THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

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STD Screening and Treatment in Pregnancy

Sexually transmitted diseases (STD) are common among women of childbearing age, and may be asymptomatic. The goals of STD screening during pregnancy are 1) early detection and treatment of infection; 2) prevention of maternal complications; and 3) prevention of vertical transmission and neonatal disease. The Centers for Disease Control and Prevention (CDC) 2006 STD Treatment Guidelines recommend screening pregnant women for STDs. The CDC screening recommendations are incorporated into the recommendations below. Note that these are screening recommendations for asymptomatic pregnant women. Women presenting with signs or symptoms of STDs should be examined, tested, and treated if an STD is suspected at any time during pregnancy. This document is limited to an overview of STD screening and treatment guidelines and does not address issues regarding diagnostic work-up, STD counseling, and/or partner management. Treatment of HIV, including prophylaxis for HIV positive pregnant women, is beyond the scope of this document.

STD Screening Recommendations by Disease

HIV

- Screen *all pregnant women* as early in the pregnancy as possible. Testing is voluntary but HIV information and testing should be offered to all pregnant women in opt-out format.
- Re-test in third trimester in high risk women (injection drug use, concurrent STDs, women with multiple sex partners, domestic violence or abuse or HIV-infected partners).
- Rapid HIV testing for women in labor if undocumented HIV status. If rapid screen is reactive, antiretroviral prophylaxis (with consent) prior to confirmatory test results.
- Have linkages to HIV services/care and follow up in place
- Document HIV screen was offered and/or completed in patient medical records or electronic medical records system.

Note: Some states require specific counseling or written signed consent.

Syphilis

- Screen *all pregnant women* at first prenatal visit with a non-treponemal test (VDRL or RPR), and if positive, confirm with treponemal test (TP-PA or FTA- ABS).
- Retest at 28 to 32 weeks and at delivery for women living in areas with excess syphilis morbidity.
- Stat RPR should be done at delivery for women with no prenatal care.
- No infant or mother should leave the hospital without having the maternal syphilis status documented at least once during pregnancy.
- Any woman who delivers a stillborn after 20 weeks' gestation should be tested for syphilis.

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Note: If a treponemal EIA test is used for syphilis screening all positive tests should be confirmed by a non-treponemal test (RPR or VDRL). If the non-treponemal test is positive then syphilis is confirmed. If the non-treponemal test is negative a second treponemal test should be done. If this is positive then syphilis is confirmed, if this is negative then the first treponemal EIA was a false positive. Contact your local health department to find out about areas with excess syphilis morbidity where the risk for congenital syphilis is high.

Hepatitis B

- Screen *all pregnant women* in first trimester with hepatitis B surface antigen (HBsAg) in each pregnancy even if previously vaccinated or tested.
- Test/retest at time of admission to hospital for delivery in unscreened women and high risk women (more than one sex partner prior six months, concurrent STDs, recent or current injection drug users (IDU) or HBsAg-positive partner).

Note: Hepatitis B vaccine is safe in pregnancy. Women who are at risk for hepatitis B should be vaccinated. HBsAg serologic testing should be done prior to starting the hepatitis B vaccine as transient positive HBsAg tests can occur post vaccination.

Chlamydia

- Screen *all pregnant women* at first prenatal visit.
- Retest in third trimester for at-risk women (ages 25 years or younger or who have new or multiple sex partners or if tested positive earlier in pregnancy).

Note: Urine or patient obtained vaginal swab Nucleic Acid Amplification Tests (NAATs) for chlamydia have the advantage of being non-invasive and can be obtained when a pelvic exam is not being done or when there is a risk to the pregnancy in taking cervical specimens. Because NAATS are the most sensitive testing technology to detect chlamydial infection, they are recommended for screening.

Gonorrhea

- Screen at first prenatal visit for women ages 25 years or younger or women at risk (history of gonorrhea in prior two years, more than one sex partner in past year, partner with other partners, commercial sex work, and drug use) or women living in an area with high gonorrhea prevalence (certain geographic regions). African American women are also at higher risk for gonorrhea.
- Retest in third trimester for women at continued risk or if tested positive earlier in pregnancy

Note: Urine or vaginal swab NAATs for gonorrhea have the advantage of being non-invasive and can be obtained when a pelvic exam is not being done or when there is a risk to the pregnancy in taking cervical specimens.

Hepatitis C

- Screen at first prenatal visit in high risk women (history of IDU, history of blood transfusion or organ transplantation before 1992).

Bacterial Vaginosis

- Screen women with a history of preterm labor and delivery at first prenatal visit.
- Benefit of screening women at low risk for preterm labor is unproven.

Human Papillomavirus

- No recommendation for routine HPV screening apart from work-up of abnormal Pap tests.
- If the patient has not had a Pap in the past year, it may be warranted to obtain a Pap test for cervical disease at the first prenatal visit.
- Examination to assess for genital warts can be done during prenatal physical examination.

Note: the HPV vaccine is *not* recommended in pregnancy. If the series is started prior to pregnancy, it should be discontinued for the duration of the pregnancy.

Trichomoniasis

- Currently no CDC guidelines for screening asymptomatic pregnant women.

Herpes Simplex Virus

- Insufficient evidence to recommend routine Type Specific HSV-2 serology screening.
- Screen (HSV-2 Type Specific Serology) for HIV co-infected women.
- Consider HSV Type Specific Serology if sex partner with HSV infection and pregnant women has no history of HSV.
- Third trimester serial cultures for HSV are *not* recommended in asymptomatic women with a history of HSV.
- All pregnant women should be examined for evidence of genital herpes at the time of delivery.

Table 1. STD Screening Recommendations in Pregnancy and Time of Screening

Time of Screening	Tests for All Pregnant Women (unless specific risk group noted)
First prenatal visit	' hilis (RPR or VDRL). Always confirm a itive RPR or VDRL with treponemal test ·PA or FTA- ABS) amydia norrhea for women ages 25 years or younger vomen at risk (histo ry of gonorrhea in prior ears, more than one sex partner in past year, ner with other partners, commercial sex k and drug use) or women living in an area n high gonorrhea prevalence (certain graphic regions). African American women also at higher risk for gonorrhea. patitis B surface antigen (HBsAg) patitis C if high risk (history of IDU, history lood transfusion or organ transplantation ore 1992) terial Vaginosis if hi story of preterm labor delivery test if no Pap in prior year pes (HSV-2 Type Specific Serology) for ' co-infected women and consider HSV e Specific Serology if sex partner with HSV ction and pregnant women has no history of /
28-32 weeks	hilis if women lives in area with excess hilis morbidity
Third Trimester	' if high risk (IDU, concurrent STDs, tiple partners or HIV + partner) amydia for women ages 25 years or younger or at risk (new or multiple partners) or if tested positive earlier in pregnancy onorrhea if continued risk or if tested positive arlier in pregnancy
During Labor & Delivery	IV rapid testing if undocumented HIV status yphilis if women lives in area with excess yphilis morbidity at RPR if no prior prenatal care BsAg on admission to delivery if no prior creening or if high risk women (multiple partners prior 6 months, concurrent STDs, recent or current IDUs or HBsAg-positive partner)

STD Treatment in Pregnancy

(See Table 2 for treatment regimens)

Chlamydia

- Azithromycin or Amoxicillin are the two recommended regimens.
- Test of cure should be done 3-4 weeks after completing therapy.

Gonorrhea

- Ceftriaxone and Cefixime are the *only* recommended regimens. For patients with cephalosporin allergy, anaphylaxis-type (IgE-mediated) penicillin allergy, or other contraindication, CDC recommends considering desensitization. However, in the vast majority of cases, this may not be feasible. Judicious use of azithromycin is a practical option if spectinomycin is not available or not indicated. If azithromcyin is used, a test-of-cure is prudent because efficacy data are limited and there are concerns about emerging resistance.
- Cefixime tablets have not been available in the US since November 2002. An oral suspension formulation is available.
- Spectinomycin is an alternative regimen; however it has not been manufactured in the US since January 2006, and future availability is uncertain.
- Co-treatment for chlamydia infection is indicated unless chlamydia infection is ruled out using sensitive NAAT technology.

