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

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 the College 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.

Dine' Bits'íís Baa O'lta'go Bił haz'á
NAVAJO AREA HEALTH EDUCATION CENTER
NAVAJO HEALTH AUTHORITY
P.O. BOX 643
WINDOW ROCK, ARIZONA 86515

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AHEC is a component of the Navajo Health Authority.

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BRAD PATTERSON

PARTICIPATING in the groundbreaking of the NHA-AHEC Family Health Center, Shiprock, N.M., were: from left: Dr. Donald Megill, Dr. Luverne Husen, Mrs Harriet Goodluck, R.N., Dr. Graham Watkins, Dr. Taylor McKenzie (with shovel), Dr. Merle Pennington and Mrs. Shirley Lowe.

VOLUME 1 NUMBER 1 JUNE 1976

Family Health Center Keeps Families Well

The empnasis of the Navajo Health Authority Family Health Center, Shiprock, New Mexico, is preventive medicine: keeping their 560 families well rather than just treating their episodic illnesses.

The primary goal however, is to develop an accredited family practice residency program on the Reservation.

The philosophy behind this, according to Dr. Merle Pennington, director of the center which opened in January, is that doctors who do their residency in a rural area will be more likely to establish a permanent practice in a rural area later.

"The success of our program depends, to some extent on our selection process. First, the resident physicians must be interested in a rural placement; and secondly, they must be self-reliant," he explained, "especially on reservations where specialists are not readily available."

When the center is fully operational, up to 18 residents will spend three years in the program; the first year will be spent at the University of New Mexico Medical Center; the last two at the Family Health Center in Shiprock.

The first full-time resident began last January; the second resident will start in July; but to begin with, rotating residents from other residency programs who will spend up to six weeks at the center, have been scheduled through February 1977.

To develop a patient load, Dr. Pennington ran an imaginary line around an easily definable area of Shiprock; from the San Juan River east to the hogback (a rocky ridge descending from the Rocky Mountains) and north to the Reservation line. Then, before the clinic opened, the entire staff canvased the area telling the inhabitants about the new center.

Through the cooperation of the Indian Health Service hospital, all Indian patients from the identified area are now referred to the Family Health Center. This includes Anglos who live inside or outside the area but who have not had medical services available in Shiprock before.

The patient load is purposefully controlled because the clinic is a teaching center. Although the resident physicians do much of the clinical care, such as taking medical histories, doing physical exams, and treating patients, the staff doctors must give close supervision.

"We will arrive at a diagnosis together; they may do some additional research or library work and they will come up with a treatment plan which we will discuss together," Pennington explained.

Teaching responsibilities will eventually involve not only the full-time staff but also physicians from the Indian Health Service, from private medicine in the surrounding communities, and from the consortium universities.

The trim 2,900 square foot Family Health Center, was established because several agencies cooperated.

First, the Shiprock Health Board and the Indian Health Service hospital lent their support.

The Navajo tribe provided the building and the tribally operated Navajo Health Authority provides administrative and technical assistance.

The program is supported by an Area Health Education Center contract from the Bureau of Health Manpower, to the university of New Mexico, Department of Family-Community, and Emergency Medicine.

The academic institutions involved in the initial planning were a consortium of Family and Community Medicine Departments from the universities of Arizona, Utah, Colorado, and New Mexico. Other assistance has come from the University of Rochester, Family Practice Department, and Overlook Hospital-Columbia Presbyterian Family Practice Residencies, the University of Utah, Maternal and Child Health Project, and others.

AHEC Supports Health Professions Training

The goals of the Navajo Health Authority and Area Health Education Centers, as established by Congress in 1971; were practically the same.

The first goal of NHA was to develop health manpower training programs to support the development of the American Indian School of Medicine.

AHEC's were to improve the quantity, quality and geographical distribution of all health personnel. So it was natural that the Navajo AHEC should become a component of the Navajo Health Authority.

AHEC's grew from attempts to answer the question, "How can medical education be designed to better fulfill the health needs of Americans in the 70's and 80's.

