The original documents are located in Box 3, folder “Health Services” of the Bradley H. Patterson Files at the Gerald R. Ford Presidential Library.

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Allied Health Directory Helps Answer "What To Do Next Year"

A complete directory of all Allied Health Training programs in Arizona, New Mexico, Colorado, and Utah is ready to be distributed to high school counselors and others who might need the information early next fall. The 31-page booklet lists the programs by occupation and also includes entrance requirements, length of program, details of the job training prepares you for, cost and available stipends or scholarships.

It was developed by Dr. James R. Crook, director of the Office of Allied Health Sciences, Navajo Health Authority, assigned to work at the Navajo Community College; with the assistance of Dr. Alan Goodman, AHEC Director, and under a DHEW contract.

Dr. Crook, who came to the Navajo Reservation last summer, is coordinating the development of Allied Health Sciences in the four state area and at Navajo Community College, and working to upgrade, improve, and increase training programs and opportunities as well as the chance of success for Indian students interested in an Allied Health career. Developing the American Indian School of Medicine, is part of this job.

Since he arrived, the Community Health Medic basic pharmacology and Emergency Medical Technician courses have been approved for academic credit at Navajo Community College; bilingual-nutrition training courses have been developed and the Indian Health Service medical laboratory technical training has moved to Navajo Community College.

AHEC is a component of the Navajo Health Authority.

AHEC Director
Dr. Alan Goodman

AHEC Editor
Barbara Lacy
Family Health Center
Keeps Families Well

The emphasis of the Navajo Health Authority Family Health Center, Shiprock, New Mexico, is to provide primary health care to residents of the Shiprock area. The primary goal is to provide a comprehensive health care system that is easily accessible to the entire community.

The center is located in a building that was formerly a school. The facilities include an examination room, a laboratory, and an office for the physician. The center is staffed by a full-time nurse practitioner and a part-time physician.

The center provides a wide range of services, including primary care, preventive care, and diagnostic services. The center also has a pharmacy and a dental clinic.

The center has a sliding scale fee structure, so that all residents can afford to use the services. The center also accepts Medicaid and Medicare.

The center is open six days a week, and is closed on Sundays and holidays.

The center is supported by the Navajo Health Authority, which is a federally funded agency.

The center is located at 100 Navajo Drive, Shiprock, NM 87415. The phone number is (505) 643-3443.
Ten students will become Navajo Community College's first class of medical laboratory technicians next fall, according to the director of the new two-year program, Ms. Kay Blosser, MT (ASCP).

After they graduate, the medical laboratory technicians will not only have an associate degree from Navajo Community College but will be able to do hundreds of laboratory tests, (such as matching blood samples, growing cultures, and testing for chemicals or antibodies) that are now done by physicians as a guide for diagnosis and treatment.

The program is an expansion of a one-year Indian Health Service medical laboratory assistance training program formerly offered in Gallup, New Mexico.

Consistent with the concept of the Indian Self-Determination Act, this is one of the first IHS programs to be taken over by an Indian-owned institution. While discussing the program it was decided that the area's real need was for medical laboratory technicians rather than technologists. Also, students in the former program did not receive academic credit for their year-long course.

"The medical laboratory technicians can do more work with less supervision and thus are more valuable on the job," Ms. Blosser said.

Ms. Blosser received her MS from the University of Oklahoma and previously worked there as the assistant supervisor of the Department of Microbiology and Serology, dividing her time between supervision and teaching. She predicts that her new job will be humbly administration which she finds exciting. "Of course, starting a new program also is exciting as well as challenging," she added.

The program must follow requirements set by the National Accrediting Agency for Clinical Laboratory Sciences.

"They want to know all background, the instructors' background, and the content of the courses. We must have an overall director of the program with a technical pathologist." The first year will be equivalent to any freshman year in college with an emphasis on basic science stated she said. The second year will be held in Gallup, New Mexico. We will use the Indian Health Service training laboratory which is the perfect student setup. The instructors who worked with the medical laboratory assistant program are staying on and the laboratory has very sophisticated and expensive equipment in it.

"Although the laboratory is close to the Gallup Indian Hospital, the students won't work on any patient samples until the last six months when they work in a hospital as clinical practitioners. After this, they qualify to take the national qualifying examination for registered medical laboratory technicians.

The Third Indian Nursing Education Conference will be held on June 25-26, 1976, at the College of Ganado, Ganado, Arizona. The conference is sponsored by the Navajo Health Authority, Office of Nursing Education. The conference will "Spark out - Who We Need More Nurses," will focus on identifying the need for more nurses in the Four Corners area and will develop recommendations to solve the nursing shortage problems.

The conference is open to all nurses in the Four Corners area. For more information, contact the Navajo Health Authority, Office of Nursing Education, Window Rock, Arizona. (602) 871-4831.

Five students received an Associate Degree in Nursing from Navajo Community College on May 8, 1976. They are: Diane Brigham, Roberta Moore, Rita Cowboy, Carol Todd, and Larry Rossburn, who qualified by meeting the requirements in December, 1975. Congratulations NCC Nursing graduates!

A nursing coordinator for the NCC Nursing Program has been hired. Ms. Lynda M. Pourier, R.N., M.P.H., Director of the Navajo Health Authority, Office of Nursing Education, has been on loan to the NCC Nursing Program since January, 1976. The new coordinator, Mrs. Linda Roberson, who will arrive in August, has a master's degree in medical-surgical nursing and is an experienced associate degree nursing graduate. She has been the Coordinator of the Coconino College Nursing Program in Flagstaff, Arizona. Effective May 11, 1976, the NCC Nursing Program has received continued accreditation from the Arizona State Board of Nursing and is exempt to accept new nursing students in the fall.

Now, there are small core medical libraries in each Indian Health Service hospital and clinic on the reservation. The librarian will work with the nursing journal at the Area Health Education Center to develop a "Health Information Collection," and tie-in with the Southwest Regional Medical Library.

Isolated health professionals can be as medically informed as their urban counterparts. How did it happen? A librarian was hired whose enthusiasm and love of books rivaled those around her. Books were so much a part of her life that Ms. Hendryson was actually shocked as what he called the "information desert" of the reservation.