Pelvic Inflammatory Disease

- Parenteral therapy in an inpatient setting is necessary because of risk of preterm delivery and maternal morbidity.
- Clindamycin plus Gentamicin are the recommended regimen.

Cervicitis

- Azithromycin is the drug of choice for presumptive treatment.
- If local prevalence of gonorrhea is greater than 5%, co-treat for gonorrhea infection.
- Co-treat for bacterial vaginosis and/or trichomoniaisis if infection detected.

Trichomoniasis

- Metronidazole (pregnancy category B) is the only recommended regimen.
- Some experts defer treatment in asymptomatic women until after 37 weeks gestation.
- For suspected drug-resistant trichomoniasis, rule out reinfection, and see 2006 CDC Guidelines, Trichomonas Follow-up p. 53, for other treatment options. Evaluate for metronidazole-resistant *T. vaginalis*. For laboratory and clinical consultations, contact CDC at (770) 488-4115; *http://www.cdc.gov/std.*

Bacterial Vaginosis

- All pregnant women with symptomatic bacterial vaginosis should be treated.
- Treatment of asymptomatic pregnant women with bacterial vaginosis who are at high risk for preterm delivery (prior delivery of a premature infant) might reduce risk for premature outcomes.
- Metronidazole and clindamycin are the recommended regimens.
- Follow-up evaluation for treatment effectiveness should be considered one month after therapy is completed in women at high risk for preterm delivery.

Herpes, Anogenital

- The safety of acyclovir in pregnancy has not been established; however, available data do not show an increased risk of birth defects in women treated with acyclovir in the first trimester.
- Acyclovir is the recommended regimen for women with first clinical episodes or severe recurrent herpes, and IV acyclovir should be used in severe infection.
- Symptomatic HSV identified late in pregnancy or at the time of delivery should be managed in consultation with an infectious disease specialist.
- Many experts recommend suppressive acyclovir treatment late in pregnancy for women with recurrent genital herpes as it reduces frequency of C-section by reducing recurrent outbreaks at term.

Warts, Anogenital

- Cryotherapy, TCA, BCA, or surgical removal are recommended treatments in pregnancy.
- Cryotherapy can be used on vaginal, urethral meatus, and anal mucosal warts.
- TCA or BCA can be used on vaginal, anal mucosal warts
- Surgical removal is another option for anal mucosal warts.
- Cervical warts should be managed by a specialist.

Syphilis

- Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting formulation, Bicillin® L-A (the trade name) which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.
- Pregnant women allergic to penicillin should be treated with penicillin after desensitization.
- Some specialists recommend a second dose of benzathine penicillin G 2.4 million units IM 1 week after initial dose for pregnant women with primary, secondary, or early latent syphilis.

Table 2. STD Treatment Regimens for Pregnant Women

DISEASE	REGIMENS
CHLAMYDIA	**Recommended** • Azithromycin 1 g po once *or* • Amoxicillin 500 mg po tid x 7d **Alternative** • Erythromycin base500mg po tid x 7d *or* • Erythromycin base250mg po qid x 14 d *or* • Erythromycin ethlysuccinate 800mg po qid x 7d *or* • Erythromycin ethlysuccinate 400mg po qid x 14d
GONORRHEA	**Recommended** • Ceftriaxone 125 mg IM once *or* • Cefixime 400 mg po once **Alternative** • Cefpodoxime 400 mg po *or* • Spectinomycin 2 g IM *or* •Azithromycin 2 g po in a single dose
PELVIC INFLAMMATORY DISEASE	**Recommended** •Clindamycin 900 mg IV q 8 hrs **Plus** •Gentamicin 2mg/kg IM orIV followed by 1.5 mg/kg IM or IV q 8 hrs. Discontinue 24 hours after patient improves clinically and continue with oral clindamycin 450 mg qid for a total of 14 days.
CERVICITIS	**Recommended** • Azithromycin 1 g po once **Plus** • Metronidazole if BV is present 100 mg po bid x 7 d
TRICHOMONIASIS	**Recommended** • Metronidazole 2 g po once
BACTERIAL VAGINOSIS	**Recommended** • Metronidazole 500 mg po bid x 7d *or* • Metronidazole250 mg po tid x 7d *or* • Clindamycin300 mg po bid x 7d
CHANCROID	**Recommended** • Azithromycin 1 g po once *or* • Ceftriaxone 250 mg IM once *or* • Erythromycin base 500 mg po tid x 7 d
LYMPOGRANULOMA VENEREUM	**Recommended** • Eythromycin base 500 mg po qid x 3 wks *or* • Azithromycin 1 g po once per week x 3 wks

WARTS -Anogenital External Genital/ Perianal Warts OR Mucosal Genital Warts	**Recommended** • Cryotherapy Apply once q 1-2 wks *or* • Tricholoacetic acid (TCA). Apply once q 1-2 wks *or* • Bichloroacetic acid (BCA) 80%-90%. Apply once q 1-2 wks *or* • Surgical removal
HERPES- Anogenital First Clinical Episode Episodic Therapy for Recurrent Episode Suppressive Therapy	**Recommended** • Acyclovir 400 mg po tid x 7-10 d *or* • Acyclovir 200 mg po 5/day x 7-10 d • Acyclovir 400 mg po tid x 5 d *or* • Acyclovir 800 mg po bid x 5 d *or* • Acyclovir 800 mg po tid x 2 d • Acyclovir 400 mg po bid
SYPHILIS Primary, Secondary, and Early Latent Late Latent, and Unknown duration	**Recommended** • Benzathine penicillin G 2.4 million units IM • Benzathine penicillin G 7.2 million units, administered as 3 doses of 2.4 million units IM, at 1-wk intervals
NEUROSYPHILIS	**Recommended** • Aqueous crystalline penicillin G18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d **Alternative** • Procaine penicillin G, 2.4 million units IM q d x 10-14 d **Plus** Probenicid 500 mg po qid x 10-14 d

- Some specialists recommend 2.4 million units of benzathine penicillin G q week for 1 to 3 weeks after completion of neurosyphilis treatment.

STD Resources

1. The California Department of Public Health, STD Control Branch website (*http://www.std.ca.gov*) has many STD resources including clinical guidelines, treatment guidelines, surveillance reports, and links to local STD data.
2. The California STD/HIV Prevention Training Center (CA PTC) website(*http://www.stdhivtraining.org/*) has a variety of STD resources including information about STD/HIV prevention training courses, resources to assist providers in risk assessment, diagnosis and management of STDs, as well as STD fact sheets for patients.
3. Centers for Disease Control and Prevention 2006 STD Treatment Guidelines (*http://www.cdc.gov/std/treatment*)

Training Available from the American Indian and Alaskan Native STD/HIV Training Work Group

In April 2001 the Indian Health Service (IHS) National Epidemiology Program began collaborating with a taskforce from the National Network of STD/HIV Prevention Training Centers (PTCs) to address Sexually Transmitted Disease (STD) training needs among providers working at IHS, tribal, and urban sites. The PTCs are a CDC-funded group of regional centers created in partnership with health departments and universities. The PTCs are dedicated to increasing the knowledge and skills of health professionals in the areas of sexual and reproductive health. The entire network includes ten Clinical Training Centers, four Behavioral and Social Intervention Training Centers and four Partner Services and Program Support Training Centers located throughout the United States. For more information on the NNPTC, visit *http://www.stdhivpreventiontraining.org*.

This initial taskforce has expanded to become the AI/AN STD/HIV Training Work Group dedicated to addressing STD and HIV training needs among all providers who care for AI/AN populations. Current members of this work group include representation from PTCs, AIDS Education and Training Centers (AETCs), National Native American AIDS Prevention Center (NNAAPC), the IHS National Epidemiology Program, and several Native organizations, including the Alaska Native Tribal Health Consortium, Project Red Talon of the Northwest Portland Area Indian Health Board, and the Northern Plains Tribal Epidemiology Center. Projects that the AI/AN STD/HIV Training Work Group have worked on include STD and HIV trainings for clinical providers (MDs, NPs, PAs), Community Health Representatives, Public Health Nurses, and Health Educators; periodic update articles in *The Provider*; and providing speakers for national conferences that target AI/AN providers. If you are interested in learning more about this workgroup, contact Sharon Adler at *sharon.adler@cdph.ca.gov*.