The 1970 Carnegie Commission on Higher Education recommended that health professional education be revised to coordinate with changes in existing patterns of delivery of health care. Part of that recommendation was to develop AHEC's in medical centers.

Eleven AHEC's were established across the country in 1972, under 5-year grants. The Navajo Area AHEC is a subcontract from the University of New Mexico medical center; the only AHEC on an Indian Reservation.

It was natural that an AHEC should be here-the main thrust of AHEC's is on the production and distribution of primary health care personnel for underserved areas. Particular emphasis has been placed on the development of regional residency training programs and rural clinical practice for medical students.

Another AHEC emphasis is continuing education for all health care delivery team members as well as patient and consumer health education.

Again, these goals fit in to the overall plan of the Navajo Health Authority.

Since the AHEC was established, many programs have been successfully carried out in health education.

The stories of some of the current programs are told in this edition of the AHEC newsletter. Because the AHEC programs are vital to the Navajo reservation residents, and because community support is equally necessary to the AHEC programs; the Navajo Times was selected as the delivery medium because of its high readership across the reservation.

The AHEC Arrow symbol describes another aspect of AHEC-people: people learning about health care. AHEC programs are directed at you-whether you are a consumer or provider of health care.

People fill the AHEC arrow.

251 Students Helped By AHEC-Kellogg Funds

Two hundred and fifty-one Indian students have received financial assistance since the Navajo Health Authority Office of Student Affairs opened in 1973; 46 have graduated from a variety of allied health programs.

Thus, the Office of Student Affairs, with grants from the Department of Health Education and Welfare and the Kellogg Foundation, is fulfilling one of the basic goals of the Navajo Health Authority and the Area Health Education Center.

Eight graduates received their master's degree in Public Health, nine received registered nurse certificates or higher nursing degrees, and seven received a bachelor of science degree and have entered medical or veterinarian schools. Three are doctors now into their residency programs.

The others graduated in a variety of allied health programs: nurse midwifery, nurse practitioner, medical records, health education, physician assistant, certified laboratory assistant, and surgical assistants among them.

To keep the dropout rate of the students as low as possible, the Office of Student Affairs offers continuous emotional support to the students, including a yearly visit to each student at school by one of the Student Affairs counselors. Although few students needed it, a job placement program assists graduates in finding a permanent job.

To keep a supply of interested students coming, the Office of Student Affairs has a Summer Work Experience Program for high school and college students. Because of the popularity of the program which places students in the health career field of their choice for eight weeks, 75 job slots were created for students during the summer of 1976; only 25 could be hired in 1975.

Ms. Kay Blosser

NCC Offers MLT Plus AA Degree

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 of arts 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 used 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 assistants. 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 mostly administration which she finds exciting. "Of course, starting a new program also is exciting as well as challenging," she added.

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

"They want to know my background, the instructors' background, and the content of the courses. We must have an overall director of the program who is a clinical pathologist."

"The first year will be equivalent to any freshman year in college with an emphasis on science," 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."

AHEC Sponsors Symposium Programs

Two Area Health Education Center sponsored programs will be part of the third annual Navajo Nation Health Symposium to be held August 9 through 12 at Navajo Community College, Tsaile, Az.

They are a trauma seminar for physicians to be offered by the Navajo Health Authority Emergency Medical Services and the fourth NHA-OSA Ned Hatathlie health careers seminar of the year.

"A Long Walk to Health, a Look at the Past, Present and Future of Indian Health Care" is the theme of the conference which is sponsored by the Navajo Nation Health Association, the Navajo Tribe, the Indian Health Service and the Bureau of Indian Affairs.

The four-day session will be filled with speeches, panels, exhibits, demonstrations, cultural activities and a film festival; all leading to the increase of knowledge and skills of health concepts by health professionals on the Reservation.

Three of the featured speakers will be Dr. David Matthews, Secretary of Health Education and Welfare; Dr. Louis Hellman, director, Health Services Administration, DHEW, and Dr. Emory Johnson, director, Indian Health Service.

