubideaux, 2001). The \$12,000 was doled out to physicians at the rate of \$6 per diem or \$6 for every 100 AI/AN vaccinated (Dejong, 2008). While nearly 10,000 AI/AN were vaccinated in the course of a year, there are indications that vaccination was offered only to "friendly tribes" (R. Robertson, 2001). Some have pointed to the fact that smallpox-infected blankets from Fort Clark that were distributed to American Indians were the "causative factor in the pandemic of 1836-1840" (Stiffarm & Lane, 1992, p. 32), during which time the death toll of American Indians is estimated to have exceeded 100,000.<sup>6</sup>

The first treaty that specifically mentions health services provision by the US government to AI/AN is the treaty made with the Winnebago tribe in 1832 (Treaty with the Winnebago, 1832. Sept. 15, 1832. 7 Stat., 370. Kappler, 1904, pp. 345-348) in which the Winnebago ceded part of their nation for lands west of the Mississippi River. The treaty states that for 27 years, the United States guaranteed an annual payment of \$10,000, and funding in the amount of \$200 per year each for two physicians, one in Fort Winnebago, and the other at Prairie du Chien. The stipulation that payment and funding would end after 27 years indicates that the US government considered that payment in

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<sup>6</sup> Unlike the incident with the British in 1763 between General Amherst and Colonel Bouquet in which it was suggested that smallpox-infected blankets were intentionally given to American Indians (Ranlet, 2000, p. 427), most researchers believe the Fort Clark blankets were distributed without the understanding that they could transmit disease by traders who had brought them up the river. For more information, see (Jones, 2004, pp.103-106).

full, and thus the government's obligations, would be achieved at that time.<sup>7</sup> The practice of making treaties with tribes was not always sincere on the part of the US government, but rather an expedient and less costly way, just as Washington had imagined, of acquiring land from the American Indians.<sup>8</sup>

The treaty with the Winnebago underscores the importance American Indian tribes placed on the health of their people. From 1832 until 1871, 389 treaties were struck between AI/AN and the U.S. government. Of those, 31 treaties promised some form of health services, whether medical supplies, physicians, or hospitals, as partial payment for land cessions (Dejong, 2008; Dixon & Roubideaux, 2001; Walke, Updated June, 2008). The American Indian practice of giving up land ownership for the promise of health services has been called by some "the first prepaid health plan" in history (Statement of Daniel K. Inouye United States Committee on Indian Affairs (1993- ) Senate & Congress, 1994, p. 177). Tribes placed considerable weight on treaties, considering them to be sacred oaths. V. Deloria and Lytle (1998) state:

the idea of the treaty became so sacred to Indians that even today, more than a century after most of the treaties were made, Indians still refer to the provisions as if the agreement were made last week. The treaty, for most tribes, was a sacred

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<sup>7</sup> When the Federal Government provided services under the treaty, they very often did "adopt a policy of continuing services under so-called 'gratuity appropriations' after the original benefit period expired" (Raup, 1959, p. 2).

<sup>8</sup> From *Native American Testimony* (Nabokov, 1999): "By 1865, ..., the Winnebago had been reluctant wanderers for some forty years. They had been pressured into signing seven land-turnover agreements and had changed location at least six times" (p. 161).

pledge made by one people to another and required no more than the integrity of each party for enforcement (p. 8).

The US Government may not have placed the same level of importance on the conditions of the treaty because, as Dejong (2011) asserts, regardless of the health services itemized in a treaty, the US government “often failed to fulfill its obligations and, when it did fulfill them, it usually did so many years later” (p. 9). Tribal leaders made treaties with the goal of preserving their people even though “one can sell neither the future nor the past, and land cessions represented the loss of both future and past to most Indians” (V. Deloria & Lytle, 1998, p. 10), the land cessions and move westward did help tribes avoid the colonizers, however briefly.

In the months preceding the treaty with the Winnebago, the Supreme Court issued two monumental and contradictory decisions about the relationship between American Indian tribes and the US government. The first decision, *Cherokee Nation vs. State of Georgia* (1831) proclaimed that the relationship between the US government and American Indian tribes was a guardian-ward relationship. In the second decision, *Worcester vs. Georgia*, (*Worcester vs. Georgia*, 1832) the Supreme Court ruled that the Cherokee tribe (and therefore all other tribes) was a sovereign nation, and characterized the relationship between the US government and Indian tribes as a special trust relationship between sovereign nations. Everett R. Rhoades (2000), former director of Indian Health Service highlights “most Indians reject the designation ‘ward’ of the federal government [italics in the original] while clinging strongly to the concept of the trust responsibilities of the federal government.” (p. 68). The conflict between two roles, as ward and sovereign nation, is reflected too in the lack of clear-cut roles set by

Congress for the Bureau of Indian Affairs (BIA)<sup>9</sup> and IHS. Rhoades states, “This single factor more than any other is responsible for the often bizarre policies and regulations of both agencies” (2000, p. 69).

Other than allocations for specific needs, such as vaccines, and strict policies against alcohol sales on reservations, little else was done on behalf of American Indian’s health needs until the Office of Indian Affairs (OIA) was transferred from the Department of War to the Department of the Interior in 1849 (S. J. Kunitz, 1996). With the transfer to the Department of Interior came a new layer of oversight for tribes, with the installation of “Indian agents who would treat with, and translate for, the Indians, while providing information to the government on the activities of the various tribes” (Cramer, 2005, p. 15).

By 1871 Congress decided that the Indian agent system was difficult to control, refused to appropriate more money to OIA (Cramer, 2005), and then terminated the treaty-making process with the Indian Appropriations Act (Indian Appropriations Act, 1871). The Act also denied the sovereign nation status of AI/AN tribes, but established a new structure of Indian Agreements to replace treaties. Cramer (2005) asserts that from the earliest treaties and into the era of Indian Agreements, the US government had been acting under the auspices of keeping AI/AN and Whites separate as the most moral course of action. Regardless of the motivation of the US government, the relocation of tribes onto large reservations devastated the morale and health of tribes.

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<sup>9</sup> The Office of Indian Affairs (OIA) was renamed the Bureau of Indian Affairs (BIA) in 1947. Many authors use OIA and BIA interchangeably regardless of the date of the subject.

Policies to keep American Indians separate from white society shifted in the 1880s to integrating and assimilating AI/AN. The Dawes Act of 1887 (General Allotment Act, 1887) was the first of many Acts leading toward “assimilation, population shifting, and detribalization” (Cramer, 2005, p. 16) of AI/AN. Rather than assigning ownership of reservation land to the tribe, the Dawes Act allotted one-quarter of a section (160 acres) of tribal land to each Indian head of a family, as well as smaller allotments to single persons, minors, and orphans (General Allotment Act, 1887) and created a path to US citizenship for those who held land title. The Dawes Act aimed to convert an individual’s loyalty from the tribe to the US government through the promise of citizenship and land allotments. The remaining reservation land was under the control of OIA, and allowed to be sold to non-Indians and to other interested parties, notably the railroads. Cramer (2005) stresses, “Between 1887 and 1905, allotment reduced tribal lands from 138 million acres to 52 million acres. A full two-thirds of all tribal territory went into White hands as a result of the Dawes Act” (p. 17). Reduction of tribal land contributed to ill health, stress, malnutrition, and dependence on the government for subsistence, as allotments were either not large enough or lush enough to support individual family units.

Restrictions to the promises made in the Dawes Act surfaced in 1906. The Burke Act (General Allotment Act Amendment, 1906) amended the Dawes Act in two notable ways. The first change to the Dawes Act gave the government the right to determine whether an American Indian was competent and capable before granting title of the land to him, and the second change withheld citizenship for the American Indian until a 25-year probationary period passed. The Dawes Act and the Burke Act rewarded White-AI/AN “mixed-bloods by allotting them much larger parcels, often in better areas”

(Stiffarm & Lane, 1992, p. 41), all the while deeming full-blooded American Indians as incompetent, an action that kept their land parcels in trust for a minimum of twenty-five years.

Simultaneously with policies that sought to keep AI/AN and Whites separated, attempts at assimilation began in the 1870s with the removal of children from the reservations to boarding schools in the hopes that education would begin the cultural conversion into White society. Students were not permitted to travel home, wear native clothing or hairstyle, or speak their native language while at the boarding schools (Dixon & Roubideaux, 2001). Dejong (2008) points out, however, “schools designed to prepare youth for modern life became the cause of their morbidity” (p. 19). Because of the crowding and unsanitary conditions of the boarding schools, they were hotbeds for diseases, particularly tuberculosis (TB) and trachoma, a disease of the eye. In order to report full occupancy of the boarding schools, according to Indian inspector William McConnell in a 1899 letter to Interior Secretary Ethan Allen Hitchcock, children ill with TB were “kept until the last stage [of the disease] is reached” (as quoted in Dejong, 2008, p. 20). Further, so as not to report deaths occurring at the school, McConnell stated students were

carted home, to their tepe [sic] where in some instances even a few days suffices to bring the end. In this manner, the disease is disseminated among the pupils in the schools, and the few days they occupy the home tepe may be, and no doubt is, frequently the cause of the other members of the family becoming affected” (as quoted in Dejong, 2008, p. 20).



Families buried their children and were left with little recourse against the epidemic the children brought home to them.

The rise of epidemics on the reservations pointed out the need for more hospitals and medical services and by 1888, OIA had four hospitals (Walke, Updated June, 2008), although the hospitals and infirmaries “served Indian boarding school students almost exclusively” (Raup, 1959, p. 3). Some of the first hospitals were built in the Oklahoma territory and on the Osage and Menominee reservations (Raup, 1959). Progress was slow enough that by 1900 there were only five hospitals.

### **Into the Twentieth Century**

At the beginning of the twentieth century, Indian health problems began to be noticed. Francis Leupp, who became Indian Affairs Commissioner in 1905, undertook the complicated task of eradicating TB “because of its potential to decimate tribes” (Dejong, 2008, p. 22), as well as the threat an infected tribe caused to the White communities around it (Dejong, 2008). In 1909 40% of all AI/AN deaths were from TB, a rate that was 60% higher than non-American Indian populations (Dejong, 2008). The US Surgeon General, Walter Wyman, was also gravely concerned about the debilitating effects of trachoma, a contagious viral eye disease that can result in blindness; he worried not only about its effect on the efforts to improve the self-sufficiency of AI/AN, but also its effect on the communities surrounding infected tribes. In response, Congress appropriated \$12,000 to Leupp and the Indian Affairs Office for trachoma treatment and prevention in 1911. Also in that year, Congress appropriated \$40,000 to “relieve distress among the Indians and to provide for their care and for the prevention and treatment of tuberculosis, trachoma, smallpox, and other infectious and contagious diseases” (Dejong, 2008, p. 25),

the first ever appropriation towards the general health of AI/AN (Dejong, 2008). By 1915, the appropriation equaled \$300,000, although some critics argued that it would not be nearly enough to improve the health of American Indians (Dejong, 2008).

President Taft urged Congress in 1912 to make a special appropriation to increase the salaries of physicians working in Indian country and to build more hospitals and TB wards. Taft (1912) referred to the ward-guardian relationship in his exhortation for funds by stating, “As guardians of the welfare of the Indians, it is our duty to give the race a fair chance for an unmaimed birth, healthy childhood, and a physically efficient maturity” (p. 2). Taft’s compassion was tempered with practicality as he also pointed out that reducing disease among the AI/AN protected the surrounding White communities. Taft hoped that the funding from Congress and the altruism of the care providers would make a significant impact on the health of American Indians, yet he (1912) stressed those efforts did not require the establishment of a dedicated medical service with this statement:

It is not expected to build up a highly organized Indian medical service, but rather to put efficient physicians and nurses and field matrons, properly equipped to reach all the Indian families, in the field where service under the best conditions is one of constant self-sacrifice and hardship, but where constant application to those methods which the study of modern hygiene has developed will show results so encouraging as fully to justify the expenditure of the sums herein asked (p. 3).

Despite his impassioned plea for the health of American Indians and the surrounding White communities, Congress granted only \$90,000 of the nearly \$300,000 Taft requested.

Commissioners of Indian Affairs following Leupp, namely Robert Valentine and Cato Sells, were determined to improve the general health of the American Indian. Sells continued a “Save the Babies” campaign begun by Valentine and in conjunction with it, began a “Swat the Fly” campaign to reduce the number of disease-carrying flies around privies (Dejong, 2008). An influx of funding through a Congressional appropriation in 1915 along with Sells’ concerted efforts reduced infant mortality, until the Spanish influenza epidemic of 1918 and World War I. According to Dejong (2008), the call for physicians in WWI caused a vacancy rate of 40 percent among Indian Service physicians, and during the Spanish flu all the trachoma specialists were reassigned outside of Indian Service. Improving health among the AI/AN was further hampered by the administration following the 1920 election.

The 1920 Congress sought to reduce the size of the government and its spending, and targeted Indian Service as a place for reform. The blame for the health status of AI/AN, characterized by the American Red Cross and the National Tuberculosis Association as two decades behind the rest of the US (Dejong, 2008, p. 45), was placed directly on the Indian Service without critically examining the funding challenges given to the Indian Service by Congress. Instead of increasing funding, Congress pushed for the merger of Indian Health Service into the Public Health Service, arguing that the merger would reduce redundancies. The Indian Service resisted the merger, claiming that the health of AI/AN was better served by the long-term social and economic goals of the Indian Service. Although the attempt to merge the Indian Service with Public Health Service did not pass through both the House of Representatives and the Senate, it did lay the groundwork for passage of the Snyder Act.

The scrutiny of the Indian Service as an area to reduce costs also brought attention to the haphazard method used to provide funding for the Indian Service. Funding for services to AI/AN to that point had been given with no underlying statutory basis and for the broad general purpose of “relief for the distress among the Indians” (Dejong, 2008, p. 48). Homer Snyder, chairman of the authorizing committee of the House, sought to create a statutory authority for funding requests, but limiting those requests to only nine categories in an attempt to prevent broad general funding. Despite objections from some members of Congress that the Snyder Act gave too much power to the appropriations committee, the Snyder Act was passed in November 1921. Further, under the Act, the points of order method to challenge appropriations to the Indian Service that had been used frequently by members of Congress who favored assimilation was preempted (Dejong, 2008, p. 49).

The Snyder Act of 1921, (1921) states, in part,

The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:

- General support and civilization, including education
- For relief of distress and conservation of health
- For industrial assistance and advancement and general administration of Indian property
- For extension, improvement, operation, and maintenance of existing Indian irrigation systems and for development of water supplies

- For the enlargement, extension, improvements, and repair of the buildings and grounds of existing plants and projects
- For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges, and other employees
- For the suppression of traffic in intoxicating liquor and deleterious drugs
- For the purchase of horse-drawn and motor-propelled passenger-carrying vehicles for official use
- And for the general and incidental expenses in connection with the administration of Indian affairs

Regardless of Snyder's attempt to limit appropriations to nine categories, the categories were broad enough to "allow an almost unlimited number of programs designed to benefit American Indians" (Dejong, 2008, p. 49). However, it is the wording "from time to time appropriate" in the Snyder Act that served to classify funding for health services and the other eight categories under the Act as discretionary, rather than mandatory, and to separate health services for AI/AN from entitlement programs such as Medicare is today (Thierry, Brennenman, Rhoades, & Chilton, 2009; Westmoreland & Watson, 2006). A program funded through discretionary means requires a two step process. The first is authorization, for however many years were stated in the original bill, followed by the second step of subsequent annual appropriations (Westmoreland & Watson, 2006).

Congress's reluctance to appropriate funds kept the Indian Service from being fully funded to meet the needs of AI/AN. Physicians working for Indian Service were

paid considerably less than in the private sector, and the poor pay contributed to high turnover rates. During the early 1920s Secretary of the Interior Hubert Work commissioned an examination of the Indian Service by 100 academics and social scientists known as the Committee of One Hundred (Nabokov, 1999, p. 306). The Committee recommended “dissolution of native nations and final absorption of their members into the US” (Robbins, 1992, p. 94) in order to alleviate the “intolerable financial burden” (p. 94) on the US.

Assimilation efforts recommended by the Committee might have continued, had the OIA not angered American Indian tribes through its effort to gain jurisdiction over marriage and divorce proceedings rather than through the customary tribal channels (V. Deloria & Lytle, 1998). The backlash against the OIA prompted Secretary Work to commission the Brookings Institute to survey the state of American Indian affairs. The Brookings Institute report chronicled in “The Problem of Indian Administration”, commonly known as the Meriam Report (Meriam & Brookings Institution, 1928), advocated keeping tribal lands (and thus tribes) together, rather than assimilating them.<sup>10</sup> Their recommendations regarding the health and health care of American Indians included the need for more hospitals for AI/AN, as well as the recommendation to

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<sup>10</sup> Although outside the scope here, it is interesting to note that while health advocates for American Indians often refer to the Meriam Report as a watershed moment because of its identification of the need for more health provision to AI/AN, others point to the economic motives underlying the recommendation to keep tribal lands together: “efficient utilization of mineral resources within reservation areas – by which the country might not only ‘recover the costs associated with its support’ of the formerly self-sufficient native people it had so flagrantly dispossessed while creating its own economy, but turn a tidy profit as well – was being precluded by the fragmentation of land title inherent to the allotment policy” (Robbins, 1992, p. 94).

employ physicians directly rather than contracting them, and importantly, the need for adequate appropriations to increase the pay and qualifications of health workers in Indian Service. Further, the Meriam Report (1928) charged that:

The hospitals, sanatoria, and sanatorium schools maintained by the Service, despite a few exceptions, must be generally characterized as lacking in personnel, equipment, management and design. The statement is sometimes made that, since the Indians live according to a low scale, it is not necessary for the government to furnish hospital facilities for them which are comparable with those supplied for poor White people in a progressive community. The survey staff regards this basis of judging facilities as unsound (pp. 9-10).

The Meriam Report (Meriam & Brookings Institution, 1928) highlighted some of the social determinants of health and the government's role in creating dependence on non-native and starchy foods<sup>11</sup> with the statement:

The most important single item affecting health is probably the food supply. Whatever the situation may have been in the past, the Indian is now given, whether as rationer or as pupil in a government school, a very poorly balanced ration ... In too many instances his lands are so poor that he cannot depend upon them for his food production.

At the boarding schools the food supply is more regular, but its excess of starches and meat have been a factor in retarding the development in the Indian of a taste

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<sup>11</sup> The long-term effects of the dependence on the food supply from the government will be discussed in Chapter 5 as one of the causes of diabetes mellitus in American Indians.

for vegetables and milk. It is extremely serious that the government has not inculcated better food habits (p. 221).

The Brookings Institution also recommended that medical services of the Indian Service be made its own division rather than its current position as subordinate to the education division. Work instituted changes in his department (Trani, 1970) and made the Division of Indian Health report directly to the Commissioner of Indian Affairs. Work utilized public health nurses in the new division, and installed a Public Health Service physician as the medical director of the Division of Indian Health. The Meriam Report made visible how the lack of funds to Indian Service directly impacted the health of American Indians and served as a catalyst for increased funding. Federal funding for American Indian Health tripled from 1928 to 1930, and by 1940 was over five times the appropriation of 1928 (Dejong, 2008).

The Indian Service became responsible for the provision of health services to Alaska Natives in 1931. When the US purchased Alaska from Russia in 1867, Article III of the purchase treaty classified the inhabitants of Alaska into three distinct groups: those returning to Russia within three years and keeping their allegiance to Russia; those remaining in Alaska; and “uncivilized native tribes ... subject to such laws and regulations as the United States may adopt in regard to aboriginal tribes of that country” (Davis, 1873, p. 742). Although some scholars (Dejong, 2008; Dixon & Roubideaux, 2001) have interpreted Article III to mean that the US committed to providing the same rights and privileges to Alaska Natives as it did to American Indians, it required subsequent legal opinions to determine the distinction between civilized and uncivilized tribes (Office of the Solicitor, Department of the Interior, & United States, 1966, p. 933).



Health services to Alaska Natives were haphazard and irregular until the Alaska Native Service was created in 1914 under the Bureau of Education. Even with the creation of the Alaska Native Service, getting health services to small villages across the vast expanse of Alaska was a considerable challenge. When the Bureau of Education turned the Alaska Native Service over to Indian Service, there were “six full-time and five part-time physicians” (Dejong, 2008, p. 69) working with three dozen other medical personnel. Indian Services contracted with private hospitals to provide health services, but by 1937 the TB mortality rate of Alaska Natives remained ten times higher than other Alaskans. Despite pleas from the Chief Medical Director of Alaska for four new TB hospitals, it wasn’t until 1944 that Congress turned an old Army hospital over to Indian Service, and until 1946 before President Truman authorized the construction of several hospitals in Alaska.

One of the early advocates for the American Indian was John Collier, who subsequently became Commissioner of Indian Affairs from 1933-1945. Collier sought to reverse the assimilation efforts of the US government and championed returning rights to the tribe from OIA control. The Indian Reorganization Act (1934) (IRA), or also known as the Wheeler-Howard Act, restored some of tribal authority and lands to AI/AN, but the program was not the far-reaching proposal that John Collier had promoted in 1934. Allotments of tribal land were halted, and surpluses of land were returned to the tribes. Tribes were allowed to elect their own tribal charter of incorporation, and many tribes established constitutions based upon the US constitution. Through incorporation and establishment of a constitution, the tribes were granted “all powers not inconsistent with

the US Constitution ... Under the IRA, tribes became partners within a government-to-government relationship” (Cramer, 2005, p. 18).<sup>12</sup>

While Collier’s motivations in designing his original “Collier Bill” that evolved into the IRA were guided by a desire to restore rights to AI/AN, the bill assumed that all tribes had similar needs and goals, and pressured them into fitting into the US model of democracy and business (V. Deloria & Lytle, 1998). Although the bill was also called the “Indian New Deal,” not only were tribes pressured into fitting in the US model of business, but the bill also had been drafted and passed without significant input by the tribes (Philp, 1995), and most decisions made by the tribe had to be approved by the Secretary of the Interior or the Commissioner of Indian Affairs (Philp, 1995). For some tribes, the constitution and business model meant a forced separation between religion and tribal governance, a concept foreign to them. Others argue that “the Indian New Deal actually further disempowered tribal governments and hindered the creation of efficacious tribal politics” (Cramer, 2005, p. 19).

The IRA was also instrumental in establishing a definition for racial identity. Section 19 of the Wheeler-Howard Act sets guidelines for determining who is an American Indian. Section 19 states, to be an American Indian one must live on a reservation or be a recognized member of a tribe, be a descendant of a tribal member, or

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<sup>12</sup> Not every constitutional right persisted for the tribes. Voting in several states, sales of alcohol on the reservation, and tribal oversight of criminal justice eluded the tribes for many years regardless of the intent of the IRA. A Supreme Court decision in 1978 stripped tribes of the power to arrest and prosecute non-Indians who committed crimes on tribal land. It was only in 2015 that the right to arrest and prosecute non-Indian criminals accused of sexual violence on the reservation was returned to the tribes (Crane-Murdoch, 2013).

have a blood quantum of one-half Indian blood, regardless of domicile on a reservation or membership of a tribe (V. Deloria & Lytle, 1998, pp. 308-309). In drafting their own constitutions, many tribes set their own blood percentages for membership in the tribe. John Collier effected other changes for the benefit of American Indians. In the early 1930s, he closed boarding schools and built day schools. He constructed eleven hospitals and renovated ten others. He opened two new tuberculosis sanatoria. He closed an insane asylum known for particularly cruel treatment of its patients and fired its medical director. He secured federal funds to build new housing for 900 families (Dejong, 2008).

Once John Collier left his position as Commission of Indian Affairs in 1945, the political winds and attitudes toward AI/AN shifted again. Dillion S. Myer, who was named Commissioner of Indian Affairs in 1950, was determined to use his office to “free” the tribes from the control of the BIA. Myer brought his professional experience from his position as head of the War Relocation Authority, an agency charged with relocating Japanese-American citizens during World War II, first to relocation camps, and then “freeing” the detainees from the camp (Philp, 1995). Myer sought not only to assimilate AI/AN, but also to terminate the trust relationship with AI/AN and eliminate the BIA. Instigated by Myer, the “Termination” policy, as it came to be known, sought to overturn many of the provisions of the IRA, and “liquidate the special ‘ward’ status of Indians and the ‘trust’ responsibilities of government to look after their best interests” (Nabokov, 1999, p. 334) through “rapid assimilation through terminating tribes’ legal existence by removing their federal recognition as tribes, eliminating their reservations, and relocating Indians away from their homeland” (Shelton, 2004, p. 9). During this period the legal recognition of 109 tribes was terminated (Shelton, 2004), which released

1.4 million acres of land for individual ownership to 12, 000 persons in the terminated tribes. The AI/AN from the terminated tribes retained the ethnic designation of “Indian” but lost all access to the federal social and health programs of the trust responsibility. Cramer (2005) states, “Congress had separated the ethnic identity of ‘Indian’ from the legal protection and political identity offered by ‘tribe’” (p. 21). Myer also urged the return of boarding schools for AI/AN children and “ordered classes to stop stressing native culture” (Nabokov, 1999, p. 334), and insisted that classes should prepare the children for employment off the reservation.

The assimilation plan coincided with Myer’s plan for termination, as the BIA began urging AI/AN to relocate to urban areas. American Indians were relocated from the reservations to eight cities throughout the US (Dixon & Roubideaux, 2001). When moving AI/AN to the cities, there was concern that they would not assimilate, so a concerted effort was made to place AI/AN geographically distant from their former neighbors (Burhansstipanov, 2000; Hall, 2001). The inducements of housing and jobs in the Indian Relocation Act of 1956 (Adult Indian Vocational Training Act, 1956) to lure tribal members off the reservation never quite materialized, and without emotional support, many AI/AN experienced loneliness, depression, alcoholism and unemployment (Nabokov, 1999, p. 336). Once in the cities, the 35,000 AI/AN who moved (Robbins, 1992, p. 99) often lost tribal status or, because of inter-marriage, no longer met blood quantum rules to qualify for tribal recognition<sup>13</sup> and health services provision.

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<sup>13</sup> Inter-marriage dilution of blood quantum includes not only inter-marriage between other races and AI/AN, but also inter-marriage between two AI/AN from different tribes or in some cases between different clans of the same tribe (Dixon & Roubideaux, 2001).

Myer's termination plan for the federal provision of services to AI/AN included the provision of health services from Indian Service. In 1951 he worked toward state and local control of public health functions by "enforcing a policy of operating facilities only when Indians could not receive care elsewhere or could not receive care without being segregated" (Dejong, 2008, p. 130). By 1953 he had closed one hospital, negotiated with the state of South Dakota to provide preventive and public health services to AI/AN residing there, and recommended the closure of seven additional hospitals (Dejong, 2008). Myer's successor in 1953, Glenn Emmons, successfully closed the seven hospitals by 1955.

### **Transfer to Public Health Service**

Congress, under the mandate to reduce government expenditures and eager to divest itself of the trust responsibility to AI/AN, supported the transfer of health provision to the States, and until that transfer could be completed, endorsed consolidation of Indian Service with the Public Health Service (PHS). Already PHS physicians had been loaned to Indian Service facilities because of the dire shortage in those facilities, since "the sixty Indian hospitals [were] staffed by just sixty-three Indian Service physicians" (Dejong, 2008, p. 132). James "Ray" Shaw, the director of the Indian health program in 1952, and later the first director of Indian Health Service under PHS, along with Surgeon General Leonard A. Scheele and prominent medical associations, such as the American Medical Association, the National Tuberculosis Associations, and the American Public Health Association, also strongly supported the transfer to PHS. For advocates of the transfer, PHS had the resources of physicians and public health preventive care protocols to improve health services for AI/AN. PHS also provided a career structure that supported

professional growth and opportunities to medical personnel, and therefore recruitment of trained and competent physicians was more likely. Advocates of the transfer also pointed to the BIA officials' authority and misdirected use of money designated for health services provision to other projects. As one example, Shaw noted that funds designated to fight TB on the Navajo Nation had been used by the OIA agency superintendent to build a warehouse and community center (Dejong, 2008).<sup>14</sup> Many tribes objected to the consolidation because they feared that the consolidation took them one step closer to renege trust responsibilities by the federal government and left them with no one agency working for the betterment of AI/AN. In fact, the transfer was delayed until the Oklahoma Congressional delegate missed an essential vote to move the bill out of committee. The pressure to consolidate outweighed any objections and in 1954, the Transfer Act moved the BIA's health programs to the Public Health Service in what is now the Department of Health and Human Services (DHHS) with an effective date of July 1, 1955. Accompanying the programs were the assets and responsibilities of "fifty-six hospitals, thirty-six school infirmaries, and 970 building valued at \$40,000,000, as well as some 3500 health employees (Dejong, 2008, p. 136). The AI/AN population was estimated to be 472,000 persons, although that number did not include AI/AN of mixed blood living off the reservations (United States Department of Health Education and Welfare & Public Health Service, 1957). Just prior to the transfer, Indian Service hospitals held 1746 patients per day and saw 1145 persons daily as outpatients. Shaw became the first director of the Branch of Indian Health under PHS.

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<sup>14</sup> The severity of the TB epidemic on the Navajo Nation is discussed in Chapter 5.

The first three directors of IHS guided the development of IHS once it was moved under PHS. Shaw served as the first director from 1955 to 1962, and during his term “the IHS had evolved into a large, organized rural health system with hospitals, clinics, allied health personnel, environmental health services, and a \$60 million annual budget” (Bergman, Grossman, Erdrich, Todd, & Forquera, 1999, p. 584). His successors, Carruth Wagner, (1962–1965) and E.S. (Stu) Rabeau, (1966–1969) established training programs for personnel, training of community health representatives (CHR), and an emphasis on the “use of research findings to plan and evaluate intervention programs” (Bergman et al., 1999 p. 584).

Following the Transfer Act (1955), Congress held the expectation that the Public Health Service would be able to terminate the provision of health services to AI/AN at a reasonable pace, so Congress allocated funds to upgrade some facilities and hire more physicians. The House Appropriations Committee also allocated funds for two surveys. The first survey, due October 1955, was to gauge the most pressing needs to bring facilities, such as hospitals, clinics, and homes to an acceptable level (Rife & Dellapenna, 2009). The second survey, with a due date of October 1956, was to be a comprehensive look at the AI/AN health problem.

Shaw returned the first survey in October 1955. Shaw reported that the health of AI/AN was a half century behind the rest of the US. Recruitment and retention of health professionals was difficult, and the medical facilities were in dire need of repair. Shaw estimated that to bring the infrastructure to an acceptable level would require “over \$51 million in supplemental 1956 funds and an additional \$43 million for 1957” (as quoted in Rife & Dellapenna, 2009, p. 31).

The report from the second, more comprehensive survey, was over three hundred pages, and became known as the “Goldbook”<sup>15</sup> because of its cover (Rife & Dellapenna, 2009). The Goldbook found that compared to the whole US population, among American Indians total mortality was 20% higher, children ages 1-4 had a mortality rate 5 times higher, life expectancy was 10 years lower, and deaths from infectious diseases such as influenza and TB were at a level matched by the entire US population 20 years earlier (United States Department of Health Education and Welfare & Public Health Service, 1957). The Goldbook also pointed to poor sanitation and inadequate fresh water supplies as environmental factors impacting the overall health status of AI/AN. Malnutrition also contributed to the poor health status, given the median income on the reservations was \$1000/year (Rife & Dellapenna, 2009). Bringing the health status of the AI/AN to an acceptable level through a health program would require, according to the report (United States Department of Health Education and Welfare & Public Health Service, 1957) in excess of \$60 million per year for a maximum of 10 years. Additionally, the report states Congress should prepare to spend capital costs of \$42 million and sanitation facility construction costs of \$29 million.

Shaw knew sanitation was contributing to the health issues on the reservations and even before the transfer to PHS was complete, investigated to see if construction funds for sanitation facilities were included in the Transfer Act. Since they were not, once the transfer was complete Shaw used his political acumen to push for improved sanitation

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<sup>15</sup> Grim, the IHS Director from 2002-2007, states, “The Gold Book is recognized as a founding historical marker outlining the challenges that faced the newly formed IHS” (Indian Health Service, n.d.-a, p. 3).



on the reservations. The first two bills introduced to Congress failed, but an additional push for sanitation on the reservations came from a local project in Nevada. Senator Alan Bible, a member of the appropriations committee asked Shaw for advice because Bible's constituents in Nevada were complaining about contamination of their water supply from an Elko reservation runoff. Congress allocated \$34000 to provide water and sewer lines. The Elko project was completed after five months and considered so successful (Rife & Dellapenna, 2009) that on July 31, 1959, Congress approved Public Law 86-121, the Indian Sanitation Facilities Act (1959).

### **Self-Determination and Self-Governance**

The improvements brought to IHS under the leadership of its first three directors did not necessarily improve the health of American Indians. Jones (2006) writes:

Health conditions remained bad into the 1970s: life expectancy was two thirds the national average, and the incidence of infant mortality (1.5 times), diabetes (2 times), suicide (3 times), accidents (4 times), tuberculosis (14 times), gastrointestinal infections (27 times), dysentery (40 times), and rheumatic fever (60 times) also were above the national average (p. 2130).

In the first two decades of its existence, IHS was predominantly a "highly integrated regionalized system dominated by White professionals (some Public Health Service career officers, some individuals serving 2-year military obligations, some civil servants" (Kunitz, 1996, p. 1466). As Bergman et al (1999) write, "Until the late 1960s, services for Indians were conducted on their behalf but without their involvement" (p. 585).

In 1970, President Richard Nixon challenged Congress to forgo termination policies and “build upon the capacities and insights of the Indian people” (Public Papers of the Presidents of the United States: Richard Nixon, 1970, p. 565) to design the future for AI/AN. Nixon’s policy statement to Congress also acknowledged that the relationship between the US government and AI/AN historically had vacillated between two extremes. In the first, the relationship was guided by a sense of paternalism on the part of the government leading to dependence on the government by AI/AN. In the second extreme, the government sought to shed its responsibilities and terminate its relationships with AI/AN. Nixon (Public Papers of the Presidents of the United States: Richard Nixon, 1970) was emphatic in his rejection of either extreme, noting:

Down through the years, through written treaties and through formal and informal agreements, our government has made specific commitments to the Indian people. For their part, the Indians have often surrendered claims to vast tracts of land and have accepted life on government reservations. In exchange, the government has agreed to provide community services such as health, education and public safety, services which would presumably allow Indian communities to enjoy a standard of living comparable to that of other Americans (pp. 565-566).

Nixon’s statement to Congress calling for AI/AN self-determination without termination foreshadowed legislation increasing AI/AN input into policies intending to

improve the health and welfare of AI/AN<sup>16</sup>. Led by Senator Henry (Scoop) Jackson, in 1975 Congress passed the Indian Self-Determination and Educational Assistance Act (Indian Self-Determination and Education Assistance Act, 1975) (ISDEAA). ISDEAA established that tribes could contract with the Secretary of the Interior (specifically the agencies of the BIA and the Bureau of Indian Education) and/or the Secretary of the Department of Health, Education, and Welfare (specifically the IHS) to carry out the services and programs the Federal Government provides to AI/AN. Tribes could request contracts to manage federal funds for health programs (Indian Health Service, 2016b; Thierry et al., 2009), education, and land management. The federal department would oversee that the quality of the program did not diminish under tribal control.

The fourth director of IHS, Emory Johnson (1969-1981) sought to regain the trust of Indian communities as well as their input about health services. Johnson was encouraged by Nixon's policy statement to Congress about American Indians, and remarked years later:

Nixon's Indian policy statement turned Federal/Indian relations on its [sic] head.

At one fell swoop a colonial system was brought into the modern world. His concept of a business deal, i.e., land from the Indians in exchange for federal

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<sup>16</sup> AI/AN activists began organizing in the early 1960s and often protested the status of their peoples and the government's broken treaties. Of note, between Nixon's statement in 1970 until the passage of ISDEAA, conspicuous protests included the Indians of All Tribes occupation of Alcatraz begun in 1969 and lasting until 1972 and the American Indian Movement's occupation of the BIA in 1972. For additional information on the activists' influence on politics and legislation, see (Cramer, 2005; V. Deloria & Lytle, 1998; Jaimes, 1992)

services, gave credibility to our position that the tribes had purchased a prepaid health care plan in perpetuity (as quoted in Bergman et al., 1999, p. 588).

Under Johnson's leadership, the Association of American Indian Physicians (AAIP) was formed. Further, Johnson gathered recommendations from 90% of Indian communities regarding their own health needs and a comprehensive plan to meet those needs. Johnson encouraged tribes to voluntarily establish health boards "to evaluate their own health programs while providing IHS with a 'consumers [sic] assessment' of the health care services that the Indians were currently getting from the government" (Rife & Dellapenna, 2009, p. 63), and to prepare the tribes to eventually manage their own health programs. Using their input, Johnson, with the help of Scoop Jackson, introduced the Indian Health Care Improvement Act (1976) (IHCIA) which was passed in 1976 in the U.S. Congress (Bergman et al., 1999, p. 587).

In the Indian Health Care Improvement Act of 1976 (IHCIA) the US government explicitly states its aspirations for Indian health in Section 3:

The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy (Indian Health Care Improvement Act, 1976).