As the visit area health facilities to catalog what was available, she discovered that the frequent Indian Health Service budget cuts usually hit the library first. She also asked the National Library of Medicine for advice. The plan decided on was that a core library of certain basic reference works be included. The Braden Core Collection be kept in every health care institution, plus some subscriptions to keep everyone up on the recent developments and knowledge of information, beyond that was available.

The resulting collection has been used as a reference library by the Navajo Health Authority staff as well as health professionals.

Some books were put on loan in Indian Health Service facilities. Some were purchased as funds allowed. The Braden Core Collection is now the whole world of audio visual materials to the staff of the Navajo Health Authority.

As it was with much regret that she resigned her position as librarian when her husband became ill, although she is still an active consultant to the library.

Now running the library is Mr. Paul Hughes. Mr. Hughes, from Navajo, who graduated with honors from San Francisco State University, has just completed his master's degree in library science from the University of Arizona.

What is left for her to do? We are still ordering books that need to be catalogued. Mr. Hughes is a native of Arizona and is familiar with the area, with which he is at ease. The whole world of audio visual materials we want to get into as soon as we have more space."
Prevention Team Tries To Catch Diseases Before You Do!

The caller was brief: A suspected outbreak of Salmonellosis at a BIA boarding school near the hospital.

As soon as possible, the Indian Health Service preventive medicine team was on the scene. They took water samples, throat cultures, and rectal swabs. This time they'd catch the epidemic.

But the water samples were pure, although they did discover that the chlorinetank didn't work. The cultures were negative.

What caused the outbreak? Over a dozen people had obviously been sick, but the team never discovered the cause and everyone quickly recovered.

To do fill miles away the scene was different. No one was notified when the first child came down with measles. Between two weeks and 25 people in the small community came down with scabies, the kind of measles that leave young children deaf, brain damaged, or with other permanent disabilities.

"We could have stopped at least half of those cases, if the first case had been reported," said Dr. Charles Kallenbach, Director, Preventive Medicine, BIA, who acted as a consultant to the local HHS field operations.

That's the challenge he faces--preventing a disease before it becomes a community-wide epidemic.

Of course, he'd like to change living conditions so that many diseases never occur at all.

But that's another story.

Right now he is designing a model community follow-up procedure for a Family Health Center at Shiprock, New Mexico. His team is the clinic's resident.

"Residents usually only know clinical medicine. We're going to teach them how to deal with disease in a community setting."

"We get some false alarms. But even in the first incident I must say, the community service by discovering the broken water filter and showing the community how we cared.

There are two parts to this really: Teaching residents how to work with the community and teaching the community how to ask for help.

Who asks first?

First the schools; the hospital, the doctors, but the method we have now is not responsive enough.

The Laboratory Psychiatric Care Information cards filled out by the doctors at each patient examined are precious. They don't tell us what the actual diagnosis is because they don't include laboratory work.

"I despised, if asked what his next words to think is."

"There is no possibility that I can develop a weakly 'notifiable disease report.'"

"I was excited by this," he usually mild-mannered Kallenbach admitted.

The present disease report used by Indian Health Service is a computer printout of APC forms. The report for March arrives in July. It is a developed disease report. I want physicians to actually see positive results. Right now, I'm working with the Director of Community Health Services in each Indian Health Facility to develop the mechanics of the report.

"I'd also like to do a monthly summary and include information from those who are bored by the reservation. Each school works on a different schedule so I can't incorporate their reports into anything other than a monthly summary."

"By the way, notifiable diseases are those transmitted from man to man, communicable. Some of the ones you'd want to follow are strep, rheumatic fever, rubella, salmonellosis, tuberculosis, poliomyelitis, flu."

Strep, the one communicable disease he has been working on for several years is showing a definite decrease. He hopes that it is due to the Reservation-wide JNAO Tribal strep prevention program he has been involved with as a consultant.

"The importance of this program is its effect or the incidence of rheumatic fever on the Reservation. The reported cases have gone down 50 percent in the last five years, but it will be five more years before we know how significant that is. The incidence curve has varied over the years in the past so that we can't tell yet if it is our strep program that's done it, or if it is an artificial drop."

"The State of Arizona is discontinuing their rheumatic fever registry. I hope to have it transferred to the Reservation because most of the patients till now are Indians."

"We are currently following 315 active patients. Most of them will be on prophylactic medicine for at least 10 or 20 years; if not the rest of their lives."

"We're not talking about large numbers. Our records show that the high incidence of new cases of rheumatic fever was in 6 to 12 years."

"Once again, don't worry."

"We do know rheumatic fever is caused by lack of medical care and overcrowded conditions. It's prevalent among lower social-economic areas."

You have the feeling that that's the challenge that keeps the former microbiologist excited.

You also have the feeling that he's ready to lead the team when the call comes.

Animal First-Aid Offered To Area Residents, Students

The Navajo Community College offers a practical course, he'd like to change living conditions so that many diseases never occur at all.

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EMS System Meets Stringent Standards

Do you think that your CB is the latest thing in radio equipment?
It's not. There is a growing and extremely exclusive network installed only in special vehicles that might save your life. And it works precisely because it is so exclusive.

Who gets it? Ambulances and hospitals. It is the 450 mile-wide emergency medical system. In the Navajo Health Authority region it is installed in most emergency facilities. Emergency medical technicians in most hospitals, critical patient transport vehicles which the IHS recently added to the EMS system; an example of the careful coordination and planning between the two agencies.

These vehicles are equipped to stabilize a patient's condition as they are transported to another facility—and don't be up emergency vehicles on what are routine runs.

The final tier of the plan covers the vast areas left, unpaved roads or roadless areas where heavy ambulances can't travel.

EMS bought, equipped and leased to Navajo chapters, red, four-wheel driver suburban van, called "wolacbee," or "red ant" in Navajo, which are available to carry patients to scheduled appointments or on emergencies and are equipped with basic first aid equipment.

This is where training comes in. All EMS vehicles must be operated by 1 certified emergency medical technicians. The requires 80 hours of class work and training.

Since the program started two years ago, EMS has trained 125 EMT's, 59 percent women. They have also trained 25 others in basic emergency care techniques.