Many other well known Indian health and educational professionals will participate in panels and be available to speak informally with conference participants.

Special sessions will feature an alcholism workshop, a health professions career recruitment workshop, and a health board seminar.

New this year will be a Manuelito Begay distinguished health services award, in memory of Begay, a medicine man in the Crownpoint area who lived to be over 100 years old and did much to improve the health status of the Navajo people.

Evening events include a barbecue, a traditional Navajo meal, pow-wow, modern and traditional music and a demonstration of Navajo native healing sciences.

Food and lodging are available at NCC; camping facilities are adjacent to the college.

Manpower Registry Completed

Approximately 1,500 Indian and non-Indian health professionals have been identified as part of the first health manpower registry of the Navajo Area. This registry is being compiled by the Office of Health Statistics and Research of the Area Health Education Center. Name, age, sex, occupation, job location, and ethnicity are part of he information gathered which is being coded and computerized.

"Who wants it?"

Many agencies. Registries are an invaluable tool for planning and analyzing health resources on the reservation. They can show distribution, numbers, turn-over, and other data essential to developing and maintaining adequate health care levels in an area.

In fact, the National Center for Health Statistics will require all Health Service Agencies to develop a health manpower registry which is updated regularly.

States will develop their own registries: the New Mexico Regional Medical Program has completed its registry except for information on the Navajo portion of the area.

Information Desert Shocks Navajo Health Authority Librarian

It was a medical information desert. The hospitals had little more than a row of old medical journals. The newly developed Navajo Health Authority had only an empty room designated as a library.

But most important were the health professionals who worked on the 15 million acre Navajo Indian reservation. They often complained about their isolation and the fact they they were so far from medical resources. This had a great effect on their decision to continue to practice on the reservation.

Now, there are small core medical libraries in each Indian Health Service hospital and clinic on the reservation; many thousands of books and journals at the Area Health Education Center Media Center an extensive "Southwest Collection," and a tie-in with the National Library of Medicine's Regional Biomedical Network.

Isolated health professionals can be as medically informed as their urban counterparts.

How did it happen?

First a librarian was found whose enthusiasm and love of books radiated to those around her. Books were so much a part of her life that Ms. Elizabeth Hendryson was actually shocked at what she called the "information desert" of the reservation.

As she visited 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 books called the Brandon Core Collection be kept in every health care institution, plus some journal subscriptions to keep everyone up on health developments, and knowledge of where information beyond that was available.

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

Some books were put on loan in Indian Health Service facilities. Then came a $25,000 Indian Health Service-Navajo Health Authority contract to put an accredited library in each Indian Health Service service unit. By the end of the second year, all the IHS hospitals met the Southwest Pacific Regional Medical Library Advisory Board standards and the contract was renewed for another year.

Meanwhile in old book stores or from Publisher's Central and the best seller lists, Ms. Hendryson was collecting a wide variety of old and new literature on Navajos, other Indians medical uses of plants, and other subjects that might have a bearing on the far flung activities of the staff of the Navajo Health Authority.

So 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 Ms. Patricia Bradley, a Navajo, who graduated with honors from San Francisco State University and received her 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 catalogued, delivered, and shelved. Then there is the whole world of audio visual materials we want to get into as soon as we have more space."

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, "Indian Nurses Speak Out - Why 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 Bilagody, Roberta Moore, Rita Cowboy, Carol Todd, and Larry Roanhorse, who completed the requirements in December, 1975. Congratulations NCC Nursing graduates!

A nursing coordinator for the NCC Nursing Program has been hired. Ms. Lydia 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, Ms. Linda Robberson, who will arrive in August, has a master's degree in medical-surgical nursing and is an experienced associate degree nursing educator. She has been the Coordinator of the Cochise College Nursing Program in Douglas, Arizona. Effective May 11, 1976, the NCC Nursing Program has received continued accreditation from the Arizona State Board of Nursing and has been approved to accept new nursing students in the fall.