The IHCIA addressed AI/AN health needs and appropriated funds in five particular areas: identifying qualified AI/AN and encouraging AI/AN to apply to schools for health professions; constructing and renovating sanitation and health care facilities; allowing Indian Health Service facilities to bill Medicare and Medicaid for health

services; contracting with urban Indian health organizations that provide health services to urban AI/AN; creating a feasibility study for the establishment of an AI/AN medical school; and most importantly, funding for additional personnel and services to “eliminate health services backlogs” and which were meant to supplement IHS funding rather than “to offset or limit the appropriations required by the Service to continue to serve the health needs of Indian people during and subsequent to such fiscal-year period” (Indian Health Care Improvement Act, 1976).

The IHCIA provided many positive consequences. The first was in providing scholarships to AI/AN to enter professional health fields. By 2013, “4,064 individuals graduated and entered IHS employment” (Rife & Dellapenna, 2009, p. 70). Funding for the improvement of health facilities was long overdue, as in 1975 it was reported that less than half of the IHS hospitals, and none of the health centers “met the standards of the Joint Committee on Accreditation of Hospitals” (Rife & Dellapenna, 2009, p. 70).

Many refer to IHCIA when pointing to promises made by the US government to provide the “highest health status” to AI/AN, but it expired after the initial seven years and required additional authorizations. It was reauthorized four times until 2000, when it was no longer authorized (Thierry et al., 2009). Without the additional funding, IHS struggled to provide health services after 2000, constrained by a budget that was less than half what was needed. There is a saying in Indian Country, “don’t get sick after June,” that refers to the time of year when IHS may run out of funds (Jalonick, 2009). It wasn’t until 2010 that IHCIA was permanently authorized as part of the Patient Protection and Affordable Health Care Act (Patient Protection and Affordable Care Act, 2010).

Johnson's successor as IHS Director was Everett Rhoades, MD. Rhoades, a member of the Kiowa Nation of Oklahoma, was an infectious disease specialist who was nationally known for his "teaching and research in the fields of nosocomial infections, tuberculosis, and fungal diseases" (Rife & Dellapenna, 2009, p. 82) at the University of Oklahoma. Rhoades faced a political maelstrom during his tenure under the Reagan administration, but was able to incorporate oral health into IHS health services, as well as initiatives to address injury prevention and alcohol and substance abuse.

One of Rhoades' initiatives was regrettable, namely his push to establish blood quantum rules for eligibility for health services. Rhoades initially pushed to have a one-quarter blood quantum as the standard for eligibility, but reconsidered his position after the tribes voiced opposition to any entity other than themselves determining tribal membership. Unfortunately, despite Rhoades' reversal of his opinion, the department of Human Resources and Services Administration (HRSA) ordered the implementation of the blood quantum rule. Congress noticed the tribes' resistance and vocal opposition, however, and in 1987 Congress imposed a moratorium (Rife & Dellapenna, 2009) on implementation of the blood quantum eligibility rule.<sup>17</sup>

During Rhoades' tenure, IHS was elevated to an agency, the seventh under US Public Health Service, from its status as a Bureau under HRSA. As an agency, IHS had more direct reporting and visibility in the Department of Health and Human Services.

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<sup>17</sup> Tribes are still able to determine who qualifies as a member of their tribe, and while many tribes have adopted a blood quantum determination, there is no universal standard. The Affordable Care Act, however, does require a potential patient to provide documentation from the tribe to prove membership, if other methods of proof are unavailable (U.S. Centers for Medicare & Medicaid Services, n.d.).

Rhoades saw the elevation as a means to increase tribal involvement in health programs. Despite the administration's fiscal conservatism, under Rhoades IHCIA was reauthorized in 1988 extending it to September 30, 1992, and authorized under George HW Bush until September 30, 2000 (Rife & Dellapenna, 2009).

Besides authorizing funds for another eight years, the 1992 amendments to IHCIA included urban Indians in the statement "possible health status for Indians and urban Indians" (Indian Health Amendments of 1992). The 1992 amendments also created an avenue for the US government to extend the tribal self-governance demonstration project to IHS programs. The self-governance demonstration project had begun in 1988 after the newspaper, *The Arizona Republic*, reported on widespread corruption and mismanagement at the BIA. Following the exposé, the self-governance project gave ten tribes the ability to redesign programs and reallocate funding from the BIA to suit their needs. One of the complaints about the self-determination contracts previously established by ISDEAA had been the required oversight by the government, and the tribes' inability to move funds to other programs under their management. The self-governance demonstration project allowed ten tribes to form a negotiated compact with the government, in which the federal government provided the funds it would have otherwise allocated to the programs. The tribes then managed and administered the funds and the programs.

Seven tribes who had participated in the BIA self-governance demonstration project compacted with IHS for health services after the passage of the 1992 amendments to IHCIA. The program continued to develop with more tribes and was so successful that in 1994 Congress made self-governance a permanent pathway for Department of the

Interior programs (such as the BIA) when they amended the ISDEAA with the Indian Self-Determination Contract Reform Act (1994). Technical amendments to the Act (Technical Amendments Act of 1994) instructed IHS to allow up to thirty new tribes per year to compact for health services for the next 10 years. The Act underscored the intentions of Congress in its statement of policy:

It is the policy of this title to permanently establish and implement tribal self-governance—

- (1) to enable the United States to maintain and improve its unique and continuing relationship with, and responsibility to, Indian tribes;
- (2) to permit each Indian tribe to choose the extent of the participation of such tribe in self-governance;
- (3) to coexist with the provisions of the Indian Self-Determination Act relating to the provision of Indian services by designated Federal agencies;
- (4) to ensure the continuation of the trust responsibility of the United States to Indian tribes and Indian individuals;
- (5) to permit an orderly transition from Federal domination of programs and services to provide Indian tribes with meaningful authority to plan, conduct, redesign, and administer programs, services, functions, and activities that meet the needs of the individual tribal communities; and
- (6) to provide for an orderly transition through a planned and measurable parallel reduction in the Federal bureaucracy (Indian Self-Determination Contract Reform Act, 1994).



It's against this backdrop that the next director came to IHS when Rhoades retired in 1993. Because IHS now had the status of an agency, new directors had to be politically appointed and confirmed by the Congress. Tribes in Alaska put forward the name of Michael H. Trujillo, MD as their suggestion for the post. Senator Jeff Bingaman and Representative Bill Richardson, both from New Mexico, made a formal nomination for Trujillo. After confirmation hearings before the Senate Select Committee, at which tribes testified on Trujillo's behalf, President Bill Clinton chose Trujillo for the position, and Congress confirmed him as new director of IHS on March 25 1994. Trujillo's mandate from the administration and Congress was threefold: to include tribes in the political process and on the road to self-governance; to streamline IHS so that tribes had more direct access to the agency to make their needs known; and to make sure the needs of the tribes were visible to the administration. To meet the mandate, Trujillo began the redesign of IHS and its delivery of health services to tribes.

Trujillo began this redesign process by forming an Indian Design Health team that included tribal representatives selected by the tribes, IHS staff members, health care providers, and other stakeholders. Rather than a restructuring of IHS, Trujillo encouraged the team to reimagine IHS by building on its strengths such as rural care delivery (Rife & Dellapenna, 2009), but keeping in mind its future included "tribal self-determination, self-governance, and federal downsizing" (Dixon & Roubideaux, 2001, p. 101). Besides recommending tribal input and power sharing with the federal government, the team developed a new acronym "I/T/U" to reflect the three-pronged system of health care delivery to AI/AN, that is, IHS direct care, tribally contracted/compacted care, and urban care centers.

Tribes were also brought into the budget formulation process, and eventually gave the annual presentations to Congress. Funding for services remained a challenge, but Clinton issued an Executive Order in 1998 “Consultation and Coordination with Indian Tribal Governments” which not only validated Trujillo’s efforts to include tribes in all discussions and planning, but also opened the door to allow the recruitment of other partners, such as the Mayo Clinic, the World Health Organization, and the CDC to develop new revenue streams and utilize their expertise to support the tribes’ specific health needs.

During Trujillo’s tenure, more tribes sought the ability to enter self-determination contracts or self-governance compacts with IHS to administer their own health programs. Congress made permanent the ability for tribes to enter a self-governance compact with IHS when they passed the Title V of the Tribal Self-Governance Amendments of 2000 (Tribal Self-Governance Amendments, 2000). The amendments allow an additional fifty eligible tribes to participate in self-governance compacts annually. In the amendments, Congress reiterated its promises to AI/AN in Section 2:

Congress finds that—

- (1) the tribal right of self-government flows from the inherent sovereignty of Indian tribes and nations;
- (2) the United States recognizes a special government-to-government relationship with Indian tribes, including the right of the Indian tribes to self-governance, as reflected in the Constitution, treaties, Federal statutes, and the course of dealings of the United States with Indian tribes;

(3) although progress has been made, the Federal bureaucracy, with its centralized rules and regulations, has eroded tribal self-governance and dominates tribal affairs;

(4) the Tribal Self-Governance Demonstration Project, established under Title III of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f note) was designed to improve and perpetuate the government-to-government relationship between Indian tribes and the United States and to strengthen tribal control over Federal funding and program management;

(5) although the Federal Government has made considerable strides in improving Indian health care, it has failed to fully meet its trust responsibilities and to satisfy its obligations to the Indian tribes under treaties and other laws; and

(6) Congress has reviewed the results of the Tribal Self Governance Demonstration Project and finds that transferring full control and funding to tribal governments, upon tribal request, over decision making for Federal programs, services, functions, and activities (or portions thereof)—

(A) is an appropriate and effective means of implementing the Federal policy of government-to-government relations with Indian tribes; and

(B) strengthens the Federal policy of Indian self-determination. (Tribal Self-Governance Amendments, 2000).

Trujillo completed his second term with IHS and resigned in 2002. As the director charged with bringing IHS into the 21<sup>st</sup> century, Trujillo oversaw many changes in the delivery of health services to AI/AN and created the template for including AI/AN in decision-making and planning for their future health needs.

The historical context given in the preceding sections details how some policies of the US government ran counter to ensuring that the American Indian was raised to the highest possible health status as well as the steps taken in the last half of the 20<sup>th</sup> century to amend those policies. In the next chapter, I'll examine how actions of the US government affected the health status of three tribes during the days of the separation and containment policies. The second case study looks at the Menominee and how the loss of their federally recognized tribal status during the termination period affected their health status. The final case study examines the expectations for the improvement of health for two tribes that participated in clinical research projects against the promises made to them about those specific projects.

## CHAPTER 3

### SEPARATION AND CONTAINMENT POLICIES

The policy that restricted the AI/AN to living on reservations, whether by removal to other lands or from a reduction of their tribal land, developed out of the US government's desire to separate and contain the AI/AN from the rest of the population as settlers moved into previously held American Indian territory. The US government envisioned AI/AN tribes as eventually becoming "civilized" or assimilated, but until that time, separation was necessary for their own protection as confrontations developed between Whites and AI/AN (Trennert, 1975). According to historian Robert A. Trennert (1975), the actions of the US government were not motivated by racial hostility but rather a general acceptance of the superiority of "Anglo-American institutions as a fact" (p. 1). While separation may have served to allow AI/AN to slowly assimilate, historian S. Lyman Tyler (1973) asserts it also allowed settlers to obtain the land held by AI/AN.

Those tribes removed from their native lands to other areas faced malnutrition and exposure on the trek to the new location. One notable example was the removal of the Cherokee along the Trail of Tears that resulted in the death of nearly half the tribe. The health of American Indians suffered as restricting them to reservations became the policy of the US. Many tribes were already debilitated by the extinction of the buffalo, and the confines of the reservation and reservation housing contributed to their ill health. The US government made a number of promises to provide for the care of those tribes that ceded land and lived on the reservation, but the fulfillment of those promises was often delayed or absent. Often the missing items, whether supplies or annuity payments, were integral to survival for the tribe.

In this chapter, I examine how the policy of separation and containment led to diminished health statuses for American Indians, not only at the inception of the policy, but also to present day life on the reservation. Besides health, the reservation system also changed the relationship between AI/AN and the US as it created AI/AN dependence on the US government for basic needs.

The chapter begins with a history of the development of the removal policy. To understand the impact of the removal policy on tribes, I've chosen two case studies. In the first, I outline how the removal of the Five Civilized Tribes from their homes in the southeastern States of the US to Indian Territory, or what is now Oklahoma, was devastating and deadly to the tribes during the removal process. Despite winning lawsuits that endorsed their sovereignty, the tribes were forcibly removed from their land and homes. After their removal to Indian Territory, the US government did not follow through on its promises to pay the tribes annuities, provide supplies, or protect the tribes from settlers encroaching on their lands. The broken promises served to divide the tribes in their loyalties to the US government versus the Confederacy in the Civil War. Following the war, the US punished the tribes by reducing the size of their reservations.

The second case describes the effect of the removal policy on the Poncas. The Ponca tribe had “never raised arms against the United States” (Howard, 1965) or the White settlers. Miscommunication and egregious blunders led to the US government removing the Poncas to Indian Territory. Nearly a third of the tribe died on the journey and the remaining members of the tribe arrived sick or disabled. It was nearly three years from the beginning of their removal before the birth rate for the Poncas exceeded the death rate, and then only by a small margin (Howard, 1965).

The policy of containment on a tribal-specific reservation developed after the initial removal policy. Whereas the US government had assumed that the land acquired in the Louisiana Purchase would be open for many years in the future, as the demand for gold and settlements increased, the US viewed the containment of AI/AN on reservations as an attractive option. While some professed that restricting AI/AN to reservations was for their own protection from the vices of Whites until the AI/AN could be fully assimilated, the restriction also ensured safe passage for emigrants. Despite promises made to American Indians by the US government, AI/AN often found that the reservations left them vulnerable to attacks from other tribes, encroachment by settlers and emigrants, and dependent on the US government for their basic needs when the lands did not meet their needs for survival. AI/AN also found that a treaty was not a permanent guarantee when the Senate changed the terms, or the treaty was renegotiated in subsequent years resulting in more land cessions. The example of the Sioux provides considerable insight into how the reservation policy made the Sioux susceptible to ill health. The BIA also placed structural constraints on the Sioux that has made poverty, hunger, and illness persistent on the Sioux reservations today.

### **Removal to Indian Territory**

The arrival of the first settlers on the North American continent had challenged the AI/AN's use and occupancy of the land. The French, Spanish, and British explorers developed their own ways of interacting with the native populations. The US adopted the British approach to relationships with AI/AN after the signing of the Treaty of Paris in 1783 and the "Jay Treaty" of 1795 that turned the British lands over to the United States. The British lay claim to the land under the right of discovery from John Cabot and others

in the service of the British Crown who had landed in North America (Perdue, 2002). To the British, the AI/AN found on the shores of North America were rightful occupants of the land, but only in so far as they made use of it by cultivating it and permanently dwelling upon it. Since most tribes at that time were hunter/gatherers and transitory dwellers, the British viewed AI/AN occupancy of the land as temporary. In their treaties with the British, then, “Indians surrendered their right to live on the land” and acknowledged “legitimate ownership of the land to the ‘civilized’ nation that had discovered the land” (Perdue, 2002, p. 70). Although not expressly articulated, the treaties also served to separate AI/AN from the British by delineating the boundaries of the land ceded. The British viewed tribes as sovereign nations for purposes of treaty-making, but not as rightful owners of the lands the British had discovered.

In its early interactions with AI/AN, the United States adopted the British policy of making treaties with the tribes to secure use of the land. George Washington encouraged the first Congress to make treaties with the AI/AN as treaties gave the US the rights to the land with less cost and trouble than going to war (V. Deloria & DeMallie, 1999). Besides making treaties rather than war, the US began the practice of providing some form of compensation for land cessions as well as for signs of friendship. In the treaty with the Six Nations in 1784 that identified boundaries of the tribal land but did not specify any land cessions, the US government promised to provide gifts to the tribes. The first treaty that specified an annuity for land cessions was in 1790 to the Creeks in the amount of \$1500 in perpetuity. Paying tribes for land in annual payments allowed the federal government to reduce their initial outlay of funds, create the tribal dependence on the annuities, and use the annuities as a bargaining point for future land cessions.



The first treaties between the US government and tribes in the late 1700s identified boundaries that separated AI/AN lands and the US, with a promise that any citizen of the US settling on the land reserved for the tribes lost the protection of the US government, and the tribes could punish the encroachers as they wished. By 1805, the treaties stated that tribes were to complain to the US government if settlers came onto their lands, and the US government would remove them. Henry Knox, as first Secretary of War, was responsible for establishing policy for AI/AN affairs. Knox held that the boundaries of treaties needed to be enforced, “in order to secure the confidence of the Indians and the respect of United States citizens that lived on the frontier” (Tyler, 1973, p. 39). Knox wanted non-Indian trespassers removed from tribal land, by force if necessary, to protect tribes from becoming extinct “from the migratory pressures of the Nation's citizens” (Tyler, 1973, p. 39).

In response to Knox’s ideology on Indian Affairs, four temporary trade and intercourse acts were passed between 1790 and 1799 that “established [the federal government] as a protector of the Indian's rights in land against any third party” (Hagan, 1961, p. 44). The acts required traders to be licensed, prevented private sales of tribal land between AI/AN and non-Indians, and gave the US government the authority to punish non-Indians for crimes committed by them on Indian land. The 1796 legislation required non-Indians to have passports before entering tribal land and restricted them from driving cattle on that land. The last legislation in 1799 softened the stance toward non-Indian trespassers, however, when it enjoined the military to “handle squatters ‘with

all the humanity which the circumstances will possibly permit' ... If Indian and white interests conflicted, the Indian was sacrificed" (Hagan, 1961, p. 44).<sup>18</sup>

Besides setting up the federal government as protector of AI/AN land, the trade and intercourse legislation assigned jurisdiction for crimes committed by AI/AN off tribal land to the federal government. It allowed for the federal government to punish AI/AN who committed crimes outside of tribal land, if the State in which the crime was committed was unable to reach a satisfactory settlement with the victim. The federal government's form of punishment, however, was limited to withholding some of the annuity payment promised to the entire tribe (Tyler, 1973). The temporary trade and intercourse acts were codified permanently in legislation in 1802 that duplicated the 1799 act with the addition of a clause in Article 21 designed "to help assure fairness in trade and to assist with the maintenance of peace on the frontier" (Tyler, 1973, p. 42) by granting power to the President to restrict sales or distribution of alcohol among the tribes.

Despite the legislation aimed at preventing non-Indians from trespassing on tribal land, the US government was unable to protect tribes from the westward movement of settlers because of the sheer expanse of the area and the rush of settlers and speculators. Affecting the limited action against settlers on the frontier too was the US's conflicted policy stance on the future of AI/AN. Tyler (1973) notes:

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<sup>18</sup> Additional trade acts were passed in 1834 and 1847. The 1834 act tightened some of the restrictions and penalties, but remained essentially unchanged from earlier acts. The 1847 act tightened up the restrictions on liquor trade with tribes, and made the annuities payable to heads of households in the tribe to reduce the temptation of the chiefs who had been given the annuities prior to 1847 (Trennert, 1975).

The basic policy of the United States intended that white settlement should advance and the Indians withdraw. Its interest was primarily that this process should be as free of disorder and injustice as possible. The government meant to restrain and govern the advance of the whites, not to prevent it forever (a quotation from Robert H. White, *Messages of the Governors of Tennessee* (5 vols., Nashville. 1952-1959) as quoted in Tyler, 1973, pp. 49-50).

Creation of a separate territory for AI/AN had first been proposed by the British as they tried to recruit AI/AN to fight with them against the US. The newly-formed US government also envisioned a separate State for some AI/AN as evidenced by a 1778 treaty with the Delaware that offered for them “to join the present confederation, and to form a state whereof the Delaware nation shall be the head” (Treaty with the Delawares, 1778. Sept. 17, 1778. 7 Stat., 13. Kappler, 1904, pg 3), an option never acted upon.

**The Five Civilized Tribes.** The pressures for a removal policy arose originally from settlers surrounding the tribes in Georgia. In 1802, following a land sale of 20,000,000 acres that angered the State of Georgia, the US agreed to “extinguish the Indian title to land in Georgia” (as quoted in Hagan, 1961, p. 54). The removal of AI/AN in Georgia, though not expressed, was implied as there was no other mechanism that could extinguish title without voluntary land cessions. Pressure from Georgia to act upon that promise persisted, and with his political opponents questioning the necessity for the Louisiana Purchase, President Thomas Jefferson “responded that the eastern Indians could now be moved west of the Mississippi and ‘civilized’ at their own pace” (Perdue, 2002, p. 74).

In 1804, Jefferson persuaded Congress to include in the act organizing the Louisiana territory the provision that allowed the exchange of AI/AN in the East to lands in the new unorganized territory that were less likely to be necessary for the settlers in the near future. Trennert (1975) asserts that there was no intent to place tribes on “lands unfit for habitation” (p. 2) but rather on good lands suitable for agriculture. To Jefferson, “White contact with the Indian was degrading to the native and the cause of most interracial difficulties” (Trennert, 1975, p. 2). Many felt that contact with White culture had introduced AI/AN to the vices of the culture, such as alcohol and the additional opportunities for gambling, and that civilization through education, Christianization, and separation, could transfer the appropriate culture.

The US government used two tactics to introduce civilization to AI/AN tribes. The first was to create an agent system whereby the agent lived among the AI/AN and taught the “principles of commercial agriculture, animal husbandry, and the domestic arts” (Perdue, 2002, p. 71). The government’s second method of civilizing tribes was to pay missionaries to convert tribes to Christianity, as the government’s vision of civilization included Christianity (Perdue, 2002).

The agents were able to work with several southern tribes and convince the tribes to “settle on isolated homesteads” in preparation for the individualistic ownership of property, as well as to forego traditional gender roles of the women as farmers. The agents provided the men with the farming implements and taught the women the domestic arts.

The primary goal of civilization of tribes was for the government to get the tribes to relinquish their land as they became assimilated. Besides the activities aimed toward

civilizing the tribes, the US government also created a factory system that the President oversaw. Trading houses were designed to provide a means for AI/AN to sell their goods and to allow the traders, as representatives of the government, to “undersell the British rivals and soon eliminate them from the trade” (Tyler, 1973, p. 43). The factory system, however, was challenged by the requirement that the factory had to purchase all goods offered for sale, regardless of the public demand for it. Initially, the factory was required to restrict credit and only sell American goods even though they were inferior to those supplied from the British (Hagan, 1961). Despite the requirement to restrict the amount of debt allowed to accrue, Jefferson (1853) envisioned that the factory system could relieve some of the pressure in the southern States in 1802. Jefferson (1853) described the Chickasaw tribe that at the time lived in Kentucky, Tennessee, Alabama and Mississippi, as “the most friendly to us, and at the same time the most adverse to the diminution of their lands” (p. 460) yet advocated methods to induce them to relinquish their lands:

The method by which we may advance towards our object will be, 1, [sic] to press the encouragements to agriculture, by which they may see how little land will maintain them much better, and the advantage of exchanging useless deserts to improve their farms. 2. To establish among them a factory or factories for furnishing them with all the necessaries and comforts they may wish (spirituous liquors excepted), encouraging these, and especially their leading men, to run in debt for these beyond their individual means of paying; and whenever in that situation, they will always cede lands to rid themselves of debt. A factory about the Chickasaw bluffs, would be tolerably central, and they might admit us to tend corn for feeding the factory and themselves when at it, and even to fix some

persons for the protection of the factory from the Indians west of the Mississippi, and others. After awhile we might purchase these, and add to it from time to time.

3. We should continue to increase and nourish their friendship and confidence by every act of justice and of favor which we can possibly render them. What we know in favor of the other Indians, should not constitute the measure of what we do for these, our views as to these being so much more important. This tribe is very poor, and they want necessaries with which we abound. We want lands with which they abound; and these natural wants seem to offer fair ground of mutual supply (pp. 460-461).

In 1802 the federal government built a factory on Chickasaw land, and by 1805, the tribe's debt was \$12,000. In an 1805 treaty with the US government, the Chickasaw ceded all the land north of the Tennessee River for \$20,000 (Perdue, 2002) of which they realized only \$8,000 after the debt was cleared. The factory system was discontinued in 1822, in part because the threat of the competition from British and Spanish goods to the market had diminished (Hagan, 1961).

Indebtedness to the factory system was but one method the federal government used to secure land cessions from southern tribes. Perdue (2002) asserts that treaty commissioners also used bribery and played upon tribal factionalism to coerce southern tribes to cede land. Although some of the treaties that had been signed using these tactics were rejected by the President, the "willingness of the federal government to use bribery and factionalism demoralized southern Indians" (Perdue, 2002, p. 73). To counteract the persistent demand for their land, tribes in the southern States began to adopt the political

systems of the US.<sup>19</sup> They created a centralized government, policies and procedures for action by that government, and identified chiefs as leaders and made them responsible for their actions. The Cherokees and the Choctaws made it a capital offense to cede tribal land (Perdue, 2002). But the tribes experienced some factionalism between groups that were more traditional and the progressives as the some of the actions leaned more toward assimilation, and such factionalism made the tribes vulnerable to unscrupulous treaty commissioners.

Most treaties after the War of 1812 were concerned with the removal of the southern tribes, following Jefferson's ideal of having tribes move voluntarily. Southern states complained that the relinquishment of title was moving too slowly, particularly as cotton became a valuable agricultural crop. Georgia, in particular, pressed the federal government to honor its commitment to extinguish title to the lands held by AI/AN in its boundaries. After the Cherokees created a government and written constitution in 1827, Georgia "interpreted this act as a violation of state sovereignty and renewed demands for extinction of Indian land titles" (Perdue, 2002, p. 76). Georgia passed several laws to assert the state's dominance over the tribe, including a law that prevented tribal leaders from speaking against removal, and a law that created a militia solely to enforce state law in the Cherokee country (Perdue, 2002). Additionally, the Georgia legislature began the process to survey and divide Cherokee land for "distribution by lottery to whites"

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<sup>19</sup> Some tribes, namely the Creeks, the Choctaws, and the Cherokees, also adopted the system of owning Black slaves. After the War of 1812, the Creeks promised to reimburse White planters for the slaves who had sought refuge with the Creeks, but most of them had actually settled with the Seminoles. For more information on how the ownership of slaves shaped the settlement of the Five Civilized Nations in Indian Territory, see (Perdue, 2002, pp. 81-82)

(Perdue, 2002, p. 76). Although sympathetic to AI/AN in the dispute with Georgia, President John Quincy Adams lost the election in 1828 to Andrew Jackson.

President Andrew Jackson made his agenda known when he addressed Congress in 1829 and advised tribes that there were two alternatives open to them. The first was to follow the laws of the states in which they lived, or barring that, the second was to move to the West to maintain their tribal governments (Perdue, 2002). Congress passed the Indian Removal Act in 1830, which appropriated \$500,000 to compensate tribes for improvements made to their land once a tribe agreed to be removed to the West. Besides compensation for the improvements, to those who removed, the federal government promised transportation to the new location, subsistence for one year after removal, and an annuity “to provide for education and other tribal services” (Perdue, 2002, p. 77). The US government expected that tribes could be moved to the Indian Territory, the unorganized land roughly where Oklahoma is today, and remain there without much federal supervision. Little thought was given to whether the tribes, some of whom were historical enemies, could live peaceably together.

The Choctaws were the first tribe after the passage of the Indian Removal Act to agree to be removed and cede their land. For those Choctaws that remained within Mississippi, the US government gave them fee simple title to 640 acres of land and they became citizens of the State. The first removal of Choctaws took place in fall 1831. The government had delegated supervision of the move to two civilians who then hired agents in the field to provide supplies and assist the group as it moved to the new location. The Choctaws suffered from exposure and hunger on their trek, as the field agents often did not supply the rations as promised (Perdue, 2002). Subsequent removals were observed



by the military and less subject to corruption and by 1834 as many as 15,000 Choctaws had been removed. Nearly 7000 Choctaws remained in Mississippi, many of whom were non-English speakers and unfamiliar with individual land ownership and were often tricked out of their land by unscrupulous speculators (Perdue, 2002).

The Creeks and the Chickasaws also suffered greatly in their removal. The Creeks who remained and received land allotments of the 640 acres were also often defrauded out of their land, yet refused to leave their homeland. In response, the War Department forcibly removed thousands of Creeks in 1836, and their journey West was plagued with disease and hunger (Perdue, 2002) and by the sinking of a steamboat in which 300 Creek men, women, and children were killed (Rozema, 2003). The Chickasaws agreed to give up their land in the East, but while the government sought suitable land for the tribe in the West, they allotted individual plots to tribal members. The government then opened the rest of the Chickasaw land, over two-thirds of it, to speculators, many of whom then defrauded the remaining Chickasaws to give up title to their plots.

Georgia continued to pressure the US government to get Indian title to the lands in Georgia, but the Cherokee refused to leave, particularly after learning of the corruption that had occurred with the Chickasaw and Creek land allotments and removals. Georgia and its citizens continued to harass the Cherokee, particularly after the discovery of gold on their land (Hagan, 1961). In defiance of federal law, Georgia hanged an American Indian, even though the Supreme Court had voided his sentence. State authorities tried to seize the plantation belonging to a Cherokee because the plantation owner had hired a white worker contrary to state law (Hagan, 1961). When Georgia jailed two White missionaries residing on Cherokee land for refusing to sign an allegiance pledge to the

State, the Cherokee appealed to the Supreme Court. The case, *Worcester v. Georgia* (1832) is considered a landmark case because the Supreme Court ruled that Georgia could not apply State law to the Cherokee Nation as it was a sovereign nation with a special trust relationship with the US. The Supreme Court enjoined Georgia to immediately release the prisoners.

The Cherokee Nation began to entertain the idea of negotiating their removal when Georgia refused to release the missionary prisoners, and President Jackson did not advance federal enforcement of the Supreme Court ruling. The treaty in 1835 that the Cherokees negotiated with the federal government initially had allowed acculturated Cherokees to remain on allotments and to come under State rule, but subsequent articles eliminated that provision, and no Cherokees were allowed to remain. Over 15,000 Cherokees protested against the treaty but the Senate ratified it regardless. In 1838, federal troops rounded up and imprisoned thousands of Cherokees in stockades in preparation for the removal to the West. Because the Cherokee had been “driven from his home and possessions, he was unable to prepare for the trip facing him or to dispose of his property profitably. Jackal-like local whites accompanied the squads and immediately fell on the abandoned property, looting and burning” (Hagan, 1961, p. 81). The death toll in the stockade was high, as the Cherokees had been imprisoned without adequate food, water, or clothing. In response to their request, the newly elected Van Buren administration allowed the Cherokees to “conduct their own removal in the winter of 1838-1839” (Perdue, 2002, p. 80). The statistics on the number of deaths that occurred

during the imprisonment and the trek to Oklahoma are incomplete, but the numbers range from 2,000 to 8,000 Cherokees, or as many as half those removed.<sup>20</sup>

The Seminoles resisted their removal militarily beginning in 1835, and for the next seven years the federal government used the military and a number of volunteers to find the Seminoles hiding in the swamps and the everglades. The government also used bloodhounds to locate and capture the Seminoles after being encouraged to do so by General Zachary Taylor. Troops captured Osceala, one of the Seminole leaders, by violating a flag of truce. The tactic of capture under a flag of truce proved so effective that it was used repeatedly. “The Seminoles forced the United States to commit a total of 40,000 men, between \$30 million to \$40 million, and suffer substantial casualties over the next seven years” (Perdue, 2002). By 1842, the federal government ceased military operations in removing the Seminoles, as most of the tribe had been removed to Indian Territory (Hagan, 1961). Even after the military action ceased, soldiers continued to capture bands of Seminoles until there were only a few hundred left in Florida with 3000 in the West (Perdue, 2002).

Once in Indian Territory, the Five Civilized Tribes, as the Cherokee, Chickasaw, Choctaw, Creek, and Seminole tribes were called, often suffered through the federal government’s “general nonobservance of treaty obligations in the years following removal” (Weeks, 2002, pp. 85-86). Already angry at the government because of their removal, as the Civil War approached, the Five Civilized Tribes were divided in their

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<sup>20</sup> One Texas writer challenges the death toll numbers of the Cherokees on the trek west. William R. Higginbotham (1988) writes that the number of deaths was closer to 800, rather than the 2,000–8,000 commonly reported.

loyalties. Further, the Confederate envoy to AI/AN, Albert Pike, made certain to inform the Five Civilized Tribes of the 1860 campaign speech of William Seward, now serving as Abraham Lincoln's secretary of state, that "advocated the appropriation of the land of the Five Civilized Tribes for white homesteaders" (Weeks, 2002, p. 86). In the spring of 1861, "the federal Indian Bureau withdrew all Indian service agents from the Indian Territory and Secretary of War, Simon Cameron ordered the abandonment of Forts Washita, Arbuckle, and Cobb in the Indian Territory" (Weeks, 2002, p. 86). Confederate forces moved into the abandoned forts. Because the Indian service agents were outside of Indian Territory, the federal government withheld the annuity payments to the tribes in Indian Territory. At the first approach of the Texans at the frontier, the Union troops surrendered their position "leaving the bewildered tribes entirely at the mercy of the pro-Southern agents and Confederate emissaries" (Abel, 1910, p. 283). The Choctaw, like the rest of the tribes, were surrounded by the Confederate States of Arkansas and Texas, and were concerned that a Union win in the Civil War would free their slaves. Along with the Chickasaw, who were also slaveholders, they pledged their allegiance to the Confederacy on July 12, 1861. The Cherokee, Seminole, and Creek tribes were split into two factions: those who wanted to remain neutral, and those who wished to join the Confederacy.

Trying to hold a neutral position was difficult when the tribes were left in Indian Territory without support from the federal government. Opothleyahola, Chief of the Creeks, wrote "in a long letter to Abraham Lincoln, [and] demanded to know why they did not hear from him" (Weeks, 2002, p. 87). In his letter the chief reminded Lincoln of the promise made in their removal treaty that guaranteed that the tribe would be "defended from all interference from any people, and that no white people in the whole

world should ever molest us unless they came from the sky” (Weeks, 2002, p. 87). The neutrals from Cherokee and Seminole tribes exiled to lands occupied by the Creeks, but were soon expelled through a series of battles with the AI/AN factions who sided with the Confederates. In the final battle on December 26, 1861, the same Confederate Indian soldiers, with 1600 Southern army reinforcements, chased the neutrals out of Indian Territory and destroyed all their belongings, including livestock, that had been left behind. The neutrals remained in Kansas for three years, and despite destitution in the new location, offered to assist the Union (Weeks, 2002). The Union organized the previous neutrals into two regiments that accompanied Union soldiers into Indian Territory and captured John Ross, the Cherokee chief who had allied with the Confederates. Many Confederate AI/AN defected as the Union army approached.

After his capture, Ross asked President Lincoln to pardon the Cherokee people for their alliance with the Confederates. Ross detailed that the Cherokee were abandoned by the evacuation of Union forces before the war, and had signed the treaty with the Confederacy “under duress, and only after the United States failed to protect his people under obligations set forth in earlier treaties” (Weeks, 2002, p. 90). Lincoln denied that the US government had broken any treaty obligations, and therefore was less likely to be forgiving of the Cherokee alliance with the Confederates. Lincoln did promise, however, to review the matter more closely after the War was over.

Indian Territory, like the South, was left in ruins at the end of the Civil War. Homes were gone, livestock were dead or roaming free, and fields were destroyed. Reconstruction had begun in the South, but after the Lincoln assassination, the mood in Washington toward the tribes was one of retribution and vindictiveness. The federal

government viewed the actions of the Five Civilized Tribes as treachery and therefore claimed that the existing treaties were compromised (Weeks, 2002). Each of the tribes was forced to sign a Reconstruction treaty. Besides abolishing slavery in the tribes, the treaties called for land cessions from all five tribes. The land ceded amounted to the western half of Oklahoma, reserved by the government for use by other tribes. The Reconstruction treaties also “mandated tribal acquiescence to rights-of-way for future railroad construction across the Indian Territory” (Weeks, 2002, p. 92). John Ross lamented that peace for the Cherokees following the war proved difficult as

victory perched upon the banners of the United States . . . has been achieved at the sacrifice [sic] of hundreds of precious lives, the loss of wealth and resources of the [Cherokee] Nation and amid pain, suffering and destitution hitherto unknown to our people (John Ross as quoted in Weeks, 2002, p. 92).

Recovery for the Five Civilized Tribes was slow, considering that “the Indians lost ground financially, socially, and morally that it had taken them half a century to gain” (Abel, 1910, p. 296). White squatters raced into Indian Territory during the Reconstruction Period, thinking that the treaties had vanquished the rights of the tribes living there. What the squatters saw for “years and years . . . was a sad picture of charred dwellings, broken fences, unstocked homesteads, and woe-begone people” (Abel, 1910, p. 296).

**The Poncas.** Although much has been written about the removal of the Southern tribes, other tribes in the Midwest and the Plains also were removed from their homes with similarly unhealthy outcomes. Some tribes were moved multiple times as the land they occupied became desirable to White settlers. Hagan (1961) notes:

Between 1829 and 1866 the Winnebagos ceded land in seven different negotiations, involving six possible changes of residence ... In constant dislocation for the next thirty years, shifted from one place to another, the Winnebagos deteriorated as a tribe and degenerated individually. Their population declined perhaps 50 per cent as disease and dissipation took their toll. "Miserable and degraded," "profligate, worthless and vindictive," and "besotted" are terms recurring in official reports on the tribe (pp. 81-82).