The 13th Annual Elders Issue

The May 2008 issue of *The IHS Provider*, to be published on the occasion of National Older Americans Month, will be the thirteenth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

Oral Health Risk Assessment Training for Pediatricians and Other Child Health Professionals

The Oral Health Initiative of the American Academy of Pediatrics is pleased to announce the release of the Oral Health Risk Assessment Training for Pediatricians and Other Child Health Professionals for Continuing Medical Education Credit. The training can be found online at *http://www.aap.org/commpeds/dochs/oralhealth/cme/*. The title page is a bit text heavy as it contains the purpose of training, learning objectives, and standard CME information. But please continue to the bottom of the page where you will find the button to begin the training. Questions about the training can be addressed to *oralhealthinfo@aap.org*.

New Educational Opportunities from the New Mexico Geriatric Education Center

The University of New Mexico Geriatric Education Center (NMGEC) is happy to announce a grant award from the Health Resources and Services Administration (HRSA) Bureau of Health Professions through 2010. NMGEC has been funded for the past 17 years by a HRSA grant in five-year cycles (latest cycle 2001-2006). Thanks to everyone for the letters and support during the recent period of Congressional budget cuts.

Under the grant goals, the NMGEC provides geriatric continuing education and training to health care professionals with an emphasis on providers in tribal and Indian Health Service clinics. NMGEC education and training programs concentrate on fostering an appreciation of the richness of Indian culture and traditions, and an awareness of the use of traditional healing practices. In the past five years, the NMGEC has trained over 3,800 interdisciplinary health care professionals and paraprofessionals on elder care in culturally appropriate geriatric educational workshops, trainings, and collaborations.

The NMGEC is pleased to announce the return of training and educational offerings. The Summer Geriatric Institute will be taking place in Albuquerque on June 19 - 21, 2008, with CME/CEUs offered. The title this year is "Better Outcomes, Healthier Elders: Collaboration in Management of Chronic Disease." The last half day of the Institute will be on Health Literacy, which can be applied toward a Certificate in Health Literacy of 25 credit hours. Additional sessions for the certificate will be announced soon.

Tuition waivers will be available to tribal and Indian Health Service health care professionals to attend the Summer Geriatric Institute; please call the NMGEC at (505) 272-4934 for waiver request application. A reduced fee of $100 is available for CHRs wishing to attend.

The Interdisciplinary Geriatric Certificate Program (40 credit hours) will resume this year with four Saturday sessions. The first session will start March 29, 2008, with subsequent sessions on July 12, September 27, and November 15. The Interdisciplinary Geriatric Certificate Program is for all health care professions with an interest in geriatrics. The certificate requires 20 hours of core courses in geriatrics and 20 hours of elective courses/workshops to complete the program. Four sessions of core courses (20 hrs) will be offered in spring and fall 2008 and will repeat each year with CME and CEUs available.

Visit the NMGEC website at *http://hsc.unm.edu/som/fcm/gec* for more information on upcoming events and projects or call us at (505) 272-4934.

Open Door Forum Update

SAVE the DATE for the Indian Health Service
Open Door Forum on Health Initiatives-Forum #7
Quarterly Tele-conference/WebEx

When:	**April 24, 2008**
Time:	**12:00 p.m. to 2:00 p.m. EST**
Toll free number:	**888-455-6771**
Pass code:	**042408**
Leader:	**Candace Jones**

Obesity prevention and control will be the focus of this forum and will include National, Area and local presentations on this topic. More information to follow. The accredited sponsor is the IHS Clinical Support Center.

Save the Dates!

2008 Nurse Leadership in Native Care Conference
May 12-15, 2008

New Directions in the New Frontier: Education, Evidence and Empowerment

Anchorage, Alaska

Jointly sponsored by the Alaska Native Medical Center and the IHS National Nurse Leadership Council.

Hotel Captain Cook
939 West 5th Avenue, Anchorage, AK 99501
(907) 276-6000 *www.captaincook.com*

AUDIENCE
Designed for nurse administrators, directors of public health nursing, nurses, public health nurses, and advanced practice nurses working for Indian health programs. This CE seminar provides an opportunity to network with peers/colleagues on nursing issues of common concern, update knowledge of current nursing trends/issues and enhance nursing practice to improve patient care, as well as receive accredited continuing nursing education.

CURRICULUM
The agenda will include plenary and concurrent workshop sessions and poster presentations on a variety of clinical and public heath nursing topics focused on leadership, education, evidence-based practice and best practices. On-line access to the agenda and registration materials will be available in late March. Visit the NNLC Conference Website.

ACCREDITED SPONSOR
Alaska Native Medical Center is an approved provider of continuing education by the Alaska Nurses Association, an accredited approver by the American Nurses Association Credentialing Center's Commission on Accreditation. Provider Number AP-06-002.

LODGING
A block of rooms has been reserved at the Hotel Captain Cook in Anchorage. Please make your room reservation online at *www.captaincook.com*, by calling the toll-free reservations number, 1-800-843-1950 or call the Hotel Captain Cook directly at (907) 276-6000. Mention "Alaska Native Medical Center" to secure the special single group rate of $105 + tax single or double occupancy per night. The deadline for making room reservations is April 11, 2008. Book early – regularly priced hotel rooms in Anchorage average nearly $200/night + tax in the summer! Note: for those wishing to see some of Alaska, this rate is good for three days before and three days after the conference, on a space available basis.

CONTACT INFORMATION
For more information about this event, contact Casie Williams, Nurse Educator, Alaska Native Medical Center, *cwilliams@anmc.org* or 907-729-2936 visit the NNLC Conference Website.

REGISTRATION FEES
Indian Health Service, tribal and urban programs employee: $100
Students: $50 (submit copy of current student ID)
All others: $150

SAVE THE DATE

* Challenges in Indian Health Care *
* Health Care Budgets & Financing *
* Data and Information Technology *
* Law *
* Integrity and Ethics *
* Negotiation *

Session One: May 5 - 9, 2008

Session Two: June 16 - 20, 2008

Session Three: July 21 - 25, 2008

You can be a part of the 2008 Class
of the Executive Leadership Development Program (ELDP)!

The purpose of the Executive Leadership Development Program is to provide a forum where participants learn new skills and encounter different approaches to reduce barriers, increase innovation, ensure a better flow of information and ideas, and lead change. The goal is to provide essential leadership training and support for Indian health care executives, whether they work in Federal, tribal, or urban settings.

Look for the registration material in January on
http://www.ihs.gov/nonmedicalprograms/eldp/ .

ELDP Coordinators:
Gigi.Holmes@ihs.gov and ***Wesley.Picciotti@ihs.gov***

This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

"Ignoring facts does not make them any less true."

Aldous Huxley

Article of Interest

Laterality of acute otitis media: different clinical and microbiologic characteristics.
Pediatr Infect Dis J. 2007 Jul;26(7):583-8.

Is bilateral acute otitis media clinically different than unilateral acute otitis media?
Pediatr Infect Dis J. 2007 Jul;26(7):589-92.

Recently there has been an emphasis on decreasing the use of antibiotics for acute otitis media (AOM). There is increasing antibiotic resistance among many bacteria in this country. It is also acknowledged that most cases of AOM will resolve without antimicrobial treatment. The American Academy of Pediatrics recently released guidelines for treating AOM which include an option to withhold antibiotic for some patients with AOM. The authors of these two studies were interested in whether bilateral ear infections might be more severe than unilateral AOM and more likely to benefit from antimicrobial treatment.

Bilateral AOM was more likely to have bacteria recovered on tympanocentesis (70% versus 57%), more likely to have *Haemophilus influenzae* recovered (31% versus 9%), be younger (< 1 year) and have more severe and persistent symptoms. The authors suggest that physicians should take these factors into account when deciding whether to prescribe or withhold antimicrobial therapy for AOM.

Infectious Disease Updates
Rosalyn Singleton, MD, MPH
The RSV Season: Is there relief in sight?