Also, how all Navajo police officers must pass the EMT course and EMS recommends that others who deal with the public such as security officers, teachers, and supervisors of dangerous jobs, have at least 40 hours—a basic emergency care course.

The next step will be training some EMT's at the 120 hour level and eventually bringing them up to the Para-Medic 480 hour level.

Presently, all EMT's receive a refresher course every six months, for an updating in what Lincoln calls their hand skills—handcuring, cardiopulmonary resuscitation, applying splints, etc.

"We do other types of continuing education," Lincoln added, "We hold classes for doctors, nurses and other emergency room personnel.

The next step is...
May 14, 1976

Dear Mr. Means:

This is in response to your letter of April 13, 1976 to the President regarding the 1976 funding level for the Indian Health Service.

The President's 1976 budget request contained an increase of $30 million over the comparable 1975 appropriation for Indian Health Services. The President's 1977 budget proposed that $5.3 million added by Congress to the 1976 request be rescinded. These funds would have provided specific new and expanded outpatient care and preventive health care projects as well as services to non-reservation urban Indians who are already entitled to services through other federal health services programs.

Congress did not accept the President's proposal and thus the $5.3 million proposed for rescission was made available to the Department of Health, Education, and Welfare on March 18, 1976.

I hope this information is helpful.

Sincerely,

Theodore C. Marrs
Special Assistant to the President

Mr. Warren W. Means
Executive Director
United Tribes Educational
Technical Center
3315 South Airport Road
Bismarck, North Dakota 58501
FOR IMMEDIATE RELEASE

OCTOBER 13, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

STATEMENT BY THE PRESIDENT

I have approved H.R. 5546, the "Health Professions Education Assistance Act of 1976," which will materially assist in insuring that all Americans throughout the country will have sufficient access to physicians and dentists. Last year the Administration submitted to Congress a legislative proposal based on findings which showed that while there was no longer a shortage in the total number of physicians in the United States, there were alarming signs that this country was facing two growing problems with respect to these practitioners. There are not enough doctors in rural and inner city areas, and there is a continuing decline in the number of doctors practicing primary care, i.e., the problem of specialty maldistribution.

I am pleased that the bill specifically addresses those issues which we identified as being of greatest concern. Although the bill contains some undesirable features, I believe that, on balance, it represents a definite step toward improving health care delivery, and, accordingly, warrants my signature.

There are several provisions of this legislation which will be instrumental in solving the problems of geographic and specialty maldistribution. The bill continues and expands a scholarship program which will provide individuals with financial assistance to attend medical school. In exchange for these scholarships, each recipient will be required to serve in a health manpower shortage area for a period of at least two years. Coupled with this scholarship program, the bill authorizes the establishment of a Federal program of insured loans -- a proposal I have supported -- to assist health professions students. This program virtually assures that no individual will be denied a medical education for financial reasons. Also the bill establishes a program of special assistance to disadvantaged students in an effort to equalize opportunities among all individuals who wish to become health professionals.

In order to deal with the problem of specialty maldistribution and increase the number of doctors who deliver primary care, the bill authorizes the continuation of the existing program of financial support to health professions schools through capitation grants. However, a significant new condition is attached to the receipt of these grants. Medical schools would be required to provide annually an increasing percentage of residency positions for individuals in primary care specialties (i.e., pediatrics, internal medicine and family medicine).
The bill authorizes funding for numerous special projects relating to the education and training of physicians and allied health personnel. Special grants are authorized for programs in family medicine and the general practice of dentistry. In addition, grants for programs for the training of physician extenders and expanded function dental auxiliaries were authorized. Such programs are designed to enhance the overall capacity of physicians and dentists to deliver health care.

Finally, the bill revises and extends the existing National Health Service Corps Program -- a program which has made significant strides in alleviating the problem of inaccessibility to health care services in medically underserved areas. This program currently has more than 600 professionals working in shortage areas. It is estimated that by next year, this number will grow to almost 700. And, with the authorizing legislation before me now, we expect the capabilities of this program to increase dramatically during the following three years.

As I noted, however, the bill is not without some defects. Because I am particularly concerned about the potential impact of some of these troublesome provisions, I intend to submit legislative recommendations to remedy these problems as soon as the Congress returns.

Primarily, these concerns relate to the levels of spending authorized by the legislation, provisions which deal with medical school admission requirements for Americans returning from foreign medical schools, and payback conditions for students who do not fulfill their obligations under the National Health Service Corps scholarship program. I am convinced that the authorization levels attached to this program are excessive. I believe that the desired results can be attained at a much lower cost. I particularly object to the provision which creates an automatic funding "trigger" for the scholarship program and which penalizes other programs authorized in the bill if certain scholarship funding levels are not met. Not only does this provision impose unwarranted sanctions, but it distorts the entire Congressional appropriations process.

Furthermore, I have reservations about the capitation condition which requires medical schools to accept a certain number of American citizens who have been students in foreign medical schools and who meet certain criteria. Not only does this requirement potentially create administrative problems, but, equally as important, it undermines our medical schools' admission policies by imposing Federal law to override an individual school's admission criteria.

Finally, I object to the unduly harsh penalties assigned to those scholarship recipients who fail to fulfill their service obligation in the National Health Service Corps. With respect to these people, the bill requires them to pay back three times the amount of the scholarship, plus interest...
(with adjustment for any portion of a service obligation performed), within one year of the breach of this obligation. In my view, a penalty of twice the amount provided, plus interest, would be more than sufficient.

As I indicated earlier, I plan to recommend action to remedy these problems as soon as Congress reconvenes. Despite the drawbacks of the bill, however, I believe this legislation is necessary. Many of the programs which are contained in this bill have been without authorizing legislation since June 1974. Furthermore, the bill addresses the important problems we identified last year. In weighing all of these factors, I believe that it is in the best interest of the American people to sign this measure into law.

