THE IHS PRIMARY CARE PROVIDER

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The Role of Firearms in American Indian Deaths

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The authors are frequently asked about the relationship of firearms to injury deaths in American Indian and Alaska Native (AI/AN) people. A review of the Indian Health Service mortality database reveals some very interesting information on this subject.

Causes of Injury Deaths

Five thousand two hundred and ten (5,210) AI/ANs died of injuries of all types during calendar years (CY) 1991-1993 (Table 1). Using the categories presented in Table 1, it would appear that only 73 injury deaths were caused by firearms, but standardized categories used to identify cause of death do not make the total number easy to recognize. Table 2, which details the causes of death in suicides and homicides, shows that, in actuality, 591 AI/ANs died as the result of the use of a gun during this time period. Of all suicides, 53.1% (310/584) were committed by the use of a firearm, while 36.8% (197/535) of all homicides were committed with a gun.

Firearm-related Deaths

As illustrated in Table 2, the 591 firearm-related deaths were distributed as follows: unintentional, 12.4%; suicide, 52.5%; homicide, 33.3%; and undetermined whether unintentional or purposely inflicted, 1.9%.

Handguns accounted for 89 (15.1%) of firearm injury deaths, while rifles and shotguns accounted for 120 (20.3%) of these deaths. For the overwhelming majority of firearm-related deaths (382, or 64.6%), the specific type of firearm used was not identified. Reliable generalizations about the type of firearms involved in these deaths, therefore, cannot be made.

Firearm-related deaths accounted for 11.3% (591/5210) of all injury deaths, making this the second leading cause of injury death after motor vehicles.

Deaths, By Sex

Although the numbers of fatal firearm injuries are small, comparisons between males and females are particularly interesting. For instance, Table 3 shows that for unintentional

In This Issue...

Table 1. Deaths caused by injuries or poisonings, American Indians and Alaska Natives residing in the IHS service area, calendar years 1991-1993 (3-year total population = 3,811,930).

	Number of Deaths	Percent Distribution	Death Rate per 100,000 Population
All Injuries	5210	100	122.6
Unintentional	3475	66.7	91.2
Railway	34	0.7	0.9
Motor vehicle	2167	41.6	56.8
Off road vehicle collision*	10	0.2	0.3
Water transport	9	0.9	1.3
Air and space	11	0.2	0.3
Vehicle NOC†	1	0.0	0.0
Poisoning	142	2.7	3.7
Medical misadventures	34	0.7	0.9
Falls	160	3.1	4.2
Fire/flames	128	2.5	3.4
Lightning	4	0.1	0.1
Drowning/submersions	169	3.2	4.4
Inhalation/ingestion	74	1.4	1.9
Firearms	73	1.4	1.9
Hot substances/objects	3	0.1	0.1
Electric current	13	0.3	0.3
All other injuries and late effects	401	7.7	10.5
Drugs in therapeutic use	2	0.0	0.0
Intentional Injuries	1119	21.5	29.4
Suicide	584	11.2	15.3
Homicide	535	10.3	14.0
Undetermined (whether unintentional or intentional)	616	11.8	16.2

* Off road vehicles, including all terrain vehicles, snowmobiles, etc.
† NOC = not otherwise classified.

injuries, males die at rates 14 times greater than females. Rates of firearm-related suicide were 8.1 times greater for males than females, and homicide rates were 4.2 times higher for males than females. Males accounted for 86.8% (513/591) of all firearm-related deaths.

Comparison With U.S. All Races

Rates for suicide, homicide, and "undetermined intent" (three of the four major types of firearm injury death) are lower for the AI/AN population than for the U.S. All Races. The AI/AN unintentional firearm injury death rate is almost 3.5 times higher than that for the U.S. All Races.

Limitations of Data

There are several limitations to this data analysis. First, only fatal events are included. Besides mortality data, the IHS has a rich database of hospital discharge information that could make a valuable contribution to our understanding of the role of firearms in injury events.

Secondly, only a short period of time was explored (1991-1993). More than 20 years of data are available for review. A more detailed review and analysis may reveal changes, over time, in mortality incidence and severity of firearm injuries.

Thirdly, within the public health sector, other types of data (e.g., hospital discharge data, outpatient visit data, and Catastrophic Funds data) are gathered for the purposes of quantifying the size of the problem and developing possible intervention strategies based upon identification of significant contributing factors. Subsequent reports will describe promising intervention strategies.