On December 7, CDC reported the RSV activity in the US for the 2006-7 season using the National Respiratory and Enteric Virus Surveillance (NRVSS), a passive, voluntary network of laboratories. The national RSV season onset began during the week ending Nov. 11, 2006, and continued for 19 weeks until the season end March 17, 2007. The season onset ranged from late October in the south, to mid December in west. The season end ranged from mid February in the northeast to late March in the west – an average duration of around 15 - 16 weeks. Alaska is not represented in the NRVSS data, and the RSV season in Alaska is unique. The average RSV onset over a 10 year period was the week ending October 21 and the average end was the week ending May 21 (30.5 weeks duration).

There are preliminary data from CDC on the season onset for 2007 - 8 season. Reports through Nov 24 indicate that although the national RSV season has not yet occurred, the regional season onset occurred during the week ending Nov 17 in the south, and the week ending Nov 24 in the northeast.

There is exciting news in the RSV prevention arena. Motavizumab, an enhanced monoclonal antibody against RSV that is more potent than Synagis in animal models is in clinical trials, some of which have results to share. In a head-to-head study among premature infants and those with chronic lung disease, Motavizumab was non-inferior to Synagis in preventing RSV hospitalizations; it was superior in preventing outpatient RSV disease. In a trial among otherwise healthy full term Navajo and Apache infants, Motavizumab was found to be 83% efficacious compared with placebo for prevention of RSV hospitalizations and 71% efficacious compared with placebo for prevention of RSV outpatient respiratory illnesses. Motavizumab remains investigational at this time. IHS representatives are involved in the policy development process regarding this product if it should become licensed.

Recent literature on American Indian/Alaskan Native Health
Doug Esposito, MD

Pollack LA, Stewart ST, Thompson TD, Li J. Centers for Disease Control and Prevention. Trends in Childhood Cancer Mortality — United States, 1990–2004. *MMWR*. 2007;56(48):1257-1261.

This study investigates childhood cancer mortality trends for the period 1990 - 2004 using National Vital Statistics System data. Overall, childhood cancer mortality rates have declined over the period for all cancers combined (from 34 deaths per million in 1990 to 27 deaths per million in 2004, or an average decline of 1.7% per year), and for the two most prevalent childhood cancer diagnoses: leukemia (3.0% per year average decline) and brain and other nervous system neoplasms (1.3% per year average decline). Fortunately, this

trend in improved mortality has occurred despite the increased cancer incidence trends reported in other studies, and is likely the result of advances in cancer treatment.

On the darker side, disparities do exist and probably relate at least in part to health care access inequities, although other factors could be at work. Death rates declined at a significantly slower rate for Hispanics (1.0% per year) than for non-Hispanics (1.6% per year). In addition, regional differences existed whereby the decline in cancer mortality was highest in the midwest (2.1% per year), followed by the south and northeast (1.8% per year), with the west trailing behind (only 1.4% per year).

Of course, the same data limitations exist regarding AI/AN children as described in a previous issue of the *Notes*. Although aggregated cancer mortality rates (20.0 deaths per million AI/AN children vs. 29.7 deaths per million overall) and the annual percentage change (2.0% per year for AI/AN children vs. 1.7% per year overall) over the 15-year period appear to be most favorable for AI/AN children in the present report, case numbers and the issue of racial misclassification cast doubt that things are quite so rosy. With underestimates of mortality for AI/AN populations as high as 21% (attributable to racial misclassification of death certificate data), the true AI/AN childhood cancer burden remains unclear. Nevertheless, there might be some hope on the horizon.

I would like to direct the reader's attention to the recently published *Annual report to the Nation on the status of cancer, 1975-2004, featuring cancer in American Indians and Alaska Natives*. Although the direct relevance of this report to AI/AN children is limited (it reports on the top 15 cancers overall, and with cancer in children and adolescents thankfully a fairly rare occurrence, children end up being excluded), it accomplishes something very important. The methods employed by the authors provide the most comprehensive cancer data and best estimate of cancer burden in the AI/AN population to date. Hopefully, this method can be generalized to include other age groups and even disease conditions, giving us a more accurate picture of disease burden in AI/AN populations and sub-populations than has so far been available. I will try to keep you posted.

References

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Editor's Note: The Chief Clinical Consultant's Newsletter (Volume 6, No. 2, February 2008) is available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Concern for rising Cesarean rates in Native American populations

Larry Leeman MD, MPH and Eve Espey MD, MPH

Editorial Note: the following is in response to a discussion of trial of labor after cesarean (TOLAC) in rural hospitals in the December CCC Corner.

We appreciate the opportunity to engage in discussion about trial of labor after cesarean (TOLAC) availability and the approach to cesarean delivery at W. W. Hastings Hospital. Every facility faces unique factors in the decision to offer TOLAC services. However, we fear that the high total cesarean rate and lack of TOLAC services will ultimately result in worse perinatal outcomes considered from a population level.

Not only is vaginal birth after cesarean (VBAC) highly desired by many women, but it is preferable to a repeat cesarean delivery in certain women, including those with a single cesarean delivery who have had a successful vaginal birth before or after their cesarean delivery. Evidence suggests that such women should be encouraged to have a TOLAC, particularly if they plan to have additional children. Given these data, anesthesia staff should be strongly encouraged to change their policy and offer VBAC services in accordance with guidelines similar to those developed in the Northern New England Perinatal Quality Improvement Network (NNEPQIN). Ethically, it is difficult to justify withholding TOLAC when it is the safest option. If services were offered to this group of women, obstetrical and anesthesia staff could develop greater comfort with TOLAC and expand the local eligibility criteria.

Annual cesarean rates at some Indian health facilities in Oklahoma are > 37%, and short term rates over 40%, hence are above the recently published 2006 national rates for the total US population (31.1%), the Oklahoma state population (33.3%), and the US Native American population (27.5%). We note that the Native American cesarean rate increased 1.5% from 2005 to 2006, almost double the 0.8% increase for the total US population. The rising cesarean rate is likely a reflection of both rising primary cesarean delivery rates and decreased vaginal birth after cesarean delivery.

Given the limited availability of TOLAC services for women in the Oklahoma service area, efforts should be made to minimize the primary cesarean delivery rate. The decision to lower the threshold for primary cesarean delivery as evidenced by an acceptance of the high rate and an unwillingness to look at physician specific factors will result in higher adverse outcomes in future pregnancies, particularly when combined with the lack of TOLAC services. Women in the Hastings area with primary cesareans can be anticipated to have cesareans in all future births, placing them at increased risk for placenta accreta, increta, and percreta. These complications of abnormal placentation may be particularly difficult to address in a rural community hospital setting.

Although Healthy People 2010 does not include a recommendation for the total cesarean rate due to varying patient factors, it recommends that efforts be made to decrease the primary cesarean rate to 15% in women who are giving birth for the first time. ACOG similarly recommends that comparative cesarean delivery rates for populations, hospitals, or physicians should be based on the subgroup of nulliparous women with term singleton vertex gestations. We would be interested in seeing the rate for this population at those affected facilities in Oklahoma Area.

We worked at the Gallup Indian Medical Center (GIMC) and Zuni-Ramah Hospitals in the 1990s and continue to work with Native populations in Albuquerque and New Mexico. Our study of the population based CS rate in Zuni-Ramah in the 1990s demonstrated a 7.3% cesarean rate despite an incidence of diabetes and hypertensive disorders well above national rates. Physician specific practices influence cesarean delivery rates. We believe that the cesarean delivery review initiated at GIMC in the early 1990s was important in identifying factors in patient management that can result in a high cesarean rate.

An important factor in reducing cesarean delivery, either

in nulliparous or parous women, is to place value on vaginal delivery. The attitude that "None of the physicians in our department are concerned with our cesarean delivery rate" may prove the largest stumbling block in developing strategies more consistent with national goals.

We suggest that the maternity care providers in Hastings present the evidence for improved maternal outcomes in women with prior vaginal delivery to their anesthesia colleagues and make TOLAC available at least for this group of women. Addressing the high total (and, presumably, primary) cesarean rates will require analysis of the indications and physician specific patterns. Given the increasing evidence for adverse outcomes with multiple, repeat cesareans and the limited ability of community hospitals to address problems with placenta accreta, increta, and percreta, we support labor management strategies to reduce cesarean rates in the Native American population in the Oklahoma Area and nationwide.