# # # #
Mr. Bradley H. Patterson, Jr.
Presidential Assistant
American Indian Affairs
White House Office
Washington, D.C.

Dear Mr. Patterson Jr:

I am writing to you about my concern regarding an Indian health problem. My wife and I are both pediatricians, retired from active practice in Grand Rapids, Michigan and now living in Gunnison, Colorado. Since retirement we have been serving tours of duty as medical officers on volunteer and sometimes contract arrangements on the Navajo and more recently on the Hopi Reservation. We have just completed a 12 month tour of duty at Keams Canyon Hospital on the Hopi Reservation. While President Ford would probably remember us, I do not want to trouble him during his re-election campaign. Perhaps you could give me some advice and help.

When we reported for duty July 1, 1975 at Keams Canyon Hospital, Mr. Glenn Randolph, the administrator of the hospital, asked me to try and identify problems and outline ways to improve the health care service. We found that there were many areas where we felt improvement was needed, (see attached report to Dr. Charles McCammon, Director of the Phoenix Health Area, Indian Health Services, 801 E. Indian School Rd, Phoenix, Arizona).

The problem which gave me great concern, in which I failed to see improvement was in the area of prenatal clinics, prenatal parent classes, the identification of the high risk mother and baby and monitoring during labor. I tried to get the staff to identify the small for gestational age baby and also the baby that is prone to develop respiratory distress syndrome but the medical officers just refused to cooperate. As one said, "In no way will we go through such a routine, we are just too busy."

Of the seven medical officers that were reporting for duty on July 1, 1976, two had never delivered a baby and the others had various obstetrical experiences, but none would have really qualified for obstetrical privileges in the average city hospital, certainly not without supervision. I don't think this is fair to the doctors that were sent to Keams Canyon and certainly not fair to the Indian mothers and their babies. I think that every baby has the right to be well born.
I pointed out this major defect in the health care at Keams Canyon and the chief of staff was notified by memorandum and also the administrator of the hospital. I also outlined a plan to improve the services as quickly as possible. This plan consisted of obtaining Board Certified Obstetricians through the American Obstetrical Society as volunteers. Some of my obstetrical friends have done this and they only ask for transportation expenses and housing. Most of these volunteers served monthly tours of duty. The executive officer of the American Obstetrical Society stated that he would have no difficulty getting very high quality obstetrical teachers for as long as a year, if it were necessary. These obstetricians could establish a really meaningful prenatal clinic, they could help to identify the high risk mother and baby, they could institute techniques of monitoring during pregnancy and labor. I am sure the results of such a training for the officers at Keams would have been very valuable. I saw the letter that the American Obstetrical Society wrote to Glenn Randolph, the Administrator of the hospital and Mr. Randolph was really pleased with the idea of getting this program started. The medical staff, however, apparently had a meeting, discussed the possibility of having obstetricians at Keams and they turned the whole plan down. They apparently wanted to keep Keams Canyon Hospital a "general practice type of experience" and they didn't want obstetrical specialists telling them what to do. The result was, more babies were born with problems which will result in mental retardation, seizure problems, learning problems, etc. as they get older. This could have been avoided.

I think that the administration could have asked "What is best for the patient?" Instead the administrator gave in to the staff and the patient suffered. I know that you realize that during the past 5 to 10 years, much of the progress in medicine has been in this area. The area of good prenatal care, monitoring of labor and the prevention of birth damage at the time of delivery. To me it was like rolling the clock back 30 years when I entered medicine, when any Tom, Dick and Harry with an M.D. degree could deliver babies. I am sure this isn't what the Health Education and Welfare want, certainly the tribes deserve something better.

The fact that I was unable to convince the chief of staff the administrator of the hospital and the nurses that something needed to be done in this area has weighed heavily on my conscience. As a citizen of the United States, what government does, at least in part, is my responsibility and that of other citizens. That is why I am writing this letter.
Mr. Bradley H. Patterson Jr.

I would like to see the Indians have good obstetrical care and knowing Jerry Ford, I am sure that he would want to help the Indian mothers. I pointed out a way that at least temporarily, these mothers could have had good care and the administrator turned it down. Why?

I am enclosing copies of my letter to Dr. McCammon in Phoenix and also my letter to you, to be sent to Mr. F. David Mathews, Secretary of Health Education and Welfare, Office of the Secretary, North Building, 330 Independence Ave., S.W. Washington, D.C. 20201.

I hope that you will send these copies to the Secretary if you feel that it is appropriate to do so and you feel that he could do something to help. The letter indicates only a few of the things I found that could be improved at Keams Canyon but the thing that weighs heaviest on my mind is the fact that babies were allowed to be born inappropriately when it could have been avoided.

Sincerely,

Mark W. Dick, M.D.
MARK W. DICK, M.D.
308 E. Ohio St.
Gunnison, Colorado 81230

September 1976

Charles MacCammon, M.D. Director
Phoenix Area Indian Hospital Services
801 E. Indian School Rd.
Phoenix, Arizona

Dear Doctor MacCammon:

Having completed an eleven month tour of duty at Keams Canyon Hospital, Mr. Glenn Randolph asked me to write to you about my impressions of the hospital. My wife, Louise Schnute Dick, also a pediatrician, worked as a volunteer for the same period.

When I arrived for duty July 1, 1975, Glenn Randolph asked me to make suggestions whenever I felt medical services could be improved. Specifically, he wanted a survey of the Children's Center on the Hopi Reservation. He also stressed the need for helping out with an in-service nursing program. I was to work in the outpatient department where at least 50% or more of the patients were in the pediatric age group and act as a consultant when requested by the commissioned medical officers.

I don't know why Glenn asked me to write this letter to you, but suspected he felt maybe an outsider's view might be helpful. At least these are my impressions and thoughts about Keams Canyon Hospital. Most of these are on file in my folder in Glenn's office, unfortunately only a few could be implemented while I was there. I met a lot of resistance to any change on the part of the nursing staff and the medical staff.

1. Maintenance Department. I felt that the physical plant was well maintained and improvements were being made or planned. The need for a larger waiting room space was recognized and I felt should have had a higher priority than doing over the outside of the hospital and landscaping the grounds. If one has a good waiting room, in a hospital such as Keams, it can be put to good educational purposes with films, tapes, etc. on medical subjects, sanitation, how to handle the ordinary type of illnesses that children are prone to develop.