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 they didn't. The water samples were pure, although they did discover that the chlorine pump 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.

Several hundred miles away the scene was different. No one was notified when the first child came down with measles. Within two weeks over 235 people in the small community came down with rebella, the kind of measles that leaves 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 Kaltenbach, Director, Preventive Medicine, AHEC, who acted as a consultant to the local IHS field health operations.

That's the challenge he likes--preventing a disease before it infects more than the bare minimum of people.

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 The Family Health Center at Shiprock, New Mexico. His team is the clinic's residents.

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

"We get some false alarms. But even in the first incident I mentioned, we did a community service by discovering the broken water filter and showing the community that 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?

"It should be the hospitals, the doctors, but the method we have now is not responsive enough."

"The Ambulatory Patient Care Information cards filled out by the doctors as each patient is examined are premature. They don't tell us what the actual diagnosis is because they don't include laboratory work."

He paused, as if wanting his next words to sink in.

"There is a possibility that I can develop a weekly 'notifiable disease' report."

He paused again, but with a new glint in his eye.

I'm excited by this," the usually mild-mannered Kaltenbach admitted.

The present disease report used by Indian Health Service is a computer printout of APC forms. The report for March arrives in July. "I want to develop a current disease report. I want physicians to actually see positive results. Right now, I'm working with the directors 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 the four states bordering the Reservation. Each state 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 we'd want to follow are strep, reheumatic fever, rubeola, salmonellosis, tuberculosis, influenza and syphilis."

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

"The importance of this program is its effect on the incidence of rheumatic fever on the Reservation. The reported cases have gone down steadily in the last five years, but it will be five more years before we know how significant that is. The incidence curve has varied so much over the years 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 on it are Indians."

"We are currently following 315 active patients. Most of them will be on prophlatic medicine for at least 20 or 30 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 reheumatic fever was 45 in one year; the low was 15."

"Once again, we don't know why."

"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.

Workers Attend Nutrition Workshop

Over 100 cooks, food service personnel and counselors received up-to two hours college credit at a nutrition workshop in early June.

Two courses, taught at Navajo Community College, were sponsored by the Arizona Department of Education, which is holding similar conferences around the state.

Attending were counselors, food handlers, and cooks from WIC, public schools, BIA schools, private schools and Indian Health Service Hospitals.

"Nutrition and Foods" was taught by Dr. Alan Ackerman, instructor in Anatomy and Physiology at Navajo Community College. Dr. Ackerman is supported by a grant to Navajo Community College from the Area Health Education Center at the Navajo Health Authority.

"Food and Safety and Sanitation" was taught by Ms. Susan Foerster, dietitian with an M.P.H. degree, who works with the California Department of Health.

Animal First-Aid Offered To Area Residents, Students

Can you castrate a bull, dehorn a cow, or check an injured sheep for his vital signs?

What veterinary skills do you need to know? A unique course, now in its third year, offers practical veterinary techniques, and skills to animal owners and future veterinarians.

Sponsored by Navajo Community College, the Navajo Health Authority, and Colorado State University, the eight-week course offers six hours of college credit to eligible college students; yet is also open to high school students who hope to enter health careers or Navajos who own livestock.

It is a practical course, because there are only three veterinarians on the entire Navajo reservation, an area of more than 15 million acres and only limited services are provided by local veterinarians in towns near the reservation.

Dr. Gale Pate is director of the program and instructor of Animal Health Science at Navajo Community College.

Her assignment is to train animal health aids on the Navajo, Hopi, and Zuni reservations in Arizona and New Mexico, as well as develop an interest in an allied health career among the students. Because of the Indian's feelings for their animals, this seemed to be a good starting point to develop health professionals in any field.

The purpose of the program is to fill a void in vitally needed areas of veterinary care and range livestock management. Since livestock production is a major part of the Indian economy and livelihood, a lack of veterinary services is a cause for concern.

"If a serious animal health problem were to develop on the reservation, it could reach advanced or epidemic proportions before it is even detected," Dr. Pate said.