OB/GYN CCC Editorial Comment

An argument for better teamwork: Trial of labor after cesarean in Indian Country

First, I want to thank the leaders of the Indian Health Midwives listserv for raising these important issues, as this discussion was originally begun in the Midwives Corner feature. Though the current discussion revolves around Indian health facilities, it is reflective of most small rural hospitals, and increasingly some larger urban facilities.

Next, the availability of the trial of labor after cesarean option is really a "systems" issue, not just a problem confined to midwives or physicians. To decrease the long term morbidity and mortality associated with cesarean rates that now exceed 40%, we need to approach this issue systematically. Specifically, how can we engage our Indian health administrative staff to foster an environment whereby anesthesia, pediatric, and nursing services work together with the provider staff to decrease excess morbidity in Native women? Should you offer vaginal birth after cesarean delivery at your facility? Should your referral facility be offering VBAC?

Let's put some of the above issues into perspective. Here are just a few of the risks that you should currently handle very well:

	Incidence per 100
Shoulder dystocia	0.2 -3.0
Cord Prolapse	0.14 -0.62
Abruptio placenta, overall	0.4 - 1.3
Abruptio placenta, severe - stillbirth	0.12
Placenta previa, third trimester	0.1 to 0.4
Placenta accreta, overall	0.18
Placenta accreta/previa unscarred	1 - 5
Placenta accreta/previa with 1 Ces Del.	11 to 25
Placenta accreta/previa with 2 Ces	35 to 47
Placenta accreta/previa with > 3 Ces	50 to 67
Post partum hemorrhage	1 - 5
Trauma	7

In all but one of the above situations, the incidence of these obstetric emergencies is actually increasing each year.

If you can't provide VBAC because of the 0.5% risk of uterine rupture, then should your facility be offering intrapartum care at all?

If you work at a facility that cannot develop a rapid response for a clinical issue like symptomatic uterine rupture in a VBAC setting, which happens ~ 0.5 percent of the time, then your facility should re-evaluate its ability to manage obstetric intrapartum care.

Taken individually, most of the above common urgencies and emergencies occur more frequently than 0.5 percent. Taken as an aggregate, the risks above far outweigh the risks of VBAC. Now, seeing the above risks, if you feel you need to re-evaluate offering obstetric intrapartum care, then please contact me as soon as possible. For those facilities that feel they are able to continue to offer obstetric intrapartum care within the risk environment above, I would suggest a program of emergency obstetric drills, ALSO certification for all nurses and providers, and ongoing quality assurance.

Each of the last three national Indian Women's Health and MCH Conferences has devoted significant blocks of time to improve systems of care and specific content updates.

Lastly, there seems to be some confusion, as some providers at times combine the risk of a TOLAC sequela vs the relative success of a vaginal birth in TOLAC. These are two separate issues that need to be discussed with our patients separately for fully informed consent.

Success of vaginal delivery

Overall, the rate of successful vaginal delivery in TOLAC is quite high, often in the range of 75% in the general population, and much higher in the AI/AN population, at 85-90% over the years. A previous successful VBAC is probably the best predictor of future success; about 90 percent of such women deliver vaginally with trial of labor. By comparison, women delivered abdominally for dystocia are least successful, although approximately two-thirds are delivered vaginally.

In the previous dystocia group, the success rate is higher if cesarean delivery was performed in the latent phase of labor and lower if performed after full dilatation. Within the former group, 79% of women who originally had surgery while still in the latent phase of labor had a successful trial of labor, compared with 61% of patients who had an arrest of dilation in the active phase of labor and 65% of those who had an arrest of descent (Duff et al. *Obstet Gynecol* 1988 Mar;71(3 Pt 1):380-4).

Multivariate logistic regression analysis identified as predictive of TOL success: previous vaginal delivery (OR 3.9;

95% CI 3.6-4.3), previous indication not being dystocia (CPD/FTP) (OR 1.7; 95% CI 1.5-1.8), spontaneous labor (OR 1.6; 95% CI 1.5-1.8), birth weight <4000 g (OR 2.0; 95% CI 1.8-2.3), and Caucasian race (OR 1.8, 95% CI 1.6-1.9) (all P < .001).

The overall TOL success rate in obese women (BMI ≥ 30) was lower (68.4%) than in nonobese women (79.6%) (P < .001), and when combined with induction and lack of previous vaginal delivery, successful VBAC occurred in only 44.2% of cases (Landon et al. The MFMU Cesarean Registry: factors affecting the success of trial of labor after previous cesarean delivery. *Am J Obstet Gynecol*. 2005 Sep;193(3 Pt 2):1016-23).

The combination of previous cesarean for dystocia, no previous vaginal delivery, and induced labor had a particularly poor prognosis in the Flamm system; fewer than 50 percent of such women achieved a successful TOL.

A decision analysis model favored TOL if the chance of success was > 50 percent and if the desire for additional pregnancies was 10 to 20 percent (Mankuta et al. *Am J Obstet Gynecol* 2003 Sep;189(3):714-9).

Risks

Numerous risk factors have been cited for uterine rupture during labor in women with a previous CD. However, these risk factors are not consistent across studies, which are generally hampered by small numbers of patients with uterine rupture. Unfortunately, no single factor or combination of risk factors is sufficiently reliable to be clinically useful for prediction of uterine rupture.

Purported risk factors include maternal age greater than 30 years, induction of labor, more than one prior CD, postpartum fever, interdelivery interval less than 18 to 24 months, dysfunctional labor, and one layer uterine closure. Within this framework of incomplete data the New England Perinatal Quality Improvement Network (NNEPQIN) has developed a system to appropriately manage the risks.

Low Risk Patient:

- 1 prior low transverse cesarean delivery
- Spontaneous onset labor
- No need for augmentation
- No repetitive FHR abnormalities
- Patients with a prior successful VBAC are especially low risk. (However, their risk status escalates the same as other low risk patients)

Medium Risk Patient:

- Induction of labor
- Pitocin augmentation
- 2 or more prior low transverse cesarean deliveries. (Two prior uterine scars and no vaginal deliveries is listed as a circumstance under which trial of labor should not be attempted, by the American College of Obstetricians and Gynecologists ACOG Practice Bulletin No. 54, "Vaginal birth after previous cesarean delivery."
- < 18 months between prior cesarean delivery and current delivery

High Risk Patient:

- Repetitive non-reassuring FHR abnormalities not responsive to clinical intervention.
- Bleeding suggestive of abruption
- 2 hours without cervical change in the active phase despite adequate labor

Here is a suggested management system per NNEPQIN

Low risk: Notify Pediatrics, Anesthesia, and operating room crew of admission; OB/GYN on campus during active phase; Perinatal Guidelines of Care, ACOG, observed

Medium risk: Notify Pediatrics, Anesthesia, and operating room crew of admission; Operating room on campus in active phase or other plan if crew is busy

High risk: OB/GYN, Anesthesia, and Pediatrics available; No other acute care responsibilities; Rapid decision to incision

Please see the Midwives Corner and Oklahoma Perspective for further discussion on this topic. A complete discussion of risk, benefits, and systems issues is available in the Perinatology Corner module, "Vaginal Birth after cesarean."
http://www.ihs.gov/MedicalPrograms/MCH/M/PNC/VB01.cfm

Reference: Online

Hot Topics

Chronic disease and illness

"Awake" during surgery: Examining intraoperative awareness

Estimates show as many as 2 in every 1,000 patients who receive general anesthesia remember events that occurred while they were "under." Given that over 40 million patients undergo general anesthesia each year in North America, it is not surprising the phenomenon has become the subject of a new Hollywood movie. Dr Beverley A. Orser from the University of Toronto and colleagues use the occasion of the recent release of "Awake," a film depicting a man who experiences "anesthesia awareness" and is conscious, but physically paralyzed during surgery, to delve deeper into the issue of intraoperative awareness.