Helen Hunt Jackson (Jackson, 1881), a writer and social activist, highlighted the plight of the Ponca tribe in her book, *A Century of Dishonor*.<sup>21</sup> The Poncas lived near the Niobrara River in Nebraska, and when Lewis and Clark saw the tribe, it consisted of about 200 members, a number that had been significantly reduced by a smallpox epidemic in 1800 (Howard, 1965). The Poncas signed their first treaty with the US government in 1817 in which both parties pledged perpetual peace and friendship” (Treaty with the Ponca, 1817. June 25, 1817. 7 Stat., 155. Kappler, 1904, p. 140). In a subsequent treaty in 1825, the Poncas accepted that they “reside within the territorial limits of the United States, acknowledge their supremacy, and claim their protection” (Treaty with the Ponca, 1825. June 9, 1825. 7 Stat., 247. Kappler, 1904, p. 225). Although the tribe participated in raids and war parties against the Pawnee and other tribes, the Poncas never “raised arms against the United States” (Howard, 1965), or the White settlers. In fact, in 1846, they allowed a group of 400 Mormons to winter on their

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<sup>21</sup> Jackson has been criticized for a lack of balance in her writings and for suppressing facts but she did publicize the AI/AN struggle in a way no one had before (Hagan, 1961, p. 123). Every effort has been made, using multiple sources, to ensure a full telling of the story of the Poncas.

land. Other tribes, particularly the Pawnee and the Teton [Lakota] Sioux, continued raids on the Poncas. The Poncas often faced starvation after 1855 because the Sioux blocked their access to the buffalo plains for their semi-annual hunt and the Poncas feared leaving their corn fields unattended. With White squatters settling on the verdant bottom land fields, the Poncas realized that the advance of Whites was the inevitable outcome, so ceded much of their land in an 1858 treaty.

In the treaty of 1858, the Poncas acknowledged “their dependence upon the Government of the United States,” and ceded much of their land in return for the promise from the United States “to protect the Poncas in the possession of the tract of land” (Treaty with the Ponca, 1858. Mar. 12, 1858. 12 Stats., 997. Kappler, 1904, p. 772) reserved for them. The government also promised annuities in decreasing amounts over time, as well as an initial outlay of \$20,000 to provide subsistence and housing for the Poncas for the first year (Treaty with the Ponca, 1858. Mar. 12, 1858. 12 Stats., 997. Kappler, 1904, p.772). According to Jackson (1881), once the treaty was made, the Poncas moved to the tract of land as established by the treaty, but the promised improvements and housing did not materialize, in fact because the treaty was not ratified by the Senate until a year following its making. Until ratified by the Senate, the treaty was unenforceable. The Poncas had left their corn-fields at the ceded property and were facing starvation, relieved only by food furnished “at the last minute” by the government (Jackson, 1881, p. 190).

A party of Sioux and Cheyenne warriors attacked the Ponca hunters during their 1859 spring and summer hunts, killing two chiefs and 13 hunters as well as abducting three children. The Sioux claimed they attacked because the Poncas had made a treaty



with the US and sold their land. Incensed by the attack, a chief of the Poncas demanded to know from the Indian agent why the government was rewarding the Sioux and not protecting the Poncas on the land (Howard, 1965). Helen Hunt Jackson (1881) charges that the improvements to the Ponca land in 1861 had far less value than the \$20,000 allotted to make them. Further, the new Indian agent in 1861 sent the Poncas on a hunt since there was no food at the station, nor money to purchase any. Jackson (1881) reports that the Poncas straggled back in less than a month “begging for provisions for their women and children, whom they had left on the plains half-starved, having been unable to find any game, or any food except wild-turnips” (p. 192).

The situation of the Poncas improved modestly over the following years, but suffered a considerable setback in 1868. That year the US negotiated a treaty with the Dakota Sioux and in an “inexplicable and almost criminal blunder, ceded to the Teton [Lakota Sioux] Dakota a tract of land which included all the Ponca land, ceded and unceded” (Howard, 1965, p. 32). The action afforded the Teton Dakota permission to raid the hapless Poncas, since the Poncas now resided on Dakota land. The US government made no attempts to correct the situation nor protect the Poncas over a period of eight years as promised in the treaty of 1858, and in fact, Howard (1965) says, “the Government was supplying the Teton warriors with heavy caliber rifles of the latest make, ostensibly for bison hunting” (p. 32). Finally in 1876, the government appropriated \$25,000 to remove the Ponca tribe to Indian Territory, if they consented to go. Although the chiefs had not been aware that removal was being considered, eight of them consented to travel with an Indian Affairs agent to see if any of the lands in Indian Territory was acceptable to them. Finding none they liked, the chiefs begged to return

home. The agent refused to give them any money, show them to the rail station, or provide them with their interpreter (Jackson, 1881). Rather than remain, the chiefs walked the 500 miles home in the winter. After 50 days they arrived at the Otoe Reserve, where the Otoes gave each of them a pony for the rest of their journey. The government agent stationed with the Otoes remarked that their moccasins had worn through and “when the chiefs entered his room they left the prints of their feet in blood on the floor” (Jackson, 1881, p. 201).

Although the Ponca chiefs appealed to Washington to remain on their lands, on April 12, 1877, an order was issued for them to be removed, using military troops if necessary. Two groups of Poncas left for Indian Territory on April 30 and May 16, the latter group accompanied by 25 troops. Their trip was “a ghastly and miserable experience, recalled by present-day tribesmen as the Ponca ‘Trail of Tears’” (Howard, 1965, p. 33). Rainy weather, swollen rivers, muddy roads, illness, and death were consistent in their journey. A tornado killed one child and seriously injured several others, besides carrying away the gear and supplies. There was at least one death nearly every day of the journey. When the group of 681 Poncas arrived in Indian Territory, they found that no accommodations had been made for their housing (Foreman, 1946).

Agent Howard was shocked at the lack of preparation for the comfort of his charges, by now broken down by sickness and the hardships of the journey. Discouraged, homesick, and hopeless, the Ponca found themselves on the lands of strangers, in the middle of a hot summer, with no crops nor prospects for any. (Howard, 1965, p. 35)

The land the government set aside for them was land acquired from the Cherokee in their treaty of 1866 after the Civil War. The removal of the Poncas had reduced their numbers considerably:

having been on the move through the summers of 1877 and 1878, the Ponca had been unable to cultivate the soil for 2 years. Also in 1878 they suffered greatly from malaria, or "chills and fever" as it was then termed. As the Ponca had come from their northern home where such ills were little known, the disease was peculiarly fatal to them, and many died of it after they reached the Indian Territory. In fact, since the tribe left Nebraska one-third had died, and nearly all of the survivors were sick or disabled ... By the summer of 1879, 26 more persons had died and 16 births had been recorded. The population of the Ponca in the Indian Territory now stood at only 530 (Howard, 1965, pp. 36-37).

In 1879 the young son of Chief Standing Bear died, and Standing Bear was determined to bury him on familiar soil, an action that "set in motion events which were to bring a measure of justice, and worldwide fame, to the chief and his tribe" (Howard, 1965, p. 36). He and a few members of his tribe, 66 in all, began the journey back to Nebraska with the boy's body in a wagon. Upon notification of their departure, Secretary of the Interior Carl Schurz ordered that they be arrested and returned to Indian Territory. General Crook arrested the group and began the trek back to Indian Territory, with a stop overnight in Omaha. When the citizens of Omaha learned of the expedition, they were "seething with indignation at this latest evidence of the Government's cruelty" (Howard, 1965, p. 36) and arranged for legal representation for Standing Bear. The attorneys for Standing Bear's group argued that the group had been imprisoned illegally while the US

government argued that “an Indian is not a person within the meaning of the law” (Howard, 1965, p. 36) and therefore had no right to sue. In his own defense, Standing Bear made an eloquent speech pointing out that AI/AN and Whites share the same humanity. The judge was moved by his speech and the arguments of the defense attorneys and declared “that an Indian is a person the same as a White man and similarly entitled to the protection of the Constitution” (Howard, 1965, p. 37). Standing Bear was set free and he returned to the lands on the Niobrara River where he buried his son. Although an important victory for AI/AN in that it recognized the AI/AN as human beings, it did not override the government’s ability to require AI/AN to remain on their own reservations or within Indian territory.

Much was made in the political arena during the removal period about the humanitarian treatment of the American Indians in their removal to lands in the west for their protection. One critic was the French visitor Alexis de Tocqueville (1849) who expresses his disdain of the removal policy:

Provided that the Indians retain their barbarous condition, the Americans take no part in their affairs: they treat them as independent nations, and do not possess themselves of their hunting grounds without a treaty of purchase: and if an Indian nation happens to be so encroached upon as to be unable to subsist upon its territory, they afford it brotherly assistance in transporting it to a grave sufficiently remote from the land of its fathers.

The Spaniards were unable to exterminate the Indian race by those unparalleled atrocities which brand them with indelible shame, nor did they even succeed in wholly depriving it of its rights; but the Americans of the United States have

accomplished this twofold purpose with singular felicity; tranquilly, legally, philanthropically, without shedding blood, and without violating a single great principle of morality in the eyes of the world. It is impossible to destroy men with more respect for the laws of humanity (pp. 385-386).

For the Whites, removal of AI/AN achieved the goals of protecting AI/AN from abrupt introduction to, and protection from the seamier side, of White culture, but importantly also opened millions of acres of land in the previous Indian territories to White settlements. The death toll of AI/AN is but one measure of the effect on the tribes that were removed, as they had been removed, with little input from them, to lands that were foreign to them in topography and history.

### **The Reservation System**

The removal policy provided only a temporary solution to the problems facing White settlers as well as to tribes that had been assured of a place in Indian Territory. The vast open spaces of the land acquired during the Louisiana Purchase fell prey to the US's actualization of its Manifest Destiny, the belief that the US expansion into unsettled territories was inevitable and justifiable because it was "prearranged by heavenly authority" (VanDevelder, 2009, p. 143). As Tyler (1973) notes:

So long as the settlers moving westward could find ample fertile, accessible and unclaimed regions elsewhere, there was little pressure to open up the Indian Territory for settlement. As we review our history, however, and consider that removal was officially enunciated as Government policy in 1830, that Texas, California, and the Oregon country were being settled in the 1830's and 1840's,

and that the Middle West was settled soon thereafter, we see how temporary this effort really was (p. 63).

Twelve new states came into the United States between 1816 and 1848. The British had ceded the Oregon Territory in 1846. From Mexico, the US acquired California and New Mexico, as well as the acknowledgement of the annexation of Texas after the Mexican-American War ended in 1848. Between 1845 and 1848 alone over 1.2 million square miles were added to the US possession. With nearly 200,000 AI/AN living in that area, the population of AI/AN nearly doubled (Tyler, 1973). The remainder of the land acquired with the Louisiana Purchase was then unorganized Indian Territory.

Statehood for California and Texas brought challenges for the native populations within their borders. Spain had created the mission system in what is now California in which the friars indentured AI/AN in the attempt to Christianize and assimilate them. When Mexico acquired the area in 1833 from Spain, it secularized the mission system, an action that was meant to free the AI/AN from the “benevolent despotism of the mission system” (Hagan, 1961, p. 96). Countless AI/AN who knew of no life other than the mission system were suddenly set adrift from the mission villages. Mexico also gave many land grants for 100-acre rancheros to its wealthy Mexican citizens so many mission natives then found work on the rancheros. In the *Treaty of Guadalupe Hidalgo* at the end of the Mexican-American War in 1848, the United States recognized the citizenship of the California AI/AN (Tyler, 1973). To some Americans, if the AI/AN were citizens, then the United States did not owe them special protection as AI/AN. “Often, in actual practice, they were denied the rights of citizenship and also failed to receive the special protection of the United States they were entitled to as Indians” (Tyler, 1973, p. 68). But

the end of the war had again left the California AI/AN with few options since many of the Mexican rancho owners had lost their land and the gold seekers had rushed in (Hagan, 1961). The rancheros were divided into smaller parcels and the new landowners had little use for, nor tolerance of, AI/AN. Grazing and farming on the rancheros further depleted the AI/AN's food supply, and runoffs from the gold mines and ranches contaminated the creeks and streams.

Agents from the government negotiated land cessions in 18 treaties with California tribes in the hopes of establishing a reservation system that was similar to the mission system. Congress refused to ratify those treaties with the justification that because the United States had purchased California, the natives had no legal right to use nor receive any profit from the land (Hagan, 1961, p. 96). Although the treaties weren't ratified, the AI/AN were moved to reservations.

In 1852, while not acknowledging any claims of California Indians to the land, the United States appointed Edward F. Beale as the first Superintendent of Indian Affairs in California. Beale's plan was to establish five reserves on which the Indians would reside. Congress appropriated \$250,000, and in September 1853, Beale gathered some 2,000 Indians and established the 50,000-acre Tejon Reserve. By focusing all his effort at Tejon, Beale neglected some 61,000 hungry natives. 'Beale declared that humanity must yield to necessity, they are not dangerous, therefore they must be neglected' (Heizer, Robert F., et al. Handbook of North American Indians. Vol. 8. Washington: Smithsonian Institution 1978: 110 as quoted in Dutschke, 2014).

The next Superintendent of Indian Affairs in California, Col. Thomas J. Henley, moved AI/AN to the other four reservations Beale had imagined, but did not show any concern for the AI/AN even though water was scarce on those lands. As one commissioner wrote frankly, "That these reservations will cause any considerable annoyance to the whites we do not believe. They consist, for the most part, of ground unfitted for cultivation, but suited to the peculiar habits of the Indians" (Hagan, 1961, p. 97).

Squatter friends of Henley grazed animals that trampled the crops of the AI/AN on the unfenced properties. These early reservations "eventually left federal ownership, and the Indians who resided on them were once again forced to move to other lands to make new homes" (Dutschke, 2014, p. 9).

Like the AI/AN in California, the native populations in Texas also found that statehood left them without land. When Texas became a state in 1848, the federal government assumed control of the AI/AN within its boundaries, but Texas retained the rights to land. This left the Texas AI/AN without any claims to the land on which they lived. The rush of gold seekers in 1849-1851 riled the AI/AN because they trampled over their lands and slaughtered more buffalo. Land grants were made to railroads, and there was a clamor within Texas to open west Texas to settlements (Dickerson, 2010). In response Texas opened two reservations in 1852. Critics claimed that in the months between October 1857 and April 1858, AI/AN attacks in the nearby communities resulted in the theft of over 500 horses and the deaths of 25 settlers (Dickerson, 2010). Many of the raids were most likely from the Plains Indians, but the reservation Indians were blamed. The settlers began to demand that the reservation AI/AN be moved, and in June



1859, the state and federal government agreed to move the Brazos Reservation AI/AN to Indian Territory. “Escorted by soldiers and rangers, the 1,000 or so reservation Indians crossed the river out of Texas on September 1” (Dickerson, 2010).

The short-lived reservations in California and Texas were unique because not only were they the first attempts at creating reservations, but also because they had arisen out of the land ownership issues. In other areas of the country, the “government did little towards solving the Indian problems facing the nation prior to 1849” (Trennert, 1975). As many as 10,000 settlers, gold seekers, and emigrants had followed the Oregon Trail across Indian Territory in 1849. Large numbers of people had crossed the plains using the Platte River route, bringing them into contact with tribes that had not been bothered previously with emigration along the Santa Fe Trail. The Plains tribes found their “buffalo ranges invaded by gold-inflamed whites” (Hagan, 1961, p. 94) as the hope of more gold drove prospectors westward. “Some wagon trains were twenty miles long and drawn by thousands of oxen” (VanDevelder, 2009, p. 151). The livestock brought with the wagon trains had stripped the prairies and the settlers had cleared the land of timber. The buffalo had been pushed further and further away from those tribes settled along the borders of the frontier, so that only horse-mounted AI/AN could hunt.

Whites also brought cholera via steamboats to Saint Louis and other staging areas “where perhaps 20,000 people” (Trennert, 1975, p. 180) were awaiting suitable weather for their journey west. In Saint Louis alone in 1849, over 4500 people perished (Daly, 2008). The AI/AN, particularly along the emigrant trail soon were afflicted. Especially hard hit were the AI/AN in the Upper Platte (Trennert, 1975). There is no definitive account of the number of losses in the AI/AN communities to cholera, but anecdotal

reports state some tribes lost between one-half and two-thirds their number because of the 1849 epidemic (Powers & Leiker, 1998).

The AI/AN were feeling the pressure from the decimation of their natural resources and their tribal way of life. Whereas some tribes had settled in along the frontier, nomadic tribes such as the Sioux were unwilling to negotiate with the White man or cede lands (Trennert, 1975). The sheer numbers of people crossing the Plains made confrontations with AI/AN inevitable. Not all confrontations were violent, but there were enough attacks that the US army put its first forts, Forts Laramie and Kearny, “beyond the eastern periphery of the great plains” (Dunlay, 2002, p. 105) in 1848 and 1849.

The idea of reservations germinated in 1848 when the commissioner of Indian Affairs, William Medill, with the border tribes in mind proposed “two reservations (called colonies) for the tribes standing in the way of expansion” (Trennert, 1975, p. 30). His report echoed the sentiment that by placing AI/AN in the colonies, the AI/AN would be protected from the White population and thus assured of their survival until they were fully assimilated. Besides segregation of the races, Medill also highlighted that the colonies would ensure safe passage for the emigrants, and allow Indian Affairs to economize, since the smaller tracts of land would require fewer personnel to work with the AI/AN. Once in the compact units, the missionary groups would be more active in the civilization efforts, and further reduce the amount of government expenditure to that end. Although the Senate rejected Medill’s proposal on July 25, the idea of reservations for AI/AN and clear passage for travelers to the West would reappear in subsequent years.

With the election of Zachary Taylor as President in 1849 came the creation of the Department of the Interior and the move of the Office of Indian Affairs to it from the War Department. Taylor selected Thomas Ewing as the first Secretary of the Interior. Ewing “pursued a more energetic Indian policy from the beginning” (Trennert, 1975, p. 42). One of Ewing’s first actions was to move Indian agencies closer to the west, and to add more agents. This action was controversial because the territories into which he moved the agencies were still under military rule as they had not yet been organized by Congress. The debate centered on whether civilians could represent the national government in unorganized territory. Ewing also named Orlando Brown as Commissioner of Indian Affairs in place of Medill. One of Medill’s last acts was to officially recommend to Ewing that because the plains tribes were “growing restless over the white invasion of their country” (Trennert, 1975, p. 47), the federal government should make an effort to protect the emigrants. Because the “natural state of these Indians was one of war and that they could not be expected to abstain from molesting white travelers” (Trennert, 1975, p. 47) unless some effort was made to compensate them for a right of way through their country. Medill recommended a generous treaty. Ewing agreed to Medill’s proposal and gave it to Brown to manage. Brown embellished Medill’s original suggestions with the comment:

There should also be a clear and definite understanding as to the general boundaries of the sections of the country respectively claimed by them, as their residence & hunting grounds; and they should be required not to trespass upon those of each other without permission from the occupant tribes, or from the

proper Agent or agents of the government (Brown to Fitzpatrick as quoted in Trennert, 1975, p. 47).

The idea of colonies or reserved lands, albeit with the common hunting ground Brown also envisioned as being set aside for the nomadic tribes, had become, in the minds of federal policy makers, a well-defined area in which to restrict them.

Urged by the superintendent of Indian Affairs in Saint Louis, David Dawson Mitchell, and the Indian agent for the Upper Arkansas and Platte country, Thomas Fitzpatrick, Brown submitted a proposal to Ewing to hold a treaty council of all the western tribes to secure safe passage for the emigrants and to compensate the tribes for the depletion of their natural resources. While waiting for Congressional action, Brown advanced \$5000 to Fitzpatrick and Mitchell to start purchasing gifts for the tribes who would attend.<sup>22</sup> Congress, though distracted by the question of whether slavery should be allowed in the Kansas and Nebraska territories, soon turned their attention to the potential of an uprising by the western tribes. The realization that the “western two-thirds of the continent was still legally owned by the Indians” (VanDevellder, 2009, p. 153) provided the impetus for Congress to quickly appropriate \$100,000, half of the original request, for the “expense of holding treaties of friendship with all the wild tribes and savages of the prairie” (VanDevellder, 2009, p. 154). Mitchell and Fitzpatrick were named co-commissioners of the peace council to be held in late summer 1851 at Fort Laramie in Wyoming.

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<sup>22</sup> The advance of the \$5000 was the last act Brown performed for the endeavor as the sudden death of Zachary Taylor in July 1850 brought in James Polk as President who then appointed Luke Lea as Commissioner of Indian Affairs.

As Mitchell and Fitzpatrick arrived at Fort Laramie, over fifteen thousand AI/AN filled the valley around the fort, representing nearly all the tribes of the west. From that council, Mitchell and Fitzpatrick negotiated the treaties of Fort Laramie with the Sioux, the Cheyenne, and Arapahoe tribes, as well as tribes with less fierce domination of the plains. In the treaties, the government established boundaries for the tribes as the “formal recognition by the Great White Father of the Indian world as it already existed” (VanDevellder, 2009, p. 194) but not to restrict a tribe from hunting or travelling out of their territory, as long as they did not fight with other tribes or cause trouble for white settlers. In compensation, the treaty specified that the tribes were to get annuities of \$50,000 for 50 years. Before Congress would ratify the treaty, however, it amended the treaty to reduce the number of years for the annuity from 50 years to only 10.

The Treaty of Fort Laramie, despite its promise of unrestricted travel for tribes outside their boundaries, nevertheless manifests the government’s commitment to separating tribes in reserves away from the Whites. With the Sioux and other tribes away from the Oregon Trail, the only obstructions to a wide corridor to the Pacific were the lands of the border tribes, such as the Omaha, Otoe, and Pawnee. By 1854, treaties with the border tribes resulted in the government acquiring another 13 million acres of land.

Trennert (1975) remarks of this period in the US government’s relations with AI/AN:

Thus for a handful of presents, the Indians were each given a defined land where they were told that they could live ‘forever’ in peace. Little did they realize that in the future this arrangement allowed the Americans to divide and conquer—to force individual groups onto more restricted reserves without upsetting their neighbors” (Trennert, 1975, p. 191).

While the restriction of tribes to fixed boundaries was idealized at the Treaty of Fort Laramie, the enforcement of reservations began after the Civil War. A study of Sioux in the next section allows a clearer understanding of how reservation life affected the health status of AI/AN and created their dependence on the government to supply their basic needs.

**The Sioux.** The French shortened an Ojibwa (Chippewa) name to “Sioux” for an alliance of tribes occupying the northern plains of America and spoke the Siouan language. Though sharing roots of a common language, the Sioux alliance consists of “three main divisions, the Dakota to the east, the Yankton-Yanktonai in the middle and the Lakota to the west” (Gibbon, 2003, p. 2). Besides the three divisions, there are also several subdivisions and even smaller political units within each tribe. Although each tribe’s history with the US government may be slightly different, when they overlap the label “Sioux” will be used to describe them. Every effort will be made to distinguish the divisions when it is pertinent to their interactions with the US government.

When the Europeans first arrived on the continent in the 1600s, the Sioux occupied the forests of central Minnesota and northwestern Wisconsin. Because of competition between other tribes, and to improve accessibility to fur traders, the Sioux moved southward and westward. The Lakota Sioux obtained horses in the early 1700s and by mid-century became nomadic Plains horsemen, who hunted bison from their territory in Wyoming and eastern Montana. The Yankton-Yanktonai settled in what is now South Dakota, while the Dakotas were predominantly in what is now Minnesota. The US government made its first treaty with the Dakota Sioux in 1805. In it, the Dakota ceded two nine-square mile sections of land for forts along the St. Croix and the

Mississippi rivers. Lt. Zebulon M. Pike negotiated that treaty and left blank any amount of money for compensation to the Dakota, although Pike had placed the land value at \$200,000. When the Senate ratified the treaty, they filled in the compensation amount of \$2,000 (Meyer, 1967). Other treaties were signed beginning in 1815 through 1816 in which the bands of Sioux acknowledged that their previous land cessions to the British, the Spanish, and the French now belonged to the United States, and that the Sioux placed themselves under the protection of the United States. In 1819 the government built Fort Snelling in an attempt to “keep peace between the Sioux and the Ojibwa, and to keep non-Indian settlers off Indian lands and British fur traders out of American territory” (Gibbon, 2003, p. 5). Indian agents at the fort began the civilization of the Dakota by introducing the Dakota to agricultural techniques and by inviting missionary teachers to teach reading and writing English.

The Dakota Sioux agreed in the Prairie du Chen Treaty of 1830 to sell large tracts of their land in Minnesota. The government promised them an annuity of \$3000 for 10 years, \$3000 annually for the education of the children in the tribe, and the usual items the US government provided to ensure civilization of a tribe, namely a blacksmith and agricultural tools (Treaty with the Sauk and Foxes, etc., 1830. July 15, 1830. 7 Stat., 328. Kappler, 1904, pp. 305-307). By 1837, the Dakota ceded the rest of their land in Minnesota. Much of the money the US government paid for the land went to satisfy the Dakota’s debts to the traders. In the next decade, the land restrictions and reduction in game resulted in the Dakota becoming more dependent on the US government for goods and food (Gibbon, 2003).

The Yankton also ceded land beginning in the 1830 Prairie du Chen treaty and in subsequent treaties gave up the 2.2 million acres guaranteed to them in that particular treaty (Gibbon, 2003). Unlike their Sioux relatives on either side of them, although the Yankton employed horses in their hunting, the Yankton spent most of the year in permanent villages. In 1857-1859 as the American emigrants and squatters moved onto the eastern borders of their lands, the Yankton tried to chase the squatters off. In 1858, however, a number of Yankton chiefs signed the Treaty of April 19 in which they ceded a great deal of their land for the guarantee of annuities from the government. The Yankton also agreed to be assigned to a reservation as long as they had unrestricted use of the pipestone quarry in southwestern Minnesota (Gibbon, 2003).

The Lakota Sioux, a nomadic band of tribes, dominated the northern plains in the early nineteenth century. Their territory ranged from the Rocky Mountains in the west to the southward turn of the Missouri river in the east, as well as from the Platte River in the south to the Saskatchewan River in the north (Gibbon, 2003). Well-equipped with British guns and horses, they sent war and hunting parties westward, particularly as the bison herds advanced to the west in front of the settlers. War parties targeted the river tribes and those on the still rich hunting grounds of the Platte River valley as bison numbers diminished.

To keep the peace between the warring tribes, the US government used a show of military force in the 1830s and 1840s and built Fort Leavenworth, Fort Atkinson and other forts on the Missouri River, as well as Fort Kearny and Fort Laramie on the Platte River. "By 1854 the US army had 52 forts in the West, although few had garrisons of more than 100 men" (Gibbon, 2003, p. 105). There were approximately 20 million people



in the US, and as described earlier, in 1849 as many as 55,000 prospectors crossed Indian country with tens of thousands of AI/AN on the Plains impeding their path to the Pacific. The Treaty at Fort Laramie in 1851 with the Lakota Sioux, their northern allies of Cheyenne and Arapahoe, and other northern Plains tribes established three years of relative peace until the Mormon Cow incident. In that incident in 1854, a Lakota Sioux from the Brulé band had killed a stray cow belonging to a migrating Mormon party and shared the remains with the 4000 Lakota camped at Fort Laramie awaiting their annuities. Lt. John Grattan, in violation of an earlier treaty that called for restitution for transgressions to be made from the tribal annuity, took 29 soldiers and an interpreter with him to apprehend the thief from the camp. “Grattan, a hot-tempered West Point graduate who was openly contemptuous of the Sioux’s reputation for bravery, had only recently arrived on the frontier” (VanDevellder, 2009, p. 217). Grattan refused to let the head chief deliver the thief, and instead rode into the camp to arrest him. When the chief rose up in protest, a rifle shot rang out. A bloody melee ensued leaving the head chief dead with an army bullet in his back, and the entire Grattan party also killed (VanDevellder, 2009). In retaliation, Jefferson Davis, the Secretary of War, sent General William S. Haney west “to subdue the savages” (VanDevellder, 2009, p. 218). Haney’s troops surrounded the Brulé band, and “provoked them to put up resistance” (VanDevellder, 2009, p. 218). When the Brulé obliged, Haney’s troops fired indiscriminately, killing dozens of women and children and ultimately taking 70 surviving women and children as hostages. Haney moved on to seek retribution from other Sioux bands on the Platte. For two decades, the dominant forces who had signed the treaty at Fort Laramie were involved in full-scale war that had begun because of a cow. During the first 10 years following the Mormon

Cow incident, the skirmishes were small, but served to teach the tribes that the “peaceful coexistence promised in the 1851 treaty was a chimera” (VanDevelder, 2009, p. 219).

Haney’s actions enlightened the AI/AN to the fact that the US government did not bother to enforce the treaties and protect the tribes from the White citizens who “demonstrated brazen contempt for the laws and treaty obligations of their government” (VanDevelder, 2009, p. 219).

Helen Hunt Jackson (1881) asserts that it was the US government’s failure to meet the obligations of the 1830 treaty that incited the Dakota to war in 1862. Annuities owed under that treaty were often late. The roads to the lands on which they were to stay were impassable in winter, so often food and other supplies were unavailable in the winter. Housing, the blacksmith, and other promises in the treaty were slow to materialize. The government’s non-payment of the education fund was particularly bothersome to the tribe.

In 1838 the Indian Bureau reports that all the stipulations of this treaty have been complied with, "except those which appropriate \$8230 to be expended annually in the purchase of medicines, agricultural implements, and stock; and for the support of a physician, farmers and blacksmiths," and "bind the United States to supply these Sioux as soon as practicable with agricultural implements, tools, cattle, and such other articles as may be useful to them, to an amount not exceeding \$10,000, to enable them to break up and improve their lands." The fulfilment or non-fulfilment of these stipulations has been left to the discretion of the agent; and the agent writes that is "must be obvious to any one with a general personal intercourse" on his part "is impracticable," and that "his interviews with many of

the tribes must result from casualty and accident." This was undoubtedly true; but it did not, in all probability, occur to the Indians that it was a good and sufficient reason for their not receiving the \$18,000 worth of goods promised. (Jackson, 1881, p. 145)

Other treaty negotiations, particularly one drafted in 1841, promised large annuities, so the tribe neglected its hunting and farming as they waited. The 1841 treaty was never ratified, and the AI/AN were in a miserable state in the fall of 1842 (Meyer, 1967). The Dakota Sioux became reservation AI/AN after the signing the Treaties of Traverse des Sioux and Mendota in 1851. In the treaty, the Dakota Sioux had specified land that they expected to be reserved for them, but the Senate struck that article of the treaty before ratifying it. Once the government decided on lands for them, it took over a year to make it ready. In the meantime, the Dakota Sioux returned to their ceded land to hunt, as there was little game on their reservation. Driven by starvation because "the annuities were paid so late and in such small amounts in both 1853 and 1854 that the Indians could not live through the winter on what they received" (Meyer, 1967, p. 92). The government's attention to the Civil War had diverted men and appropriations away from Indian Affairs needed to pay annuities and provide supplies. Settlers continued to invade their lands. "A sense of wrong in the past and distrust for the futures was ever deepening in their minds, and preparing them to be thrown by any small provocation into an antagonism and hostility grossly disproportionate to the apparent cause" (Jackson, 1881, p. 163). The Sioux Uprising, as it is known, began with four young Sioux hunters killing white settlers on a dare in 1862. To sanction the killings, factions of the tribe called for the Dakota Sioux to wage war on the Whites. In bloody battles that lasted more

than a month, over 800 Whites were killed. At the end, over two thousand Dakota Sioux surrendered. A military commission sentenced 303 AI/AN to death, but President Abraham Lincoln intervened and all but 38 were reprieved (Utley & Washburn, 2002). The government also confiscated the lands of the Dakota, declaring that the actions of the Dakota violated their treaties. Most Sioux were banished from Minnesota as a direct result of the conflict. Those bands that were allowed to remain faced anti-Indian resentment and by 1867, only 50 Dakota remained in Minnesota of the nearly 6,000 that had lived there in 1850.

Not all the Dakota surrendered in Minnesota, as many of the most militant escaped to the Lakota Sioux and recounted their story of the uprising. The Plains Sioux were already angered by the hordes of settlers crossing their lands after the discovery of gold in Montana. Military expeditions increased on the Plains, and by 1865, all the Lakota Sioux, along with their Cheyenne and Arapaho allies were at war. Galvanizing their alliance was the Sand Creek Massacre.

The Sand Creek Massacre in 1864, in which a Methodist minister of the Colorado militia, Colonel John Chivington, went in search of AI/AN outside Denver, fueled the Plains AI/AN's simmering anger at the government. A group of approximately 500 Cheyenne, consisting of mostly women, children, and elders, camped without fear because of a peace treaty they had just signed with the government that promised the group US Army protection from other tribes. Chivington burst into the camp and ordered his troops to fire and kill them all, including the women and children. Once all were dead, Chivington's soldiers mutilated the bodies by taking trophies of scalps, ears, fingers, and genitalia that were eventually hung at the Denver Opera House as decorations. Although

Congress investigated the incident and denounced Chivington, neither he nor any of his troops were ever punished for their deeds.

Outraged by Chivington's attack on the Cheyenne camp, the Sioux "renewed their blood oaths of friendship [to the Cheyenne] and vowed to fight to the last man to exact revenge" (VanDevelder, 2009, p. 223). In the ensuing years, war continued between soldiers and AI/AN. When Ulysses S. Grant became President in 1869, he outlined his new peace policy for AI/AN. If AI/AN were peaceful and in place on their reservations, they would be "educated, Christianized, taught to support themselves by farming, and given rations, clothing and other goods to ease the transition. There too they would be safe from the army" (Utley & Washburn, 2002, p. 227). Grant's policy warned AI/AN that if they left the reservation, they could expect to be treated as hostiles. Grant put William Tecumseh Sherman, a Civil War general, and Major General Philip Sheridan to apply warfare tactics learned in the Civil War to the Plains Indians. Engaging with the AI/AN in the winter when they were most vulnerable, Sherman "aimed to destroy the shelter, food, and horses of 'renegade' Sioux, and to capture the families of fighting men. No peace was to be made with a tribe until it admitted defeat" (Gibbon, 2003, p. 115). These expeditions further solidified the resolve of the Sioux and their allies to stop the encroachment of settlers on their lands.

Military expansion and travelers on the Bozeman Trail riled Red Cloud, chief of one band of Lakota Sioux, and his battle with them in 1866-1868 led to the Fort Laramie Treaty in 1868. In that treaty, the government acquiesced to Red Cloud's demand to close the Bozeman Trail and established the boundaries of a Great Sioux Reservation bound by the Missouri River to the east and the western half of what is South Dakota today. Not all

Lakota were happy with the treaty, particularly those bands following Crazy Horse and Sitting Bull.

Although both Whites and the followers of Crazy Horse and Sitting Bull ignored the Fort Laramie Treaty, in the summer of 1874 a survey team for the railroad, accompanied by Lt. Col. George Armstrong Custer and a group of prospectors, found gold in the Black Hills of Wyoming and South Dakota. Purportedly, Grant had sent the group to find gold to “relieve the banking crisis that had suspended construction of the transcontinental railroad” (VanDevelder, 2009, p. 223). More prospectors followed and encroached on the lands set aside for the Sioux. The government did nothing to remove the prospectors and in fact, protected gold miners as the Black Hills became home to the towns of Deadwood and Rapid City. The Black Hills were sacred to the Sioux not only as “their home where their ancestral bones have slept for centuries, but as the home of their Great Spirit” (Gessner, 1931, p. 6). To quell hostilities, Grant ordered for meat rations to be withheld by the government if reservation AI/AN joined the battles, and gave the military permission to act against any militant AI/AN roaming free (Gibbon, 2003).

When none of the bands of AI/AN complied with an order to appear at the Indian agencies by January 31, 1876, the army set out to “destroy the camps of the bands and force them onto reservations” (Gibbon, 2003, p. 116). The results were fierce battles, but the Sioux were victorious only in the Battle of the Little Bighorn in 1876 in which Custer and 210 of his men were killed. The US Army won subsequent battles and the Sioux and their allies surrendered. As a result, the Lakota lost their beloved Black Hills in an 1877 treaty.

Because the US Army had won the war for the Northern Plains, the Lakota were regarded as a conquered people.

As a conquered people, their land was regarded as obtained by conquest rather than through purchase or treaty negotiations. The tribes were forced to negotiate and were required to accept what was offered them, which generally was land poorly suited to farming ... [To learn American ways] the decisions made by Congress at this time contain not only provisions for reservations but also for agents, education, tools, health benefits, clothing, foods and so forth. (Gibbon, 2003, pp. 118-119).

Confined to the reservation, the Lakota became dependent on the provisions given to them by the government. Missionaries and Indian agents encouraged the Lakota to give up all vestiges of their tribal way of life for one of farming, on land that was “plagued by lack of rain and grasshoppers” (Gibbon, 2003, p. 119). Proud hunters, with no bison left to hunt, had “no choice but to hunt other game and to live on the annuities distributed at their agencies” (Gibbon, 2003, p. 119). The reservations took from the Sioux their occupations of hunting and making war—activities that “shaped their social economic, political, religious and military institutions ... To make matters worse, the issues of food and clothing were too little and of poor quality: the people were hungry much of the time” (Utley & Washburn, 2002, p. 291). Reservation life affected all members of the family.