Thus, the Animal Health Science Training Program teaches Indian students how to recognize and treat common livestock diseases, how to manage sick animals, and how to use the common techniques and treatments which are needed in good livestock management practices.

The veterinary program at NCC is not limited to the summer session. Three or more classes in animal health sciences are offered each semester of the school year.

"We also are teaching trainees how to react to animal health crisis and to learn when to seek outside assistance," Dr. Pate said.

She pointed out that most veterinarians will give medical advice over the telephone if they cannot reach a distant location. To give advice they must know an animal's symptoms. After the training session, trainees should be able to give a veterinarian that type of information.

Dr. Pate, a 1969 graduate of Colorado State University's College of Veterinary Medicine, also provides veterinary care whenever her schedule permits.

Before coming to the Reservation, she was with the Peace Corps in Kenya, Africa, and had a private practice in Clovis, New Mexico.

A long-range goal of the program is to set up an animal disease diagnostic facility and a pre-veterinary curriculum through Navajo Community College in Tsaile, Arizona.

Pate said, "the final step of the program is to have Indian students trained well enough to make it through the Doctor of Veterinary Medicine Program at a recognized College of Veterinary Medicine.

A scholarship, in the memory of Dr. Wilson Francisco, the first Navajo veterinarian, for a Navajo veterinarian student at Colorado State University, was established in 1974 by the Francisco family and the Navajo Health Authority. Presently, over $1,500 is in the bank, waiting for the first recipient. Perhaps the first student will come from the Navajo Community College animal health science program.

ZONCIE NEZ, herblist from Hunter's Point, talks with Carl Gorman.

Hatathlis Talk To Carl Gorman

Carl Gorman, Director of Office of Native Healing Sciences has been talking to Hatathlis or medicine men; herbalists and diagnostitians the 'Navajo Way,' to get information for the first Navajo registry of Native Practitioners.

"You don't just go up and say that you want an herb for cancer or that you want to know what their specialities are," he explained.

"We don't go too fast. You practically have to live with them," he added for emphasis.

"First you find out their clan and tell them yours. Then you see if you have any clan relations."

"Later you tell them why you came."

At first the Hatathlis didn't want to be interviewed; they were afraid of giving their secrets away. But when it was emphasized that the information was to be reserved for future generations of Navajos, the Hatathlie cooperated.

The result is a few copies of a registry listing 550 native practitioners and their specialities such as a certain ceremony or other treatments that they perform, for use by the Navajos.

Now a second more ambitious study has been started: an ethno-medical encyclopedia which is funded by the National Institutes of Mental Health through Northwestern University.

Each of the practitioners listed in the Native Practitioners Registry who are willing to participate are being asked sets of 100 or more questions on subjects related to health: nutrition, disease, childbirth, pregnancy and others.

The final project will be over 10 volumes of information on how the Navajos feel and deal with their health--from the creation myths to their treatment of disease by modern or native methods.

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 mhz-- nationwide emergency medical system.

In the Navajo Health Authority region it is installed in most emergency

ambulances and in 16 health facilities. Emergency medical technicians can be in constant contact with a physician as they transport an injured person to the hospital.

Radio communications are one of 15 components of a total emergency medical system designed to save lives, being developed by the NHA-EMS under grants from the Department of Health, Education and Welfare and the Robert Wood Johnson Foundation. The Navajo Health Authority Emergency Medical Services was conceived originally under the AHEC contract. Now it is its own division of NHA althought it still receives AHEC support, especially in continuing education.

The area covers the Navajo, Hopi and Zuni reservations, where the highway accident rate is the highest in the nation. It is an area bigger than West Virginia, where a motorist can go for 250 miles without meeting a stoplight or passing more than 5 or 6 areas where a telephone is available.

Yet, according to director, Mike Lincoln, the area's EMS system is "advanced" by the Department of Health, Education and Welfare standards.

It's a well thought out plan.

For instance, the emergency vehicles operate on what Lincoln calls tiers.