Recommended Reading

- *Homicide and Suicide Among Native Americans, 1979-1992, Violence Surveillance Summary Series, No. 2.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 1996.
- Perkins R, O'Connor MB. Firearm-related deaths in the Alaska Native population. *The IHS Primary Care Provider*. 1996;21(3):33-35.
- *Injury Mortality Atlas of Indian Health Service Areas, 1979-87.* Atlanta, GA: Centers for Disease Control and Prevention; December 1993.

Acknowledgements

We are grateful to L.J. David Wallace III, IHS/CDC Liaison Officer, National Center for Injury Prevention and Control, the Centers for Disease Control and Prevention, for his thoughtful review and comments. □

Table 2. Firearm deaths by external cause of injury (E-Code), American Indians and Alaska Natives residing in the IHS service area, calendar years 1991-1993 (3-year total population = 3, 811,930).

External Cause	Totals	E-Code
Unintentional	73	
By handgun	9	(E922.0)
By shotgun	7	(E922.1)
By hunting rifle	8	(E922.2)
By unknown firearms	49	(E922.9)
Suicides	310	
By handgun	59	(E955.0)
By shotgun	17	(E955.1)
By hunting rifle	54	(E955.2)
By unknown firearms	180	(E955.4)
Homicides	197	
By handgun	20	(E965.0)
By shotgun	20	(E865.1)
By hunting rifle	10	(E865.2)
By unknown firearms	147	(E965.4)
Undetermined Intent	11	
By handgun	1	(E985.0)
By hunting rifle	4	(E985.2)
By unknown firearms	6	(E985.4)
Legal Intervention	0	(E970.0 to E970.9)

Table 4. Firearm-related death rates, by type, for American Indians and Alaska Natives residing in the IHS service area, calendar years 1991-1993 (3-year total population = 3, 811,930); U.S. All Races rates, 1992; and ratio of AI/AN to U.S. All Races.

	Total AI/AN Rate*	U.S. All Races Rate	Ratio AI/AN to U.S. All Races
Unintentional	1.9	0.5	3.5
Suicide	2.4	7.1	0.3
Homicide	5.2	6.9	0.7
Undetermined	0.2	1.6	0.1
Total	9.7	14.8	0.7

* Rate per 100,000 population

Table 3. Number of firearm-related deaths and rates (per 100,000 population), by type and by sex, American Indians and Alaska Natives residing in the IHS service area, calendar years 1991-1993 (3-year total population = 3,811,930).

	Total	Males	Females	Male Rate	Female Rate	Ratio Male/ Female Rate
Unintentional	73	68	5	3.6	0.2	14.0
Suicide	310	276	34	14.7	1.7	8.1
Homicide	197	158	39	8.4	2.0	4.2
Undetermined	11	11	0	0.6	NA	NA
Total	591	513	78	27.3	4.0	6.8

NA Not applicable.

Acceptance of Travel Reimbursement from Non-Federal Sources

Karen Santoro, Office of the General Counsel/Ethics Division for the U.S. Department of Health and Human Services, Washington, DC; and Jeanelle Raybon, Program Integrity Specialist, IHS Program Integrity and Ethics Staff, Rockville, Maryland.

Introduction

It is common that federal health care practitioners receive invitations to attend conferences, seminars, or training courses offered by a non-federal source, such as a medical school or university. The invitation may include an offer to pay for the federal employee's travel expenses, including airfare and hotel costs. Presently, due to increasing budget demands, it is not always possible for the Indian Health Service (IHS) to pay for this type of travel. Pursuant to law and regulations issued by the General Services Administration, travel reimbursement from a non-federal source may be accepted under certain conditions. A summary of these conditions follows:

- attendance by the federal employee is in an official duty capacity and is in the interest of the IHS,
- the federal employee has not solicited reimbursement of travel expenses from a non-federal source,
- only travel to conferences, seminars, training courses, and certain award ceremonies which take place *away* from an employee's official duty station may be paid for by the non-federal source,
- acceptance of travel reimbursement by a non-federal source is *prohibited* for site visits, investigations, negotiations, or vendor promotional training,
- the IHS, *not* the employee, accepts the reimbursement from the non-federal source,
- reimbursement for the travel expenses of an employee's spouse may be accepted *only* in very limited situations, and
- a conflict of interest analysis is required in certain situations.