Soon entire families became dependent on government rations that infrequently lasted until the next issue day. Once on the reservation, tough beef and rancid bacon replaced the meat of buffalo and large game in the Native diet. Small

amounts of flour, corn, coffee, sugar, and baking powder supplemented beef issues, and, as Congress reduced appropriations, food available for an adult varied from one-third to one-half that of a standard army ration. With large game becoming scarce, women were unable to dress and tan hides for sale to reservation-based traders to raise cash to buy food, cloth, and other necessities. Hunger and privation became a familiar condition in lodges of formerly successful hunters (Berthrong, 2002, p. 135).

The Sioux made further land cessions, beginning in 1890 in which the Great Sioux Reservation was divided into five smaller reservations that eventually were reduced further in size by the allotment policy begun in 1887. The government threatened to cut rations if the Sioux opposed accepting allotments. Given that rations “in the late 1880s and early 1890s had already been reduced by half” (Gibbon, 2003, p. 136), the Sioux “were living on the brink of starvation” (Gibbon, 2003, p. 136), and so assented to the allotments. The allotment policy gave 160 acres of land to each individual family and opened the rest of the reservations to non-Indians for settlements or were placed in federal trust for military posts or national parks. Of the Pine Ridge reservation, “more than half the land in allotments was eventually sold or leased to non-Indians” (Gibbon, 2003, p. 137).

The close quarters and difficult living conditions on the reservations contributed to the ill health of the Sioux. After confinement to the reservation in 1876, “tuberculosis exploded on the Sioux reservations” (Jones, 2004, p. 128). David S. Jones (2004), a historian of science and physician, chronicles that of the 152 reports between 1877 and 1906 from physicians and agents on the Sioux reservations, tuberculosis (TB) was cited



as the leading cause of mortality in 75 percent of them (p. 128). The inevitability of TB on the reservations left “a depressed, almost gloomy feeling to the people” (Jones, 2004, p. 129). The inevitability of TB and its mortality on the reservations caused one agency physician to comment in 1879 that tuberculosis “is slowly but surely solving the Indian problem” (Jones, 2004, p. 137).

The death rate from American Indian TB as compared to other groups shows the disparity in health statuses. Whereas the hospitalization rate for AI/AN soldiers was approximately 36/1000, the rate for White soldiers was 3.27 and 4.42 for Blacks. “In 1911, Joseph Murphy, the medical director of the Indian Medical Service reported that tuberculosis mortality was three times higher among Indians than among whites” (Jones, 2004, p. 129). These high mortality numbers may be incomplete as the sole physician on a reservation may not have known of all the deaths, may have underreported deaths to make their work seem more successful, or perhaps even overreported deaths “to obtain more resources from the BIA” (Jones, 2004, p. 129). Further, the diagnoses of TB were refined in the years under study here, so assignment to a particular diagnosis may have changed. Regardless of the accuracy of the reported deaths to TB, the values do show the trend of increasing incidence and mortality because of TB on the reservations.

Although by the late 1880s scientists had discovered the cause of TB and that it was a transmissible disease, for the physicians, the fact that a bacillus was the cause did not explain why some were more susceptible to the disease than others. Like with other diseases, the theory that there was some predisposition to susceptibility that could be exacerbated by “careless living” (Jones, 2004, p. 133) circulated among the medical profession.

Some physicians blamed the behaviors of the Sioux for their susceptibility to TB. Smoking, alcohol, sharing peace pipes, and dancing were some of the vices these physicians felt led the Sioux to be susceptible to TB. Other physicians noted the multitude of cesspools in and around the teepees, as well as the consumptive spittle deposited within the teepee as some of the causes. Whereas the nomadic tribes would have broken camp as they followed the bison, thus allowing time for the human waste to decay, once located on a reservation, they remained surrounded. Still others blamed the government for the log cabins that kept the stale air within, and the fact that the rations the government supplied were insufficient for the Sioux to maintain good health. In fact, “if asked why the Sioux suffered from so much tuberculosis, agents and agency physicians were far more likely to cite living conditions than racial susceptibility” (Jones, 2004, p. 137).

The task of tending to AI/AN on the reservations was a daunting one for physicians. Congress extended medical services to AI/AN as “gratuity appropriations” after the provisions for medical care expired at the end of their term in the twenty or so treaties that specified medical care. By 1875, half of all Indian agencies had doctors, and by 1882 most agencies had a least one physician (Jones, 2004). Even with one physician per agency, when in 1888 there were 81 doctors, they were responsible for the care of 200,000 AI/AN. The low pay could not induce qualified physicians to take a position in the Indian Office medical service, and accordingly the physicians were often “ill-trained, uninterested, and generally incompetent. The physicians had to get along without adequate equipment and medicines and with little chance to improve their knowledge” (Prucha, 1986, p. 289). The agency medical office had to remain open at all times so if

there was only one physician at an agency, he was unable to make house calls. One physician reckoned that “186 Sioux died without treatment in 1892 because of the impossibility of visiting them in their distant homes” (Jones, 2004, p. 149). For those who could make house calls, it could take a day or two to arrive at the patient’s house because of bad roads and vast distances.

When treating patients, physicians often found they had run out of their supply of medications, or that the medications were obsolete, or had spoiled in shipment to the agency. Physicians frequently were frustrated when their patients would not follow directions regarding treatment. Failure of the patient to complete courses of medicine, or to take the medicine at a particular time of day were obstacles many of the physicians complained about in their reports. Gaining the trust of their patients was also difficult as “medicine men undermined their authority and ministrations” (Jones, 2004, p. 152).

Challenging though it was dealing with their AI/AN patients, many physicians also complained about the struggles they faced with the bureaucracy of the Indian Affairs office. Whereas the Indian Affairs budget increased by 60 percent from the 1878 fiscal year to the 1895 fiscal year, the amount appropriated to the medical services division was low. The appropriations in 1890 when compared to military medical appropriations “equated to \$21.91 spent on each army patient, \$48.10 on each navy patient, and a paltry \$1.25 on each Indian patient” (Ruby, Collins, & Mutschler, 2010, p. xxv). “The portion of the staff devoted to medicine actually decreased, from 2.9 percent in 1881 to 2.2 percent in 1897” (Jones, 2004). Of the \$5 million dollars Congress appropriated to Indian Affairs in 1884, “\$2 million went to subsistence programs, and schools nearly \$700,000, medical personnel received roughly \$75,000, medical supplies only \$15,729, and

vaccination only \$246” (Jones, 2004, p. 161). In 1890, “an Indian Service surgeon-physician was treating a staggering 830 patients” (Ruby et al., 2010, p. xxv) compared to the army surgeon-physician’s case load of 137 patients and the navy’s 72.

Crop failures and the smaller acreages prevented many Sioux from becoming successful farmers. By the 1920s poverty on the reservations increased “leading to higher rates of hunger and malnutrition” (Gibbon, 2003, p. 137) and besides tuberculosis, malaria and venereal disease also began to rise. On July 15, 1929, Charlie Black Horse from the Pine Ridge Reservation testified before the Senate Investigating Committee—charged with the task of surveying the condition of the Indians of the United States—about the starvation at Pine Ridge:

On this reservation the conditions are in very bad shape; we are starving and most of these people here all look black; they get that way from eating too much horsemeat, and we are in very bad condition, and you people come to see about this and we hope when you get back to Washington you will do what you can to help us. I am eating horses, and I have only four or five left, and when I eat them up there will be no more food and I can not go anywhere. I eat so much horsemeat I hear the horses neigh neigh- neigh-neigh in my sleep. The rations that we get here are not fit to eat, the bacon is yellow and the flour has an awful bad taste, and you people can go over there and see it yourself. We do not get enough to eat. We get about that much rations (indicated a small package). When we get it I count the grains of green coffee and it was 600 grains and we are supposed to live on that for two weeks (Survey of Conditions of Indians in the United States, Hearing

before a Sub-Committee of the Committee of Indian Affairs, U.S. Senate, 72nd Congress, 1st Session, Part 7 as reported in Gessner, 1931, p. 21).

Two physicians catalogued their experiences serving on the Pine Ridge Reservation and give incredible insight into the conditions on the reservation contributing to the health statuses of the Lakota. The first autobiography is by Charles A. Eastman, a physician of Sioux ancestry assigned to Pine Ridge from 1890 to 1892. Eastman was one of the physicians who treated survivors, Sioux or military, following the Wounded Knee massacre in 1890. He described the reservation upon his arrival as a “bleak and desolate looking place in those days” (Eastman, 1916, p. 76). In August 1953 Robert H. Ruby, a US Public Health Service surgeon arrived at Pine Ridge Indian Hospital for his latest post and his letters to his sister describe the reservation. His first impression varies not too differently from Eastman’s in that he found Pine Ridge “teeming, teeming with shacks, referred to as houses. The majority are used to house Indians, being the town is on reservation land” (Ruby et al., 2010, p. 3). Ruby found that for “tribal members, survival, even at a most meager level posed a precarious proposition” (Ruby et al., 2010, p. xiv). Poverty was rampant as the “annual per capital of the Oglalas [Sioux] ranked among the very lowest in the nation” (Ruby et al., 2010, p. xiv). The BIA dominated every aspect of reservation life for the Sioux by controlling the police, the courts, and management of the rangelands. BIA leased those rangelands to non-Indian cattle companies at below market value, then had the lease payments sent to BIA, where, instead of cash, the Sioux were paid in vouchers (Ruby et al., 2010, p. xix). Ruby remarks that besides the residual resentment for Whites because of “earlier historic violent confrontations”, the Sioux also resent that “much of the money set aside for them in the Bureau budget goes for the

homes and living expenses for white BIA employees” (Ruby et al., 2010, p. 16). Ruby’s assignment at Pine Ridge coincided with the transfer of the medical service from BIA to the US Public Health Service. Ruby was optimistic that the move would improve health conditions for AI/AN, as he saw abuses of power and misappropriation of funds during his time at Pine Ridge.

Although just one of the Sioux reservations, Pine Ridge Reservation gives a snapshot of reservation life for the Sioux. Today, the economic and health conditions at Pine Ridge Reservation remain poor. “The poverty on Pine Ridge can be described in no other terms than third world. It is common to find homes overcrowded, as those with homes take in whoever needs a roof over their heads. Many homes are without running water, and without sewer.” (Pine Ridge Indian Reservation, 2016). The average number of persons living in the same house is 17, and that house may have only two or three rooms and a dirt floor. Further, “at least 60% of homes on the Reservation need to be demolished and replaced due to infestation of potentially fatal black mold; however, there are no insurance or government programs to assist families in replacing their homes” (Friends of Pine Ridge Reservation, 2016). Weather conditions on the reservation can be extreme, ranging from minus 50 degrees in the winter to over 110 degrees in the summer, yet there is no public transportation on the reservation and only one grocery store (Friends of Pine Ridge Reservation, 2016) to serve the tribe whose membership rolls show 38,000 people living on the reservation (Pine Ridge Indian Reservation, 2016). The unemployment rate is 80-90% and the per capita income is \$4,000. The nearest city, Rapid City, is 120 miles away for those who can travel there for work, and otherwise

there is no industry on the reservation (Friends of Pine Ridge Reservation, 2016). Other statistics of the reservation compiled as of 2007 detail:

- 8 Times the United States rate of diabetes
- 5 Times the United States rate of cervical cancer
- Twice the rate of heart disease
- 8 Times the United States rate of Tuberculosis
- Alcoholism rate estimated as high as 80%
- 1 in 4 infants born with fetal alcohol syndrome or effects
- Suicide rate more than twice the national rate
- Teen suicide rate 4 times the national rate
- Infant mortality is three times the national rate
- Life expectancy on Pine Ridge is the lowest in the United States and the 2nd lowest in the Western Hemisphere. Only Haiti has a lower rate (Pine Ridge Indian Reservation, 2016).

The depletion of the bison herd and the emigration of prospectors and settlers across their lands signaled that a change in the way of life for the AI/AN was inevitable. Those forces may have led to their extinction and as Trennert claims (1975) the reservations were an alternative to extinction. Some activists were motivated to move AI/AN with the humane goal of protecting AI/AN from the vices of the Whites rather than by racial hostility. Those activists always envisioned, however, that the AI/AN should be assimilated into White culture because of its superiority, but the reservations were necessary to allow AI/AN the time to become “civilized”. As the removal and reservation policies have shown, treaties with promises of ensuring reserved lands for

AI/AN were instruments to gain access to lands held by AI/AN. Battles between the Sioux and the government led to the conquest of the Sioux, and relinquishment of most of the Great Sioux Reservation. Trennert (1975) asserts that there was no intent to place tribes on “lands unfit for habitation” (p. 2) but rather on good lands suitable for agriculture. While some of the reservation lands may have eventually succumbed to the plow, very often the supplies that would have made that possible were delayed or missing. The promise of rations and supplies made AI/AN dependent on the US government for them, yet the rations were often too little or too late. The health statuses of the Sioux reflect the years of malnutrition and extreme poverty in which the tribes have suffered.

### **Protection and Poverty**

The treaties made with American Indians leading up to the removal and reservation era did not promise to improve the health of the AI/AN, but conversely, the AI/AN had no expectation that the health of their tribes would worsen. What the treaties did promise, besides annuities and supplies for “civilization” was, using the treaty with the Cherokee as an example, to protect tribes who removed to Indian Territory “from domestic strife and foreign enemies and against intestine wars between the several tribes” as well to ensure they were “protected against interruption and intrusion from citizens of the United States” (Treaty with the Cherokee, 1835. Dec. 29, 1835. 7 Stat., 478. Kappler, 1904, p. 442).

Death and illness accompanied the tribes’ passages to Indian Territory. Once in Indian Territory, the tribes found little in the way of accommodations for their arrival, nor lands hospitable to farming. The promise to protect the Five Civilized Tribes from



interruption and intrusion was quickly abandoned, just as the military forts and annuity payments were, in the months leading up to the Civil War. The consequence for those tribes that allied with the Confederates was cession of even more land.

The US government broke its promise to the Poncas when it gave away the land promised to them and then forcibly removed them to Indian Territory. Like the Five Civilized Tribes, the trials of the trek decimated the tribe. Farmers on their lands in Nebraska, the tribe faced starvation in the new lands as they had been unable to plant for two seasons.

The fact that the US government carved the Great Sioux Reservation out of lands already occupied by the Sioux spared the Sioux from the removal trials, but the containment on the reservation and the paltry rations left the Sioux unprotected from the diseases that then ravaged the communities. The continuing poor socioeconomic status of the Sioux on their reservation is reflected in the health status of the Sioux today as it ranks among the poorest in the nation.

The tribes who removed, and those who remained on their reservations had the expectation that the US government would honor the promises made in the treaties and protect them. As Everett Rhoades (2000) pointed out, there is a tension between AI/AN as wards of the government and sovereign nations, but it is difficult for tribes to retain their sovereignty when placed on inhospitable and unforgiving lands, without the provision of adequate supplies and medical attention.

Once contained on a reservation, the US government expected that tribes would assimilate into the dominant culture. As described in the historical context, Congress was not content with containing tribes on reservations, and attempted to assimilate them

beginning in 1887 with the Dawes Act that allotted 160 acres of reservation land to individual heads of households. Besides working to shift the individual AI/AN's loyalty from the tribe and the ideals of communalism, for the government, allotment freed millions of acres of reservation lands that were not allotted that could then be sold to non-Indians. The Indian Reorganization Act (1934) ended allotments, but the government used another method in its effort to assimilate tribes. As the next chapter illuminates, Congress, tired of the "Indian Problem," terminated the federal recognition of tribes. For one of the tribes terminated, the Menominee, termination thrust them into dire poverty.

## CHAPTER 4

### TERMINATION AND THE MENOMINEE

The government's attempts to assimilate tribes as well as individual American Indians had a resurgence after John Collier left as Commissioner of Indian Affairs in 1945. The idea of assimilation had been floated earlier in the 1940s, but Collier, Secretary of the Interior Harold Ickes (1933-1946), and some members of Congress were able to thwart those attempts. Once Dillon S. Myer became Commissioner of Indian Affairs in 1950, he promulgated the idea that assimilation of AI/AN into mainstream society freed the tribes from interference and oversight by the federal government. The goal of assimilation prefaced the move toward what was called "termination" of several tribes, through a proposal advanced in Congress by Senator Arthur Watkins. Termination voided any treaty promises or trust responsibilities, and removed the designation of a tribal identity from the individual as well as the tribe. The idea of reducing the federal expenditures that had been made on behalf of tribes because of the trust relationship was a compelling reason for the administration to support assimilation efforts.

While there may have been benefits to the federal government and for Myers' agenda in establishing the policy of assimilation, the termination of tribal recognition along with the removal of federal services was devastating to the tribes selected to spearhead the effort. The initial termination actions were against the Menominee in Wisconsin and the Klamath in Oregon. Both tribes had been successful in generating their own revenue for the tribe, but were ill-prepared for the termination of federal services. Faced with shrinking revenues and increasing costs, all aspects of tribal life diminished under termination, including the health status of the individual members.

In this chapter, I detail the actions of the federal government leading up to termination of the Menominee tribe, and the subsequent effect on the tribe during termination and after they regained federal recognition. The government or its representatives used what are widely acknowledged as deceptive and coercive tactics to get the Menominee to accede to the termination plan. The tribe agreed to allow the government to break its promise to hold their lands as “all Indian lands are held,” yet the US Supreme Court recognized that the tribe had inherent rights that could only be nullified if expressly named in a termination document.

To the Menominee, termination threatened to destroy tribal unity and culture. To keep the tribal unity, the Menominee formed its own county comprised solely of the reservation land and people. That decision was costly, and the tribe that had once required little monetary assistance from the US government became impoverished and required substantial government assistance to meet its barest survival needs. I argue that the federal government’s termination actions negatively impacted the socioeconomic conditions of the Menominee and contributed to the poor health status for the individuals in the tribe.

### **Assimilation and Termination as Policy**

Although the federal government had often alternated in its attitudes and policies affecting AI/AN between extermination, containment, and assimilation, the move toward termination was a marked shift from attitudes that had prevailed during Collier’s term as Commissioner of Indian Affairs and the passage of the Indian Reorganization Act (IRA) in 1934. John Collier had become Commissioner of Indian Affairs in 1933. Collier had three goals for his term in the Office of Indian Affairs: “restoration of Indian cultural and

religious liberty, rebuilding of the Indian land base, and development of limited self-government for the tribes” (Kersey, 1996, p. 2). Early in his term, Collier had also successfully brought federal services in the form of the “Indian Emergency Relief Work (later called the Civilian Conservation Corps-Indian Division), the Works Progress Administration (WPA) and the Civil Works Administration (CWA). Indian health and education programs were also upgraded with federal funds” (Kersey, 1996, p. 2). To his critics who protested his bringing those New Deal programs to the reservations, Collier asserted that because the 1924 Citizenship Act granted citizenship to all AI/AN, all programs and services available to any citizen were also available to AI/AN.<sup>23</sup>

Besides ending the apportionment of tribal lands to individuals that had begun with the Dawes Act (General Allotment Act, 1887), the Indian Reorganization Act (1934) (IRA) ensured that allotments remained in trust by: extending the trust period; prohibiting additional lands from being taken away from tribes without their consent; and establishing that the Secretary of the Interior could accept new tribal lands in trust as well as purchase additional lands and proclaim them reservation land. The federal government gradually gave more control over the tribal resources and disbursement of funding to tribes that established constitutions.<sup>24</sup> The IRA emphasized that there was a government to government relationship that existed between the federal government and tribes, a topic that proved particularly troublesome to the administration in the following years. Felix S.

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<sup>23</sup> Many AI/AN were granted citizenship three times: once during the period of allotment, again if they served in WWI, and a third time in the Citizenship Act of 1924.

<sup>24</sup> Roberta Ulrich (2010) reports, however, that in the Northwest by 1953 only 17 percent of AI/AN were in positions of authority to disburse tribal or governmental funding (p. 5).

Cohen, who had been asked to assist in drafting the IRA, emphasizes the sovereignty of tribes in his *Handbook of Indian Law* (1942):

Perhaps the most basic principle of all Indian law, supported by a host of decisions hereinafter analyzed, is the principle that *those powers which are lawfully vested in an Indian tribe are not, in general, delegated powers granted by express acts of Congress, but rather inherent powers of a limited sovereignty which has never been extinguished* (p. 122).

In the years since the passage of the IRA, the US had slowly recovered from the Great Depression and fought in World War II (WWII), and the strain on finances affected programs on the reservations. During the war, the government cut special programs and services utilized by American Indians to divert money to the war effort. Once the special programs that provided jobs on the reservations evaporated, nearly 40 thousand AI/AN moved to urban areas where defense jobs awaited while another 20 thousand joined the military (Philp, 1999). Besides employment options, the financial needs of the war also drastically reduced health and educational services on the reservations.

In addition, the government appropriated a million acres of reservation land for military bombing sites and internment camps for Japanese-Americans (Kersey, 1996; Philp, 1999).<sup>25</sup> The main office of the Office of Indian Affairs (OIA) moved to Chicago in 1942 to allow more wartime offices in Washington, DC. The move caused several administrative and service disruptions as it took several months to complete and required

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<sup>25</sup> The lands appropriated during the war were never returned to the tribes, but the conservatives in Congress were unconcerned since, by all appearances, tribal populations on the reservations were declining (Kersey, 1996).

that several tons of files be shipped to Chicago (Benson, 1994). It also foreshadowed the diminished influence of Indian Affairs on policy for AI/AN. Further, during the war OIA experienced numerous personnel vacancies, as 40 percent of its experienced employees enlisted in the military (Philp, 1999), and the large number of physicians and nurses who were called away from Indian Service to other areas created vacancies and cut service (Benson, 1994).

Collier's abrasive personality (O'Neil, 1995) and his passion for preserving the culture and arts of AI/AN had created some enemies in Congress, and they sought opportunities to not only reverse the IRA, but also to eliminate any special status for American Indians. Senator Elmer Thomas, chair of the Congressional Investigative Committee initiated the first attempt to terminate the federal government's obligation to tribes in a May 1943 report that called for the abolition of the BIA. Thomas criticized Collier and the IRA with the statement that Collier's policies "promoted segregation, made the Indian a guinea pig for experimentation, tied him to the land in perpetuity, and made him satisfied with all the limitations of primitive life" (Thomas as quoted in Officer, 1995, p. 116). Collier and the Secretary of the Interior, Harold Ickes, were able to counter that attack, but the fallout was costly. Another opponent of Collier's, Congressman Jed Johnson, was able through his position on the House Appropriations Committee to cut the 1945 OIA budget by \$2 million, a drastic cut for the times. Collier resigned in 1945, in part James E. Officer (1995) suggests, because Collier was discouraged by the constant fighting with Congress and the struggle to keep the OIA intact.

Congress was deeply involved with Indian Affairs after WWII. The war had solidified the image of the supremacy of American ideals of equality and democracy and Congress feared the national identity would suffer if there were racial divides and deprived groups within a nation with those ideals (V. Deloria, 1985; Fixico, 1990; Fugikawa, 2011). To that end, Congress moved to assimilate AI/AN through the rights of citizenship. Besides ensuring the national identity, Republicans in Congress saw the assimilation of AI/AN as an opportunity to eliminate the need for OIA.

Waiting for disposition after WWII were petitions from tribes for compensation for lands taken from them in violation of treaties or purchased unfairly by the government. To settle these claims, Congress passed the Indian Claims Commission Act in 1946 that ultimately settled 370 petitions for \$800 million (Philp, 1995; Ulrich, 2010). Whereas some advocates for the creation of the Indian Claims Commission were motivated by the belief that the limbo of waiting for claim settlements kept some AI/AN on the reservation, others looked at the claim settlements as one step toward termination since the funds could allow individual AI/AN and tribes to become self-sufficient. Senator Arthur Watkins (1957) saw the Claims Act as the means “to clear the way toward complete freedom of the Indians by assuring a final settlement of all obligations—real or purported—of the federal government to the Indian tribes and other groups” (p. 50). Ultimately, a narrow interpretation of what was meant in the Claims Act by the term “identifiable group of Indians” excluded the claims of all tribes whose political existence wasn’t recognized by Congress or the executive branch (Philp, 1999, p. 31). It also excluded the claims of individuals who based their claims on moral grounds or the “negative impacts of land allotment” (Philp, 1999, p. 31). The government dealt a final



blow to tribes hoping that the settlement money would assist in their self-governance pursuit when Congress withheld the claims payments. The federal government, in its effort to compensate for its past wrongs of broken promises or deceptive practices, asserted its continued dominance over AI/AN by withholding the payment. In some instances, the withheld claim payment was used to coerce AI/AN into accepting termination of federal services.<sup>26</sup>

The Indian Claims Commission Act was but one piece of legislation Congress worked on following WWII. In 1947, Congress dealt with 135 items specific to AI/AN. In the Senate, out of the 25 bills specifically related to AI/AN, “15 would have ended federal supervision and granted full citizenship rights or transferred jurisdiction to states” (Ulrich, 2010, p. 8). The climate of Congress was evident when, just six months after the passage of the Indian Claims Commission Act, the Senate Committee on Civil Service summoned the Commissioner of Indian Affairs, William A. Brophy, to testify. Members of the committee were “advocates of states [sic] rights and unrestrained economic development of the West” (Philp, 1999, p. 70). Besides wanting to allow more control over land and water rights, states and counties asserted that reservations provided no revenue because of their tax-exempt status. The committee looked at the BIA as an area with excess employees. Because Brophy was ill, the Assistant Commissioner, William Zimmerman, went in his place and answered the committee’s inquiry about which tribes could be freed from oversight by the BIA through termination. Zimmerman’s list of 10

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<sup>26</sup> For more information on the establishment of the Indian Claims Commission, including some of the tactics used that were detrimental and exclusionary to tribes filing claims, see (Philp, 1999).

tribes (including the Menominee and Klamath) purportedly was drawn up by looking at “the amount of mixed blood, literacy, acceptance of White institutions, and local non-Indian support to determine levels of acculturation” (Philp, 1999, p. 71). Zimmerman also described three more criteria that should be used to identify the appropriate tribes for termination as: “the ability of tribes to make a decent standard of living, tribal consent, and the willingness of states to assume responsibility for their Indian citizens” (Philp, 1999, p. 71).

The next major advancement toward assimilation occurred when Truman established a Commission on Organization of the Executive Branch of Government. Commonly known as the Hoover Commission because Herbert Hoover chaired it, the commission was to review the executive branch of the government with an eye for reducing redundancies and spending. The 1948 report from one of the task forces, the Project Committee on Indian Affairs, advocated that assimilation of AI/AN should be the goal of federal policy. It further advocated for the closure of the BIA, indicting the BIA as the reason AI/AN were ill-prepared to manage their own affairs (Philp, 1995). The report recommended that many of the BIA’s operations and programs be moved to other federal agencies or to the States that held reservations.

President Truman welcomed the results of the Hoover Commission. When Truman sought a replacement for Brophy upon his resignation in 1948 as Commissioner of Indian Affairs, Truman set as one criterion that the director should work toward assimilation of AI/AN and the closure of the BIA (Philp, 1999). Truman chose John R. Nichols who had worked on the Hoover Commission. Nichols was approved in 1949, and then surprised Truman by using some of the Hoover Commission’s recommendations to

iterate that treaties “guaranteed [tribes] continuous possession of their lands and the right to self-determination” (Philp, 1999, p. 81). To alter that arrangement would require consent of the tribes, the Secretary of the Interior, and Congress.

While Nichols did recommend that AI/AN children attend public schools if the schools were easily accessible, he argued that states had no jurisdiction over criminal offenses committed on reservations by AI/AN, and that assigning jurisdiction to states required tribal consent. According to Kenneth R. Philp (1999), Congress expressed its disapproval of the Indian Reorganization Act (1934) by appropriating \$7.8 million in the BIA to Indian health, education, and welfare programs instead of the tribal development plans begun in the IRA. The move left the BIA without funds to maintain its administrative services or programs to improve tribal organization and economies. Because of the funding reduction, Nichols was forced to drastically reduce staffing in the central office as well as in the districts (Philp, 1999). Recognizing the prevalent attitude in Congress, Nichols subsequently requested that tribal councils update their reservation rehabilitation plans (drafted during WWII) to include provisions “for the progressive transfer to states of the responsibility for education, health, agricultural extension, public welfare, and other federal services” (Philp, 1999, p. 82).

For a group of 14 governors from states with large AI/AN populations, the BIA and Nichols were not moving quickly enough in instituting the Hoover Commission’s recommendations. At a conference in March 1950, the governors and 75 AI/AN delegates came to a consensus that the reservation system needed to be abolished, and that with adequate education and economic resources, AI/AN “should come under state control” (Philp, 1999, p. 87). The group formed a committee, the Governors’ Interstate Indian

Council (GIIC), to formulate a plan for transitioning to state control. Shortly after that meeting, Truman replaced Nichols with Dillon S. Myer.

American Indian groups, namely the Association on American Indian Affairs (AAIA), the National Congress of American Indians (NCAI) and the American Restitution and Righting of Wrongs (ARROW), supported withdrawal of federal oversight of tribal matters. NCAI had been instrumental in the passage of the Indian Claims Commission Act. ARROW was begun as an adjunct to NCAI with the stated goal of raising money to “liberate impoverished Indians from second-class citizenship” (Philp, 1999, p. 87). Will Rogers, Jr., the son of the political satirist and an activist in his own right who worked with NCAI, stated in an October 1949 press release that the AI/AN no longer were willing to live as wards of the government waiting for handouts. ARROW, with the support of Hollywood celebrities and others such as Senator Hubert Humphrey and Franklin D. Roosevelt, Jr., raised funds to provide scholarships to AI/AN and produced national broadcasts outlining the plight of AI/AN.

Despite advocacy groups supporting AI/AN withdrawal from the BIA, Theodore H. Haas, the chief counsel for the Indian Bureau pointed to an apathy on the part of tribes toward managing their financial and tribal affairs. Haas stated that recruitment efforts aimed at placing more AI/AN in professional positions within the BIA had failed, despite an appeal to NCAI for a list of interested candidates. AI/AN had complained that the IRA, rather than its claim as a path to self-determination, had created more oversight of tribal life by the BIA, yet few AI/AN had utilized IRA to gain more control through the creation of economic enterprises. However, Haas acknowledged that the BIA had “exercised virtually absolute power over Indians” and when AI/AN were asked to

formulate policy, “they acted merely as rubber stamps” for plans already designed by government officials. John Embree, an anthropologist from Yale, argued that the formula of indirect rule in place with the IRA “did not encourage democratic self-reliance ... instead, it perpetuated wardship” (Philp, 1999, p. 85). NCAI and ARROW sought to change that dynamic and pushed for the end of federal guardianship. They thought their goals would be achieved with Dillon Myer as head of the BIA, even though their ideas of the timeline for self-determination differed from that of Myer’s (Castile, 1998). They were soon to learn that the differences were vast.

Truman had tried to recruit Myer as head of the BIA when Brophy resigned in 1949, but Myer turned him down. Truman especially admired Myer’s work with the War Relocation Authority, first in its operation, and finally on the relocation of Japanese-Americans from the camps at the end of WWII. Truman’s announcement that Myer was to be Commissioner of Indian Affairs after Nichols had been in the position for less than a year came as a surprise to Nichols, who submitted his resignation the next day. Myer’s plan for self-determination included termination of all federal services for AI/AN as soon as possible. Donald L. Fixico (1990) charges, “His [Myer’s] unbending and tyrannical attitude, which advocated swift action and quick results, sometimes unleashed anger from a previously passive native populace” (p. 69). In his three-year term as Commissioner of Indian Affairs, rather than reducing the interference of the BIA into tribal affairs, he increased it.<sup>27</sup> Felix S. Cohen (1953), an attorney who consulted on drafting the IRA,

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<sup>27</sup> Myer followed a hundred-year history of the OIA/BIA officials who in their attempts to get out of the “Indian business” “had managed to increase its own appropriations (mostly for salaries) 53,000 per cent, while the corresponding appropriations for the tribes decreased 80 per cent” (Herzberg, 1977, p. 306).

wrote a scathing article in the *Yale Law Journal* outlining how the actions of the BIA, Myer, and the Secretary of the Interior during Myer's term eroded the rights of AI/AN. Some of the most egregious acts included refusing to allow tribes to employ their own counsel in lawsuits against the government, withholding tribal funds held in trust by the BIA until criticism over the BIA actions to Congress was recalled, and denying tribes the right to use their income as they saw fit.<sup>28</sup>

During Myer's term at the BIA, one action that directly impacted the health of AI/AN on reservations was the proposal to transfer the BIA hospitals to non-Indian entities without tribal permission. Tribes had often contributed funds or labor to build the hospitals on reservation land, but the hospitals were slated to be transferred without the tribes' consent. Activist groups persuaded Congress not to pass those bills without including a clause requiring tribal consent (F. S. Cohen, 1953). Myer had a single purpose in the way he sought to provide health care to AI/AN, that of assimilating AI/AN into the mainstream of the American public. Assimilation would be impossible if the health of AI/AN was below that of the rest of the citizenry, and like other citizens, AI/AN should learn "that they, rather than the government, were responsible for meeting their own health needs" (Benson, 1994, p. 298). Myer was opposed to building additional BIA hospitals because he felt the segregated nature of the hospitals worked against assimilation. To that end, he was able to garner support for his proposal that non-Indians be allowed to use the BIA hospitals, a move approved in 1952 by both houses of

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<sup>28</sup> For a robust understanding of the impact of Myer's policy on the right of tribes to choose their own counsel, see (Philp, 1999) as well as Myer's recollection of the controversy in his autobiography (Myer, 1970).

Congress with Public Law 82-291 (An Act to provide for medical services to non-Indians in Indian hospitals, and for other purposes, 1952).

Public Law 82-291 also allowed the Secretary of the Interior to contract with entities other than the BIA to operate the hospitals built by the BIA, as long as the entity continued to provide care to AI/AN. The bill included the option to transfer the hospital to the outside entity so long as a hospital built for a specific tribe or group of tribes was transferred with their approval. The law allowed the BIA to close three BIA hospitals and contract for care with state or community facilities as well as to completely transfer one hospital to a private organization by June 1953 (Benson, 1994). Although the cost for contracted care was more expensive than the provision of care in the BIA hospitals, the intent of Public Law 82-291 was to assimilate AI/AN and terminate the responsibilities of the BIA.

Myer's term as Commissioner of Indian Affairs ended soon after Dwight D. Eisenhower took office as President in 1953. Although Myer was unable to see the BIA dissolved or an assimilation/termination plan pass during his term, Senator Arthur Watkins, chairman of the Senate subcommittee on Indian Affairs kept the momentum going toward termination. During the confirmation hearing of Glenn Emmons, Eisenhower's pick to replace Myer, Watkins pressed Emmons to commit to dissolving the federal government's role in AI/AN affairs as soon as possible (Hoxie, 2012). Members of Watkins' committee, namely Representative William Harrison and Senator Harry Jackson, introduced House Concurrent Resolution 108 (House Concurrent Resolution 108, 1953) in June 1953 (Fixico, 1990) and it passed in August 1953. Known as the Termination Plan, House Concurrent Resolution No. 108 (1953), ostensibly sought

to “grant them [Indians] all of the rights and prerogatives pertaining to American citizenship” yet Indians “should assume their full responsibilities as American citizens.”

The way in which AI/AN would assume full responsibilities was by being “freed from Federal supervision and control and from all disabilities and limitations specially applicable to Indians” (House Concurrent Resolution 108, 1953). The bill also identified the tribes of the Flathead, Klamath, Menominee, Potawatomi, and Turtle Mountain Chippewa, as well as all tribes in the states of California, New York, Florida, and Texas to be freed from federal control.<sup>29</sup> The bill went on to state that the BIA offices that served the identified tribes should be abolished. The actual termination of tribes required an additional act of Congress, and Congress passed the first Acts in 1954 to terminate both the Menominee and the Klamath tribes.<sup>30</sup> In all, Congress passed additional Acts that terminated 109 tribes between 1955 and 1966.

Once tribes were terminated, the BIA released its protection and control over the nearly 1.4 million acres of land it held in trust for the tribes, an action that led to the sale of approximately 1,362,155 acres or 3% of all AI/AN land (Wilkinson & Biggs, 1977). For some of the small tribes terminated, the land was sold to the highest bidder and the proceeds went to the tribes. The Menominee and the Utes placed the land into

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<sup>29</sup> Since 1944, BIA had listed tribes ready for termination on three lists: Collier’s reservation plans in 1944, Zimmerman’s list to Congress in 1947, and a questionnaire Myer sent out in 1952. Tyler (1973) says, “The information available in these three studies and the lists themselves are often contradictory. Several lists of requirements for readiness for termination also appeared, both from within and outside the Bureau, none of which were followed consistently” (p. 172).

<sup>30</sup> Congress passed the Menominee Termination Act (Menominee Termination Act, 1954) on June 17, 1954 and the Klamath Termination Act, (Klamath Termination Act, 1954) on August 13, 1954.



corporations, whereas the Klamath had the option of selling the land immediately or placing it into a private trust (Wilkinson & Biggs, 1977).