During our stay to Keams, the home that we were living in on the medical complex, was painted and I don't think that I have ever seen a poorer paint job, much of the paint got on the windows and doors. Also while we were there, they "insulated the attic." I am positive the amount of insulation that was put in would accomplish nothing. Coming from Colorado where we have rather severe winters, I am familiar with the types of insulation and the amounts that are needed. The amount used was simply not enough.
2. House-keeping. This area was excellent, the hospital was kept very clean and under very trying conditions, I think they were to be congratulated.

3. Library. The library was in poor condition when I arrived there, but suggestions were made. They did have a librarian come and get rid of a lot of old books that were of no value and outline a program for getting some new books in all of the different disciplines along with the current journals which are of value including "Pediatric Alert" which is edited by Sydney Gillis.

4. Record Room. This department had an excellent filing system and excellent recall. The records themselves however were disappointing. This was especially true of the OB and newborn records. I made every effort that I know how to get the doctors to improve their records in the newborn area during the neonatal and delivery periods. I failed completely because as one doctor stated, "in no way, will we spend time doing that."

5. Dietary. The facilities seem to be adequate and were well run. I think they could make more use of dietitians than they were doing. I found that food handling examinations and stool cultures were not being done at frequent enough intervals and were only being done on those that were working in the kitchen. Nurses, nurses aides and practical nurses are food handlers and no examinations of this group were being made.

6. Pharmacy. The Pharmacy was excellent. Pharmacists were a big help to busy clinicians. Clinical judgment by the physician would be questioned but they always respected the doctor's viewpoint. I tried to get a record established for every mother during pregnancy and delivery and have this put on a special area of the chart. This could be easily surveyed by the pediatrician when the baby was born in trouble. I was a little disappointed that the pharmacy didn't push this idea.

7. X-Ray Department. Doctor Wood's help in this area was excellent. I don't think it could be equaled anywhere.

8. The Laboratory. I thought the laboratory was well run, the Chief Technician complained that he didn't have enough help. Probably he was right. For this reason, he complained that there were too many cultures and spinal taps and that we ordered more lab work than we needed. I think this was not true. If anything, we ordered fewer cultures than we should have, because we really didn't get much help.
Charles MacCammon, M.D., Director

from them. The cultures from the satellite clinics, after 3 o'clock in the afternoon, were just left standing at room temperature and were not plated until the next day. Sometimes there was a lapse of 24 or 40 hours. There was no culture media for whooping cough and I saw one case during this period of time. During the year, many new tests were added, such as blood gases, serum levels for anti convulsive drugs, digitals levels, etc, all of this added to the load of the laboratory staff. They probably do need more help.

9. Nursing. This department showed a wide range of competency or lack of competency. Isolation techniques were generally disregarded, a knowledge about keeping intravenous running was nil, there was no in-service training of nurses. I gave three lectures in July and the Director of Nursing then said, she could not spare the nurses from the floor, not even for 45 minutes a week, "patients needed them more." I'm sure it wasn't the quality of the lectures, because none of the other doctors were giving any lectures to the nurses. Many of the graduate nurses said that the lectures I did give were exactly what they needed. The Director of the Social Service Department said that when she came, the Director of Nursing was so pleased, that they would now be able to have lectures but she never arranged for it. The dietitians don't lecture to the nurses, to keep them posted on food problems, formulas, etc.

I felt that the Director of Nurses' comments about patients and parents could not be verified and on some occasions were proven false. I feel that the nursing situation at Keams Hospital will never improve until they get a well trained nursing director.

10. Outpatient Department. This department is generally very good, but there is no facility for isolation of measles, chicken pox or any other contagious diseases. This could be corrected without too much changing, but it is being ignored. A very sick child sometimes isn't recognized during the registration process or in the screening room and doesn't get seen promptly. For the present staffing, I don't feel that they have to close up the outpatient department from 12 noon to 1 p.m. They could stagger the hours for the nurses, LPN's, emergency technicians, etc. The same could be done with the laboratory, X-ray and the pharmacy. Some of the specialty clinics, such as diabetes need re-evaluation. I don't believe they are doing a very good job. During the year, we did establish a chronic disease clinic, chiefly to take care of the convulsive disorders so that one person could more or less supervise it. This has helped a little, but I think it could be improved. The big problem of chronic diseases, such as diabetes hypertension, obesity, eye problems, ear problems, etc, are not given proper follow-up and nobody seems to care whether they return for rechecks at the proper time or not.
11. Field Health Nursing. This department functions surprisingly well in spite of the fact that supervision is poor and the medical direction for the field work is practically nil. When I requested that there be a field health survey on salmonella, shigellosis, otitis media, pneumonias, etc, the nurses in the field were anxious to carry out these assignments, but they weren't too successful in remedying problems. In this area again, in-service training is practically negligible. I think this could be corrected and could have a very active department that would accomplish a great deal.

12. Medical Education. A few months before leaving, a Director of Medical Education was assigned to Keams. I think that she, if given support by the medical staff and the director of nurses and dietitians will accomplish a great deal for the tribe. I stressed the importance of prenatal education for mothers and fathers to be and outlined in detail all of the subjects that should be covered and by whom and gave them to the medical chief of staff. He turned them over to the medical education director and as far as I know nothing has happened.

13. Prenatal Clinics. A real effective prenatal clinic does not exist at Keams Canyon Hospital. Without a prenatal clinic, the infant mortality and morbidity rates rise. This is exactly what is happening at Keams. There is no real effort being made to identify the high risk mother and baby. At a hospital that does not have the facility for doing a section, I think it is doubly important to recognize these mothers and babies early and arrange for their transportation to Phoenix.

I suggested that it might be wise to have help from voluntary obstetricians. The Executive Secretary of the American Association of OB and Gym, in a letter which he wrote to Glenn Randolph, agreed to send a board certified OB man to Keams, a different one every month for a whole year (if needed). The hospital would just pay for the traveling expenses and provide a house. I was personally aware that the OB Executive Secretary in Chicago was anxious to carry through this program. Either Mr. Randolph or the medical staff disapproved it. Mr. Randolph at first seemed to be anxious to have this take place until he talked to the staff. I have a feeling that the staff, who are oriented to a family type of practice, resented having a board certified man around to tell them how to deliver babies.