Conflict of Interest

If a non-federal source seeks any action, does business with, or is regulated by the IHS, or has interests that may be affected by the employee who is offered the travel, then the IHS Deputy Ethics Counselor (or designee) must make a conflict of interest analysis. The analysis includes several factors such as the nature and sensitivity of matters the non-federal entity has pending before the IHS, the identity of other participants, and the monetary value of the travel benefits being offered. Before reimbursement can be accepted, the Deputy Ethics Counselor must determine, based on the conflict of interest analysis, that a reasonable person, with knowledge of all the facts and circumstances surrounding the travel, would not question the integrity of the IHS' programs or operations.

Example

Here is an example of the application of the above travel regulations and conflict of interest analysis. An IHS pharmacist stationed in Arizona receives an invitation to attend a seminar about pharmacy customer satisfaction offered by the University of New Mexico. The University offers to reimburse the pharmacist's travel expenses. The pharmacist's supervisor approves of the attendance as part of the pharmacist's official duty activities.

At the time the offer is made, the University has a large grant application pending with the IHS. The pharmacist has no official duties relating to the pending grant application. Other persons who will be attending the seminar include pharmacists from other agencies, pharmacy students, and state health officials. The monetary value of the travel benefits offered is consistent with federal travel reimbursement guidelines. May this pharmacist accept the offer?

Yes! Such a seminar is among the categories of activities covered by the regulation. Attendance at the seminar is an approved official duty activity. The offer to reimburse the pharmacist's travel expenses was not solicited by the employee. The seminar will take place in a location away from the pharmacist's duty station.

The University is seeking action by IHS (approval of its grant application). Therefore, a conflict of interest analysis must be undertaken. Although the University's pending application is for a large grant, the pharmacist has no official duties relating to that pending application. It is appropriate for IHS pharmacists to attend and interact with the other participants expected at this seminar (other federal pharmacists, pharmacy students, state health officials). By contrast, a seminar at-

tended exclusively by drug company representatives would not be considered appropriate. The value of the travel benefits offered by the University is consistent with federal travel reimbursement guidelines. Therefore, under these circumstances, the Deputy Ethics Counselor (or designee) could make a determination that a reasonable person would not question the integrity of the IHS pharmacy program if the pharmacist accepted the travel reimbursement offer. However, as noted earlier, IHS, not the pharmacist, accepts the actual travel reimbursement. The reimbursement process will be discussed in further detail below.

Numerous questions are raised when agencies receive travel reimbursement from non-federal sources, particularly when the agency does business with these sources. Twice each year, the Office of Government Ethics requires agencies to report on travel reimbursements accepted from non-federal sources. This report is sent to Congress and is available to the public.

Procedures

The acceptance of travel expenses from a non-federal source must be authorized *in advance* by an IHS official who has been delegated the authority to approve this type of travel. Employees should consult their executive officers to determine who has this authority.

Employees must complete an HHS Form 348, "Request and Approval for Acceptance of Payment of Travel Expenses," sufficiently in advance of the anticipated travel to allow time for review and approval. The letter of invitation from the non-federal source must accompany the Form 348.

Finally, employees should consult with their Deputy Ethics Counselor (or designee) who will assist in the determination of whether the benefit of accepting travel expenses outweighs any conflict of interest. Employees may be asked to provide additional supporting documentation so that such determination may be made.

Conclusion

This article is intended only as a general summary. The application of the regulations and conflict of interest analysis may vary depending on the circumstances of each situation. Please consult your Deputy Ethics Counselor (or designee) prior to accepting any offer of travel reimbursement from a non-federal source. □

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Health Facilities Planning Update

Henry Cruz, General Engineer, IHS Office of Public Health, Division of Facilities and Environmental Engineering, Rockville, Maryland.

The December 1996 issue of *The IHS Primary Care Provider* carried an article describing the task that the Indian Health Service (IHS) is undertaking to revise the existing Health Facilities Planning Manual (HFPM) and so improve the method for planning and designing health care facilities. The manual revision entails developing a modular approach to health care facility design using standard templates; these templates can be used in a variety of combinations to tailor the facility to the needs of a specific community. The intent is to provide a process that will permit planners to plan better facilities, more quickly, and at lower cost than is possible presently. This follow-up article reports the progress and summarizes how the IHS arrived at the planning criteria being used.

At the outset, the steering committee, charged with overseeing the manual revision, sought to ensure that the final product would cover the range of service levels required by the different health care facilities on the Health Facilities Construction Priority List. To accomplish that goal, the IHS retained the services of an architectural/engineering (A/E) firm experienced in building health care facilities both in the private sector and the IHS. The A/E reviewed IHS Program Justification Documents for each of those health care facilities projects awaiting funding to determine how IHS should plan their health care facilities.