The Citizen's Advocate Group (Cahn, 1969) in their 1969 book, *Our Brother's Keeper*, reflected experiences of AI/AN regarding termination and the role of the US government:

The Indian knows that termination takes many forms. He can be flooded out of his reservation; he can be relocated; his reservation can be sold out from under him if he cannot meet taxes to which it is subject. His limited power to protect himself on the reservation from local prejudice and discrimination can be wiped away by the substitution of state laws for tribal law, and state jurisdiction for tribal jurisdiction. All of these, the Indian knows, are variants on one basic truth: the United States Government does not keep its promises. Sometimes it breaks them all at once, and sometimes slowly, one at a time. The result is the same—termination. When the Indian is asked to forsake his status under the Bureau in exchange for cash, for promises of technical aid, for public works improvements and industrial developments, he has learned to expect two things:

*—That the promises will not be kept.*

*—That even if they should be kept, they will prove inadequate to maintain the Indian at even his reservation level of deprivation (p. 21).*

Two weeks after the passage of the Termination Plan, Congress transferred more of federal and tribal authority to states with the passage of Public Law 280 (Public Law 83-280, 1953). There jurisdiction over civil and criminal matters on the reservations was required for states specifically named in the law and allowed any states to opt to assume

jurisdiction later. The federal government relinquished its jurisdiction in the named states immediately, without seeking consent from the tribes, even though it meant that they lost jurisdiction over crimes committed on their reservations.

In another effort to divest itself of the trust responsibility to AI/AN, Congress supported the transfer of AI/AN health provision to the States. Until that transfer could be completed, Congress stripped the BIA of the direct responsibility for AI/AN health care when it passed the Transfer Act of 1954 (Public Law 83-568, 1955) thereby consolidating Indian Service with the Public Health Service (PHS). Besides allowing the Secretary of the Interior to continue to contract with any state, territory, or nonprofit organization to provide health services to AI/AN, the Transfer Act (Public Law 83-568, 1955) authorized the transfer from the Department of the Interior to the Public Health Service effective July 1, 1955 of all “functions, responsibilities, authorities, and duties ... relating to the maintenance and operation of hospital and health facilities for Indians, and the conservation of the health of Indians” Transfer Act (Public Law 83-568, 1955). As discussed in Chapter 2, Congress hoped that eventually all AI/AN would be assimilated, or at least no longer eligible for federal services, and a separate health system would be unnecessary. Until that time, however, Congress thought the consolidation would provide better services to AI/AN and allow the recruitment of more medical personnel to the service. Not all AI/AN supported the transfer of Indian Health to PHS as they saw it as one more opportunity for the government to forego its trust responsibilities (Dejong, 2008).

Although tribes may have had grievances with the BIA and its control over every aspect of their lives, they were not envisioning an alternative that included termination of

treaty rights and responsibilities. As one of the first tribes terminated, the Menominee provide a case study of the consequences of termination on socioeconomic status and health outcomes.

### **The Menominee March toward Termination**

In his role as Assistant Commissioner of Indian Affairs, William Zimmerman identified the Menominee tribe as one well-suited for termination. In selecting the tribes ready for immediate termination, Zimmerman stated:

I took these as examples, as specimens, because each of them has substantial assets, each of them has a small degree of tribal control, and each of them has indicated that it wants to assume more control, if not full control, of its tribal assets and its tribal operations” (Tyler, 1973, p. 164).

The Menominee tribe consisted of approximately 3700 members in 1947 of which over 2500 lived on reservation land in Wisconsin. When Jean La Follette recorded his observations about the Menominee in 1634, the tribe claimed and lived in an area of more than 9 million acres—an area that has now become part of the States of Wisconsin and Michigan. The name Menominee is the English adaptation of the American Indian word that translated to “Wild Rice Men.” As the name suggests, the tribe regularly harvested wild rice in autumn and supplemented their diets with fish, naturally growing berries, nuts, and vegetables, and wild game. The Menominee allied with the French when the France claimed their territory until the mid-1700s at the end of the French and Indian War. At that time, the British claimed the territory and the Menominee aligned with the British in the Revolutionary War. The Menominee fought against the Americans with the British and French in the War of 1812, even though the Treaty of Paris in 1783 and the

“Jay Treaty” of 1795 turned the British lands over to the United States thus making the Menominee subjects of the United States. Although the US had opened an agency in the Green Bay, Wisconsin area in 1815, it wasn’t until 1855 that OIA opened an agent’s office on Menominee land. An agent’s role was “to provide benefits as required by treaty and by law and it was his task to generally supervise Indian affairs on the reservation as a representative of the United States” (M. Robertson, 1958, p. 5). In 1876 OIA assigned a physician to Keshena.

Although the Menominee historically had formed alliances with their potential enemies (Beck, 2005), the Menominee resisted when their goals for the good of the tribe did not align with the federal government’s plans for the tribe. The first treaty with the US government in 1817 was a means of “re-establishing peace and friendship between the United States” and the Menominee. The treaty also affirmed that the tribe was “under the protection of the United States, and of no other nation, power, or sovereign, whatsoever” (Treaty with the Menominee, 1817. March 30, 1817. 7 Stat., 153. Kappler, 1904, p. 138). In subsequent treaties with the federal government, the Menominee ceded much of their land in exchange for small sums of money. In 1848, U.S. Commissioner of Indian Affairs, William Medill, threatened to take the land from the Menominee if they did not agree to sell it. The Menominee acquiesced and in the 1848 treaty, the tribe agreed to move to lands in Minnesota. Once Chief Oshkosh and other tribal leaders saw the new land, however, they refused to move there because they felt the land could not sustain the tribe (Shames, 1972) and because it was located between two warring tribes, the Sioux and Chippewa (Herzberg, 1977).

The tribe was able to resist enough that BIA moved the tribe to a “temporary location” along the Wolf River at Keshena Falls until the disagreement could be resolved. In the Treaty of Wolf River in 1854, the temporary location of approximately 276,480 acres was designated to be “home, to be held as Indian lands are held” for the Menominee (Treaty with the Menominee, 1854. May 12, 1854. 10 Stats., p. 1064. Kappler, 1904, p. 626), meaning that the US government held the legal title to the land, but the tribe held the beneficial title (M. Robertson, 1958). Beneficial title was held in perpetuity and the lands were to be untaxed (Hart, 1960). In two subsequent treaties, the Menominee ceded more land, first giving a home to two New York tribes in 1856, and then giving land for a school in 1918, leaving a reservation size just over 233,800 acres (M. Robertson, 1958), upon which the Menominee currently live. Because the 1854 treaty superseded all other treaties, “it is the agreement under which the Indians [the Menominee] and the Government have since functioned” (M. Robertson, 1958, p. 4).

In treaties with the Menominee prior to the 1854 treaty, the US government promised to provide five farmers and a variety of farm animals, along with the promise to erect a grist and sawmill for the purpose of “weaning them [Menominee] from their wandering ways,” (Treaty with the Menominee, 1831. Feb. 8, 1831. 7 Stat., 342. Kappler, 1904, p. 321), a plan to make the Menominee farmers instead of hunter/gatherers. The Menominee resisted giving up their traditional culture, and the farming experiment failed (Herzberg, 1977). The 1854 treaty provided a gristmill, a blacksmith shop, and a sawmill to provide lumber for the needs of the tribe, as well as annual annuities to compensate for the difference in land value between the Minnesota land and the Wisconsin land, a sum of \$242, 686. Notably, the money was to be paid out over 15 years but only as was seen fit

“under the direction of the President of the United States, and for such objects, uses, and purposes, as he shall judge necessary and proper for their wants, improvement, and civilization” (Treaty with the Menominee, 1854. May 12, 1854. 10 Stats., p. 1064. Kappler, 1904, p. 627).

Rather than becoming the agrarian society the government desired, the Menominee looked to the forests on the reservation as their source of income. Beginning in 1854, White logging interests, known as the Pine Ring, sought to purchase Menominee land for the timber but the tribe refused to sell (M. Robertson, 1958). Instead, the tribe asked OIA for permission to sell lumber from the tribal sawmill to outside interests. OIA refused that request, but contracted with the White lumber companies to remove dead and down trees from the reservation. In 1868, the Menominee complained to OIA that the White lumber companies were cutting standing timber and setting fires to create more dead and down timber and asked the government to protect the tribal property. Meanwhile, the Pine Ring lobbied Congress for the right to purchase Menominee land, and in 1871, Congress passed a statute authorizing the sale of the land. However, the statute stated it was not effective without consent of the tribe, consent that the tribe unanimously denied, so the land was not sold (Herzberg, 1977).

The Secretary of the Interior gave the Menominee the right to sell timber to off-reservation mills in 1872. The logging operation was successful right away, and employed many workers from the reservation. The government put all proceeds from the timber sales during those four years into the Menominee trust account, and then used that money to pay the tribe the annuity payment for the purchase of the land ceded in 1848. In other words, the Menominee were paying themselves the annuity owed them from the

government (Beck, 2005). The Pine Ring again lobbied in Washington for the right to purchase the reservation land and timber. Because of their lobbying efforts, OIA shut down the logging operation after its fifth year (Herzberg, 1977).

The Menominee continued to press for the right to harvest the trees on the reservation and in 1882, OIA granted permission, renewed annually for six years, for the tribe to harvest “dead and down” trees. However, the new Indian agent established the rule that “only those Indians who farmed in the summer would be allowed to cut timber in the winter” (Herzberg, 1977, p. 279), an action that induced some Menominee to attempt to farm again, with limited success.

When the Dawes Act went into effect in 1887, the Menominee voted at least twice to approve apportionment of their land to individual tribal members. Rather than individual ownership of the land, the Menominee viewed allotment as an opportunity to protect their land from outsiders and permanently gain the right to use the forest as a means of income (Beck, 2005). Allotment never occurred on the reservation since the Menominee insisted that allotment had to include the right to harvest timber from the land. Perhaps because of that stipulation, the US government never surveyed the land.<sup>31</sup>

In 1888, the Pine Ring once again sought to purchase the land and timber of the Menominee reservation. Herzberg (1977) states, “under pressure from the lumbering interests, the Attorney General of the United States issued an opinion to the Secretary of the Interior in which he stated that reservation Indians did not have the right to harvest timber commercially” (p. 283). The Attorney General stated that AI/AN had only the

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<sup>31</sup> For a complete discussion of the allotment period and the Menominee, also see (Herzberg, 1977).

right of a tenant (for life) on their reservation and that all timber remained the property of the US government to use as it saw fit. In response, the OIA once again shut down the Menominee's logging operation.

To fend off the Pine Ring, the Menominee sought the help of an off-reservation attorney to petition Congress to allow the Menominee to restrict the sale of the timber on the reservation. An act of Congress in 1890 gave the tribe the right to harvest and commercially sell twenty million board feet of timber and permanently guaranteed that the Menominee had the right to use the forests for income.<sup>32</sup> Initially, the Menominee had refused to approve the statute as they hoped to take more board feet of timber each year (Herzberg, 1977), but the statute itself established that if the Menominee did not approve, all logging was to stop immediately (An act to authorize the sale of timber on certain lands reserved for the use of the Menomonee tribe of Indians, in the State of Wisconsin, 1890). The OIA was still in charge, however, as Congress gave the agent on the reservation the right to “to employ Indians in cutting, selling, and transporting logs” (M. Robertson, 1958). Between 1890 and 1905, the logging operation on the Menominee reservation generated considerable income and provided employment for the tribe. Beginning in 1890, a percentage of the profits was set aside in a “stumpage” fund used by the Menominee to provide for the sick and elderly among the tribe. In later years, a percentage of the profit was paid annually directly to tribal members so even those members who did not work for the logging operation received some income,

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<sup>32</sup> (An act to authorize the sale of timber on certain lands reserved for the use of the Menomonee tribe of Indians, in the State of Wisconsin, 1890)



(approximately \$120/year) from the trees. The stumpage fund also was used to pay for the hospital operation (Beck, 2005).

By 1905 the trust account at OIA for the Menominee held over 2.5 million dollars. Unfortunately, in 1905 a tornado destroyed 35 to 40 million board feet of trees on the reservation. The trees downed by the tornado could be salvaged if action was taken quickly. However, in the 1905 and 1906 harvest, the Secretary of the Interior allowed contractors to take a total of 35 million board feet of lumber from the forest; none came from the trees downed by the tornado. Although legislation in 1906 allowed the tribe to cut and transport the downed trees to sawmills, the OIA ignored the tribe's request to do so (Herzberg, 1977). OIA didn't commence logging of the damaged trees until 26 months after the tornado. OIA appointed John W. Goodfellow to oversee the logging operation. Herzberg (1977) charges, "because it was inadequately supervised, the project was characterized by waste, corruption, inefficiency, and violations of statutory and contractual requirements. Corruption and nepotism in the making of contracts increased costs" (p. 285). Logging contractors dumped logs at sites other than those specified in their contract. Heavy logs were left alongside the riverbanks, since they were unable to float to the sawmill site. When railway spurs were built, they ended in areas of standing rather than downed, timber, thus making the logging of standing timber more expedient than the downed timber. Regardless of legislation allowing for three sawmills to be built, none of them were built. Despite notifications of the problems, Goodfellow took no action to correct the violations.

Attempting to mitigate the losses to the tribe, Senator Robert La Follette from Wisconsin sponsored legislation in 1908 that called for the government to erect three

sawmills on the Menominee reservation, to employ members of the tribe to run the sawmill operations as often as feasibly possible, and to prohibit contracts from any “logging, driving, sawing timber, or conducting any lumber operations upon said reservations shall hereafter be let, sublet, or assigned to White men” (An act to authorize the cutting of timber, the manufacture and sale of lumber, and the preservation of the forests on the Menominee Indian Reservation in the State of Wisconsin, 1908). La Follette’s Act also has been credited with establishing the sustained yield forestry methods for the Menominee. La Follette, upon advice from a Wisconsin state forester, added a provision to limit the harvest of standing trees to 20 million feet, and a section directing the Secretary of the Interior to pay out of the funds received all expenses relating to the harvest as well as “those for the protection, preservation, and harvest of the forest upon such reservation” (An act to authorize the cutting of timber, the manufacture and sale of lumber, and the preservation of the forests on the Menominee Indian Reservation in the State of Wisconsin, 1908). The Act assigned the responsibility of preserving the forest of the Menominee reservation to the US Forest Service. In order to “preserve” the forest, the US Forest Service’s responsibilities included identifying and supervising the cutting of mature trees to a maximum of the 20 million feet per year. Often the Forest Service did not identify the trees and “for sixteen years, between 1910 and 1926, the Forest Service failed to comply with these requirements” (Herzberg, 1977, p. 287). In fact, in 1912, it “officially sanctioned the clear-cutting of large areas of the Menominee forest” (Herzberg, 1977, p. 289). The clear cutting in the Menominee forests continued until 1934, resulting in a “net loss of half a billion board feet of timber between 1908 and 1934” (Beck, 2005). Further, it was of no benefit to the Menominee to clear cut

the forest as the proceeds did not exceed what they would have received had the government practiced the sustained yield foresting.

The mismanagement of their forests was the basis for a series of lawsuits brought by the Menominee in 1935 against the federal government. Although they had protested vigorously to their OIA agents and sent delegations to Washington to complain, Congress did not approve their request to hire a law firm to investigate their complaints until 1931. The law firm found that the tribe had “substantial claims against the government” (Beck, 2005, p. 120), although OIA denied any responsibility for mismanagement. When Roosevelt appointed Collier as Commissioner of Indian Affairs in 1933, the Menominee supported him and the IRA. Likewise, Collier saw to it that the current mill manager was replaced and “promised to support the tribe’s efforts to press logging and mill mismanagement charges against the government” (Beck, 2005, p. 121). In 1935, Congress passed a law allowing the tribe to pursue a claim against the government. Initially the tribe filed one suit, but the Court dismissed the suit. The tribe persisted and filed 13 separate lawsuits. Four were dismissed and one regarding swampland on the reservation was settled in the mid-1940s (Beck, 2005). The others were languishing in the Court of Claims when Congress passed the Indian Claims Commission Act in 1946. The Court of Claims did not hear and settle the Menominee claims until 1951.

The lawsuits against the government may have stagnated, but the Menominee did not. In the years between 1905 and the claims settlement in 1951, the tribe had increased their communal assets considerably. The tribally-owned sawmill built after the La Follette Act had burned down in 1924 but was rebuilt and provided employment and income to tribal members. The tribe “owned and operated two hydroelectric plants, one

steam plant, water and sewer systems in Keshena and Neopit, and maintained a network of reservation roads” (Herzberg, 1977, p. 296). The tribe maintained its own police force, a court system, and a jail, all paid for out of tribal revenues through the OIA trust account. In fact, “the tribe paid almost entirely for its own services including the salaries of five dozen federal employees who managed the reservation” (Ulrich, 2010, p. 25). The federal government spent less than \$150,000 annually or \$50.85 per tribal member to provide services to the reservation in 1951 (Shames, 1972; Ulrich, 2010).

The tribe also provided health care through its facilities for tribal members. Menominee contracted with a Roman Catholic mission to run a hospital in Keshena into which the tribe had invested \$750,000. The tribe paid for health care in their facilities for all enrolled members in what amounted to an annual charge of \$38 per member. For that tribal expenditure, tribal members could remain in the hospital for however long they needed or wanted. Mission volunteers staffed the hospital with the one salaried physician (Shames, 1972). The tribe paid for dental services, a public health nurse, and a sanitarian.

Zimmerman’s identification of the Menominee as a tribe ready to be freed from federal support started a cascade of events that ultimately pushed the tribe toward termination. Although Zimmerman had suggested that his criteria be used in the future to select tribes for termination, it’s not clear that the Indian Policy Review Committee used any criterion other than reports from BIA agents to create the list of tribes to terminate (Ulrich, 2010). However, the monetary judgment as a resolution of the lawsuits against the federal government solidified the choice of the Menominee as one of the first tribes to be terminated.

In 1951 the Menominee and the federal government settled the remaining Menominee lawsuits in the Court of Claims. The Menominee received a judgment of \$8.5 million dollars, netting \$7.6 million after paying the attorneys (M. Robertson, 1958).

The Court stated:

that the [1908 La Follette] act had as one of its purposes, equal in importance to the others, the preservation of the Menominee forest in such a way that it would provide a continuing source of income to the Indians who could not, if its resources were depleted, move on to another forest (*Menominee Tribe v. United States*, 1951).

When added to the funds held in trust by the BIA, the account totaled \$10 million. The Menominee saw the judgment money as an opportunity to improve the living conditions of the tribe. To that end, in 1952 they submitted a request to BIA to spend \$9.5 million on a reservation development plan<sup>33</sup> that included a one-time \$1000 payment to each member of the tribe (Ulrich, 2010). Tribal leaders wanted the per capita payments to offset the poverty on the reservation, rationalizing that those monies would have come to members earlier if the forests had been managed properly in the form of annual stumpage payments (Native American Rights Fund, 1973). The BIA, under Commissioner Dillon Myer, refused to approve the proposal because it did not include a plan for termination (Ulrich, 2010). Wisconsin Congressman Melvin Laird then introduced legislation asking Congress to approve a one-time \$1500 per capita payment from the judgment money.

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<sup>33</sup> The reservation development plan included expansion of the lumber operation, creation of more economic diversification, and improvement of social services on the reservation (Peroff, 1982).

Given the earlier refusal from BIA to approve the tribe's development plan, a delegation of Menominee met with Dillon Myer to discuss how the judgment money could be spent. Myer told the delegation that they should plan to take over all the operations of the tribe and allow the federal government to shed its current responsibilities (Beck, 2005). Congress and the BIA resented the Menominee for the judgment in their favor not only for past mismanagement of their forest, but also because it raised concerns that the Menominee might bring additional lawsuits for current BIA actions (Beck, 2005). With the judgment money in place for the Menominee tribe, then, Congress and the BIA were ready to terminate the Menominee. In testimony at a House hearing regarding the per capita payment, the tribe's attorney, Gordon Dickie, stated that the tribe was setting self-governance as a long-term goal. He underscored, however, that the Menominee felt that an important step was learning how to handle their own business and that they wouldn't be ready for many years (Beck, 2005).

The Menominee had a weak system of self-governance, despite having tried several different methods. The tribe had been fractured by different religious beliefs, an elitist mentality by some who had been more acculturated, and trying to fit into the US government's ideal of a government. The tribe had adopted a constitution in 1924 and from that had created a twelve-member Advisory Council given the power to liaise with government officials regarding the budget and mill management. The Advisory Council answered to the General Council made up of all the members of the tribe. Although the tribe approved of the IRA, it had not incorporated under it. They prophetically were afraid that by incorporating they would relieve the federal government of its responsibilities. Even though the Advisory Council and General Council were in place

during this period, they were not effective. It was during “General Council meetings that the tensions of tribal factionalism were most obvious. Attendance at most meetings did not achieve a quorum, and it was difficult to characterize it as a body representing the entire tribe” (Herzberg, 1977, p. 299).

The General Council meetings also pointed to two notable differences between tribal government and White government. The first difference was in the method used to determine a resolution. Consensus was reached only after every meeting attendee had an opportunity to voice his opinion, leading to lengthy meetings that may not have a vote at the end. Once a consensus was reached “then all, or nearly all, of the members voted with the majority regardless of their individual preferences or convictions” (Herzberg, 1977, p. 299). Even if a vote were taken, the Menominee might rescind that result at the next meeting with another vote. Further, to show displeasure at an agenda item, it was common for a tribal member not to attend that meeting. Because they were unfamiliar with the Menominee tribal member’s show of disapproval, White government outsiders during this period assumed incorrectly that an opinion from the General Council was final and was a consensus from the entire tribe.

Regardless of the cautionary approach the tribe wanted to take toward self-determination, the federal government pressed ahead with termination. Although the per capita payment bill passed the House, when it reached Arthur Watkins on the Senate Subcommittee on Indian Affairs, he completely rewrote the bill and included a statement requiring the Menominee to accept termination of federal services to receive the payment. The Menominee delegation in Washington was alarmed at the insistence of

termination as a requisite to receive the per capita payment. The delegation invited Watkins to the reservation to explain his position.

In a meeting with the General Council on the Menominee Reservation, Watkins eschewed any of the value-laden rhetoric he had used elsewhere regarding the termination proceedings to “free the Indian.” Watkins (1957) saw the freeing of the Indian as “an ideal or universal truth, to which all men subscribe,” (Watkins, 1957, p. 47) driven in part by his Mormon faith that sought to “lead Indians into the light” (Beck, 2005, p. 135). The deliverance of Indians to the light did not require their consent (Shames, 1972). Rather, Watkins told the tribe:

that they were going to be terminated whether they liked it or not, that they would be allowed no more than three years to prepare a plan for termination, and that unless they agreed to termination their own tribal funds would not be released for the requested, and much needed, \$1,500 per capita payment. He further stated that the United States was unwilling to continue paying interest on the Menominee funds held in trust in the Treasury (Ray, 1971, p. 14).<sup>34</sup>

Watkins left the General Council meeting, unconcerned about the coercive tactics he had used or whether his speech had been understood since he had refused an interpreter. Immediately following Watkins’ speech, the General Council voted on a resolution they had drafted earlier in the year after government officials repeatedly requested that the Washington delegation prove that the Menominee were committed to

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<sup>34</sup> Watkins made five references to the lawsuit during his speech suggesting that if the Menominee thought the government had done such a bad job, the government wanted out before it got sued again (Herzberg, 1977).



self-governance.<sup>35</sup> Although the resolution passed with a vote of 169 to 5, most of those who voted to accept the resolution were under the impression that the resolution did not commit the tribe to termination, rather it was “in favor of a study of termination rather than termination itself” (Herzberg, 1977, p. 314). Being allowed to get the \$1500 was important to the tribal members.

The vote, however, could not be reflective of the whole tribe’s wishes since there were so few members in attendance. Furthermore, the meeting had not followed the usual consensus building procedure that allowed everyone present to participate. The tribe had drafted the resolution to show the government that the Menominee tribe were *considering* self-governance. Watkins returned to Washington and refused to acknowledge the suggestion that the vote was invalid. Instead, when speaking to Congress, he referred to the vote as confirmation of Menominee consent to termination. A month later, the Menominee rescinded the termination plan vote and renounced the per capita payment by a vote of 197 to none, but Herzberg (1977) states, “Watkins ignored and never mentioned the subsequent repudiation of the resolution” (p. 316).

Watkins amended the per capita payment bill in the Senate to include the phrase to provide for the “orderly termination of federal supervision over the property and members of the Menominee tribe” with termination effective December 31, 1956 (Herzberg, 1977, p. 316). Because the Senate bill was vastly different from the House bill that had only stipulated that payment could begin to the Menominee, the bill was sent to a conference committee. Watkins was on the committee and urged the passage of the bill,

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<sup>35</sup> To read the entire resolution, see (Ray, 1971, pp. 19-20).

but the House rejected the conference committee's report, primarily because the committee had refused to meet with Laird or a Menominee delegation.

Government officials returned to the Menominee reservation. Glenn Emmons, Commissioner of Indian Affairs, told the General Council that termination was inevitable but didn't mean that the tribe had to lose its cultural identity. Laird asked the tribe to draw up a draft plan so that he could use their input to craft a bill in the next session. Herzberg (1977) maintains "the Menominee were reacting to pressure and without substantive knowledge of the possible consequences of termination" when they proposed a plan that "gave the tribe until 1956 to complete its termination studies and planning, and called for a termination date to be set five years from enactment of the statute" (p. 318). In January 1954, Laird introduced a bill to the House using the Menominee draft, and Senator Joe McCarthy introduced a similar bill to the Senate. Both bills were sent to subcommittees.

Watkins was chair of the Senate subcommittee and the House subcommittee chair was Congressman E. Y. Barry. They took the unusual step of calling for a joint hearing. The hearings lasted three months, although only three days were devoted to the Menominee termination bill.<sup>36</sup> None of the witnesses at the hearing testified against termination of the Menominee. Laird testified that government support should not be withdrawn too quickly. A BIA spokesperson testified that the tribe met the criteria set out by Zimmerman in 1947. The State of Wisconsin sent its Tax Commissioner who testified that the State had not been notified in a timely manner to address the implications of

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<sup>36</sup> During the hearings, "individual bills terminating sixty-one groups of Indians were passed" (Herzberg, 1977, p. 319).

termination. He asked for a delay of termination until mid-1959 to give Wisconsin time to prepare. The Menominee expressed concern over the operation of the mill, and asked for time to get ready for withdrawal of support. Without any protest against termination or the knowledge of the coercive tactics used by Watkins, Congress passed the bill in both houses. The bill, (68 Stat. 250; 25 U.S.C. 891–902) signed by Eisenhower on June 17 1954, was modified to allow the Menominee until December 31, 1958 before termination would take effect. Later amendments shifted a portion of the costs for implementation of the termination plan to the federal government, and extended the termination date to April 30, 1961. One caveat to the bill was that the tribal corporation had to be in place by March 1, 1961 or the Secretary of the Interior could transfer all the tribal assets to a trustee of his choice.

Two things occurred immediately upon Eisenhower's signature on the bill. The first was that the tribal membership roll was closed. Children born after that date were no longer added to the roll. Secondly, the \$1500 payment was distributed, although even that payment wasn't without controversy, as originally it had been stated that the payment to minors would be given to their parents. The final bill had been changed so that the United States was to hold onto the minor's money in the form of savings bonds until they reached the age of 18 (M. Robertson, 1958). The tribe was required, too, to prepare and present a termination plan to the Secretary of the Interior by December 31, 1957. The march toward termination was in its last mile.

While the vast forest and communally owned property may have made the Menominee appear ready to be terminated from federal services when William Zimmerman identified them to Congress in 1947, a closer inspection would have

revealed the difficulties termination might bring to the tribe and its members. Through its forestry operation the tribe paid for a number of necessities for its members, but as the sole industry the profitability of the operation was dependent on management skills and market conditions. The Menominee had never been in management positions at the mill so were ill-prepared to take over its operation. As the forestry operation also had to pay the costs of running a county, tribal members felt the consequences. The tribe had sought the opportunity to upgrade the mill and provide additional social services in their initial proposal to use a portion of the settlement money. When BIA rejected that proposal, the tribe hoped to provide some immediate relief to their members until the tribe could apply again to use the money for the benefit of the tribe as a whole.

Regardless of the money in the trust account, before the tribe was terminated most reservation Menominee were poor and lived in inadequate housing, or shared a single house with multiple families. Tribal mill employees earned approximately \$2300 annually or 82 percent of the median income of non-Indian families living around the reservation. Even that figure is misleading, as the counties surrounding the reservation were poorer than other counties in Wisconsin, and Menominee families were larger than the families to which their income was being compared. Menominee who did not work in the mill had an annual income of only \$650 (Peroff, 1982).

Also overlooked by those who viewed the Menominee as a prosperous tribe was a report in 1952 by the Wisconsin Human Rights Committee that noted “less than 5 percent of the children had an adequate diet, and the community hospital had been condemned with an estimate that it would require \$100,000 to bring it up to state standards” (From the Joseph Papers as cited in Ulrich, 2010, p. 26). Infant mortality was high. In 1956 the

University of Wisconsin (1956) reported to the Menominee Indian Study Committee in preparation for terminating the tribe, “the birth rate on the Menominee Reservation for the five-year period 1950-1954 was 36.9 per thousand population, considerably above the state rate of 25.2; but the infant mortality rate of 62.7 per thousand live births for 1951-1954 on the Reservation contrasted with the state rate of only 23.5” (p. 7).

Although the tribe provided some support to the schools prior to termination, in 1950 the median education level for Menominee males was 8.5 years, while for females it was 8.2 years (Bureau of Government at University of Wisconsin Madison, 1956). Only 11 percent of Menominee males had finished high school, and 2 percent had graduated from college. The statistics on education belie the fact that most of the adults who would be responsible for the tribe after termination had less than an eighth-grade education.<sup>37</sup>

Even though the Menominee suffered from many of the problems seen on other reservations, by those same standards they were well off in comparison. Hospital care, guaranteed employment at the mill, and access to the tribally-paid utilities were benefits unknown to other reservation AI/AN. Termination eliminated those benefits for the Menominee and brought taxes as well.

### **From Riches to Rags: The Menominee are Terminated**

Once Eisenhower signed the bill terminating the rights of the Menominee, the tribe found itself in a state of political limbo. Charged with developing a termination

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<sup>37</sup> Figure 8 of the 1956 (Bureau of Government at University of Wisconsin Madison) Report to the Menominee Indian Study Committee, Joint Legislative Council, State of Wisconsin, on county and local government for the Menominee Indian Reservation highlights the educational level of the tribal members who held positions on the Menominee Advisory Council.

plan, the tribe had neither the cohesive leadership nor objective experts to help with the task.

Although the actual termination date was years away, the BIA was still running the mill and forestry operation, but refused to participate in creating a termination plan. Shortly after the Eisenhower signed the termination bill, the BIA halved the number of personnel on the reservation.

It wasn't until 1955 that the State of Wisconsin created the Menominee Indian Study Committee (MISC) whose members consisted of state agency representatives, legislators, surrounding county representatives, and three members of the Menominee Indian Advisory Council (Peroff, 1982; Wisconsin Legislative Council, 1957). The Menominee contributed \$20,000 to fund the group (Ulrich, 2010), even though the primary objective of the MISC was to aid the State legislature as Wisconsin absorbed the reservation and the Menominee tribe into its responsibilities and tax rolls. MISC sought advice from the University of Wisconsin at Madison, but the reports from the University offered little advice for the tribe.

It was left to the tribe to come up with the termination plan. The lack of clear leadership in the Menominee was evident as the deadline for creating a termination plan loomed. Herzberg (1977) notes that between 1955 and 1960 so few tribal members attended General Council meetings that “for lack of a quorum, no business could be conducted at thirteen General Council meetings at which termination matters were to be discussed” (p. 323). Two factors contributed to the low attendance at the General Council meetings. Many Menominee did not understand what termination would mean to the tribe, or they were hopeful that the termination decision would be reversed (Beck, 2005).

Others “chose the traditional Menominee way of showing nonsupport for the withdrawal policy, [and] they boycotted the Council meetings” (Herzberg, 1977, p. 323).

At last, with just a year before the final (amended) deadline for submitting a termination plan, the General Council approved the formation of a Coordinating and Negotiating Committee (CNC). The General Council appointed George Kenote, a former BIA employee, as head of the CNC after he asked the Council for the position. The three-member group began its task on January 20, 1958. The General Council approved the CNC’s plan on January 17, 1959 and submitted it one week before the deadline.

The plan Kenote and the CNC developed was “enormously complex: it was 30 pages long (miniscule type, three columns to a page) in the Federal Register” (Wilkinson & Biggs, 1977, p. 152). Besides the fact that a plan to terminate an American Indian tribe had never before been conceived, the CNC plan was novel in that it called for the creation of a new county, Menominee County, whose borders aligned with the reservation borders. Despite warnings that the creation of a new county would place the Menominee in financial straits because of its small tax base becoming responsible for the expenses of “police protection, welfare services, [and] health and sanitary supervision” (Erdman, 1966, p. 46), the tribe approved that option in an effort to maintain their community rather than be absorbed by surrounding counties.<sup>38</sup>

The CNC plan also called for the formation of a corporation, Menominee Enterprises Inc. (MEI), into which BIA transferred all tribal land and assets, although

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<sup>38</sup> The State of Wisconsin gave provisional approval to the formation of a new county, renewable in 1965 and 1969 and that, unless repealed, became permanent. The County became permanent in 1969 (Wisconsin State Legislative Council Madison, 1973).

“the Menominees were forbidden to sell or mortgage their forest for thirty years without State consent” (Orfield, 1965, p. 50). All Menominees on the tribal roll before 1954 owned a certificate equal to 100 shares of the corporation in a voting trust that then elected the board members for MEI (Peroff, 1982). The Common Stock and Voting Trust owned the shares themselves (Wisconsin State Legislative Council Madison, 1973). First Wisconsin Trust held the certificates for minors and others deemed incompetent (as well as their per capita bonds) a fact that gave First Wisconsin Trust 44 percent of the voting certificates. Between 1961 and 1966, the vote by First Wisconsin Trust accounted for a range of 80 to 96 percent of the total shares voted because of low Menominee voter turnout (Wisconsin State Legislative Council Madison, 1970). Tribal members voted annually only on a choice for a Common Stock and Voting Trust member, who then voted for a member of the Board of Directors to fill a three-year term (see Figure 1). The Board of Directors, with a two-thirds majority vote, made all corporate decisions. At termination, four of the seven members of the Common Stock and Voting Trust were non-Menominee. The Voting Trust elected five tribal members and four non-tribal members to the first Board of Directors.<sup>39</sup> The voting structure gave tribal members no direct voice on topics or decisions made by the corporation. One exception occurred every ten years when shareholders voted on the continuance of the voting trust.

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<sup>39</sup> It wasn't until 1972 that Menominee gained majority of the MEI Board (Ulrich, 2010).



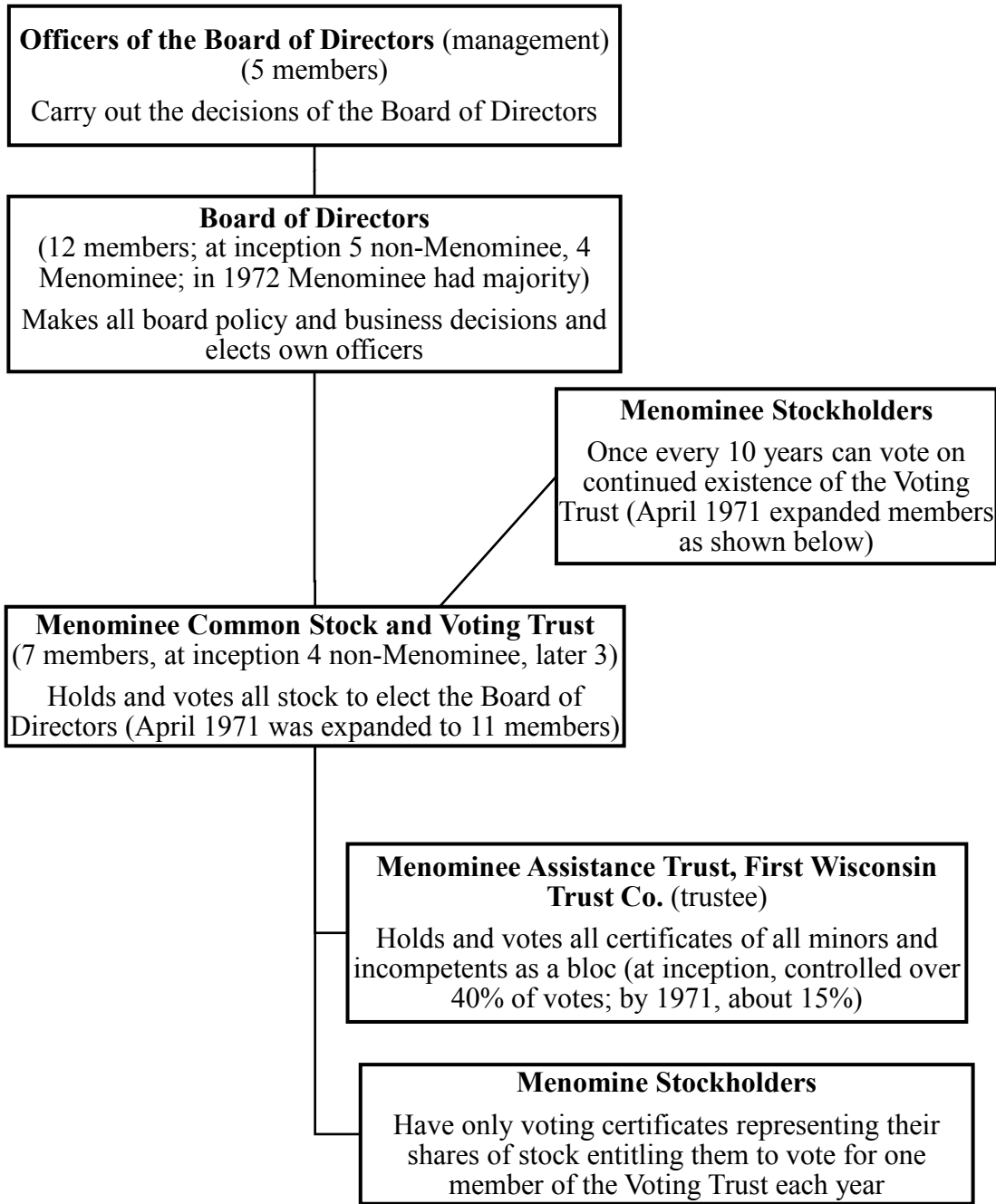


Figure 1. Structure of Menominee Enterprises, Inc.