On the top tier are the primary responders, or the first vehicles sent to answer an emergency call: $17,500, 2-patient ambulances assigned to 12 Indian Health Service facilities.

Next, at seven facilities in heavy accident areas are slightly older ambulances which serve as backup units.

Because of the limited specialized health care at many IHS hospitals, critical patients are often sent to larger medical centers. The third tier is 9 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 stablilize a patient's condition as they are transported to another facility--and don't tie 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 drive suburban vans, called "wolachee', or "red ants" 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 2 certified emergency medical technicians. This requires 80 hours of class work and training.

Since the program started two years ago, EMS has trained 188 EMT's, 29 percent women. They have also trained 145 others in basic emergency care techniques.

Also, now all Navajo police cadets 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.

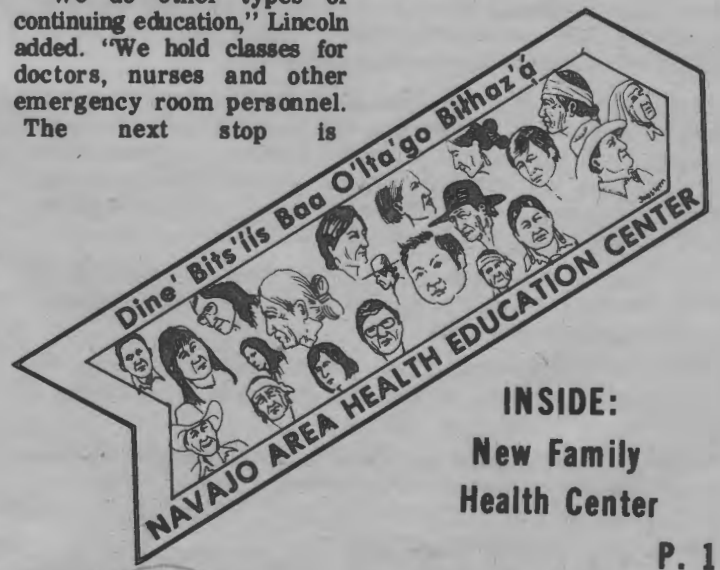
Presently, all EMTs receive a refresher course every six months, for an updating in what Lincoln calls their hand skills--bandaging, cardiopulmonary resuscitation, applying splints, etc.

"We do other types of continuing education," Lincoln added. "We hold classes for doctors, nurses and other emergency room personnel. The next stop is communications: without this vital link, nothing operates.

Each vehicle has two radios. One is a police dispatch radio which connects the ambulance to the police station. The second, part of the nationwide EMS system lets the EMT keep in constant contact with the hospital and the physician; through voice contact the doctor monitors the patients vital signs and assists the EMT in carrying for patient.

Does the system work?

That's what five types of evaluation will tell.



CY PROVIDED: J. MITCHELL
B. KILBERG
B. PATTERSON
J. BROWN
E. JOHNSON

THE WHITE HOUSE

WASHINGTON

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 recision 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).

more

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 which 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.

# # # #

MARK W. DICK, M.D.
308 E. Ohio St.
Gunnison, Colorado 81230
303-641-3790

October 23, 1976

Returned by phone 11/1/76

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, Phoeniz, 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 priveleges 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.

Copy sent to Dr Ens. - HHS for further follow-up

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

October 23, 1976

Mr. Bradley H. Patterson, Jr.

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.

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

October 23, 1976

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.

MARK W. DICK, M.D.
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September 1976

Charles MacCammon, M.D., Director

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. Pharmists 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

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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, digitalis 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 intraveous' 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 varified 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.

MARK W. DICK, M.D.
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Charles MacCammon, M.D., Director

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 Gyn, 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

MARK W. DICK, M.D.
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September 1976

Charles MacCammon, M.D., Director

M.D. would delivery 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 Samitaritan 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 <u>this must be corrected.</u>

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.

MARK W. DICK, M.D.
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September 1976

Charles MacCammon, M.D., Director

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 out houses 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.
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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 Povetea, 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. Ophthalmalogy Department. The control of trachoma was excellent. There was no trouble in getting refractions, I thought they had a very good program.