During this review process, the A/E analyzed the demographic data for each community, and researched and assessed the utilization rates for each demographic category in communities where the IHS had recently completed health care facilities. That information was compared with demographics and utilization rates for the entire United States to determine the similarities and differences in how IHS customers use medical services (inpatient, outpatient, obstetrics, pediatrics, laboratory, etc.). Also, the A/E studied the productivity rates for each service (number of outpatient visits, number of inpatients per day, number of laboratory tests performed, etc.) within IHS and private/public organizations so that cost-effective thresholds for each service could be established.

After completing this phase of the project, the steering committee, IHS workgroups, users, and representatives from various tribes were asked to critique these data, as well as the process to establish their validity and applicability for the IHS. As a result, the steering committee determined the essential elements and the workload or drivers of each medical service, and identified the cost-effective workload thresholds for each service to be provided at those health care facilities currently on the Health Facilities Construction Priority List. This information, once validated by research and review, provided the tools for programming and planning of the various service levels required to support the future needs of the IHS.

On December 11, 1996, the Council of Area and Associate Directors (CAAD) and the Chief Medical Officers of the IHS Area offices previewed the work developed. The CAAD indicated its support, signaling that the process proposed for completing the Health Facilities Planning Manual update, and developing a health systems planning tool, should continue.

The original mission, to make the process of planning and constructing IHS health care facilities "better, faster, and more cost effective," is on track. The templates will be completed in August 1997 and the computerization will be available in October 1997.

In March 1997, the A/E introduced the first step of the computerization effort required in the Health Facilities Planning Manual (HFPM) Update. They presented the layout, function, and organization of the software being developed. This software will essentially pull together the HFPM update work of the past two years, creating a tool that will facilitate the IHS Program Justification Documents (PJD), the Program of Requirements (POR), and facility design efforts. By incorporating service-specific data (inpatient data, radiology tests ordered, etc.) into annually updated databases, a framework for PJD is provided, the POR is produced, and the room-by-room equipment and design criteria reports are formulated. This program will be called the IHS Space Planning System (SPS) and Equipment Planning System (EPS). SPS will generate the space requirements and EPS will generate various equipment lists sorted by department, type of equipment, room-by-room, etc. In June 1997, a test run was conducted in IHS Headquarters in Rockville, Maryland, for the final acceptance by the steering committee.

For further information, please contact Henry Cruz, IHS Office of Public Health, Division of Facilities and Environmental Engineering, 12300 Twinbrook Parkway, Twinbrook Metro Plaza, Suite 600C, Rockville, MD 20852 (phone: 301-443-1852; Internet address: hcruz@smtp.ihs.gov). □

Advocates for Indigenous California Language Survival

Editor's note: *As a result of efforts to locate information about Native American elders programs to include in the May 1997 issue of* The Provider, *which focused entirely on elders issues, the editors came across a brief description of the Advocates for Indigenous California Language Survival (AICLS) on the Internet. When attempting to confirm the information before publication, the AICLS asked the editors to wait for a more detailed description of their program. We missed the deadline for the May issue, but thought our readers would be just as interested reading about this exciting and important program now.*

"I surprised myself, the words came out like a string of beads." These are the words of Chemehuevi elder Gertrude Leivas, describing how it felt to speak her native language for the first time since she was a young woman.

Like so many other members of California tribes, she had assumed this aspect of her heritage was lost to her, or no longer relevant. And, like many others, she was thrilled to discover how much she remembered, and eager to pass it on to the next generation.

Of the hundred or more different languages that were spoken in California when Europeans first arrived (the only other places in the world with such linguistic diversity are Papua New Guinea and the Caucasus), fifty are still spoken.

The continued existence of so many languages despite the ravages of recent history is an indication of the great cultural endurance of California Indian communities. Until 1992, virtually all of the fluent speakers were elderly, and their languages were hanging by the delicate thread of their own lives. Today, it is still true that most of the fluent speakers of California languages are elderly, but now, throughout California, younger people are learning and speaking their languages. The Advocates for Indigenous California Language Survival (AICLS) have been instrumental in this revival.