Orser and colleagues said most patients who experience intraoperative awareness do not experience pain but have "vague auditory recall or a sense of dreaming and are not distressed by the experience." The authors add, however, that

some patients do experience pain, and it is occasionally severe.

In a study involving 11,785 patients who had received general anesthesia, the incidence of awareness was 0.18% in cases in which neuromuscular blockers were used and 0.10% in the absence of such drugs. Of the 19 patients who experienced recall, 7 (36%) reported some degree of pain, ranging from soreness in the throat because of the endotracheal tube, to severe pain at the incision site. Patients may remember these events immediately after surgery, or hours or days later.

"Immense efforts have been made to understand the effects of anesthetics on physiologic processes and to develop strategies and technologies to manage the adverse effects of these drugs," the authors said. "However, certain risks remain, including the possibility of intraoperative awareness."

The authors conclude that intraoperative awareness should be viewed as a recognized complication, with many features similar to those of other adverse intraoperative and perioperative events. They add that anesthesiologists are directing research and patient care efforts toward reducing the incidence and consequences of this adverse event, but they suggest that more large-scale studies of the efficacy of brain-monitoring devices in the prevention of awareness are required.

Orser BA, et al. Awareness during anesthesia. *CMAJ*. 2007;Dec 11.

Behavioral Health Insights
Peter Stuart, IHS Psychiatry Consultant
Autism Screening
Guest editor Joshua Cabrera, MD

Identifying children with autism early has several benefits: it allows family to adapt to unusual and challenging behaviors in their toddler, it leads to early interventions that may improve outcomes, and it opens the door for increased services at school. The American Academy of Pediatrics currently advocates screening for autism at the age of 18 months.

General developmental screening tools may be abnormal when administered to autistic children, especially language screens. General screens do not distinguish children with developmental delays from autism, but can trigger further screening and evaluation. A specific screening tool for autism is the Checklist for Autism in Toddlers (CHAT). This screen consists of nine questions asked of the parents and five simple in-office tests, administered at the age of 18-24 months. The key elements of the CHAT assess the child's capacity for shared attention and imaginative play, both per history and in the office.

A child demonstrates shared attention when pointing to an object of interest, for example, a stuffed giraffe, and then glancing at another person's eyes or face to measure if they are also noticing the giraffe. The examiner also should initiate the test for shared attention by pointing to an object, demonstrating interest in it, and observing the child share the examiners attention in the object (usually through gaze). Autistic children may point as part of an imperative, but not as part of sharing attention. For example the autistic child may point at food, and may even lead you by the arm to the food, but will likely not look at your eyes or face to measure or implore your shared attention. The second key ability, imaginative play, is abundantly demonstrated in an office that has age appropriate toys. In the CHAT, developed in the UK, the examiner uses a cup to pretend to drink tea and asks the toddler to join in. Using a spoon and play bowl to pretend to scoop up stew or blue corn mush may be more appropriate for those in the southwest. Autistic toddlers may play with toys, but do not play imaginatively with them at 18 months, focusing instead on sensory qualities such as its sound or feel. Often their play is repetitive and stereotyped as well. Toddlers who lack shared attention and imaginative play, by history and on exam, likely have an autism spectrum disorder. Children who have a mixed result, for example those whose parents report shared attention, but who cannot do so for the examiner, have a moderate risk of autism.

So what role does autism screening have in day-to-day practice? Children who have family histories, who have language delays, or whose parents express concern for their development in language/social domains, warrant further screening and evaluation. General screening, advocated by the AAP, may be the first step to improving outcomes. Becoming familiar with, or having easy access to some form of the CHAT, can improve its routine use in the office. Its essential elements, shared attention and imaginative play, can be screened for effectively with brief office tests and have good specificity for autism spectrum disorders.

For further reading on screening for autism, visit the website *http://www.autismresearchcentre.com/*.

References: Online

Breastfeeding
Suzan Murphy, PIMC
Breast Pumps: The good, the bad, and the ugly

New families usually ask about breast pumps. Many retail pumps work well for occasional pumping. But most retail pumps are not clinically evaluated or labeled so that families know what to expect. For example, a retail hand or electric pump may work well for the occasional bottle so mom can go to the store or out to eat, but not work well enough to maintain a milk supply when mom goes to work or school. It can be confusing and frustrating for new families and providers.

The following are suggestions for suggesting a pump:

- If the family needs a pump for once in a while, often a retail breast pump will work. Also the hand pumps from hospital grade electric pumps producers, such as Medela or Ameda/Egnel will work.
- If the family needs a pump for more than 3-4 hours

of routine separation, encourage them to consider a hospital grade electric pump. Resources for these pumps are:

- *WIC*. If WIC has electric pumps available, the rules are that the mom needs to be exclusively breastfeeding. This means the family cannot be receiving formula from the WIC program. If the family is getting formula on their own for occasional use, that is usually okay. If WIC doesn't have pumps, they might be able to suggest local resources.
- *Locally*. If the baby is in a NICU, hospitals often have pump loaners. If not, the hospital usually has hospital pump available for moms to use when they are at the hospital. Usually they have a breastfeeding consultant or staff members trained in breastfeeding support. They can be very helpful. Encourage families to check with local hospital gift shops. Sometimes they have pump loaners/rentals.
- *The yellow pages/Internet*, under "breastfeeding" is another place to look. Suggest that families look for pump resources that have an IBCLC (International Board Certified Lactation Consultant) on staff. Pump rentals often cost at least $30 per month to rent; attachments are often $30 or more.
- *Ebay*. A word of caution: The Medela Pump in Style pumps are designed for single person use; the contaminant filter is inside the machine. Replacing the attachments will not reduce the potential contamination risk.

If your hospital or clinic is interested in having pumps to loan, the hospital grade pump companies have rental programs. Some companies have low cost "loss waivers/insurance" so that if a pump is loaned and lost, the company will assume responsibility. Rental costs to IHS vary, depending on manufacturer and pump. For example, one IHS facility reported a current cost of ~ $125/year for Medela Lactina Plus pumps. Attachments are $30-40 per set. For more details, check with local pump loaner stations or call PIMC Breastfeeding Helpline at 1-877-868-9473.

Domestic Violence

Denise Grenier, Tucson/Rachel Locker, Warm Springs

Family violence in health care and public health settings: accepting manuscripts

The Family Violence Prevention and Health Practice e-journal invites you to submit manuscripts on addressing family violence in health care and public health settings. The next issue will look at the relationship between childhood and adult sexual and physical violence and obesity. For information on submission guidelines, go to the "info for contributors" tab of the journal or contact *Denise.Grenier@ihs.gov*.

International Health Update

Claire Wendland, Madison, WI

Multiple Chlamydia species pose an unexpected challenge for blindness prevention

In the US, most health care providers hearing the word "chlamydia" think immediately of the sexually transmitted infection caused by *Chlamydia trachomatis*. Chlamydia the STI is common around the world, but *C. trachomatis* has long been believed also to be the major cause of trachoma, an eye infection that is the leading cause of preventable blindness worldwide. A new report calls into question some of the conventional wisdom about trachoma, and raises concerns about treatment and prevention efforts.

Trachoma is spread when ocular or respiratory secretions from an infected person get into the eyes of an uninfected person (typically through direct contact, when carried by house flies or other insects, or by shared towels). It causes a conjunctivitis that ultimately turn the eyelashes inward, resulting in corneal scratching and ulcerations. Left untreated, it progresses to blindness over a span of one to four decades. The disease is found disproportionately in poor countries, especially in Asia, the Middle East, and Africa, and especially among women. Dry and dusty places where people are inclined to rub their eyes and don't have much water to wash may be particularly affected.

Though trachoma was once a serious problem in the US, it has been greatly reduced by antibiotic treatment and by provision of clean water to affected communities. In fact, the CDC claims trachoma has been eradicated in the US, though a 1997 report on eye disease on the Navajo reservation still listed it as a significant cause of blindness there. Efforts to wipe out trachoma in the Third World, however, fail consistently. Cases quickly reappear following mass antibiotic treatment of affected communities, and may persist or reappear even when testing fails to demonstrate the presence of *C. trachomatis*. These anomalies led researchers to investigate whether another pathogen might be responsible.