(Chart compiled from Peroff, 1982, p. 140; Shames, 1972, p. viii)

Each tribal member also received a \$3000 income bond payable in the year 2000 yielding four percent interest per annum, based upon the corporation's net income. Tribal members could not sell the bond for a minimum of three years, although they could use it for loan collateral, if a bank was willing to loan on a bond that the corporation had the right of first refusal to purchase. The tribal assets, then, were disbursed to the tribal members, but in a way that effectively prevented the individual from accessing his tribal estate (Kalinowski, 1983).

**Structural financial trials.** Though creative, the formation of the county and the corporation did not protect the tribe from financial ruin as termination was finalized. The new county was not only the smallest county in Wisconsin with approximately 2,600 residents, but also the poorest. Whereas the reservation land had been free from property taxes prior to termination, now the new county had to assess property taxes to generate revenue for it to supply public services. The corporation, not individuals, owned the tribal land. Taxes on land valuations outside of the forest would generate only 10 percent of the revenue, meaning as the largest landowner, MEI was the single source of property tax revenue, and thus responsible for nearly all county expenditures.

Inherent conflicts of interest arose as the tribe, the corporation, and the county each sought to derive the most benefit. For example, the corporation was responsible for making profit to provide dividends to the shareholders, as well as paying taxes to provide county revenue. To do that the corporation had to reduce expenses, particularly in the form of excess employees. The corporation had previously run on the philosophy of community service, that is, as a mechanism of providing employment to tribal members rather than for profit (Shames, 1972). Peroff (1982) expresses the termination plan set up

a “collective series of private substitutes for the Bureau of Indian Affairs” (p. 123). The mechanism for control of the land and other assets again left the Menominee “freed of BIA supervision, but their property would remain outside their control” (Peroff, 1982, p. 123). This fact proved true as the corporation scrambled for money after termination. The power to make decisions rested in the hands of a few as

the plan for management of the tribe’s assets offered a mechanism for the governing elite not only to retain but to expand their control of tribal affairs.

While they would share their authority with non-Menominees on the MEI Board of Trustees and Board of Directors, they would not have to debate before and win the approval of the General Council for major decisions, such as land sales (Peroff, 1982, p. 123).

Financial troubles began even before the termination date was reached.

Immediately following the passage of the termination bill, the tribal account held by BIA contained less than \$5 million when the \$1500 payments were made to tribal members. BIA then discovered that it had underpaid annual payments to tribal members for several years, so took another \$2 million out of the account to make up the shortfall to tribal members. The tribe spent \$300,000 to renovate the hospital and an additional \$300,000 to renovate a church in Neopit before termination came into effect leaving a balance of less than \$2 million in the account. The federal government also reduced its reimbursement to the Menominee for the costs relating to termination from full reimbursement to a maximum of \$275,000. Tribal and federal operations along with school construction from 1954-1959 totaled \$2.4 million. By 1960, the account that had begun with a balance in

1954 of nearly \$10.5 million had paid out \$12.2 million (Wisconsin State Legislative Council, 1966).

There were additional devastating financial setbacks. The Menominee had to close the hospital at Keshena on January 1, 1961. Although the tribe had invested \$300,000 to try to bring the hospital up to the State standards (Beck, 2005), “it would have required [an additional] \$50,000 for improvements to meet state license standards, plus \$150,000-\$175,000 for operating equipment” (Wisconsin State Legislative Council, 1966, p. 24). Even with the improvements, the hospital would have run at a deficit of \$75,000 per year, and suffered from a lack of licensed personnel (Wisconsin State Legislative Council, 1966). Shortly after termination, the new county paid \$75,000 for medical care in the face of a TB epidemic.

Other expenses arose immediately following termination. The State of Wisconsin determined that the mill did not comply with State industrial standards, citing 132 violations that the tribe spent \$100,000 to correct (Beck, 2005). The mill management, brought in from other States where clear cutting was the norm, spent additional monies in an attempt to modernize the operations, but not all the expenditures achieved the desired result. For example, they immediately purchased larger trucks designed for use in clear cutting operations. Unfortunately, the trucks were too large for the roads. After widening the roads, the management discovered that the fully loaded trucks were too heavy and the roads could not support them.

Lumber prices took a downturn in 1963 and the mill management laid off a number of workers to keep the mill profitable. Hired from outside the tribe, the mill management had little sympathy with the Menominee vision for the sawmill as a means

to provide employment to tribal members. With some modernization in the mill, the management was able to permanently replace the employees with machines (Shames, 1972).

The county faced its largest increase in expenses in the areas of health and welfare. From an initial budget in 1962 of approximately \$73,000, by 1970 the county budgeted \$605, 000 or an 833 percent increase (Peroff, 1982). In 1969, the Menominee Indian Study Committee reported that 46 percent of the County residents received some kind of assistance (Wisconsin State Legislative Council Madison, 1970). Of those, over 80 percent were children. A State law in 1963 established a welfare program for bondholders in Menominee County. Although welfare recipients could not own more than \$500-750 in liquid assets, the bondholders could assign their \$3000 bonds to the State or use them as collateral for a loan. When a welfare recipient had received \$3000 or more of welfare payments, the State took over ownership of the bond, and the tribal member lost not only the bond, but also the \$120 annual income. The State offset some of the costs of welfare to Menominee County by having the recipients pay for their own assistance (Peroff, 1982). By 1969 the State of Wisconsin held ownership of over \$1 million in income bonds and \$200,000 in bonds assigned to it (Wisconsin State Legislative Council Madison, 1970). Shames (1972) alleges, “Thus, a portion of their ancestral estate had been converted, without their consent, into a negotiable asset” (p. 40). This practice was revoked in 1971, and the State returned the bonds to the bondholders (Wisconsin State Legislative Council Madison, 1973).

Without federal and State grants and aid, Menominee County would have been financially insolvent during its first 10 years. “Immediately following termination the

county was named a ‘depressed area’ to make it eligible for federal grants” (Peroff, 1982, p. 129). The result was that the federal government contributed \$5 million in aid during the first five years after termination, a seven-fold increase from the \$144,000 per year it had spent prior to termination (Beck, 2005). By 1973, the State of Wisconsin and the federal government together had provided over \$19,000,000 (federal total, \$11,702,584; state total, \$7,425,066) in assistance to the County and its residents (Peroff, 1982). Most of the money went to bring the reservation up to State standards. The federal government’s grants were approximately \$2.4 million for housing aid, \$2.2 million for education, \$900,000 for sewer and sanitation improvements, and \$500,000 aid for health. The federal money primarily came from the Nelson-Laird aid bills for the Menominee in 1962 and 1966. Distributed in five declining annual payments, the first grant in 1962 “provided \$1,674,000 for education, health and sanitation, and public welfare” while the second grant distributed, again in declining annual payments over a four-year period, “\$1,850,000 for tax relief for schools—offsetting welfare costs, health aids, and disease control—and for completion of water and sewage projects” (Peroff, 1982, p. 137). An application to obtain a grant from Johnson’s “War on Poverty” economic development office netted

less than 9 percent of their grant request, or \$138,295. Included were \$75,200 for the development and administration of a Community Action Program (CAP), \$42,145 for educational services in Joint School District Eight, \$18,300 for six VISTA volunteers, and \$2,650 for a day nursery for preschoolers (Peroff, 1982, p. 137).

The State of Wisconsin provided \$1.5 million to the county; \$1 million went to state welfare aid for the residents, but the State recouped that by the recipient's assignment of his bond, although that procedure was revoked in 1971. The State also provided \$500,000 for highway improvement. According to Peroff (1982),

The state of Wisconsin was extremely reluctant to grant special aid to Menominee County. State officials argued that, since termination was the idea of Congress, it was the responsibility of the federal government to provide the necessary funds to bring Menominee County up to state standards for government services (p. 133).

**Push toward restoration.** Real efforts to restore tribal recognition began after the MEI began to sell property along a new development called Legend Lake (also known as Lake of the Menominee.). The action of land sales galvanized the community behind urban Menominee activists.

MEI began leasing summer home-sites to non-Menominees in 1962, but the lease arrangements did not bring enough profit to the corporation. The State of Wisconsin, in an effort to preserve Wolf River, leased rights to fishing and camping access for the public beginning in 1966. The maximum amount of money the State provided was \$250,000, not nearly enough to augment the County coffers. With few other opportunities for development in Menominee County, MEI entered into a partnership agreement with a local developer to create a lakeside home-sites. Actual sale of the land required approval of 2/3 of the Menominee certificate holders. At a meeting held on September 23, 1967, shareholders approved an economic development plan from which the Legend Lake project was to be carved (Shames, 1972). Many Menominee at the meeting proclaimed afterward that they had no idea what a warranty deed was, nor that the development plan

they approved allowed MEI to sell off their land (Shames, 1972). As development progressed, however, Menominee who had relocated to the cities became alarmed when they returned to the reservation and saw bulldozers on land they considered sacred not only for the burial mounds on the land, but also because the “land provides their very identity” (Shames, 1972, p. 34). They began to act after a non-tribal land purchaser chased Menominee off land that had been a traditional picnic spot by the lake.

Led by Ada Deer in Milwaukee and Jim White in Chicago, the group DRUMS, an acronym for Determination of Rights and Unity for Menominee Shareholders, began protesting weekly in 1970 against the Legend Lake project. Inspired in part by civil rights activism, DRUMS also took their protests outside the county and picketed at the First Wisconsin Trust offices in Milwaukee. At the first meeting in the county to gather supporters from Menominee still living in the county, MEI “deputized 25 millhands to break up the gathering” (Shames, 1972, p. 72). A crew from National Educational Television who were creating a documentary on Menominee County captured the brawl. MEI allowed further meetings after they were sued for disruption of freedom of speech and peaceful assembly of Menominee. As more Menominee joined the protests, sales at Legend Lake dropped, as nontribal purchasers were concerned and scared by the demonstrations.

DRUMS continued its activism on other fronts too. DRUMS had originally sought to dissolve the MEI Board. Although DRUMS obtained over half of the votes, they did not have the requisite 51% of the total and that attempt was unsuccessful. The dissenting votes came from First Wisconsin Trust. DRUMS realized that one goal should be to get a majority of Menominee on the Board of Directors of MEI. DRUMS also



worked to reverse the Assistance Trust, the name for the trust containing the seized capital bonds by the State of Wisconsin to offset welfare assistance of individual Menominee (Beck, 2005; Shames, 1972).

Soon after DRUMS began its protests, administrators in the federal government started to denounce termination. President Nixon's public support in July 1970 of tribal self-determination—without loss of federal recognition and services—offered a shimmer of hope for DRUMS to start an organizational push to reverse termination. Ada Deer gave testimony in July 1971 on Senate Concurrent Resolution 26, then in discussion at the US Senate Committee on Interior and Insular Affairs. The resolution “expressed official Congressional repudiation of the federal policy of termination” (Shames, 1972, p. 86). In October 1971, DRUMS organized a 220-mile march from Keshena to Madison to highlight the plight of the Menominee. When the group met with Governor Lucey, “he seemed moved by the realization that it had been necessary for the tribe to go to such extreme lengths to attract the attention and help of State government” (Shames, 1972, p. 89). By November 1971, DRUMS had seen their slate of candidates elected, giving the Menominee a majority on the MEI Board of Directors. DRUMS had also filed a lawsuit challenging the legality of the Voting Trust and the sale of land. The lawsuit effectively halted sales of the land, as buyers had to be notified that there were questions regarding title (Shames, 1972). Their momentum secured the support of Wisconsin Governor Lucey, as well as Congressman Obey and Senator Proxmire in drafting a bill to restore Menominee tribal status. On December 22, 1973, the Menominee Restoration Act repealed the Menominee Termination Act, and acted:

to reinstitute the Menominee Indian Tribe of Wisconsin as a federally recognized sovereign Indian tribe; and to restore to the Menominee Tribe of Wisconsin those Federal services furnished to American Indians because of their status as American Indians; and for other purposes (Menominee Tribe of Wisconsin: Restoration of Federal Supervision, 1973)

Although the Menominee Restoration Act (Menominee Tribe of Wisconsin: Restoration of Federal Supervision, 1973) reinstated the tribe as a federally recognized tribe, the ill effects of 11 years of termination have remained for the Menominee.

**Education and economic outcomes.** Many Menominee were unemployed after the tribe was terminated because of layoffs in the mill. Although there had been few employment opportunities for women on the reservation prior to termination, once the hospital closed, women had virtually no opportunities for employment in the county. As the mill released employees in its effort to make a profit, the men also experienced high rates of unemployment. Unemployment rates for men ranged between 18 and 28 percent, and seasonally up to as high as 40 percent from 1964 to 1973 (Peroff, 1982). Educated Menominee moved outside the county to seek work. Once the tribe lost its federally recognized status, “the reservation population declined 12 percent in the 1950s and 29 percent in the 1960s” (Baumtrog, Cook, & Dresang, 2008, p. 7).

Menominee Enterprises, Inc. (MEI) had the land under the homes and farms appraised and offered for purchase to the occupants. “As many as 600 Menominee were forced to return their income bonds to the corporation to buy their homesites” (Peroff, 1982, p. 142) but the corporation retained the first right of refusal to repurchase the land. Ownership of the land as well as residence in the county meant that tribal members were

subject to taxes. The county sent out the first tax bill in May 1961 to raise funds for the fledgling county's operations, and then sent out the next bill shortly thereafter for funds for 1962. Over 88 percent of Menominee were delinquent on the 1962 tax bill. Though the delinquency rate dropped in subsequent years, in 1973 about \$33,000 remained unpaid (Peroff, 1982). Besides taxes, individuals were now responsible for paying their electricity and water bills, as the MEI sold the tribally-owned utilities to outside interests.

Termination changed the education of the children in Menominee County. Prior to termination, the tribe had paid for parochial education for the Menominee children. Following termination, the tribe could no longer afford the education subsidies, so parents sent students to public schools. There were two public primary schools with programs up to grade 5 in the county. After grade 5, the students were bussed to schools in the neighboring county. Although there had been few problems with the neighboring schools prior to termination, problems began shortly thereafter. Parents and students both complained of discrimination and segregation in the schools that taught students above grade 6. That age group experienced a 50 percent dropout rate following termination. In 1969, the US Department of Health, Education and Welfare Office of Civil Rights began an investigation of the public school in Shawano County Joint District 8 for possible segregation and ultimately fined the school district in 1972 for its practices. Parents also filed a federal lawsuit alleging discrimination and harassment in the school district in 1972 (Wisconsin State Legislative Council Madison, 1973). The court found against their suit. Undeterred, the group developed a community school modeled after other successful American Indian programs, and opened their doors to seven students shortly thereafter (Beck, 2005).

In 1969, the Menominee Indian Study Committee reported that 46 percent of the County residents received some kind of assistance (Wisconsin State Legislative Council Madison, 1970). Of those, over 80 percent were children. Many of the welfare recipients had pledged and turned their MEI bond over to the State of Wisconsin when they received welfare, although the bonds were returned when Wisconsin was forced to revoke that policy in 1971.

The federal recognition of the Menominee was restored in 1973, but the Menominee have not completely recovered. Termination left poverty, unemployment, poor health, and the associated social ills of poverty in its wake. Menominee County was preserved even as the tribal land was again restored to reservation status. The University of Wisconsin, School of Public Affairs (Baumtrog et al., 2008) noted, “the coterminous existence of Menominee County and the Reservation continues to oblige the Tribe to meet the mandates and responsibilities of a county without adequate revenues from property taxes” (p. 5). Unlike prior to termination when the tribe was able to pay for most of its services, in the 2006-2007 fiscal year, federal expenditures supplied over 50 percent of the tribe’s budget and the tribe provided only 22 percent. Public expenditures for the tribe exceed \$2,000,000 as contrasted to the \$160,000 prior to termination (Baumtrog et al., 2008). The tribe’s contribution to its budget is derived from the lumber industry, taxes, and casino revenues. The tribe has opened one casino in Keshena, but its rural location has kept revenues and patrons down. The tribe’s recent bid to manage an off-reservation casino was denied (Spivak, 2015).

Despite the money the federal government and other sources supply to the tribe, over 29 percent of individuals living in the county fall below the poverty line, compared

to an overall rate in Wisconsin of only 13 percent U.S. Census Bureau (2016). By itself, the percentage of people living under the poverty line doesn't convey the fact that most of the people in that statistic are women, children under employment age, and the elderly. In 2008, 42.1 percent of those living on the reservation were younger than 20, those under 18 equaled 38.9 percent compared to the state as a whole where only 25.5 percent of the population is under 18 (Baumtrog et al., 2008, p. 7). Of the approximately 8700 registered tribal members, over half live off the reservation because the reservation lacks employment opportunities and housing (The Menominee Indian Tribe of Wisconsin, 2015).

The tribe stresses that an aging infrastructure has not been able to support economic development on the reservation (The Menominee Indian Tribe of Wisconsin, 2015). This lack of economic development translates into a 13.1 percent unemployment rate in Menominee County in 2015 compared to Wisconsin's rate of 5.5 percent and 5.0 percent nationally (Wisconsin Department of Health Services, 2016).

**Health outcomes.** The loss of the hospital and the abject poverty negatively impacted the health of the county residents. There was not a resident physician in the county from the closure of the hospital in 1961 until mid-July 1972 when the county and the National Health Services Corp jointly paid for one (Wisconsin State Legislative Council Madison, 1973). Many of the tribal members did not own a car, and could not make the trip of between 8 and 50 miles to the nearest hospital or clinic. Others were unlikely to use a hospital in a different county where they were the minority because of "apprehension and lack of trust in white doctors who know little or nothing of the traditional Indian medicine" (Shames, 1972, p. 43). Before termination, the hospital had

cost each member about \$38 per year and a member could stay in the hospital for the full year without any additional cost. Now the resident had to pay for any illness or accident that caused hospitalization. Mill and county workers had medical insurance, but nearly 60 percent of the population had none. By 1965 the hospitals and clinics near Menominee County were expected to have over \$200,000 in unpaid Menominee medical bills (Wisconsin State Legislative Council, 1966). Public health officials attributed “unfavorable environmental conditions” (Wisconsin State Legislative Council, 1966, p. 32) as a contributing factor to the high infant mortality rate that was nearly double the State rate.

Additionally, a dental survey in 1965 found that 94 percent of the 865 children surveyed between the ages of 5 and 19 needed dental work, with the estimated costs of \$50,000 to bring the students to a level commensurate with the rest of the State (Wisconsin State Legislative Council, 1966). It wasn't until 1973 that the National Health Service Corps provided a dentist, again with the same financial arrangement as the physician (Wisconsin State Legislative Council Madison, 1973).

The *Menominee Tribe Health Care Program Planning Report* (Leatherwood, 1975), charged with creating a health care plan for the Menominee tribe once it was restored, cautioned that statistics during the period of termination are skewed by the outmigration of young adults from the reservation. Nevertheless, between 1963 and 1972 perinatal deaths and infant mortality increased. The Menominee also showed high rates in diseases that could have been controlled with regular medical attention. These include otitis media (inner ear infection) that was present in the population at a rate nearly three times greater than the entire population served by IHS. Likewise, the rate of respiratory

infections in Menominee County compared to the State of Wisconsin per 1000 persons was 173.5 to 22.3. While these specific diseases were not necessarily measured prior to termination, a tribal member would have had access to the hospital on the reservation for treatment.

In making their recommendations, the *Menominee Tribe Health Care Program Planning Report* team (Leatherwood, 1975) commented that besides health-related problems, “due to the cause/effect relationship between health and socioeconomic problems, both types must be considered within the context of design of a health problem” (Section 4-2-2 Socioeconomic Problems That Relate to Health, Leatherwood, 1975, p. 32). The primary socioeconomic problems the team identified were: poverty, with a 1970 income per person per year of \$916; unemployment that in 1972 was at a rate of 26% for Menominee County compared to the Wisconsin rate at 2.1%; and overcrowded housing with a median of 5.02 persons per occupied unit, that possibly contributed to the high rate of communicable diseases among children under the age of five.

As the *Menominee Tribe Health Care Program Planning Report* recommended, Indian Health Service opened a tribal health clinic in 1977, which the tribe now operates and manages. Despite the clinic, the health status of the county residents falls below the rest of Wisconsin. In fact, other than in environmental factors, the county when compared to other counties in Wisconsin ranks last or next to last in all measurements used by the University of Wisconsin–Madison Population Health Institute (2016). These measurements include health outcomes, quality of life, health behaviors, clinical care, and social and economic factors (University of Wisconsin–Madison Population Health

Institute, 2016). Tribal members needing hospital care must travel and stay at hospitals off the reservation. Statistics from the Wisconsin Department of Health Services (Wisconsin Department of Health Services, 2016) highlight the unmet health needs of the Menominee.

The public health department is now merged with the Shawano County health department, but the 9.8 full time equivalent staff allocated to Menominee County equal 2.1 per 10,000 persons, compared to a Wisconsin rate of 3.2. Of the staff assigned to Menominee County, three are public health nurses, and the rest are paraprofessionals or administrative and support staff. There is only one mental health provider for every 900 persons in the County (Wisconsin Department of Health Services, 2016).

Over a quarter of the hospitalizations of tribal members were classified as “preventable hospitalizations”, a term to describe those hospitalizations that could have been prevented had “timely and effective ambulatory care” been given (Wisconsin Department of Health Services, 2016). The preventable hospitalizations statewide was half that number. Those persons aged from 45 years or older accounted for all the preventable hospitalizations.

Nearly 45 percent of pregnant Menominee women do not have the desired number of prenatal visits, and a quarter of those have their first prenatal visit in the second trimester of pregnancy. The number of persons in the Supplemental Nutrition Program for Women, Infants, and Children (WIC) is 638. The maternal characteristics of the Menominee show that 83 percent are unmarried, only 44 percent of them have some college, and 43 percent are smokers.



Smoking, along with alcohol and drug use are all high on the reservation. In fact, among all Menominee, the death rate from alcohol, tobacco, or drug use is 345.6 per 100,000 compared to a Wisconsin rate of 179.3 per 100,000. The reservation is also not free from the sexually transmitted disease, chlamydia, and the rate of infection from it is increasing annually (University of Wisconsin–Madison Population Health Institute, 2016).

It is impossible to determine how the health status of the Menominee would be today had the tribe never been terminated. It is possible, however, to document that because of termination, the health and well-being of the Menominee was not improved. In just four years following termination, the BIA reported on the status of the Menominee tribe that was submitted to the Appropriations Committee of the House and found “in the 4 years following termination the problems of poverty on the reservation as measured by health, income, employment, housing, had declined” (United States Congress-House Committee on Interior Insular Affairs-Subcommittee on Indian Affairs, 1973, pp. 150-151). Some of the poverty that began with termination of the tribe is rooted in the desire of the Menominee to keep their tribal lands together in the formation of a new county, as the federal government had promised in treaties to hold the land “as all Indian lands are held.”

### **Promises, Expectations, and Rights**

Shortly after termination, the State of Wisconsin sought to assert its rights over the hunting and fishing in Menominee County by arresting two Menominee they caught hunting deer. The Menominee men admitted they had done so, but challenged the authority of the State to revoke the hunting and fishing rights granted to them in the 1854

treaty. The Wisconsin Supreme Court ruled that termination ended any hunting and fishing rights bestowed to the Menominee and made them subject to the same hunting and fishing rules as other citizens of the State. The Menominee hoped the US Supreme Court would take the case, but when it refused, they took the case to the Court of Claims. The Court of Claims found in favor of the Menominee, ensuring that the US Supreme Court would have to take the case. The final decision in 1968 from the US Supreme Court was that, although the 1854 treaty did not specifically mention hunting and fishing rights, they were accepted as inherent rights of the Menominee to maintain their lifestyle since the reservation lands had been chosen because it had sufficient game and fish. Justice William O. Douglas wrote the majority opinion and stated, “We decline[s] to construe the Termination Act as a backhanded way of abrogating the hunting and fishing rights of these Indians” (*Menominee Tribe of Indians v. United States*, 1968). The ruling confirmed those rights remained since the Menominee Termination Act of 1954 did not specifically revoke them. Justice Douglas noted the intent of the Termination Act, along with Public Law 280 (Public Law 83-280, 1953) passed two months after the Termination Act, transferred jurisdiction to the State in which the Indian lands were held, but Public Law 280 (Public Law 83-280, 1953) stated explicitly that:

nothing in this section . . . shall deprive any Indian or any Indian tribe, band, or community of any right, privilege, or immunity afforded under Federal treaty, agreement, or statute with respect to hunting, trapping, or fishing or the control, licensing, or regulation thereof (Public Law 83-280, 1953).

The Supreme Court quoted Arthur Watkins in the ruling when he had declared that the Termination Act did not “violate any treaty obligations” (as quoted in

*Menominee Tribe of Indians v. United States*, 1968). The federal government could directly revoke promises made in the 1854 treaty with the Menominee, but the highest court in the US ruled that the treaty also ensured certain inherent rights that the Termination Act did not expressly revoke.

Only four years after termination was finalized, the BIA (The Status of the Termination of the Menominee Indian Tribe as quoted in Laird, 1965) reported:

A review of developments in Menominee County since termination of the Federal trust in 1961 makes clear how ill-advised were the terms on which the Menominee were deprived of Federal services and supervision ... The Department of the Interior sees no alternative to combined State and Federal support of the county and its people, who are in desperate circumstances. Continuation of the present trend will threaten the existence of the corporation and lead to decline of county services, to the detriment of the Menominee people and their non-Indian neighbors in Wisconsin. To stand idly by and watch the further growth of such a pocket of poverty is unthinkable (p. 88).

Although no tribes were terminated after 1964, the termination policy remained in effect. In 1968 President Lyndon B. Johnson urged for the end of the termination, but the resolution was not reversed until 1971.

Scholars have since debated how the Menominee came to be chosen to be terminated. History has recorded that a cursory observation of the tribe placed the tribe as economically stable and acculturated, but that a more thorough investigation would have shown just how ill-prepared the tribe was to lose all federal support (Herzberg, 1977). Another theory posits that Whites wanted the resources of the tribe, namely their land or

timber, (Ulrich, 2010) while States objected to the tax-free status of the reservations (Philp, 1999).

Many scholars place the blame for termination on the actions and beliefs of Watkins. One theory suggests that Watkins, a devout Mormon, was retaliating because the tribe prevented Mormons from building a church and playground on the reservation (Shames, 1972). Another theory proposes that Watkins was alarmed because Catholics “stirred up the Indians on the Menominee reservation as well as other places” (Watkins’ letter to the First Presidency of his church as cited in Beck, 2005, p. 135) which led to tribal unrest. Like many others during the 1950s who opposed communism, Watkins believed in private property and individual initiative (Peroff, 1982) in contrast to tribal communalism.

Watkins (1957) refutes any claims of malicious motivations, at least on his part or of the US government, in an article he wrote following the vote to terminate the Menominee by calling the termination vote a method of removing the caste system that kept the “Indian ward” in a “social status apart from others, not basically as what he is—a fellow American citizen” (p. 48). Whether or not Watkins was firmly convinced that termination was for the benefit of AI/AN, termination voided any treaties with the Menominee and federal trust responsibilities.

Beginning in April 1967, the Menominee filed lawsuits against the US government charging that by terminating the tribe, the government breached its trust responsibility, and that the subsequent refusal to assist the tribe in termination planning further injured the tribe. Verne F. Ray, an anthropologist whose work centered on American Indian issues, lay the blame for the wrongful termination of the Menominee on

“all branches of the United States government that had any degree of authority over the tribe” (Ray, 1971, p. 94). He specifically included Watkins in his assignment of blame for his coercive tactics and misuse of power in forcing termination despite evidence that the tribe was ill-prepared. Ray identified that the one of the motivations of the US government was its desire to use the Menominee as a test case for the strength of the termination policy. Ray (1971) further charged:

The United States caused great harm to the Menominee tribe by disregarding the serious social, ethnic, and economic consequences of its cumulative acts of commission and omission, which have resulted in destroying the ethnic integrity and social character of the tribe, reducing the people to an aggregation of unfriendly and unproductive cliques torn by suspicions, jealousies and economic conflict; and has lowered the economic level to the point where the area has been officially characterized as a “pocket of poverty”(p. 100).

Although DRUMS pointed to the concerted and cohesive effort by the tribe in all its initiatives as evidence that cliques and jealousies did not split the tribe, most Menominee agree that the greatest loss was that of their cultural identity. The children born after the tribal rolls were closed have been called “the lost generation” because of their loss of tribal practices and language that accompanied termination (Beck, 2005).

The Menominee felt the US government had broken its promises to the tribe when it terminated their rights. The tribe, like many other reservation AI/AN had developed a set of expectations, derived from years of colonization under the US government. According to Gary Orfield (1964), a professor of law and political science who wrote on the termination policy:

During a long period of dependence upon federal supervision, however, reservation life had developed a system of values and expectations of its own. Tribal members were not accustomed to making their own decisions, and they had grown to expect a wide variety of service without charge. People expected to be given jobs in spite of their poor work habits. Only a small elite shared the middle class values common to a small town. Few of the Menominee had any drive to save and invest in order to improve their economic status. Most were satisfied as long as they could support themselves. There were things more important than money (pp. 2, Chapter 6).

The identity of the Menominee tribe as a sovereign nation within the borders of the United States had, for all intents and purposes, been diluted under the control of the BIA. Regardless of the control by BIA, AI/AN trusted that treaties protected them from property taxes and were irrevocable (Ulrich, 2010). Not only were they to be absolved from property taxes, but AI/AN viewed “treaties as solemn political contracts which guaranteed that the United States would always protect the limited lands remaining to the Indians in exchange for the vast portion of territory already ceded to the United States” (Peroff, 1982, p. 11). The sale of Menominee land, although orchestrated through an entity after termination, clearly was in opposition to the solemn political contract that Menominee thought protected the land and community they had struggled to maintain.

Although the Termination Act revoked the US government’s role in the provision of services to the Menominee “in the fields of health, education, welfare, credit, roads, and law and order” (Menominee Termination Act, 1954) House Concurrent House Resolution 108 (1953) expressed the termination plan as one that sought to free AI/AN

from “federal supervision and control and from all disabilities and limitations specially applicable to Indians” (House Concurrent Resolution 108, 1953). Through the action of termination, the US government stripped the Menominee of the mechanisms to maintain or improve their socioeconomic status. Termination, therefore, negatively impacted the Menominee’s ability to improve their health outcomes. The US Supreme Court asserted that the Menominee did not lose any inherent fishing and hunting rights through termination. Social scientists and philosophers argue that health and health care access are also inherent rights. In 2010, the United States endorsed the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Article 21 in the Declaration (United Nations, 2008) states:

1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions.

Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities (p. 9).

In a Presidential Proclamation honoring National Native American Heritage Month one month prior to the official endorsement of UNDRIP, President Barack Obama stated, “While we cannot erase the scourges or broken promises of our past, we will move ahead together in writing a new, brighter chapter in our joint history” (United

States Department of State, 2010). For the Menominee, a brighter future includes not only economic security and health, but also retention of their cultural identity.



## CHAPTER 5

### AMERICAN INDIAN HEALTH AND CLINICAL RESEARCH

As American Indians became dependent on the US government for their basic needs, so too, did their expectations form that the US government would work for the benefit of American Indians. The case studies in this chapter look at how two different research trials led to AI/AN expectations that the research trials would result in improved health for the tribes. One research team hoped to provide direct benefit to the tribe but was disappointed that primary care access could not overcome the dire socioeconomic conditions of the community. The other team explicitly declared that it never promised a direct benefit to the tribe. In both cases, improved health outcomes, given the nature of the studies and the condition of the communities in which the trials were held, may not have been reasonable expectations. The willingness of the tribes to participate in the trials, and their hopes that the trials would provide direct benefit to them, however, demonstrate AI/AN's desire to use whatever options are available to improve the condition of their people.

Early health services for American Indians/Alaska Natives (AI/AN) were reactionary, that is, in response to health crises, particularly if the health of AI/AN might have had a deleterious effect on non-Indians in the nearby communities. Some physicians provided to AI/AN from the Office of Indian Affairs also saw the population as a means to advancing medical knowledge. Alice Fletcher (2013), an anthropologist working among the Sioux and Omaha in 1881-82 reported on the early use of tribes for experimentation:

Another time I chanced on an agency physician, a young man, full of jokes and good humor. “Awfully slow place for a young doctor,” he said, “but it’s good for practice. One can make lots of experiments; it’s no matter how many Injuns die!” (Fletcher, 2013, p. 230).

In the middle of the 20<sup>th</sup> century, however, clinical researchers recognized the unique qualities of American Indian tribes and sought out the tribes for experimentation or ethnographic studies. Herbert Burns asserted that the “Indian, without his knowledge or consent, offers us a human experiment in immunology as well as epidemiology which we can ill afford to ignore” (Burns, 1932, p. 498) because of the ability to trace his lineage in a fairly closed kinship group, useful information can be provided to geneticists and epidemiologists.

The climate of research in the middle of the 20<sup>th</sup> century often targeted specific groups for research.<sup>40</sup> There were several advantages in choosing a specific group. For researchers, it could be the population was geographically static, or of a singular racial or ethnic group so that a genetic basis could be analyzed. Determining a genetic basis was also easier if the population group could trace its lineage, as many AI/AN could.

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<sup>40</sup> There were three notable studies using groups during this period: the Jewish Chronic Disease Hospital study (1964-1965) in which patients were injected with cancer cells; the Willowbrook Hospital study (1963-1966), in which live hepatitis virus was given to children with development disabilities (Reverby, 2009, p. 190); and the Tuskegee Study (1932-1972) that deceived Black American men with syphilis into thinking that they were receiving treatment for the disease, while the true nature of the study was to follow the “natural history of late latent syphilis” (Reverby, 2009, p. 8).

Theories about the vulnerability of AI/AN to diseases such as smallpox, tuberculosis (TB), and trachoma posited that racial differences<sup>41</sup> between AI/AN and the colonizers accounted for the epidemics in tribes. To explain the TB epidemic among AI/AN, Christian W. McMillen (2008) writes, “None was more debated than racial susceptibility—and none held on with such tenacity. Various race-based explanations—Indians’ inherent racial susceptibility, virgin soil theory, and degree of Indian blood—had great explanatory power” (p. 608).

The use of tribes for clinical research highlighted the vulnerability of the tribes to medical researchers, as well as the need for comprehensive reform of reservation life to address the social determinants of health. Two particular research trials out of many are exemplars of the inadequacies of the US government in providing “for relief of distress and conservation of health” (Snyder Act Of November 2, 1921). The two trials, one at Many Farms among the Diné (Navajo People), and the second on the Gila River Indian Community among the Akimel O’otham (Pima), also reveal what the tribes expected to receive because of the trials, and whether those expectations were met.

### **TB among the Diné**

TB came to be known as a major epidemic among AI/AN about 1870, primarily because of increasing reports from agents and physicians on TB deaths among the tribes.

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<sup>41</sup> Racial differences to some meant racial inferiorities to others and were seen not only as causal, but also necessitated radical treatment methods to conquer disease (Benson, 2001). In 1925, Commissioner Burke of Indian Affairs ordered all physicians to perform an unproven radical surgery on American Indians to treat and prevent trachoma. Lack of follow-up on patients and continued infection resulted in blindness for many of those treated with that technique (Dejong, 2008). For a narrative from an American Indian regarding trachoma treatment for a family member, see (Chinitz & Christian, 2009).

Indian Service was ineffective in controlling the epidemic because of “too little funding, too few reservation doctors, not enough hospital beds, and extreme poverty on Indian reservations” (McMillen, 2008, p. 613). The Meriam Report (Meriam & Brookings Institution, 1928) recognized TB as the primary cause of death among AI/AN, although the report noted that deaths from TB mostly likely were underreported. From the publication of the Meriam Report in 1928 until the US entered World War II in 1941, TB remained a critical health problem for AI/AN. Ray Shaw (as quoted in Bergman et al., 1999), the first director of IHS from 1955 – 1962 reported:

During World War II, between 10% and 25% of Indians drafted into the Armed Services had to be sent back to their reservations because of active TB. Thousands of them also left the reservations for the first time to be employed in defense plants. Huge numbers were found to have active tuberculosis and returned to the reservations (pp. 577-578).