What is AICLS? In 1992, the Native California Network (NCN) sponsored a meeting of a small group of tribal scholars to deal with the question of California's endangered languages. With so many languages down to just a handful of speakers, what could be done at this critical time to keep them from vanishing altogether? One answer was to form a committee that would "take an in-depth look at the problems and issues of language retention and revitalization that are unique to California people." This is how AICLS was formed, with native people on its board representing most parts of the state, from the southern California coast to the desert, the Central Valley to the Klamath River region. The group's goal is to "foster the restoration and revival of indigenous California languages so that they may be retained as a permanent part of the living cultures of native California."

The Master/Apprentice Language Learning Program

AICLS' most dramatic success so far has been the development of the Master/Apprentice Language Learning Program (MALLP). Elder fluent speakers team up with younger apprentices to engage in 320 hours or more of activity using their language together. During the program year, the teams attend two intensive trainings in immersion-style methods of language learning and teaching. Between trainings, they return to their home communities to work together.

MALLP offers program participants one on-site visit and monthly telephone appointments with the MALLP coordinator for support and ongoing training. MALLP also offers a small stipend to program participants. Since the inception of the program, over 15 California Indian languages have developed new speakers. The numbers continue to grow as families and communities join together in the love of their language and the return of tribal values, healing the wounds of the past. Graduates (new speakers) of the program go on to receive further training in teaching methods and community development skills. The ultimate goal of the MALLP is to produce enough new speakers so that communities can develop their own unique strategies for the renewed uses of Indian language.

Whether making traditional baskets or washing their cars, cleaning pine nuts for ceremonial clothing or doing the laundry, the apprentices have been able to immerse themselves in their languages for periods of time, learning not just words, but the cultural context of their language in today's world. The master/apprentice program has helped to make available that time — "that treasured, treasured time to be able to spend with someone who knows the language and just be able to listen," as Karuk learner and speaker Terry Supahan puts it.

Breath of Life/Silent No More

Not all tribes have living speakers to learn from, but there are other ways to breathe life back into a silent language. One is to use linguistic and anthropological materials collected years ago. The University of California at Berkeley is the

world center for California Indian language research and study, housing thousands of field notes, rare tape recordings, songs, stories, and other cultural resources.

Offered in conjunction with the University of California Berkeley linguistics department, the week-long Breath of Life/ Silent No More workshop, designed especially for California native languages, provides intensive training in basic phonetics, grammar, and research skills. Participants learn how to access the vast U.C. Berkeley archives through hands-on tours (including computer access) and in-depth research. A manual with basic information from the workshop (linguistic material and examples, forms to access the collections, maps, phone numbers, contact people) is available. There is a fee for the workshop, and scholarships are available. Call for a current schedule (see phone number, below).

The California Languages Conference

First held in 1992, this biannual conference has become a beloved and inspirational gathering for California Indian families dedicated to reviving their languages. When these language heroes come together, they find support, inspiration, learning, tools, and others with whom they can network. The conference offers talks by leaders of successful native languages restoration efforts in other states; the Punana Leo (Hawaiian Immersion) Schools, the Piegan Institute (Blackfeet Nation), the Cochiti and Acoma Pueblos (Southwest), and the Akwesasne Freedom School (Mohawk Nation), among others, have shared their experiences at previous conferences. Held in a rural setting, the conference also includes a children's program with nature walks, traditional skills activities, songs, and basic language learning. There is a fee for the conference, and scholarships are available. Call for a current schedule (see phone number, below).

For more information, contact the Language Program Coordinator, Darlene T. Franco or the MALLP Coordinator, Audrey Osborne, Advocates for Indigenous California Language Survival, P.O. Box 664, Visalia, CA 93279 (phone: 209-627-1050). □

OPINION □

Health From An Indian Perspective

Roberto Dansie, Executive Director, Pit River Health Service, Inc., Burney, California.

Bernal Diaz del Castillo, the official historian of the conquistadors, tells us in his book, "La Verdadera Historia de la Conquista de la Nueva Espana" (The Real History of the Conquest of New Spain) that the indigenous peoples of what is now Mexico believed that Europeans were gods, because wherever they went they were received with flowers, perfumes, and incense. No one back then asked the Indians what they really thought about the whole situation. As a matter of fact, Indians were forbidden to either write or speak their own version of those events. Five hundred years later, relying on a collection of Indian writings compiled by Mexican anthropologist Miguel Leon-Portilla in his book "The Reverse of the Conquest," we read an account of the Indians in their first encounter with Europeans. They say, "And we smell them even before we saw them. And not even with flowers, perfume or incense could we get close to them."