In an endemic community in Nepal, Deborah Dean and colleagues sampled tears from 146 people in nine affected households and also did eye exams to stage them for clinical trachoma. PCR testing on the tear samples showed that half the sample was infected. The surprise was that of those infected, 35% had only *C. trachomatis* (and even here there were eight different genotypes involved), 20% had only *C. psittaci*, 10% had only *C. pneumoniae*, and 35% had more than one species. All three species were highly correlated with severe eye inflammation consistent with clinical trachoma, and the researchers conclude that all three are pathogenic. It's not

clear that the same pattern of infection will prevail outside Nepal. What is clear is that efforts to make a vaccine have just had a significant setback, and that monotherapy with azithromycin (which may not work for all Chlamydiaceae) can no longer be counted on to wipe out the problem.

Reference: Online

Medical Mystery Tour
St. John's wort for depression in a young woman

A 28-year-old female with severe major depression has achieved partial symptom remission with a selective serotonin reuptake inhibitor (SSRI) but complains of persistent diarrhea and loss of libido. She asks you about using St. John's wort to treat her depression. Appropriate advice would include which of the following? (select all that are true.)

- St. John's wort may be effective in milder forms of major depression
- St. John's wort is more effective than placebo in patients with severe major depression
- St. John's wort is better tolerated than prescription antidepressants
- The combination of St. John's wort and SSRIs is safe and effective for major depression.
- St. John's wort may reduce the efficacy of combined oral contraceptives

Stay tuned to the March issue for the answers and a discussion.

Midwives Corner, **Lisa Allee, CNM**

VBACs: The evidence supports them, women want and benefit from them, we need to provide them.

The following is in response to the comments of Dr. David Gahn regarding VBACs at Hastings Indian Medical Center that appeared in this column in the December issue of the CCC Newsletter. This following is a conglomeration of my and other midwives' responses.

First, here is some overall VBAC information to ponder. We must all remind ourselves of recent history. The change from pro-VBAC thinking to pro-repeat cesarean delivery occurred when ACOG came out with a recommendation (not a requirement) that physicians (doesn't specify anesthesia) should be immediately available (no definition supplied).

This recommendation was based on a poorly done study of discharge diagnosis codes that actually demonstrated the same statistics on uterine rupture as previous studies of VBAC, but the authors came to very different conclusions (Lyndon-Rochelle 2001). Unfortunately, much of this country swung to the extreme end of the pendulum's arc and stopped offering VBACs. Luckily, some kept their heads and a plethora of research has been published since, which shows VBAC to be a safe and reasonable option for the majority of women with a history of cesarean deliveries, and many benefits to VBAC over repeat cesarean delivery. Please see the many citations that have been reviewed in December issue of this publication and this month's Abstract of the Month. More citations were supplied by Neil Murphy and Sheila Mahoney on the Indian Health Midwives listserv discussion related to VBACs.

Among the places that have remained sane and continued to offer VBACs are many of us in the Indian Health Service (Alaska Native Medical Center even got an award from the American College Nurse Midwifes) and a group in the Northeast, the Northern New England Perinatal Quality Improvement Network (NNEPQIN). The folks in the New England coalition have come out with useful guidelines on deciding about VBAC and providing quality care. Their work also helped us all face a bigger picture — how we handle emergency surgery in general and how we can improve. Their suggestions include improving teamwork, communications, and skills via drills. This has the potential to improve responses to emergency birth needs beyond the very few situations related to VBACs. Those of us in IHS who have continued VBACs have shown continued success with excellent statistics and outcomes (see 2007 Indian Health Data Tally Sheet below)

Overall, the pendulum is beginning to swing back towards a more rational approach to VBACs; there was even a quote from an ACOG official that suggested a possible move towards revising their "immediately available" statement.

Second, let's go over some of the specifics raised by Dr. Gahn. Since, according to Dr. Gahn, none of the physicians or midwives at Hastings are anti-VBAC, I thought I would use the responses from other midwives and myself to formulate some suggestions to help overcome the barriers to VBACs at Hastings which were elucidated by Dr. Gahn. These suggestions can also be used by the few other IHS sites that may be experiencing problems with offering VBAC services.

1. Have a journal club to present the overwhelming amount of evidence that supports providing VBAC services. Make sure to include the materials from the Northern New England Perinatal Quality Improvement Network and IHS VBAC statistics. Invite all members of the perinatal team, including anesthesia and executive staff members who supervise the provider staff. This will help ensure that all involved have the information to begin providing evidence-based care and should help to start the efforts to develop a functional interdisciplinary team. This should also help those obstetricians who "are not anti-TOLAC/VBAC," but who do not embrace the VBAC plan to start the process of getting on board.
2. Start doing drills for obstetrical emergencies. This will help to improve skills, as well as teamwork and communication between anesthesia, surgery,

midwifery, obstetrics, and nursing — your second step in team building. This should help a number of issues. It should help to impress all on-call staff to do what is necessary to improve response time, with the goal of your medical staff rules- and regulations-required 20 minutes becoming reliable. Maybe this will help folks come to the conclusion of having key personnel located close by — i.e., a call room or on campus housing. This would solve the problem of anesthesia not being available when a VBAC patient is laboring. When the larger picture of response to any emergent surgery is focused upon, then the VBAC topic, which represents a very small proportion of the potential emergency surgeries, is automatically included.

3. As a department, or even better, as an interdisciplinary team or service unit, review the World Health Organization and USPHS Healthy People 2010 recommendations for cesarean delivery rates. Both of these respected and esteemed organizations have clearly and repeatedly recommended cesarean delivery rates in the 10-15% range. This clearly answers the question about whether a cesarean delivery rate of 37%, which is more than double to triple these recommendations, is too high and gives a very good indication as to what is too high for a cesarean delivery rate.
4. Re-evaluate how VBAC counseling is done. To provide true informed consent, the numbers need to be presented clearly. The data consistently show a uterine rupture rate of 0.5-3%; it is important to explain that this means 97-99.5 women out of 100 will not have a uterine rupture and out of the few who do, not all will have problems. It is, of course, important to discuss the risk of uterine rupture to mother and baby, but to put it in this perspective of being rare, and to review the high-quality, careful care we provide to women who are undertaking VBAC, to help prevent problems. It is also very important to review the differences in postpartum morbidity and risk between a vaginal birth and cesarean delivery (be sure to include the oft ignored higher rates of breastfeeding and orgasm difficulties post cesarean delivery). If, in contrast, providers only make a recommendation of repeat cesarean delivery and an institution has a policy that only allows for repeat cesarean delivery, then they have effectively negated a woman's right to make an informed decision in a situation where there is a choice.
5. Review the postpartum morbidity and risk differences for women post vaginal birth vs. post cesarean delivery. This will help to dispel the illusion that a woman who has had a cesarean delivery is walking out of the hospital "healthy" and bring a more accurate sense of respect for what is really happening for that woman. She has just had major abdominal surgery and is in recovery from that surgery. She is in pain and is at risk for a number of post-surgical complications. Her future pregnancies have also now taken on a longer list of potential risks. Along with all this, she is also a new mother with a newborn to care for and feed every 1-2 hours with an abdominal incision that she is fully aware of each time she moves. This human perspective of the implications of a cesarean delivery might help providers to be concerned with their personal and institutional cesarean delivery rates.
6. Consider IHS as a model for the local standard of care. Since we are not controlled by insurance companies, we in IHS often have more opportunity then our colleagues outside IHS to provide care that is evidence-based. VBAC care is one of those situations and we can proudly stand up in the maternity care community as a model of excellent care.

Most importantly we need to respect the women we care for as the ones who are giving birth and realize that, therefore, it needs to be up to them where, how, and with whom they will do so. We are here to provide information and care — to serve not, to dictate.

Please feel free to contact me for any questions or comments and for links to the above mentioned resources at *lisa.allee@ihs.gov*.

Resources: Online

Judy Whitecrane: Tireless improvement of care for Native American women
Karen Carey, PIMC

CDR Judith Whitecrane started her professional career as a diploma graduate prepared nurse, and over the years has continued her education in a manner which is very inspiring to any nurse. Today Ms. Whitecrane is a post master's prepared Nurse whose professional activities involve a concentration in nurse-midwifery.