In Arizona, the 1928 Meriam Report found death from TB among certain AI/AN tribes was 17 times greater than the general US population (Meriam & Brookings Institution, 1928). The Navajo Nation straddles the corners of Arizona, Utah, and New Mexico, completely encircling the Hopi reservation within its borders. The Diné was not one of the tribes identified in the Meriam Report in its calculation of TB rates in Arizona. An earlier report on deaths among the Diné in 1909 found the reported TB death rate for the Diné consistent with the general US rate (Hrdlička, 1909). But by 1935, Indian Service knew that TB was rampant on the Navajo Nation and sought to provide bacillus Calmette Guerin (BCG) vaccinations there. BCG was a vaccination developed in 1906 and widely used, although the effectiveness of it was unproven. To test the effectiveness

of the BCG vaccine, “researchers needed a large stable population with a high prevalence of tuberculosis” (Jones, 2004, p. 183). The researchers knew that the BCG trial would not provide immediate assistance for the AI/AN infected with TB, although a positive outcome from the vaccine trial “might help future generations” (McMillen, 2015, p. 77). In preparation, several tribes throughout the West (Aronson, Aronson, & Taylor, 1958) were considered for the study of BCG, including the Diné. Early discussions about giving BCG to the tribes debated whether physicians should bother getting consent for the vaccine, although finally they did decide to ask for parental consent and cooperation from tribal councils (McMillen, 2015). Ultimately, the Diné was not among the eight tribes chosen to participate in the trial because the “Navajo reservation proved too much of a challenge; it was too big, the population too spread out and too mobile, and the leadership too angry with John Collier over his disastrous sheep-reduction program” (McMillen, 2015, p. 78).<sup>42</sup> The tribes that participated in the BCG vaccine experiment eliminated some of the variables that might obscure the results of the clinical trial.

When the BIA settled on the Pima and Wind River reservations in, respectively, Arizona and Wyoming ... they did so because these places appeared to provide stable, relatively sedentary populations who had good relationships with medical personnel and who could remain under surveillance for a number of years. They were also settled more densely than other places and had a medical infrastructure

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<sup>42</sup> Concerned about land erosion in the 1930s and silt drainage into the newly built Boulder Dam, Collier ordered three herd reductions on the Navajo Nation from 1932 - 1934. Sheep meant for sale and goats that provided milk and meat were targeted for the reduction and ultimately slaughtered. For an in-depth look at the susceptibility of the Diné to TB because of the herd reduction program, as well as the exclusion of the Diné from the BCG vaccine trial, see: (MacMahon, 2003).

staffed by doctors and nurses eager to participate in the program. Tribal councils bought in, too (McMillen, 2015, p. 78).

Whether the BCG vaccine trial would have halted the spread of TB on the Navajo Nation may never be known, but by 1948 the incidence of TB on the Navajo Nation was 4.6 %, one of the highest reported rates (Reifel, 1949). Two reports commissioned by the government identified not only the persistence of TB on the reservation, but also the grim living conditions and malnutrition that exacerbated the spread of the disease.

A group of physicians commissioned by the Department of the Interior and representatives of the American Medical Association (AMA) in 1947 compiled its observations for the first report. Although they noted the problems of “undernutrition and vitamin deficiency” (Woods, 1947, p. 981) in the Diné, they made no recommendations for improvements for those two items, but instead recommended improving the field medical services, as well as ensuring the physicians were competent and current on the latest medical education. Still little was being done to prevent TB, and treatment options were limited by resources (Woods, 1947). The 100-bed sanitarium was full with cases of chronic disease. Many patients with active TB were wandering the reservation because “in the first six months of 1949, the Medical Center had turned away over one hundred Navajo patients with active tuberculosis” (MacMahon, 2003, p. 270). A return visit in 1949 by a group of AMA physicians cited deficiencies in medical care, malnutrition, and overcrowding on the reservation as causative factors for TB on the Navajo Nation (Moorman, 1949).

To highlight the obligation of the US government to assist the Navajo-Hopis on their adjacent reservations, the 1949 report notably begins by referring to the treaty of

1868 in which the Navajos agreed to move to the reservation and educate their children. In return, the US government promised to provide a schoolhouse and teacher for every 30 children. According to Moorman (1949), author of the 1949 report, education is impossible if health needs are not met:

Coincidentally with education the necessity of economic rehabilitation was recognized by the government. Apparently nothing was said about medical care, without which neither of these treaty objectives can ever be fully realized. When mutual promises were consummated and signatures affixed, the government planted the Navajos on the present reservation without reckoning with the exigencies of the forbidding terrain ... The treaty still stands. The Navajo people are now willing to send 24,000 children to school, but the government, in approximately 80 years, has provided schools for only 8,000 children, and after all this time only 20 per cent of the Navajos speak English. Economic rehabilitation has suffered the same fate. Because of a tardy consciousness of medical needs, the Indians' health has fared no better than education and economic competency. In fact, the incidence of some preventable diseases, such as tuberculosis and venereal diseases, is increasing (p. 370).

Congress did approve some emergency funding, a total of \$3.5 million, for the Navajo-Hopis beginning in 1947 until 1950. However, based upon the recommendations in the 1949 report, Congress appropriated \$89 million in the Navajo-Hopi Long-Range Rehabilitation Act in April 1950, and earmarked \$4.75 million of it for hospitals and health preservation (Trennert, 1998). Despite exhortations from Congress to direct the \$4.75 million to serve the immediate health needs of the Diné and Hopi, the Bureau of

Indian Affairs chose to spend the bulk of the money on its customary operations and allocated 36% for hospital construction, 50% to send AI/AN off the reservation for treatments (predominantly for TB) and only 7% of the money on disease treatment (Jones, 2004).

Notwithstanding the rampant prevalence of TB on the Navajo Nation, it was a different epidemic that introduced the Diné to life-saving TB treatment through their participation in a clinical trial. In December 1951, over three-fourths of the students in a boarding school in Tuba City became ill with infectious hepatitis. The Centers for Disease Control (CDC) sent Charles LeMaistre to treat the students with gamma globulin. LeMaistre had previously trained with Walsh McDermott, a civilian physician in New York City, and when LeMaistre returned to New York for supplies to treat the hepatitis outbreak, he told McDermott about the numbers of untreated TB patients on the Navajo Nation. McDermott had a special interest in TB, as he had contracted it when he was 19 and suffered several recurrences of it until he successfully treated himself with the antibiotic isoniazid. McDermott had been involved with the clinical trials for early TB antibiotics and was now testing the new drug, isoniazid, but needed a suitable group of research subjects (Jones, 2004), who had the most fatal forms of TB but had not yet been treated with antibiotics (Jones, 2002). The clinical trial would test the efficacy of isoniazid. When McDermott heard about the TB epidemic on the Navajo Nation, he recognized the potential for his clinical trial and asked LeMaistre to have the BIA officials invite him to the reservation.

Once McDermott and a team of researchers from Cornell arrived at the reservation, the BIA gave them permission to treat “a single child with meningeal



tuberculosis” (Jones, 2004, p. 197).<sup>43</sup> Jones (2004) reports, the team “found five patients with meningeal tuberculosis and two with military (blood-borne) tuberculosis. They treated all of them” (Jones, 2004, p. 197).<sup>44</sup> The seven patients recovered quickly, and the media broadcast the results of the “secret” (Jones, 2004, p. 197) trials. The Navajo Tribal Council was pleased with the results and provided \$10,000 to offset some of the operating expenses. As the expanded clinical trial began in 1952, Kurt Deuschle became medical director of Fort Defiance, the 100-bed TB hospital. Deuschle arranged for funding to send the healthiest TB patients currently in Fort Defiance to sanatoria elsewhere, so that the beds could be freed to assist the Cornell team. Because of the success of TB treatment with isoniazid, in 1954 the Navajo Tribal Council eagerly offered another \$10,000 to cover the expenses of the expanded field health service program McDermott envisioned to “relieve the suffering caused by a treatable disease” (Jones, 2002, p. 766).

The first stage of the clinical trial with the Diné taught Deuschle and McDermott some important lessons regarding the treatment of disease in Navajo land. The researchers found that their patients did not like to spend time in the hospital for treatment. Like the reports from the AMA stated in 1947 and 1949, Deuschle and McDermott found that successful identification and treatment of TB patients required

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<sup>43</sup> Meningeal tuberculosis is the infection of the membranes, the meninges, surrounding the brain and spinal cord by the bacterium that causes TB, *Mycobacterium tuberculosis*. Meningeal TB and blood-borne or military TB are the most deadly forms of the disease.

<sup>44</sup> It is unknown whether the Cornell team sought patient or parental consent for the treatment of the seven.

more field health workers because of the vast distances between communities and the hospitals. The researchers also learned that in order to teach the Diné about “modern medicine” they needed to respect, and where possible, incorporate Navajo beliefs and customs into medical treatment. To that end, they enlisted the assistance of Annie Wanuka, a Diné nurse who was the only woman on the Navajo Tribal Council, and who proved to be instrumental as a liaison between the researchers and the Diné.

### **The Many Farms/Rough Rock Experiment**

McDermott recognized that TB was just one of the diseases afflicting the Diné. Many people, particularly children, were dying from preventable and treatable diseases such as diarrhea and measles. A firm believer in the power of medical technology, McDermott expected that the introduction of that technology, in the form of “drugs, vaccines, diagnostic equipment, or surgery” (McDermott, Deuschle, & Barnett, 1972, p. 23) would reduce mortality in the population. By 1955, McDermott had formalized his plan for a comprehensive research and medical treatment project that would allow researchers an opportunity to:

try to assist our government in its attempt to improve the situation of one of our own minority groups, and to study, from a vantage point not attainable in an operating governmental program, the wide variety of problems in this complex question of technologic aid to the economically underdeveloped countries (McDermott, Deuschle, Adair, Fulmer, & Loughlin, 1960a, p. 197).

Financial support for McDermott’s project came primarily from two sources. The Public Health Service (PHS), overwhelmed with new obligations since the transfer of Indian Health to PHS, welcomed the development of new methods to provide medical

care to American Indians under its charge and provided nearly \$1 million for the project (Davies, 2001). The Navajo Tribal Council saw the location of a Cornell research and medical center as providing a direct benefit to their people in the form of improved health and therefore provided some financial support throughout the experiment. McDermott (McDermott et al., 1972) agreed that the tribe should receive direct benefit:

It is unlikely that any of this research, with its requirement of continued and enthusiastic community participation, could have been conducted in a remote, non-English-speaking tribal society unless there were clearly visible, immediate benefits to the people living there. Indeed, without the capability of supplying substantial benefits, it would have been inappropriate even to propose the project (p. 24).

Within a few months after McDermott proposed his plan to the Navajo Tribal Council, the Cornell Research team had built a medical facility at the Many Farms/Rough Rock area. The Many Farms/Rough Rock area was chosen jointly with tribal representatives because it was “a natural and political unit” (McDermott et al., 1972, p. 24) consisting of about 800 square miles in the near center of the reservation, and the 2000 people who lived there were representative of the rest of the Diné.

The building was blessed by Diné medicine men at the opening ceremony. The physicians earned the respect of the medicine men, and likewise welcomed traditional healing practices as an adjunct to contemporary medicine. According to Jones (2004), the two groups recognized that each process had a place in the health of an individual whereby the medicine men were charged with “treating the cause of disease and the Many Farms clinic [with] treating the pain and the discomfort” (p. 202).

The researchers (McDermott et al., 1972) identified four objectives to the study: to develop effective methods for the delivery of modern medical services to the Navajo people; to see to what extent these methods could be applied to other people in similar socioeconomic circumstances; to study discrete diseases, particularly in light of their possible shaping by Navajo culture; and to find out whether the sudden apposition of modern biomedical science and technology and the disease pattern of a nontechnological society could provide valuable knowledge in the attack on contemporary medical problems (pp. 23-24).

John Adair, an anthropologist who had worked with the Diné since the 1930s, joined the researchers as the Many Farms project began. McDermott welcomed his expertise as he knew that “it would help him improve the fit between health care and local culture” (Jones, 2002, p. 777). Improving the health status of the Many Farms participants would require the work of social scientists and medical personnel (Kurt W. Deuschle, 1986).

The researchers undertook many studies of the Diné. McDermott et al (1960a) report:

The first of the three general studies consists of a socioeconomic study of the community as a whole, with special reference to factors that might be relevant to a consideration of health and disease. The second study has to do with defining the pattern of disease in the community by performing complete physical examinations and appropriate laboratory studies on the individual members of the community. The third of the general studies is concerned with determining to

what extent Navajo men and women with limited schooling can be trained to function as effective field auxiliaries of the public-health nurses (p. 200)

To gauge the demographics and pattern of disease of the community at Many Farms, the researchers first had to devise a different methodology for gathering vital statistics by grouping persons by their family living units and by clan. The assignment of a single number to represent a person was not adequate nor had it ever been adopted by the Diné. The researchers also quickly learned that gathering data, especially concerning infant deaths, was extremely difficult. Families considered that information to be personal and did not report infant deaths to health authorities.

To gauge the patterns of disease in the community, the researchers:

extracted substantial data from the bodies of Navajo patients. They hoped “to acquire complete medical and routine laboratory examinations of all members in the district.” They performed physical exams, vision and hearing tests, X rays, urinalyses, blood counts, syphilis tests, and electrocardiograms. Blood samples were drawn from as many patients as possible and “frozen and stored for later serological testing as indicated.” “Special medical studies” (e.g., ear, throat, sputum, and stool cultures) were conducted on 250 students at four local schools.

(Quotes are from the Cornell Archives of McDermott Papers, Box 10, f 9, "Research Grant Project," as quoted in Jones, 2002, pp. 780-781).

The medical information gleaned from the tests was used not only to get a baseline of the patterns of disease, but also to support numerous medical studies going on simultaneously. The medical studies examined: infant feeding practices and the development of disease; congenital hip disease; tuberculosis; genetically determined

transferrin; and coronary heart disease (McDermott et al., 1972). In the period of six years, “over 90 percent of the population (population estimated at 2000 persons) were examined in the central facility at some time during the study, and approximately two-thirds sought care at least once a year” (McDermott et al., 1972, p. 24).

Language was another barrier researchers needed to overcome. Their earlier experiences with Annie Wanuka had shown them that culturally competent communication was well-received by the Diné. To that end, the researchers began training a few Diné who were bilingual in Navajo and English to become health visitors. Training included a cross-cultural introduction to medical concepts since many concepts were foreign to the Diné as was the Diné concept of health unfamiliar to the medical team (K. W. Deuschle, 1982).<sup>45</sup> The medical team also “made detailed studies of Navajo descriptions of symptoms. They went so far as subjecting Navajo volunteers to ‘a series of painful stimuli’ and recording their descriptions” (Jones, 2001, p. 289). The team also taught the interpreters basic medical training to permit them to give vaccinations and other medications. While the use of bilingual interpreters was not unusual in a clinic, what McDermott and his colleagues did next was (Deuschle & Adair, 2006). After substantial training and working alongside the physicians in the clinic, the health visitors and were sent to visit people in their homes. They were always in contact with the public

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<sup>45</sup> An example of the medical team’s unfamiliarity with the Diné concept of health arose as the team investigated the preponderance of congenital hip dislocation in the population. The medical team learned that surgery on the hip after the child was a decade old was more harmful to the child than the hip dislocation because once the hip was fused, the person was no longer able to sit properly on the floor of the hogan. To the Diné, the surgery created a disability where previously there had been none (McDermott et al., 1960b).

health nurse of that area, but served the purpose of not only bridging the gap of medicine and Diné culture, but also that of preventive and curative medicine because they alerted both patient and clinic if the patient needed additional care (Deuschle & Adair, 2006).

Many anthropological and other non-medical studies were researched and the results published. Non-medical studies included: the prevalence of accidents; “effective cross-cultural training for paraprofessional field health workers and the development of a manual to be used as a text in training them” (McDermott et al., 1972, p. 24) and ethnolinguistics.

The Many Farms teams saw patterns of disease that they expected to see in an impoverished population. Namely, most diseases (over 76%) in the population were of a microbial nature. These included tuberculosis, pneumonia, diarrhea, otitis media (an infection of the inner ear), measles, and impetigo (a skin infection) (McDermott et al., 1960a; McDermott et al., 1972). Over half the deaths in the community during the experiment were infant deaths, predominantly caused by a combination of pneumonia and diarrhea (McDermott et al., 1972).

The conditions in the Many Farms/Rough Rock area were severe and contributed to the disease transmission in the Diné. Transportation in the area had to be completed over “corduroy dirt roads” (McDermott et al., 1972, p. 24). Water to most families had to be hauled in over those same roads, and therefore was a precious commodity. Family units slept in the same poorly ventilated hogan on the dirt floor. Animals freely excreted near the hogan, and although adults voided away from the hogan, young children were less likely to do so. Temperatures could vary considerably in the same day. Kerosene or

wood stoves provided heat in the hogan, but there was little respite from the heat during the day.

Early in the experiment, the research team acknowledged that the years of neglect of the Diné had left a population with complex needs. Diarrhea could be treated, but if the shortage of water prevented good hygiene practices, antibiotics would be only a temporary solution. Likewise, if access to medical personnel is needed to effectively treat diseases in a community, then it's important to have housing so that medical personnel could be recruited. The team lamented (Adair, Deuschle, & McDermott, 1957), "for, in many of the areas in greatest need of medical services on the Navaho reservation, absolutely no housing exists for even one physician or nurse who might be recruited to deliver the badly needed services" (p. 92).

The team finished up their work at the end of six years. They began a gradual transition for the end of medical treatment at the Many Farms facility. At the end of the term, they reviewed the impact of their work on the health status of the Diné, and were disappointed with the results. In six years, the "crude death rate"<sup>46</sup> was only slightly reduced. The team pointed to the living conditions that were virtually unchanged during the team's tenure as obstacles to an appreciable change in health status. Their hopes that technology and increased access to medical care through a physician resulted in:

1. A definite reduction in the transmission of tubercle bacilli.
2. A definite reduction in otitis media in the fifth year.
3. No reduction in the occurrence of active trachoma.

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<sup>46</sup> Crude death rate is a ratio of the total number of deaths to 1000 persons.



4. No reduction in the occurrence of the pneumonia-diarrhea complex, which remained the single greatest cause of illness and death.
5. The identification of those individuals who need hospital care (35 to 40 persons per 1000 each year)-that is, the establishment of a medical scan.
6. A possible slight reduction in crude mortality, despite an infant mortality that persisted at three times the national average (McDermott et al., 1972, p. 27).

The team's disappointment in their impact over the six years centered on the fact that modern medical technology or improved primary care access was unable to dramatically change the health status of an impoverished and malnourished people. What they did draw from the six years, however, was a model for other medical entities to incorporate cultural understanding and respect into modern medical care, as well as the benefits for careful translation of medical terms for non-English speakers.

It would be unfair, however, to characterize all the efforts of McDermott's team as noble, given that the area in which they made a considerable difference, that of TB treatment, included deceitful practices. One of McDermott's goals was to continue testing the effectiveness of isoniazid. McDermott phrased the goal differently at Many Farms as "a study of the extent to which an uneducated, nonliterate people (with partially educated children) can assume personal responsibility in a tuberculosis therapy or prophylaxis program based on the long-continued daily self-administration of isoniazid tablets" (McDermott et al., 1960b, p. 282). To that end, McDermott and the team sought ways to ensure patients took their medicine as prescribed, regardless of the fact that their own records showed at least "75 percent of the people managed their chemotherapy

satisfactorily; an additional 10 percent did so if they were regularly prodded and supervised; and approximately 15 per cent of the group, for one reason or another, could not be relied upon to do their part” (McDermott et al., 1960b, p. 232). Besides counting the days since the last tablets were given out, the team, particularly Thomas Moulding, devised mechanical devices to dispense the pills along with a radioactive emitter that left tracings when the pill box was opened (Jones, 2004). The researchers, however, predominantly refer to the method in which riboflavin was added to the tablet (McDermott et al., 1960b). The riboflavin fluoresced in the urine, and was therefore detectable. The urine collection was problematic for the Diné, as they feared the test would show their use of the recently outlawed peyote. The researchers made sure to spread the information that they were not testing for peyote use. Given their other efforts to incorporate cultural understanding and respect into their practice, it seems improbable that another method could not have been used to ensure self-administration of dosage without resorting to deceitful methods (Jones, 2001).

The researchers faced challenges too in claiming victory in their health visitor program. The first obstacle surprisingly came from those chosen to be health visitors. Outside of the clinic, a space that evoked a neutral and authoritarian aura, it was improper for a fellow Diné to ask another for a urine specimen (Adair & Deuschle, 1970; Davies, 2001). This was further exacerbated by the hierarchy of the health visitor’s clan in relation to the patient (Adair & Deuschle, 1970).

Even the research team’s goal to create an interdisciplinary health team gave surprising results as perceived infringements by social scientists on the autonomy and hierarchy of the medical staff and vice versa created tensions and anxiety in the group.

According to Adair and Deuschle (1970) these tensions “sometimes augmented by overwork and lack of relaxation resulted in mental stress; a number of the staff had to resort to psychiatric aid to regain their equilibrium” (p. 163).

The research team may have been disappointed, but they reported that the Many Farms experiment met the expectations of the Diné:

it should be noted that, in terms of individual and community expectations, the Many Farms experiment was a clear-cut success. The system was set up with full community participation, and there was a mechanism for effective, continued community control. Members of the community repeatedly expressed their satisfaction with the care they received, and the community was left with an operating system. (McDermott et al., 1972, p. 30).

While it may be true that the community was pleased with the experiment during its operation, both for the increased access to health care and the fact that the Tribal Council’s input was welcomed, once the experiment was turned back to IHS, there was no continuation of the program. The building stood empty. Clinical care was transferred to the IHS Chinle clinic fourteen miles away. Public health nurses were threatened by the use of the health visitor program, so it was discontinued. Although efforts had been made to create a Navajo-English dictionary, the medical translation program never got off the ground. McDermott returned to the reservation in 1972 and noted that the improved sanitation and water supplies had the most effect on the health of the Diné. Those diseases that were unaffected by the home environment were effectively reduced by medical intervention, but those that were, namely trachoma and the pneumonia-diarrhea complex, were not.

The Cornell Research made no explicit promises to the Navajo Nation when it began its experiment at Many Farms, other than the direct benefit to provide increased access to primary health care for the Diné, at least during the six years the Cornell team was at Many Farms. Throughout the study, however, the researchers collaborated with the Tribal Council, initially on the location for the clinic. The team also incorporated cultural competency and traditional medicine into their practices. The Diné had supported the transfer of Indian Service to PHS because they expected under PHS their health would improve. Likewise, the Diné supported the Many Farms experiment with the expectation the health of the community would improve. Unfortunately, in most areas that the Cornell researchers addressed, the results were minimal.

The Many Farms experiment can be contrasted with the research study on the Gila River Indian Community. There researchers made no explicit promises for direct benefit for the community, but continued to use the bodies of the Akimel O’otham for forty years.

### **Diabetes and the Akimel O’otham**

One of the first studies of diabetes among the American Indians of Arizona was undertaken by Elliott P. Joslin, MD in the late 1930s (Joslin, 1940). Dr. Joslin sent a letter to every physician in the state asking him to identify each of his diabetic patients, as well as to divulge if the physician was diabetic. One of the results of Joslin’s survey was that 73 Arizona AI/AN were determined to be diabetic. Of those 73, 21 were identified as belonging to the Akimel O’otham tribe, nearly twice the number of the next tribe represented in the study. This outcome established the association between the Akimel

O’otham and diabetes. Subsequent studies highlighted a prevalence of diabetes among the Akimel O’otham (B. M. Cohen, 1954; Hesse, 1959; Parks & Waskow, 1961).

The policies and actions of the US and Arizona governments created the ideal situation for the development of diabetes in the once industrious agricultural society. As indicated by the name they call themselves, “the River People”, the Gila River is integral to the life and culture of the Akimel O’otham. The banks of the Gila River had been the site of continuous settlements since approximately 6000 years ago (Gila River Indian Community, n.d.). Ruins left by the Hohokam (Those Who Have Gone), ancestors of the Akimel O’otham, suggest that a community of as many as 60,000 was sustained via agriculture using an extensive system of ditches to divert water from the Gila River to the fields. In the 1700s, missionaries introduced improved tools and Christianity to the Akimel O’otham. The society flourished and provided refuge and food not only to westward bound settlers, but also to the Pee Posh (Maricopa People), to whom they offered a home on the northwest portion of their lands. The Gila River Indian Reservation, consisting of 145,000 acres (Smith, Manahan, & Pablo, 1994), was established in 1859 in appreciation for the assistance the Akimel O’otham had given to the westward expansion (Gila River Indian Community, n.d.). The reservation currently holds 372,000 acres (Gila River Indian Community, n.d.).

By the 1870s, however, White settlements above the Gila River Indian Reservation had diverted much of the water from the Gila River to support agriculture and cattle, leaving the Akimel O’otham with little or no water for their crops.<sup>47</sup> In 1872, a

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<sup>47</sup> The political maneuverings to divert the Gila River and the impacts on the GRIC are described in (Dejong, 2009).

contingent of Akimel O’otham established a settlement along the Salt River (now called the Salt River Pima-Maricopa Community). Tensions between the White settlers and the Akimel O’otham were described in a report of Lt.-Col. W. R. Price to the Assistant Adjutant General of the Whipple Barracks, Prescott. In his report, Price (Department of United States Army Arizona, 1879) recommended that the reservation lands be surveyed and clearly marked, and that the:

Common Law or Equity of water rights, upon which the law of the Territory on the subject is based, be maintained and upheld on behalf of the Indians living on the Gila Reservation. They are the original settlers there, and they should be protected and secured in as large a volume of water as they have ever utilized out of the Gila River (p. 6).

Price (Department of United States Army Arizona, 1879) also noted, “The majority of the Pimas and Maricopas are industrious and are easily controlled and guided; they are capable of a higher state of civilization and could be made superior to the average Mexican of this country, and could become citizens” (p. 8).

By the early 1880s, water from the Gila River had been completely diverted and the once successful farming community was experiencing famine and starvation (Ritenbaugh, 1974; Smith et al., 1994). The Coolidge Dam was completed in 1926, with the goal to provide sufficient water to the Gila River Indian Community. Many Akimel O’otham, some from the contingent who settled on the banks of the Salt River and others from urban areas, returned to the reservation with the hope that farming could begin again, but water allotments included non-Indian lands, and the promise of water to the community was never completely realized (Gila River Indian Community, 1966, p. 8;

Ritenbaugh, 1974; Smith et al., 1994). In addition to the lack of water, Smith, et al (1994) detail, “The Pimas, now in debt for their agricultural equipment, began contracting with non-Indian farmers to operate their farms, and that business situation still persists” (p. 410). Water rights remained an issue into the 21<sup>st</sup> century, ending finally with a settlement in 2004 which allocated a “water budget of 653,500 acre-feet of water annually” (United States Department of Justice, 2010).

Commissioned to observe the political and management organization of the community through the Model Cities Program, Weaver (1971) noted:

In the years that followed, [the late 19<sup>th</sup> century] as the drought continued and economic depression worsened, ties with those self-confident Pima-Maricopa years widened, resulting in a temporary collapse of three vital elements of Pima-Maricopa culture: the desire to share, work and lead. These once successful, independent farmers now became dependent upon an alien government for meager food hand-outs (p. 211).

During the years of famine, the Akimel O’otham subsisted on the commodity foods provided by the government (Fortier, 2008). The commodity program still exists, and the foods available consist predominantly of canned vegetables such as beans and corn, canned fruits and juices, cheese and butter products, canned meats, and cereals (U.S. Department of Agriculture, 2011). In World War II, many Akimel O’otham became accustomed to a Western diet, and upon their return to the reservation continued to incorporate those foods into their diet (Smith et al., 1994). Further, lack of electricity and refrigeration prevented many from purchasing fresh and healthy foods (Reid et al., 1971), if they were available. Carolyn Smith-Morris asserts (2006b), “Getting healthy foods on

the reservation is also a challenge ... In these stores, the prices are high and the variety of fresh fruits and vegetables limited” (p. 15).

### **The Epidemiology Study on GRIC**

Researchers became interested coincidentally in the health status of Akimel O’otham (Pima) on the Gila River Indian Community (GRIC) in a similar fashion as had occurred with their neighbors to the north, the Diné (Navajo People). Unlike the Many Farms Experiment, researchers investigating diabetes were less concerned with improving the health status of the population than they were with finding a genotype specific to a particular race or ethnic group and following the “natural history and complications of diabetes mellitus” (Bennett, Burch, & Miller, 1971, p. 128). Whereas McDermott and his team professed that it would be unethical to research the Diné without providing some direct benefit, the researchers investigating diabetes explicitly stated they made no promise for direct benefit to the community or to the individual (Sevilla, 1999a; Stegman, 2010). Yet, the AI/AN whose bodies were examined in both research projects expected direct benefit. The variance between the expectations of the Akimel O’otham and researchers’ goals in the diabetes study is detailed below.

Although the exact etiology of diabetes was not understood, many scientists believed there was a genetic link to the disease (Fajan, 1964; World Health Organization, 1965). James V. Neel (1962) postulated that a “thrifty gene” had developed as a response to periods of feast and famine when man was a hunter and gatherer.

As described earlier in this work, there was a tendency to target specific population groups for research in the middle of the 20<sup>th</sup> century. The Diné were targeted because they had a prevalence of TB and most had never been treated with antibiotics. In



October 1964, the National Institute of Arthritis and Metabolic Diseases (NIDDK)<sup>48</sup> and the Diabetes and Arthritis Program of the U.S. Public Health Service sponsored a “Conference of Methodological Approaches to Population Studies in Diabetes” (Pratt, 1964). At the conference the advantages of targeting a specific population group were espoused by one of the attendees, Dr. Christian Klimt (Newill, 1964):

Such studies have been done in the past and can perhaps be done on a so-called captive population where you can design your study and where, with adequate inducements, you can get the possibility of doing repeated tests, and have cross-over and all the refinements of design you may wish in order to balance bias as it may arise (p. 172).

In 1963, Joseph J. Bunim, Thomas A. Burch, and William M. O’Brien (1964) from the NIDDK sought to determine whether the prevalence of rheumatoid factor (RF) or rheumatoid arthritis (RA) differed between tribes in extreme climate conditions. The researchers chose the Blackfeet of Montana and the Akimel O’otham as populations to study. Their research methods included taking blood samples from 86 per cent of the reservations’ inhabitants who were 30 years of age or older. It is not known whether the testing for glucose on the same blood samples was accidental (Peter H. Bennett interview as reported in Stegman, 2010) or intentional, but the prevalence of hyperglycemia in the

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<sup>48</sup> The National Institute of Arthritis and Metabolic Diseases was established in the U.S. Public Health Service in 1950 when President Truman signed the Omnibus Medical Research Act. The name of the Institute was changed in 1972 to the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD), and in 1981 re-named the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases (NIADDDK), until it was renamed the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) in 1986. For consistency throughout this work unless in a direct quotation, the institute will be referred to as NIDDK.

Akimel O’otham prompted Burch and Peter H. Bennett, a British rheumatologist and visiting associate at the National Institutes of Health (NIH) (Stegman, 2010), to investigate the findings.

In 1965, Burch and Bennett began the study of diabetes among the Akimel O’otham (Stegman, 2010). As on the Navajo Nation, the tribal members on the GRIC suffered from poverty, unemployment, isolation, and lived in housing that lacked electricity or appropriate sanitation.<sup>49</sup> But the researchers saw several advantages in working with the Akimel O’otham. Besides the fact that the Akimel O’otham were a small group whose members could trace their lineage, the climate in Arizona is moderate most of the year; the reservation was located close to a metropolitan area; and the medical facilities of the Indian Health Service on the Reservation and at Phoenix Indian Medical Center afforded access to laboratories and X-Ray equipment for the study. These same advantages had encouraged the researchers who were testing the BCG vaccine for TB in the previous decade to test it with the Akimel O’otham. Specifically, for the study of diabetes, the researchers state in one journal article:

The Pima Indians are, in general, obese, and their diet differs somewhat from the typical American diet; they have large families, they reside in a desert environment, and they are relatively inbred ... This natural, well-defined, and relatively homogeneous community, with such a high prevalence of diabetes mellitus, provides an opportunity to examine, by well-controlled observations, the

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<sup>49</sup> In 1966, the GRIC reported that 70% of the homes in the community did not have modern plumbing, and 65% had no electricity (Gila River Indian Community, 1966, p. 29).

genetics and natural history and complications of diabetes mellitus (Bennett et al., 1971, p. 128).

Burch and Bennett began with a pilot study to verify the results of their earlier study that found hyperglycemia in the population. The NIH through NIDDK funded the pilot study.<sup>50</sup> The pilot study tested 10% of the population for persons aged 10 and over, as well as 50% of the patients who had been tested in the RA study. The testing consisted of drawing blood and testing for high glucose levels two hours after ingesting 75 grams of glucose for the new participants; for those who had been identified in the RA study, testing was much more extensive and included “retinal photographs, electrocardiograms, serum creatinines and cholesterols, and Xrays of the lower extremities” (Miller, Burch, Bennett, & Steinberg, 1965, p. 440). The initial survey determined that between 34 and 49 percent of the surveyed population had high two-hour glucose levels (Miller et al., 1965), a prevalence far exceeding the general U.S. population.

With the confirmation that the Akimel O’otham exhibited high glucose levels, NIH funded the longitudinal study, and also funded the construction of a building directly attached to the IHS hospital at Sacaton.<sup>51</sup> The scope of the longitudinal study was broader than the initial survey in that it sought to biannually examine the entire population of Akimel O’otham over the age of five in the eastern portion (districts one through five) of

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<sup>50</sup> The study was an intramural research project of the NIH. Intramural research is funded through the NIH to institutes within in it and performed by federal employees, rather than funding outside sources, such as universities. For consistency throughout this work, when speaking of the funder, it will be noted simply as NIH.

<sup>51</sup> The study was referred as the “Pima Clinical Field Studies Unit or the Southwestern Field Studies Section. Later, it became known as the Phoenix Epidemiology and Clinical Research Branch” (Stegman, 2010, p. 68).

the Gila River Indian Community (Bennett, Rushforth, Miller, & Lecompte, 1976).

Eleven years after the start of the longitudinal study, the researchers outlined the aims of the study as:

The major aims of the study have been to (1) describe the prevalence and distribution of diabetes in the community; (2) to determine the occurrence and distribution of the diabetes-related sequelae, especially the vascular complications; (3) to attempt to identify the factors leading to the development of glucose intolerance; (4) to identify factors associated with the development of the complications of diabetes (Bennett et al., 1976, p. 334).

While the longitudinal study was designed to describe and observe the occurrence and sequelae of diabetes in the community, it required considerable use of the bodies of the Akimel O'otham. The researchers (Bennett et al., 1976) described the extensive medical exams given to the participants in the same article published 11 years after the study began:

The biennial examination of each subject has included a modified glucose tolerance test, tests of renal function, retinal examinations, and, in those aged 15 and over, electrocardiograms, radiographs of the chest and soft tissues of the thigh and calf, and retinal photographs. Initially a one-in-two sample of those aged 30 years and over received these examinations, but after examination of the first 1100 persons all those examined aged 15 years and over received them ... Serum creatinine and cholesterol were determined on an additional serum sample. Since 1967, 1-hour glucose determinations have also been made routinely in subjects

aged 15 years and over ... Carefully selected samples of the population have also received a variety of other diabetes-related tests (p. 334).

NIH exhibited a long-term commitment to the diabetes study when it designed, and NIDDK employees staffed, the 25-bed inpatient metabolic research unit on the fifth floor of the newly constructed Phoenix Indian Medical Center in 1971. During the study, NIH also funded variations of the epidemiological study using the Akimel O'otham as test subjects. One study selected individuals to undergo an arginine infusion combined with one or more glucose tolerance tests administered serially (Aronoff, Bennett, Gorden, Rushforth, & Miller, 1977; Aronoff, Bennett, Rushforth, Miller, & Unger, 1976); another required muscle biopsies (Bennett et al., 1976); yet another tested the banked blood sera from the arthritis study (Slovin et al., 1983). The frequency of congenital anomalies of the offspring of diabetic parents was determined and published (Corness, Bennett, Burch, & Miller, 1969), as well as the determination of coronary heart disease from ECGs and autopsy reports that compared "the Pima with that of an American population" (Ingelfinger, Bennett, Liebow, & Miller, 1976, p. 564). Studies that were particularly problematic to AI/AN reported results of the racial admixture of the Akimel O'otham and migration patterns of American Indians (Knowler, Williams, Pettitt, & Steinberg, 1988; Torroni et al., 1992; Williams et al., 1985).

The prevalence of diabetes on the GRIC was reaching epidemic proportion by 1977 and yet there was no work being done by NIH or IHS for prevention, education, or full-scale treatment programs. Researcher had documented 510 cases of diabetes among the Akimel O'otham, which represented "a 42 percent increase since 1967" (Smith-Morris, 2006a, p. 98). Clinical care for AI/AN is provided by IHS, a chronically

underfunded agency, and until 1979 IHS was not able to fund prevention and treatment programs.