One event, two different interpretations. After 500 years, it is time we considered the Indian perspective. It is my opinion that there are common characteristics that most Native American Indians, as well as other ethnic groups, share when it comes to healing and health. These include the following:

- Life comes from the Great Spirit, and all healing begins with Him.
- Health is due to the harmony between body, heart, mind, and soul.
- Our relationships are an essential component of our health.
- Death is not our enemy, but a natural phenomenon of life.
- Disease is not only felt by the individual, but also by the family.
- Spirituality and emotions are just as important as the body and the mind.
- Mother Earth contains numerous remedies for our illnesses.
- Some healing practices have been preserved throughout the generations.
- Traditional healers can be either men or women, young or old.
- Illness is an opportunity to purify one's soul.

There are good reasons why these principles have been around for so long: they make sense; they work. They are also practical. Those of us working in Indian health programs can enhance our efforts and abilities by incorporating the Indian perspectives of health and wellness into our work. Just as Indians have their own perspective of history, they also have their own perspective of health. Healing begins by first being aware and, then, by respecting this perspective.

References

- Bernal Diaz del Castillo. *La Verdadera Historia de la Conquista de la Nueva Espana*. Editorial Porrua. 1984.
- Miguel Leon-Portilla. *El Reverso de la Conquista*. Editorial Fondo de Cultura Economica. 1988. □

Native Americans and Type II Diabetes Continuing Education Module

Diabetes is a major health problem among American Indians. New staff need to become familiar with Type II diabetes, its management, and research findings specifically related to diabetes in Indians in order to provide quality care. This home study module was developed to meet the needs of staff new to working with American Indians and Alaska Natives. The module includes a 40-minute videotape, four articles on diabetes in Native Americans, the Indian Health Service (IHS) minimum standards of care for patients with diabetes, a bibliography, a post test, and an evaluation form. It is estimated that it will take 3 to 4 hours to complete the whole module. To obtain continuing education credits, participants will need to watch the videotape, read the articles, complete the evaluation form, and pass the post test.

Sponsors

The sponsors of this continuing education activity are the IHS Diabetes Program, located in Albuquerque, New Mexico; the IHS Phoenix Area Diabetes Program; and the IHS Clinical Support Center (the accredited sponsor), both located in Phoenix, Arizona.

Accreditation

The Indian Health Service Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The IHS Clinical Support Center designates this continuing education activity for 3.5 hours of Category I credit toward the Physician's Recognition Award of the American Medical Association. This Category I credit is accepted by the American Academy of Physician Assistants. The IHS Clinical Support Center is also accredited as a provider of continuing education for nurses by the American Nurses Credentialing Center Commission on Accreditation. This activity has been awarded 4.2 contact hours for nurses.

How to Obtain the Module

Health care professionals employed by Indian health programs may request this module by writing to the IHS Clinical Support Center, 1616 East Indian School Road, Suite 375, Phoenix, AZ 85016. Persons working for tribal programs that have taken Clinical Support Center (CSC) tribal shares may not take advantage of using this module unless arrangements are made to return some of these funds to the CSC.

Advanced Practice Nurses Network Established

A collaborative effort among Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives, (CNMs), and Nurse Practitioners (NPs) has led to the establishment of the Native Health Advanced Practice Nurse Network. A group of Advanced Practice Nurses (APNs) met in Albuquerque, New Mexico, on June 11-12, 1997. Participants at the meeting included representatives of Indian Health Service (IHS) and tribal APNs, as well as the USPHS Commissioned Corps and Civil Service APNs. It is hoped that this collaboration will result in improved communication and ultimately benefit the recipients of APN health care, American Indians and Alaska Natives.

Issues discussed at the Albuquerque meeting included wages and compensation, funding for continuing education, mentoring, independent practitioner status, medical staff membership, research, establishment of an APN databank, and development of a home page at the IHS Internet web site.

Emphasis was placed on the need for active involvement in state and national professional organizations and improved public relations. The group unanimously endorsed being referred to as *Advanced Practice Nurses*, and not as "mid-level providers." Formal position statements were drafted by the group and will be available at a later date. In addition, an agenda for next year's meeting has been outlined.

For more information, contact Charles Laine, CRNA, Anesthesia Department, Phoenix Indian Medical Center, 4212 North 16th Street, Phoenix, AZ 85016 (phone: 602-263-1554; e-mail: cdlaine@msn.com).

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THE IHS PRIMARY CARE PROVIDER

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