14. Obstetrics. The quality of the obstetric practice at Keams Canyon Hospital is sub-standard. It reminded me of the obstetrics that I saw 30 or 40 years ago when every Tom, Dick and Harry and an
Charles MacCammon, M.D., Director

M.D. would deliver babies. Two of the medical officers, when they came in July 1976, had never delivered a single baby. The others had variable training from a few babies that they delivered to a year in a general hospital. As an illustration, babies a few days before delivery, the mother's chart would be labeled a vertex delivery and at the time of delivery, it was actually a breech delivery. There was no monitoring during labor. There was no way to tell if the baby was in distress. Meconium stained babies were much too common. While most of these babies lived, many of them will be retarded. During the course of the year, we saw many of these babies back in the outpatient with seizures. I think that this is an area that should no longer be tolerated. Much of the progress in medicine, during the past 5 to 10 years has been in the field of neonatal care and delivery. Babies have a right to be well born and they are not being well born at Keams Hospital. Just from an economic standpoint, it would be profitable to have an obstetrician supervise the OB department. One baby that I saw delivered at Keams and in distress at the time of birth had an Apgar of one or two at 1 minute and only 3 at 5 minutes, was sent directly to Good Samaritan Hospital at Phoenix. The baby was there for several weeks and then was transferred to the Phoenix Indian Hospital. This baby alone in the neonatal period, ran up a bill of about twelve thousand dollars according to Glenn. I think the prevention of one or two of these would justify the expense of a good obstetrician. I don't think you can justify assigning 7 medical officers, two of which had no obstetrical experience and expect them to accomplish a good job. It isn't fair to the doctor. It certainly isn't fair to the baby. It isn't fair to the tribe. I think this must be corrected.

15. Newborn Records. The present records are inadequate. I suggested more complete physical exam forms of the check off type which would yield much information. This was rejected by the medical officers. One of the doctors said, "In no way would he take time to fill out a record of this type." Examinations to identify the small for date baby, was also rejected, they simply wouldn't consider it. They wouldn't do the simple shake test on the gastric contents to identify the baby that is prone to develop hyaline membrane disease and could be sent to Phoenix earlier before it developed.
16. Immunizations Records. The present system is inadequate. Immunizations often didn't get recorded, either at the clinic, on the clinic sheet or on the mother's card. The cards get lost, patients change clinics. The type of material used if not recorded nor the lot number or manufacturer. All of these things are important when trouble is found in the child. I think there is a need for either a manual or a computer type central recording system. I talked to people that are knowledgeable in computer techniques and they tell me this could easily be done without too much expense and perhaps along with their social security data.

17. Reporting of Contagious Diseases. Reporting of contagious diseases was being done only rarely at Keams Hospital. After I started reporting all diseases required by Arizona law, some of the doctors did start to report some cases, but it certainly was in no way a complete record. With my reporting contagious diseases (and I was seeing most of the children at the clinic) there was an increase in the number of cases of salmonella, shigellosis and measles. This seemed to upset Dr. Carlisle at Phoenix as he felt that we didn't know how to diagnose these diseases. This is not true. Actually, Dr. Carlisle was quite well informed as to lack of disease reporting at Keams, but he did nothing about it.

18. Problem of Gastroenteritis. Year after year, salmonella and shigellosis ravages the Hopis as well as the Navajos. Little has been done to prevent this disease. A great deal is talked about treatment and it is true that we have saved a lot of them by proper intravenous fluid regulation, but it seemed to me something should be done in the field of prevention. As an illustration, there was poor sanitation on the Hopi Reservation. The outhouses were on the edge of the Mesa and the excreta fell down the side of the cliff. Flies were very bad, there was no screening, no water except what was carried up and very little hand washing. It is no wonder we had trouble and I think we know the answer to control these diseases. It is a question of proper education and proper facilities.

I understand that a cadre from disease control in Georgia is going to try and study this problem this summer. When you criticize what is being done, you become unpopular with the director and the medical staff and you are also unpopular with the tribe. They don't want to know how bad their medical problems are in some areas.
MARK W. DICK, M.D.
308 E. Ohio St.
Gunnison, Colorado 81230

September 1976

Charles MacCammon, M.D., Director

19. Lack of Water. Without water the Indian falls prey to many diseases. The list is a long one. How can you teach sanitation without water to wash your hands. I don't think we are doing a very good job of supplying water to the Indians. We go on year after year and let them have these problems. Yet on the radio, some weeks ago I heard our Secretary of State on a trip to Africa, promise some of the countries there, that the USA would "move the desert back." I have heard some of the Indians make the comment, "why can't the federal government roll some of our deserts back so that we can have some water." This could be done. I think we have neglected this area much too long.

20. The Indian Schools and Educational System. During the past year, I reached the conclusion that most of the education efforts were poor. From a pediatrician's viewpoint, it is not good to take a child out of the home to go to kindergarten or first grade and keep him in a boarding home, cut off all ties with his family for so much of the year. Children certainly don't learn well and I think the whole system ought to be re-evaluated by people that are knowledgeable in this area. We have done a poor job.

21. Social Service Department. I think this department was excellent. The personnel were knowledgeable, had good programs in all areas and responded quickly to an emergency situation.

22. Mental Health. I felt this department was excellent, they have devised alcohol and drug programs. Mr. Percy Povetaa, himself a Hopi, seemed to be well trained. He understood the problems of both the Hopi and the Navajo and was respected by both tribes.

23. Dental Department. This department is excellent. I find that the old people were well taken care of. I felt the children however, needed stronger educational programs, as there was a lot of dental caries that I think could have been prevented. The amount of fluoride in the water at Keams seemed to be adequate from all the information I could get, but I think that there were areas on the reservation that fluoride with their vitamin drops was indicated.