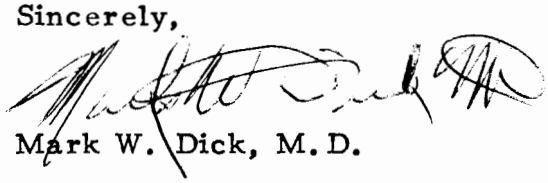
MARK W. DICK, M.D.
308 E. Ohio St.
Gunnison, Colorado 81230

September 1976

Charles MacCammon, M.D., Director

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,



Mark W. Dick, M.D.

TRADITIONAL INDIAN ALLIANCE of GREATER TUCSON INC.

P.O. BOX 26852
TUCSON, ARIZONA 85726
(602) 882-0555
(602) 791-9913

October 25, 1976

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

Dear Mr. Patterson:

JEAN CHAUDHURI
DIRECTOR

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 way 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,

Esperanza A. Mopera

Esperanza A. Mopera
Health Co-ordinator

Have applied to IHS — IHS said this is wrong place.

Talked 10/28; will send proposals

Ms. E. Mopara, RN
Traditional Indian Alliance of Greater
Tucson, Inc.
P.O. Box 26753
Tucson, Arizona 85726

Dear Ms. Mopera:

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.

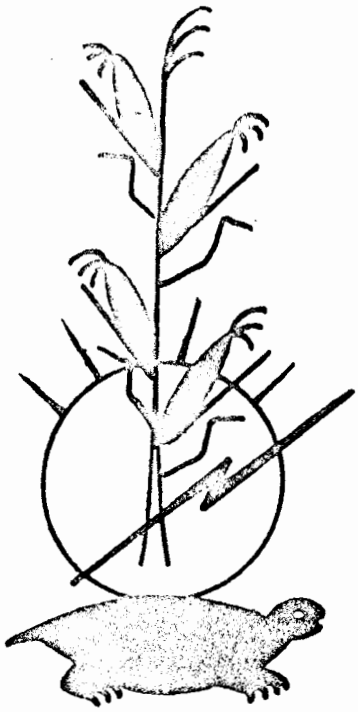
You will be apprised of developments in this program as they progress.

Sincerely yours,

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

cc: Mr. Brad Patterson

OTA/IHS
DCID/IHS
HSA/IH/DCID (DDonaldson:bkr 11/30/76



TRADITIONAL INDIAN ALLIANCE of GREATER TUCSON INC.

P.O. BOX 26852
TUCSON, ARIZONA 85726
(602) 882-0555
(602) 791-9913

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, Jean 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. Mopera

E. Mopera, R. N.

Enclosure

Mrs. Dorothy Matthews
2205 S. 21st Avenue
Birmingham, Alabama 35223

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

cc: Brad Patterson, The White House

PPL
encl

Concern re: Indians [illegible]

Nov 29, 1976

Pres. Gerald Ford
White House
Wash. D.C. 20500

BP

Dear President Ford

Know you are terribly busy, but the enclosed just horrified me, and I am hoping you will know who to contact 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 we're christians? These, too, are Americans.

Thank you

Sincerely

Mrs Dorothy Matthews

2205-21 ave South
Birmingham, Ala 35223

11/25/76
The Birmingham ? News

Thousands of Indians sterilized

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 3,400 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 report covered four of the 12 IHS services areas: Albuquerque, N.M; Phoenix, Ariz.; Aberdeen, S.D., and Oklahoma City, Okla. Sen. James Abourezk, D-S.D., asked for the survey in response to complaints about the operations.

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 per cent of the sterilizations covered by the GAO study 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 indepth 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

	Total	Tubal Ligations	Hysterectomies
U.S. short-stay hospital 1/	1,606.8	698.3	908.6
IHS Total 2/	1,103.8	700.1	403.7
Four IHS Areas Studied 2/	1,154.5	720.7	433.8

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 reason."

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 an absolute prohibition on sterilization 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