The steps toward prevention and treatment programs began when in 1976, the National Commission on Diabetes, in its *The Long Range Plan to Combat Diabetes* (United States National Commission on Diabetes, 1976), announced that grant monies were available from NIDDK for the establishment of Diabetes Research and Training Centers (DRTC). The purpose of a DRTC was to conduct research, and train and educate physicians and allied health personnel on the current methods for diagnosis and treatment of diabetes. The description of the DRTC stated:

It is the inclusion of the training and education efforts with the research program efforts that distinguishes the Diabetes Research and Training Centers from the presently supported Diabetes-Endocrinology Research Centers, which are specifically oriented to research goals. The National Institute of Arthritis, Metabolism and Digestive Diseases (NIAMDD) will, however, continue the Diabetes-Endocrinology Research Centers Program (United States National Commission on Diabetes, 1976, p. 7.)

With monies from the Indian Health Care Improvement Act, which was passed in 1976, as well as from the National Commission on Diabetes in 1979 (Indian Health Service, n.d.-b), IHS piloted “The Model Diabetes Program” at five sites. In its proposal to the United States National Commission on Diabetes (1976), IHS sought to receive funding for 50 Diabetes Control Programs and stressed that States often utilize tribal communities to augment their census numbers, but don’t always provide the services promised based upon those census numbers:

Funding for the proposed Indian Health Service Diabetes Initiative should be provided to IHS. If such funds are to be made available by another Federal agency, such as the National Institutes of Health, a cooperative agreement calling for a transfer of funds can be used. Also, if in the future, the Commission recommends additional funding for other Federal agencies /States for service programs, in particular, the Commission should be aware of the need to provide for a "set aside" for direct funding to tribes. This recommendation is based on the historic neglect that has occurred when States, in particular, receive funds to serve the total population, including Indians. Indians are counted to increase the State's share of the funding, but Indians almost never see anticipated services or other benefits (United States National Commission on Diabetes, 1976, p. 151).

The Model Diabetes Program at the five approved sites was designed to “develop effective approaches to diabetes care, provide diabetes education, and translate and develop new approaches to diabetes control” (Indian Health Service, n.d.-b). One of the sites was in Sacaton on the GRIC, perhaps because of the presentation to the United States National Commission on Diabetes (1976) by Dr. Swetter, the Acting Director of the Office of Professional Standards and Evaluation of IHS during which he suggests that AI/AN are population groups suitable for research studies. Swetter was recorded as describing the:

unique research potential that exists through the Indian Health Service noting that IHS is the primary source of health services to the Indian population, thereby concentrating the health data, and that the populations served are far less mobile than the general population, thereby making them an excellent control group for

research purposes. He also noted that many health related problems exist in the IHS-served populations which could readily be the basis for research projects, including projects involving diabetes. Whereas the Pima Indians have been extensively studied, other population groups have been neglected. Such potential research areas would not be duplicative of the Pima Indian studies” (United States National Commission on Diabetes, 1976,p. 112).

What is striking is that Swetter encourages the notion that IHS provide the bodies in its care as research subjects, especially since the second and third directors of IHS, Wagner and Rabeau, had emphasized that research findings should be used to “to plan and evaluate intervention programs” (Bergman et al., 1999, p. 584). This discordance between research goals and public health funding and interventions affected the health status outcomes for the Akimel O’otham.

The United States National Commission on Diabetes (1976) made three recommendations to the Health Services Administration, one of which was directed to IHS:

In that specific recommendation, the Commission suggests that the Indian Health Service continue its cooperative efforts with NIH to study the epidemiology of diabetes in selected Indian populations and that IHS should review its overall health care programs to ensure that they adequately address the specific needs of Indians with diabetes (p. 104).

By the early 1980s the epidemiological study had been in place for 15 plus years. It is during this time that a new study on Type I diabetes (IDDM) using the Akimel O’otham was instituted, even though IDDM was rarely seen among the tribe. Rather than



funding prevention studies for diabetes, it is estimated that “the NIH spent \$150 million on the Type 1 project” (Sevilla, 1999a), which was carried out from 1983-1993. A small, poorly funded educational project on prevention tactics for diabetes and arthritis named the “Tribal Chronic Illness Project” was funded by NIH beginning in 1980 but, “the NIH budgeted only enough to hire two nurse practitioners, one for arthritis and the other to deal with diabetes. A community awareness program reached only 12 percent of the community's population. Funding ran out in 1986” (Sevilla, 1999a).

Although the NIH did fund the Tribal Chronic Illness Project, NIH funded no studies on effective prevention methods until 1996. In fact, the key researcher went to China to test Type 2 diabetes prevention methods when NIH refused to fund the study Sevilla (1999a). The study in China showed that diet and exercise were effective in preventing the onset of Type II diabetes (Pan et al., 1997). By 1994, metformin, (that today is widely recognized as the pharmaceutical of choice for reducing blood glucose levels), had been approved by the Food and Drug Administration, and the NIH researchers involved with the Akimel O’otham study participated in prevention studies using exercise and metformin (Diabetes Prevention Program Research Group, 2002).

Data collection through biennial examinations for the initial epidemiological study continued through the first decade of the 2000s, until the Akimel O’otham withdrew their support and participation in the study (Smith-Morris, personal communication, July 20, 2011; Stegman, 2010). Despite the withdrawal of the support from Akimel O’otham, NIH has continued to fund intramural studies that used banked sera from the epidemiological study. Of interest is the study published in 2014 looking for a genetic link to diabetes (Hanson et al., 2014).

At one point, there were over “100 people, including 30 M.D.s and Ph.D.s,” (Nichols, 2002) working on the NIH floor of Phoenix Indian Medical Center along with the researchers in Sacaton conducting 15 large-scale studies, and their efforts, because of the participation of the Akimel O’otham, made significant contributions to the scientific/medical knowledge of diabetes.

The Model Diabetes Program in Sacaton initiated by IHS in 1979 and its four other sites was replicated and is currently instituted at 23 different sites. IHS states that the various sites of this program “have made significant contributions, including state-of-the-art comprehensive, clinical diabetes care through a multidisciplinary approach; diabetes education and nutritional counseling services; professional education; diabetes prevention activities in communities; support and technical assistance; development and testing of education materials; and scientific articles in peer-reviewed medical journals” (Indian Health Service, n.d.-b). That review of the program by IHS points out the dual focus of the program between supporting the biomedical community in research activities and professional education juxtaposed with patient clinical care and prevention. Through the Balanced Budget Act of 1997, IHS received another \$150 million in grants over a five-year period to establish programs to “prevent and treat” diabetes (Centers for Disease Control and Prevention, 2011).

While \$150 million toward the program was considerable, a newspaper quoted Dr. Acton, director of Indian Health Service at the National Diabetes Program in 1997 as saying:

The money is great. It's seed money for a lot of communities but it's not nearly enough to take care of the clinical problem of diabetes," she said. It takes an

average of \$5,000 to \$7,000 a year to take care of someone with diabetes. Their program is getting \$1,578 per person (Monastyrski, 1999).

Carolyn Smith-Morris (2006a) states that the early approaches toward treating and educating diabetics had its drawbacks, in that prevention efforts were not disseminated out into the community:

At the individual level members are offered a variety of programs, treatment, and prevention services. This aspect of "participation" has been criticized at Gila River for its failure to reach community members outside of the clinic or hospital. The social and economic exigencies (for example, lack of transportation to distant clinics and lack of child care) that keep many Pimas from participating more fully in biomedical approaches to diabetes prevention have been neglected until recent years (p. 99).

Although direct benefit for the Akimel O'otham was not the focus of the epidemiological study, early efforts were focused on treatment for the diabetic patient, and in that respect, NIH did contribute somewhat to the clinical care of diabetic Akimel O'otham. When Phoenix Indian Medical Center (PIMC) was built in the 1970's, NIH paid for a hemodialysis machine. Prior to that time, diabetic patients receiving care for end stage renal disease (ESRD) had to be referred to Good Samaritan Hospital in Phoenix (Sevilla, 1999b; Stegman, 2010). NIH made other contributions to improve the clinical care for diabetic Akimel O'otham. One was its advocacy that laser surgery for diabetic retinopathy should be made available at PIMC. NIH also paid for a part-time podiatrist at GIRC "after scientists discovered that good foot care could prevent amputations among diabetics" (Sevilla, 1999b).

The prevalence of diabetes among the Akimel O’otham was initially recognized in 1963, and as indicated throughout this work was reported to be as high as 50% among residents over the age of 35 (Bennett et al., 1976). The incidence rates of type 2 diabetes from 1967 to 2007 among the Akimel O’otham were reported to have “increased among Pima Indians aged 5-14 years, decreased in those aged 25-34 years, and did not change significantly in other ages over the past four decades” (Pavkov et al., 2007, p. 1761).

The 2013 report of the Arizona Department of Health Services (Bishop, Gupta, & Torres, 2015) gives an indication of the health status of American Indian residents in Arizona:

- ranked worse than the statewide average on 49 of 69 health indicators;
- had high mortality from alcohol-induced causes, chronic liver disease and cirrhosis, assault, nephritis, diabetes, motor vehicle accidents, influenza and pneumonia, septicemia, and mortality from unintentional injuries: all contributing to the premature death rate of 78.7 percent.
- ranked poorly on measures of maternal lifestyle and health, as well as in utilization of prenatal care;
- on average were 17 years younger at time of death compared to all racial/ethnic groups; (p. 5).

Specifically, the risk of diabetes for all Arizona American Indians was 178.1 percent above the average rate or ratio of all Arizona residents in 2013 (Bishop et al., 2015, p. 7). In 1997, the risk of diabetes for all American Indians served by Indian Health Service was reported to be 245% above the U.S. rate (Indian Health Service, 1999). In 2009, there were 28 deaths, out of 64 total, in the Gila River Indian Community which

were caused by diabetes, cardiovascular diseases or renal failure (Mrela & Torres, 2009, Tables 5.4-5.7, 5.11).<sup>52</sup> There were 232 births in 2009 in the GRIC, and of those, 22 mothers had diabetes and 16 had pregnancy-associated hypertension (Table 4.8). The Phoenix Service Area of Indian Health Service saw a prevalence of diabetes in 2011 of 16.3 % in its patients versus 12.8 % nationwide, a number which has increased from 15% in 2008. Warne (2009) states that the death rate from diabetes in the Phoenix service area for American Indians is 81 per 1000, compared to a U.S. rate for all races of 13.5 per 1000; the average age at death for American Indians in Arizona is 54.7 years versus 72.2 years for the general population.

Hemodialysis is now a way of life for many Akimel O’otham, as the incidence rate for ESRD among diabetic American Indians in the Southwest is 6.5 times greater than for White diabetics (Narva, 2003, pp. S-4). There is a building devoted to hemodialysis on the GIRC and in 1994 the annual estimated cost for dialysis treatment exceeded a million dollars (Garcia-Smith, 1994). What hasn’t improved, however, is the disparity that American Indians face when seeking a renal transplant as “despite similar referral rates for renal transplantation, American Indians and Hispanics were less likely than whites to be placed on a transplant waiting list or receive a transplant” (Sequist et al., 2004, p. 344) as difficulties with coordinating care arise from lack of transportation to transplantation centers, which for many American Indians are over an hour away. Clearly, diabetes remains a prevalent disease for AI/AN and the Akimel O’otham.

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<sup>52</sup> Arizona Department of Health Services changed its manner of reporting to protect the privacy of the individuals, and thus the most specific data is available for 2009.

An indication of the frustration of the Akimel O’otham was expressed a full ten years before they withdrew their support from the diabetes study:

Thirty years of research for what?’ asks Franklin ‘Pete’ Jackson, a community leader. What did we get for all of this? We were human guinea pigs. They've just been watching diabetes take its course, but the people here have been hoping for a cure (as quoted in Sevilla, 1999a).

Whether a cure would have been possible in that time is questionable, but what is certain is that the Akimel O’otham expressed their expectation to directly benefit from the invasion of their bodies early in the research.

The GRIC first made the expectation of direct benefit known in testimony before the House of Representatives Appropriations Subcommittee for the Interior and Related Agencies in 1973 (Gila River Indian Community), the Gila River Indian Community listed diabetes as a major problem on the Reservation and stated, “most of the new diabetics are diagnosed through routine screening tests performed the NIAMD field studies clinic located at the Sacaton Hospital” (p. 33). After diabetes was detected by the researchers, “patients are followed through the hospital diabetes clinic and are scheduled for routine visits at intervals determined by the severity of their disease” (p. 33). In the same testimony, Gila River Indian Community stated “a more holistic approach to research and clinical care would be to the mutual advantage of both research and medical care delivery” and that the objectives of the program were to integrate research and direct care to “better the medical care of the Gila River Indian Community” and to continue high quality research “where the Gila River Indian Community offers advantages over other populations and geographic locations which may be of benefit to medicine and

health of other Indian communities and of all peoples”(Gila River Indian Community, 1973, p. 84). The model program outlined to achieve that goal consisted of the following points:

1. The research program be integrated into the medical services delivery program provided to the Gila River Indian Community;
2. Staff physicians from the National Institute of Arthritis, Metabolic, and Digestive Diseases, Field Studies Section be given direct patient care privileges;
3. Staff physicians in the Indian Health Service be permitted to conduct research studies in conjunction with the NIAMDD Research Section;
4. A health information system be developed to computerize the health record of each patient in a summary form which contains all pertinent medical facts.

The advantages of this proposal include: availability of more physician services to the people, shorter waiting time in the clinics for patients, more specialists' services, complete and accurate summaries of patient's health status, immediate incorporation of new treatment methods into the health program, non-duplication of personnel facilities, and the availability for research purposes of all medical data; and

5. A comprehensive health center containing two beds which are to be continuously available for inpatient clinical investigations by NIAMDD research personnel (Gila River Indian Community, 1973, p. 86).

Further indication that the members of the Gila River Indian Community were no longer to be used for research without some direct benefit to the community was

underscored in 2009 when the Tribal Council established a Medical Health Care and Research Code (Tribal Council Gila River Indian Community, 2009), that states in part:

the Community Council has found that Medical and Health Care research has been conducted in ways that do not respect the human dignity of human subjects and that do not recognize the legitimate interests of the Community in the integrity and preservation of its culture (p. 18, Chapter 9.101).

Any future application to conduct medical and health care research must detail:

expected benefits of the proposed Medical and Health Care Research, including immediate and long range benefits represented in the Medical and Health Care Research, the sum total of human and scientific knowledge, human subjects or participants, and the Community (p. 18, Chapter 9.107, Section C).

### **Lessons from the Research on the Reservations**

Walsh McDermott and the Cornell research team recognized what many AI/AN tribes are now demanding from research that use their people; namely, that the research must detail how it will directly benefit the community or the individual. The expectations of the Diné that improved access to health care would be sustained, as well as that improved access to health care would improve health were minimally realized, but the fault lies outside of any promise of direct benefit made to them by the Cornell researchers.

Contrary to the Many Farms experiment, the NIH/NIDDK researchers showed very little concern for the impact of their research on the Akimel O'otham. While the NIH did provide some direct benefit to the community in the form of medical equipment and ancillary services, the direct benefit pales when compared to the length of time the



research persisted. The Akimel O'otham made their desire for direct benefit known, first by asking for collaboration at the very least between the IHS clinicians and the NIH researchers, and finally in the adoption of the Medical Health Care and Research Code. The expectations for a cure for diabetes may have been unattainable, but the Akimel O'otham desired appropriate communication and education regarding the outcomes of the diabetes study. Researchers did not meet these expectations.

## CHAPTER 6

### ANALYSIS

I began this dissertation project with the goal of demonstrating how promises and expectations have driven some of the health outcomes for American Indians with the goal to understand the moral obligation of the US government to improve health outcomes for American Indians. The major themes that had guided US policies, namely those of separation, containment and assimilation, toward AI/AN determined the selection of the case studies. Though not extensive, the case studies demonstrate how the US government's promises to American Indians were often unfulfilled or reneged in the enforcement of policies. The policies themselves were entangled with the administrations under which they were formed and were unilaterally encoded without tribal input. Yet, as the final case study showed, the AI/AN still held the expectation that the US government, through its agencies, would work toward improving the health and health outcomes of the American Indian people. It is the history of the US government's promises, and the expectations those promises engendered in American Indians that lead to the question of the contemporary moral obligation for the US government toward American Indian health outcomes.

Several legal cases have set the precedent for the US government's role in the lives of American Indians. In what is known as the "Marshall trilogy" the US government created the foundation for the US's definition of tribal sovereignty. The first case, according to law professor, Philip J. Prygoski (2011), is *Johnson v. McIntosh* (1823) in which the Supreme Court Chief Justice Marshall ruled that AI/AN were prohibited from selling their land without permission from the federal government. Marshall then decided

in *Cherokee Nation v. State of Georgia* (1831) that the Cherokee were wards and the US was guardian. The third case in the trilogy is the *Worcester v. Georgia* (1832) case in which Marshall refuted the State of Georgia's right to impose law on the sovereign nation of the Cherokee. Combined, these three cases acknowledge: some inherent sovereignty of tribes, such as described in the Menominee hunting and fishing rights challenge; that tribal inherent sovereignty is subject to diminution or elimination by Congress, but not the States; and finally, the dependence on the United States for protection as limited sovereign nations within its borders has established the trust responsibility for the US government to tribes (Prygoski, 2011). An important fourth case, *Vine Deloria (V. Deloria, 1971)* charges, is *Lone Wolf v. Hitchcock* (1903) because it has "totally handicapped us [American Indians] for the better part of a century" (p. 103). In that case:

the Court ruled that the trust relationship served as a source of power for Congress to take action on tribal land held under the terms of a treaty: The Court held that Congress could, by statute, abrogate the provisions of an Indian treaty (Prygoski, 2011).

Reviewing the history of the US government's treatment of AI/AN tribes shows that it often vacillated between a sense of paternalism, that is, of providing protection for the tribes as promised in treaties, to that of ensuring that the outcomes of interactions with them favored the needs of the US government. It is notable that the paternalism shown by the US government had always been from the perspective that the government knew what was best for AI/AN, without input from the tribes. Though the Marshall trilogy and *Lone Wolf* cases remain in force, there has been considerable effort since President Nixon's (1970) address to Congress about Indian affairs in which he challenged

Congress to “build upon the capacities and insights of the Indian people” (Public Papers of the Presidents of the United States: Richard Nixon, 1970, p. 565) to include the voices of American Indians into the design of their future. This effort has also been placed into the provision of health services, but as outlined in Chapter 1, several court cases have also ruled against any explicit legally enforceable promise or affirmative action to provide health services.

In the iteration of the historical context in this work, the history was left at the beginning of the 21<sup>st</sup> Century. Many tribes have made considerable strides by establishing self-determination or self-governance plans with the US government for a variety of services, including health services through Indian Health Service. Despite the movement toward self-governance, as a group, AI/AN still exhibit health disparities. What many tribes also experience is continued poverty with little socioeconomic development options for the tribes. Daniel Sarewitz, (2000) a professor of science and society comments, “Indeed, historical and individual country studies invariably demonstrate that the health of a population increases in concert with socioeconomic development, and that within any given society the prime determinant of health is relative social status” (p. 988).

The 1954 transfer of Indian Health Service out of the BIA separated the responsibility for the socioeconomic development of tribes away from the provision of health services to tribes. This division has created another layer of bureaucracy for tribes wishing to improve not only their socioeconomic status, but also their health outcomes. While the ideal might be that one agency work toward the improved socioeconomic and health outcomes for AI/AN, that will most likely not be realized. What the separation of

the two does for this analysis, though, is limit its focus to analyzing the performance of the federal government in providing health services and the AI/AN expectations regarding health outcomes through Indian Health Service. The analysis hopes to identify whether there is a moral obligation on the part of the US government to improve those outcomes, and if so, whether that obligation remains in perpetuity.

### **Indian Health Service Today**

The Indian Health Service (IHS) (Indian Health Service, 2015a) lists as its legal basis to provide services to AI/AN the treaties and court cases that established the guardian/ward trust relationship as described above, as well as in the Snyder Act and the Indian Health Care Improvement Act (IHCA). To that end, IHS has the following mission and goals:

**Our Mission ...**to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

**Our Goal ...**to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

**Our Foundation ...**to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes (Indian Health Service, 2016a).

The Indian Health Service provides health care to AI/ANs in a three-pronged delivery system, consisting of Indian Health Service's direct care, tribal contract/compact, and urban health care (I/T/U), which by its own measure, serves only

57% of the AI/AN population (Indian Health Service, 2015b). Over 5.5 million people identify as AI/AN in combination with other races, of which 2.5 million identify solely as AI/AN. IHS provides healthcare to only 2.2 million AI/AN (Artiga, Arguello, & Duckett, 2013), because of eligibility criteria.

To be eligible for medical care through Indian Health Service a person:

- Is of Indian and/or Alaska Native descent as evidenced by one or more of the following factors:
- Is regarded by the community in which he lives as an Indian OR Alaska Native;
- Is a member, enrolled or otherwise, of an Indian or Alaska Native Tribe or Group under Federal supervision;
- Resides on tax-exempt land or owns restricted property;
- Actively participates in tribal affairs;
- Any other reasonable factor indicative of Indian descent; (Indian Health Service, 2013c)

Restrictions on eligibility include the need for tribal membership with documentation. Urban AI/AN, or AI/AN whose blood quantum for a particular tribe may be too dilute, may not be recognized as tribal members. A tribal member is ineligible for federal services if he comes from a tribe that did not regain federal recognition following termination, or from a tribe that is recognized by a States but is not federally recognized.<sup>53</sup> The US made a concerted effort to assimilate and dilute the cultural identity

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<sup>53</sup> For a list of federal and State recognized tribes, see (National Conference of State Legislatures, 2016).

of AI/AN, and for some, that effort has made them ineligible for federal services, just as the Menominee experienced during their termination period.

Nearly half of the people who identify as American Indians live in urban areas. Many were part of the Indian Relocation Act movement in 1956, in which American Indians were promised jobs and support if they relocated off the reservations. Although IHCIA (Indian Health Amendments of 1992) provided funding for urban health centers, the portion of IHS's funding allocated to urban health centers is less than 2% (Indian Health Service, 2016c) even though over half of American Indians and Alaska Natives now reside in urban settings (Forquera, 2001). The remainder of IHS's budget is split with 40 percent going to the tribes who are utilizing the 1975 Indian Self-Determination and Educational Assistance Act (Indian Self-Determination and Education Assistance Act, 1975) (ISDEAA) to contract or compact to administer health services. The remainder of the clinical care budget goes to direct care through IHS facilities (Indian Health Service, 2016c).

Regardless of the stated goal in IHCIA for the federal government to raise the American Indian People to the highest health status, there is a considerable body of work documenting the known health disparities of AI/AN in general, as well as documenting the challenges in determining the accuracy of the rates of disparity (U.S. Commission on Civil Rights, 2003). The Meriam Report chastised the Indian Service in 1928 for the paucity of health statistics of American Indians. Today, the challenge of tracking health statistics for AI/AN remains because often they are not identified separately in health statistics that can be tracked over time (Agency for Healthcare Research and Quality, 2009). Shortages, such as in treatment options, physicians and other services, are also not

adequately measured, so never appear on reports (Westmoreland & Watson, 2006). Very often, too, when determination of race is made, it has been without input from the patient, and AI/AN patients are often misclassified as Hispanic or White (Puukka, Stehr-Green, & Becker, 2005). When people are of more than one race, the ability to track health measurements becomes nearly impossible (Agency for Healthcare Research and Quality, 2009; Kaiser Commission on Medicaid and the Uninsured, 2010). One of the benefits touted in the Affordable Care Act (Patient Protection and Affordable Care Act, 2010) in regards to American Indians is that it “invests in increase [sic] data collection and research about health disparities” ... and DHHS “has begun the process of upgrading data collection standards to better understand and ultimately eliminate health disparities” (United States White House, 2014).

Despite the limitations to fully track the health of AI/AN, there is research that details that their health status still falls below most citizens in the U.S. As stated earlier in this work, AI/AN have a life expectancy that is 4.2 years less than the average life expectancy of all races in the US (Indian Health Service, 2015b) and the mortality rate from diabetes mellitus and liver disease is three and five times higher respectively than the general US population’s mortality rate from those diseases (Indian Health Service, 2015b). AI/AN are more likely to die of alcoholism (552%) (Indian Health Service, 2013a) and tuberculosis (500%) (Indian Health Service, 2010) than the rest of the American population.

The Purchased/Referred Care (PRC) program (previously known as Contract Health Services (CHS) before it was renamed in 2014) of IHS is used for purchasing services from private health care providers in situations where the IHS or the tribal



facility may not provide that service. These specialty services are paid for as budgets allow in each Area PRC. According to the IHS, “The CHS program is not an entitlement program, therefore when funds are insufficient to provide the volume of CHS needed, priorities for service shall be determined on the basis of relative medical need (Title 42 CFR §136.23(e))” (Indian Health Service, 2013b Chapter 3, 2.3.8). IHS has a priority system for providing medical services through PRC. Dr. Yvette Roubideaux (2011), during her term as Interim Director of IHS stated that prior to 2010, “most IHS operated and tribally operated CHS programs budgets were so limited that they had to follow IHS regulations to use a medical priority system to determine which referrals to approve for payment. In general, they were only able to fund “priority 1” or “life or limb” level referrals” (Roubideaux, 2011).

IHS is a “payer of last resort,” so it requires that patients apply for any private or public insurance (such as Medicare or Medicaid) and IHS will bill such insurance before disbursing its own funds for patient care. The Kaiser Family Foundation (2013) reported “A total of \$973 million will be collected from third party payers in FY2013. By far the largest third-party payer is Medicaid, which accounts for \$683 million or 70% of total third party revenues, and 13% of total IHS program funding for FY2013” (Artiga, Arguello, & Duckett, 2013). Medicaid operates under a federal matching program of 100% when Medicaid patients receive services through an IHS or tribally run facility (Schneider, 2005). IHS was unable to bill the Veterans Administration (VA) for services provided to veterans, however, until changes in the law in 2012 (Office of Public and Intergovernmental Affairs, 2012). To date, the VA has interpreted the reimbursement model to include only direct medical care, thus excluding specialty services or referred

care outside of the IHS or the tribe. Because the IHS is the payer of last resort, the services available to American Indians may depend upon whether the State in which they reside has expanded Medicaid eligibility. This also poses a problem for some reservations, such as the Navajo Nation, that are located in more than one State.

### **Who decides?**

Regardless of the trust responsibility, Indian Health Service has been chronically underfunded, although the Affordable Care Act (Patient Protection and Affordable Care Act, 2010) improved the funding for the Indian Health Service by permanently authorizing IHCA. The increased funding may not benefit all AI/AN because, as noted above, not all AI/AN are eligible to receive services from IHS, and even if eligible, the funding for specialty services may be depleted due to the underfunding of IHS.

While IHS refers to the legal basis as the formation of the trust responsibility and its provision of services, Philip Deloria asserts that the special status under the trust responsibility for AI/AN is also dependent on their cultural distinctness and poverty (P. Deloria, 1995). Those two features “find a broad base of support in the simultaneous humanitarian impulse and sense of cultural superiority that are the peculiar heritage of Anglo-American society” (P. Deloria, 1995, p. 193). Although the legal basis for IHS services is necessary for the special status, if AI/AN were no longer culturally distinct nor in poverty, their special status would most likely be eliminated. Further, Deloria sees the policy shift of self-determination as just one more method “in the fundamental commitment of the society to bring Indians into the mainstream, not a movement toward a true recognition of a permanent tribal right to exist” (P. Deloria, 1995, p. 193). The wording of the Indian Self-Determination Contract Reform Act (1994) does seem to

underscore Deloria's point when it states that ISDEAA is "to provide for an orderly transition through a planned and measurable parallel reduction in the Federal bureaucracy" (Indian Self-Determination Contract Reform Act of 1994).

To be considered eligible to participate in self-governance compacts, a tribe must have completed a planning phase, and have demonstrated three years of financial stability and financial management. Although half of IHS's budget goes toward self-governance compacts, the growth in the number of tribes participating has slowed. Besides meeting eligibility criteria, one obstacle had been "Congress's failure to appropriate sufficient funds for contract support costs" (Strommer & Osborne, 2014, p. 49). Contract support costs are the costs to tribes to administer the program in the compact. For many years, IHS reported shortfalls in contract support costs that tribes had to absorb. Since the 2016 budget, IHS has enacted a separate appropriation account as a separate indefinite discretionary budget authority (Indian Health Service, 2016c, p. CJ4). By fiscal 2018, IHS "proposes to reclassify CSC as a mandatory, three-year appropriation with sufficient increases year over year to fully fund the estimated need for the program in the United States (Indian Health Service, 2016c, p. CJ4). Until that time, however, should there be a shortfall, tribes must absorb the costs using supplemental tribal resources, or reduce the amount used for the program to ensure contract support costs are covered, or formally petition the government to reimburse them (Strommer & Osborne, 2014).

Another obstacle Strommer & Osborne (2014) record that dissuades tribes from applying for self-governance compacts are "agencies' continuing efforts to frustrate tribal rights to self-determination and self-governance" (p. 60), efforts they identify as refusal to interpret the statutes in favor of the tribes, as mandated by ISDEAA. Strommer &

Osborne (2014) identify that despite the historical resistance agencies have shown to approve plans for tribes to administer the funds, tribes also could benefit if ISDEAA principles were expanded to other agencies, both inside and outside of Department of Health and Human Services. (Strommer & Osborne, 2014). Such expansion could allow tribes to create collaborative programs to improve health and address some of the factors that affect health outcomes.

The intent of ISDEAA was to reduce the oversight by the federal government on tribes, and accord them funds in a government to government relationship. Title V of the Tribal Self-Governance Amendments of 2000 significantly strengthens tribal rights” in that it limits the “Secretary of the Interior’s discretion not to enter into an agreement” (Strommer & Osborne, 2014, p. 44). Nearly half of the federally recognized tribes participate in a compact with IHS. Conversely that means that over half the tribes do not. What, then, are the expectation of AI/AN for the government’s role in affecting their health outcomes?

Historian Francis Paul Prucha (1984) points to the statement of the National Tribal Chairman’s Association (NTCA) in 1983 to shed some light on the expectations of American Indians. In that statement, the members of the NTCA declared that because the land cessions of AI/AN to the US were given in perpetuity, so too must the federal services from the government to AI/AN be given. Prucha (1984) continues:

Such spokesmen asserted that the federal government in fulfilling its trust responsibilities must provide Indians with education, health care, and other social services sufficient at least to bring the Indians up to the level of the general population; that the responsibility extended to all Indians, not only to those of

federally recognized tribes; and that the responsibility affected all agencies of the government, not only the Department of the Interior (p. 18).

To bring the Indians up to the level of the general population is the criteria identified by the National Tribal Chairman's Association, a standard that S. Lyman Tyler also voiced in 1973 when he referred to the Supreme Court's decision that the federal government has the right "to protect the Indians until ... they are able to maintain themselves in the midst of their more competitive neighbors" (Tyler, 1973). Both the NTCA and Tyler expect that at some point a determination will be made as to the fitness of the American Indian in comparison to the general population or its competitive neighbors to continue the special status. While Tyler (1973) asserts that determination will be a consensus between Congress and AI/AN, until that time the special relationship will continue until they "feel that the terms of the treaties have been fully honored, and until it is undesirable and disadvantageous to have the special status continue longer" (p. 12). Allowing Congress to participate in the determination not only of whether tribes are ready to be relieved of the special status, but also that the terms of the treaties have been fully honored, even with tribal input, continues that paternalism and cultural superiority evidenced in the case studies of this dissertation.

This dissertation catalogs some of the promises made by the US government that contributed, directly or indirectly, to health outcomes of American Indians. It looks at how the policies of the US government toward American Indians evolved either from those promises or in spite of them, and the subsequent effect on American Indian health outcomes from then to now. The use of case studies builds upon the previous literature by bringing to life the impact of policies that affected health outcomes. While this researcher

also performed an extensive review of the literature to ascertain the expectations that American Indians hold regarding their health outcomes, interviews with a cross-section of American Indian communities would provide a more robust understanding of their expectations for health outcomes.

Critics of allowing tribes to determine for how long AI/AN should be granted special status to receive federal services point to the fact that it is the US government that must pay for those federal services, so it must be involved in that determination of when tribes are competitive with their neighbors. Further, it can be pointed out that since many reservations are vast spaces, not totally dissimilar to other rural communities in the distances required to reach a health care facility, what does it mean to be able to maintain themselves as compared to their competitive neighbors? Critics might also claim that health disparities are not the best gauge to determine if the treaties or promises have been honored, as other factors, including some resistance on the part of tribes to utilize health services, contribute to health disparities. Those critics ignore the statistics from the Pine Ridge reservation described in Chapter 2 that show many reservations have health conditions and poverty comparable to third world countries as well as how the historical role of the US government ensured that reservations were distant from the rest of the population, and played a role in establishing AI/AN distrust of its health providers. What the criticisms do provide is an opportunity to measure those questions when health outcomes are reported in the future. Since most of the tribal self-governance compacts have been finalized after 2000, it would be useful to examine how tribal administration has impacted health outcomes. Because health outcomes are so closely tied to socioeconomic conditions, another extension of this project would be to correlate both

the tribal and the federal government's efforts in that regard to the status of health of the AI/AN communities.

President Nixon (Public Papers of the Presidents of the United States: Richard Nixon, 1970) identified American Indians as the "most deprived and most isolated minority group in our nation" (p. 564) and that their consistent ranking at the bottom of every measure of health, income, education, etc., was a "heritage of centuries of injustice" (p. 564). Nixon called upon the US government and people to renounce the idea that the

Federal government has taken on a trusteeship responsibility for Indian communities as an act of generosity toward a disadvantaged people and that it can therefore discontinue this responsibility on a unilateral basis whenever it sees fit ... The special relationship between Indians and the Federal government is the result instead of solemn obligations which have been entered into by the United States Government. Down through the years, through written treaties and through formal and informal agreements, our government has made specific commitments to the Indian people. For their part, the Indians have often surrendered claims to vast tracts of land and have accepted life on government reservations. In exchange, the government has agreed to provide community services such as health, education and public safety, services which would presumably allow Indian communities to enjoy a standard of living comparable to that of other Americans.

This goal, of course, has never been achieved. But the special relationship between the Indian tribes and the Federal government which arises from these

agreements continues to carry immense moral and legal force. To terminate this relationship would be no more appropriate than to terminate the citizenship rights of any other American ... The very threat that this relationship may someday be ended has created a great deal of apprehension among Indian groups and this apprehension, in turn, has had a blighting effect on tribal progress. Any step that might result in greater social, economic or political autonomy is regarded with suspicion by many Indians who fear that it will only bring them closer to the day when the Federal government will disavow its responsibility and cut them adrift (Public Papers of the Presidents of the United States: Richard Nixon, 1970, pp. 565-66).

Nixon underscored that the trust relationship carries “immense moral and legal force” (Public Papers of the Presidents of the United States: Richard Nixon, 1970, pp. 565-66). Following his example, the US government set as its own goal to provide “the highest possible health status to Indians” (Indian Health Care Improvement Act, 1976, p. 435), yet the US government’s broken and unfulfilled promises, as well as its persistent underfunding of IHS, contributed to the health disparities of American Indians. The promises given, and the expectations they have created, place a moral obligation on the part of the US government to have American Indians determine when, if ever, the treaties and the promises have been fully honored.



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APPENDIX A  
ACRONYMS



AAIA	Association on American Indian Affairs
AI/AN	American Indian/Alaska Natives
AMA	American Medical Association
ARROW	American Restitution and Righting of Wrongs
BCG	bacillus Calmette Gruerin
BIA	Bureau of Indian Affairs
BOP	Bureau of Prisons
CHS	Contract Health Services for Indian Health Service
CNC	Coordinating and Negotiating Committee (for the Menominee)
CWA	Civil Works Administration
DHHS	U.S. Department of Health and Human Services
DRTC	Diabetes Research and Training Centers
GIIC	Governors' Interstate Indian Council
GRIC	Gila River Indian Community
HRSA	Human Resources and Service Administration
IDDM	Insulin-Dependent Diabetes Mellitus or Type I diabetes
IHCIA	Indian Health Care Improvement Act of 1976
IHS	Indian Health Service
ISDEAA	Indian Self-Determination and Educational Assistance Act
IRA	Indian Reorganization Act
MEI	Menominee Enterprises Inc.
MISC	Menominee Indian Study Committee

NCAI	National Congress of American Indians
NIADDK	National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases
NIAMD	National Institute of Arthritis and Metabolic Diseases
NIAMDD	National Institute of Arthritis, Metabolism, and Digestive Diseases
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIDDM	noninsulin-dependent diabetes mellitus or Type 2 diabetes
NIH	National Institutes of Health
NTCA	National Tribal Chairman's Association
OIA	Office of Indian Affairs (BIA pre-1947)
PHS	Public Health Service
PIMC	Phoenix Indian Medical Center
PRC	Purchased/Referred Care (previously Contract Health Services)
TB	Tuberculosis
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
VA	Veterans Affairs or Veterans Health Administration
WIC	Supplemental Nutrition Program for Women, Infants, and Children
WPA	Works Progress Administration
WWII	World War II