24. Ophthalmology Department. The control of trachoma was excellent. There was no trouble in getting refractions, I thought they had a very good program.
25. When I am asked what were my greatest disappointments during the year I spent at Keams Canon, I would have to say:

A. Rejection by the staff, the chief of staff and the hospital administrator of the plan, to have
   1. A well trained obstetrician come, a different one each month for a year, to set up an adequate neonatal clinic, instruct in the proper techniques for monitoring and identifying the high risk baby and mother during labor.
   2. The evaluation of the newborn baby with physical and neurological examination to identify the small for dates baby.
B. Rejection by the director of nursing, to have any type of in-service training. I don't think this can be justified.
C. Failure to establish good neonatal, delivery and newborn records.
D. Failure to establish expectant parent classes.
E. Discovering that doctors, nurses, administrators, etc., when confronted with a problem, have not yet learned to ask themselves "What is best for the patient?" and be guided by that answer.

Sincerely,

[Signature]

Mark W. Dick, M.D.
October 25, 1976

Mr. Brad Patterson
White House
Washington D.C. 20500

Dear Mr. Patterson:

It is exciting to know that you can do something to help us keep going in the project we started, and have maintained for a year and one-half now.

During the NCAI we met with you personally and handed you the summary of our program, hoping you would look at it and find some to facilitate funding for our Urban Indian Clinic.

We certainly need the funds now to continue operating in the capacity we had been and certainly even exceed the volunteer work we had done. We desperately need administrative money.

Enclosed are some copies of our program and summary of what we have accomplished.

Looking forward to your response soon.

Sincerely yours,

Elders & Elders
Speranza A. Popara
Health Co-ordinator
Ms. E. Mopara, RN
Traditional Indian Alliance of Greater
Tucson, Inc.
P.O. Box 26723
Tucson, Arizona 85726

Dear Ms. Mopara:

Mr. Brad Patterson of the White House staff has asked me to reply to your letter of November 1. The newsletter and other materials you enclosed concerning activities of the Traditional Indian Alliance of Greater Tucson, Inc. (T.I.A.) are very much appreciated.

In the matter of funding, the situation remains the same as we discussed. No additional funds for urban health programs were allocated in FY 1977. We are now looking toward the possibility of funding to implement Title V of the Health Care Improvement Act. This funding would, under the legislation, not be available until FY 1978.

You will be apprised of developments in this program as they progress.

Sincerely yours,

Emery A. Johnson
Assistant Surgeon General
Director, Indian Health Service

cc: Mr. Brad Patterson
OTA/IHS
DCID/IHS
IHS/IH/DCID (HVNansen:bkr 11/30/76)
November 1, 1976

Mr. Brad Patterson
White House, Washington
D. C. 20500

Dear Mr. Brad Patterson:

Thank you much for calling us. We were all excited to hear from someone in the White House.

According to Traditional Indian Alliance director, Joan Chaudhuri, we never received a letter explaining that we could not be funded. It was through telephone conversation that we got the no answer.

Enclosed are the materials we would like you to look at.

Copies of some literature had been sent to Dr. De Montegny and Dr. Johnson. Also to Wes Halsey.

Sincerely yours, 

E. Mopexa, R. N.

Enclosure
Dear Mrs. Matthews:

Your letter to President Ford concerning the sterilization of Indians has been forwarded to us for reply.

The account which recently appeared in the news media resulted from misinterpretations of a Government Accounting Office Report regarding the Indian Health Service. There are no suggestions in the report that the IHS has undertaken any activities to sterilize Indians without their knowledge and consent.

The three-thousand four-hundred (3,400) figure referred to in the newspaper article were surgical procedures performed over a four year period which could have resulted in sterilization. Many operations are performed for medical reasons unrelated to the intent to sterilize but result in sterilization. For example, if a woman had cancer of the uterus, and received an operation for same, she would be identified as having been sterilized.

The number (3,400) is overstated and may give an erroneous impression. For example, one woman could have two procedures which result in sterilization such as a tubal ligation for sterilization purposes and a subsequent hysterectomy because of a specific uterine medical condition. A GAO spokesman states, and IHS agrees, that reliable national statistics are not available to allow valid and reliable comparison of sterilization rates. However, the best data available indicate rates of procedures resulting in sterilization among Indians are comparable to or somewhat lower than the rates of such procedures performed for the general public.

It is not the policy of the IHS to sterilize Indians as a means of controlling population size. As part of a comprehensive health care program the IHS provides, within the resources available, a full range
of family planning services including sterilization. Such sterilizations are provided only with the full consent of the Indian persons, 21 years of age or older, requesting this method of family planning.

Your concern for the welfare of the Indian people is appreciated.

Sincerely yours,

Emery A. Johnson, M.D.
Assistant Surgeon General
Director, Indian Health Service

cct: Brad Patterson, The White House
Dear President Ford,

Know you are terribly busy, but I enclose your dangerous note, and I am hoping you will know what to continue to look into this shameful thing.

How are we any better than the German Nazis in their persecution and destruction of the Jews?

Please try to find the time to look into this shameful matter and the Statesmen? These, too, are Americans.

Thank you,

Sincerely,

Max Dority Dumas

2205-26, 2nd South
Birmingham, Ala. 35223
WASHINGTON (AP) - A federal study has confirmed that the Indian Health Service has sterilized thousands of Indian women without obtaining the proper consent from them.

The General Accounting Office said Monday that a survey of Indians in just four areas found that 5,400 were sterilized during a four-year period. The total among all American Indians was probably much higher, the GAO said.

The files on the operations indicate the women often were not told the sterilization operation was optional, not mandatory.


The GAO said the sterilization consent forms found in the files of the health service "were generally not in compliance with the IHS regulations."

The most widely used consent forms gave no indication whether the patient had been informed of her right not to consent to sterilization nor did they contain a written notice of such rights.

Abourezk said 30 percent of the sterilizations were performed outside IHS facilities on a contract basis.
ANALYSIS OF
GAO REPORT/PRESS REPORTS ON
INDIAN STERILIZATIONS AND RESEARCH

The information contained in this report is in response to recent publicity regarding the Government Accounting Office report on research and sterilization among the Indian people. The information is intended to clarify any misunderstandings or misinterpretations which may have resulted from press reports on the subject.

The recommendations of the GAO are generally acceptable to the Indian Health Service and many of these recommendations have currently been implemented by the Service. The GAO recommendations regarding sterilization are as follows:

"We recommend that the Secretary of HEW direct the Indian Health Service to

-- expedite its efforts to have a standard consent form which provides for full disclosure of the information required by the regulations (enc. IV shows a form that could serve as a guide to counsel patients and which details all the basic elements of informed consent),

-- provide training to their physicians and administrators so that they fully understand the requirements concerning (a) sterilization of persons under 21 and persons who are mentally incompetent and (b) obtaining informed consent,

-- include in the contracts with non-Indian Health Service physicians and facilities, provisions to insure that contractors comply with HEW sterilization regulations,

-- continue to monitor compliance with the moratorium on sterilization of persons under 21 years of age, and

-- develop monitoring procedures to assure compliance with the regulations by contract physicians and facilities."

IHS action to date includes:

At a 11/18/76 session between the Director, IHS; Area Maternal and Child Health Consultants and others, it was agreed that an approved PHS developed narrative "Booklet" consent will be used on an interim basis in addition to the approved HSA-83 form which has been used since March 1975. Efforts will continue to develop an IHS sterilization consent form which is sensitive and responsive to unique Indian needs. The Area MCH Consultants promised enhanced efforts to provide training to administrators and physicians regarding the HEW requirements for obtaining informed consent and the moratorium on sterilization of persons...
under 21 years or mentally incompetent. Activities to assure that all contracts with non-IHS health service providers include provisions to stipulate compliance with HEW sterilization regulations and additional mechanisms to monitor compliance with such provisions will be conducted. Data regarding current activities as concerns contract provisions and monitoring was requested from IHS Areas on 11/26/76. Most IHS Areas have responded and initial reports indicate much current activities in this respect although definite improvements are necessary.

IHS will continue its strict monitoring of all sterilization of persons under 21 years and mentally incompetent and will investigate in depth any potential violations.

We have observed nothing in the report suggesting that the IHS has undertaken any activities to improperly sterilize Indian men and women. A GAO spokesman stated, and the IHS agrees, that reliable national statistics are not available to allow valid and reliable comparison of sterilization rates. However, the best data available indicates rates of procedures resulting in sterilization among Indians are quite similar to the rates of such procedures performed for the general public, i.e.:

Bilateral Tubal Ligations and Hysterectomies Rates per 100,000
Among the Female Population, 15-44 Years of Age, for Women Discharged from IHS and U.S. Short-Stay Hospitals

<table>
<thead>
<tr>
<th></th>
<th>Tubal Ligations</th>
<th>Hysterectomies</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. short-stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,608.8</td>
<td>908.6</td>
</tr>
<tr>
<td>IHS Total</td>
<td>1,103.8</td>
<td>403.7</td>
</tr>
<tr>
<td>Four IHS Areas Studied</td>
<td>1,154.5</td>
<td>433.8</td>
</tr>
</tbody>
</table>

1/ CY 1974 - NCHS Unpublished Data
2/ FY 1975 - IHS data

We have found the GAO report basically fair, constructive and responsive to the issues, however, we have observed the following inaccuracies and misinterpretations by some media regarding what the report allegedly states.

Allegation: "Indian women are being sterilized as a birth-control procedure without their consent or knowledge."

Facts: The IHS can find no basis at all for this statement. The GAO report makes no such statement.
Allegation: "3,001 sterilizations were performed by the IHS on women of child-bearing age between 15 and 44."

Facts: This is stated incorrectly. Three-thousand and one (3,001) procedures were performed during a four-year period which could have resulted in sterilization. Many operations are performed for medical reasons, unrelated to the intent to sterilize but result in sterilization. For example, if a woman had cancer of the uterus, and received an operation for the same, she would be identified as having been sterilized.

The number is overstated, and may give an erroneous impression. For example, one woman could have two procedures which result in sterilization, such as a tubal ligation for sterilization purposes and a subsequent hysterectomy for uterine prolapse.

Allegation: "Thirty-six (36) women under the age of 21 were sterilized during this (3 year) period despite a court-ordered moratorium on sterilizing persons under the age of 21."

Facts: All but 13 of the 36 procedures were performed prior to the date of the issuance of specific Departmental regulation including the moratorium on sterilizing persons under 21 years of age or mentally incompetent. These regulations were promulgated in April 1974. Furthermore, GAO notes that 7 of the 13 procedures performed after this date were "performed for legitimate serious medical reasons."

Allegation: "The report indicated that there may not have been informed consent by the patients as required by law and that the consent forms in the IHS medical files were generally not in compliance with IHS regulations."

Facts: The GAO report states, "We found no evidence of IHS sterilizing Indians without a patient consent form on file, although we did find several weaknesses in complying with DHEW's sterilization regulations."

Allegation: "Thousands of American Indians sterilized are used as medical guinea pigs in violation of Federal safeguards."

Facts: There is nothing in the GAO report to substantiate this statement.
Allegation: "Thirty-six sterilizations also violated the provisions of a 1974 Court Order which prohibited the operations except under certain specific conditions."

Facts: The Court Order stated that one cannot sterilize a minor. The Court Order did not apply to the IHS, and therefore, technically whatever was done was not in violation of the Court Order. In addition, all of the 36 procedures were performed on individuals over 18. The age of consent for medical treatment in most states is 18 years or less.

Violations occurred in regard to the Departmental regulations promulgated in April 1974 which imposed on IHS as absolute prohibition on sterilisation of women 21 years of age or younger. Only 13 of the 36 procedures were performed after this date.

Allegation: "Patients were not adequately informed of their rights."

Facts: Nowhere in the GAO Report is this statement made.

Allegation: "Fifty-six medical experiment projects used Indians as subjects."

Facts: The GAO Report stated, "We reviewed 56 proposals for research projects and of the 36 projects entailing a service or treatment to Indians, we concluded that none appeared to expose participants to serious risks."

"Our review of patient consent forms at selected projects did not indicate any significant inadequacies."

The GAO Report points out that IHS policy promotes research projects and activities provided (1) the projects are directed toward improving the health of Indians and that (2) projects have the approval of, and are understood by the tribal groups involved. The report briefly discusses research projects carried out within the IHS and cites significant benefits achieved through the projects in prevention and treatment of illness among the Indian people.

Indian Health Service
December 8, 1976