Not only is she on staff at Phoenix Indian Medical Center, but she is the first non-physician to become Vice-President of Medical Staff. She is involved with the maintenance of the

hospital's level II obstetrical certification and is the PIMC Coordinator and Liaison to the Arizona Perinatal Trust. Ms. Whitecrane is the original author of the Prenatal Questionnaire used throughout the Indian Health Service, tribal and urban programs (I/T/U). Ms. Whitecrane was one of two individuals responsible for the public health nursing teen pregnancy program, which addressed many issues related to teen pregnancy.

Annually, Ms. Whitecrane has helped oversee the Advance Practice Nurse/Physician Assistant Seminar in Scottsdale, Arizona. This national conference has been most successful in meeting the needs of advanced practice nurses and physician assistants.

Ms. Whitecrane serves on the National Nurse Leadership Council as one of two Advance Practice Nurse Consultants. In this role she has worked tirelessly on behalf of the many nurses she represents across the Indian health sysem.

Of specific commendation are her efforts to increase the awareness of the advanced practice nurse working within our current personnel system. Ms. Whitecrane has advocated for the elevation of the advanced practice nurse position to make it more competitive with the private sector. In doing so, she has successfully overseen the updating of the Advanced Practice Nurse Scope of Practice. Both of these activities have been most labor intensive and will have far reaching, positive affects on present and future advanced practice nurses working throughout the Indian health system.

Her efforts will not only pave the way for higher pay for the advanced practice nurse, especially in obsterics and anesthesia, which continue to be the hardest positions to fill, but also will serve to promote a better understanding and provide a firmer framework for facilities who hire advanced practice nurses, by having a true scope of practice which better conforms to local, regional, and national guidelines and expectations.

Over the past three years, Ms. Whitecrane has taken on the role of Chairperson of the OB Task Force. This task force has created significant changes and improvements to the Labor and Delivery Unit at PIMC. She has helped in the creation of emergency drills that allow the staff to better learn the necessary skills to help recognize potential process problems that can be corrected. The task force has also been instrumental in the completion of the remodeling of our obstetrical triage area to create a HIPAA compliant unit and allow safer treatment areas.

Ms. Whitecrane also started the Special Care Clinic for pregnant women with drug abusing problems. This clinic is working well, and we have seen many good outcomes since its initiation. She also has given many lectures to groups wanting to start such a clinic across I/T/U.

Judy has been at PIMC for 26 years and with IHS for 30 years, and has worked tirelessly for the improvement of care to our Native American patients. She retired on Jan. 1, 2008, but her valuable services may be available to worthy causes on a contract basis.

Navajo News

John Balintona, Shiprock

Biliary gallstone disease and pregnancy

Biliary tract disease is the second most common general surgical condition encountered in pregnant women. Often the care of these patients is shared between the obstetric provider and other specialists, including primary care providers and general surgeons. The purpose of this review is to discuss salient points in caring for pregnant patients with biliary gallstone disease. Included in the discussion is the pathophysiology of gallstones, incidence in pregnancy, evaluation of the patient, treatment options during pregnancy, and recommendations for care for obstetric patients with gallbladder disease.

In the US, cholesterol stones are the most common type of gallstone. The formation of cholesterol stones is a result of cholesterol supersaturation and impaired gallbladder motility. Several risk factors have been associated with the increased occurrence of gallstones:

- Obesity; BMI > 30
- Pregnancy
- Female gender
- Native American race
- Heredity
- Increasing age
- Ileal disease
- Drugs; estrogens, TPN, ceftriaxone

Cholelithiasis is found in about 20% of women over 40. Literature suggests that the yearly risk of intervention is about 1 - 2%. Therefore, treatment for asymptomatic disease is not warranted. Complications can occur however, which change the approach and management of this condition. Acute cholecystitis develops when there is a complete obstruction of the cystic duct, usually with colonization by bacteria. Choledocholithiasis occurs when gallstones migrate from the primary site of origin through the cystic duct and into the common bile duct. Gallstones can trigger an attack of acute pancreatitis by transiently impacting in the duodenal papilla. Symptoms related to gallstone disease include steady, nonparyoxsmal pain, usually lasting more than four hours. Anorexia, as well as nausea and vomiting frequently occur. Findings such as low-grade fever and leukocytosis (> 13,000 WBC) are also indicative of cholecystitis. Pancreatic involvement typically results in elevated serum amylase and lipase, elevated liver enzymes, and leukocytosis.

The incidence of gallstone disease in pregnancy ranges from 1 in 1000 to 1 in 4000 for symptomatic disease. When taking into account the presence of asymptomatic cholelithiasis, the literature suggests that 2.5% to 10% of pregnant women will have this condition demonstrated on

ultrasound. It is believed that several factors predispose pregnancy for the development of gallstones. First, the gallbladder volume during fasting and residual volume after contracting is twice that of nonpregnant patients. Second, incomplete emptying may result in retention of cholesterol crystals. The effect of progesterone on smooth muscle function is thought to be the cause of the slow emptying time of the gallbladder. Biliary sludge is thought to increase in pregnancy, again increasing the risk for stone formation. The signs and symptoms of biliary gallstone disease are similar in the pregnant and nonpregnant patient. Development of cholecystitis and/or pancreatitis during pregnancy increases the risk of maternal morbidity, as well as fetal complications, e.g., preterm labor, low birth weight, and fetal loss. Fetal loss is attributed to a combination of acidosis, hypovolemia, and hypoxia.

Evaluation of possible gallstone disease is similar among pregnant and nonpregnant patients. An appropriate history and physical are warranted. Consideration for other disease processes that are similar in presentation, such as acute fatty liver of pregnancy, preeclampsia, infection, etc. should occur. Gestational age-specific fetal surveillance and recording of maternal vital signs is warranted. Laboratory data, which may be helpful in the evaluation, include:

- Complete blood count
- Serum amylase
- Serum lipase
- Liver function tests
- Serum chemistries
- Urinalysis

Ultrasonography has been shown to be of greatest importance in the evaluation of patients with biliary tract disease. Stones as small as 2 mm can be seen, and the sensitivity and specificity of this imaging modality is well over 95%. Findings on ultrasound that are characteristic for acute cholecystitis include tenderness over the gallbladder (ultrasound murphy's sign), pericholecystic fluid, and thickened gallbladder wall. Cholecystoscintigraphy (HIDA) scan is another radiologic technique used in diagnosis, but is currently believed to be contraindicated in pregnancy.

Early in the evaluation, empiric treatment and intervention can be initiated. The patient should be placed NPO, and should be resuscitated with intravenous fluids. Concomitant medical problems should be stabilized. Consideration should be made for nasogastric suction. Paraenteral analgesics should be given and broad antibiotic coverage should be considered, especially in cases involving suspected cholecystitis or pancreatitis. In some facilities, it is standard for a consultation to be sought from general surgery and the nutrition/dietary service.

Primary treatment for symptomatic cholelithiasis in nonpregnant patients remains cholecystectomy. This procedure is safe, relieves symptoms, and has low recurrence rate. Most general surgeons would recommend immediate intervention, with the exception of gallstone pancreatitis where many suggest that resolution of the pancreatitis should occur before surgery. There is a consensus that surgical intervention is warranted in pregnant patients with obstructive jaundice, acute cholecystitis failing medical management, pancreatitis, or suspected peritonitis. However, the management of symptomatic cholelithiasis remains controversial.

Medical management of symptomatic cholelithiasis includes previously described steps of bowel rest, IV hydration, IV pain control, and surgical/nutrition consultations. A number of nonsurgical approaches have been used for gallstone disease. Oral bile acid dissolution therapy, extracorporeal shock wave lithotripsy, and contact dissolution have been described, but there is little, if any, experience with these methods during pregnancy and they are therefore not recommended. Some authors state that up to 80% of patients will get relief from the initial attack with conservative medical treatment. However, literature also suggests that the recurrence rate is high, up to 50% with even higher rates if the initial attack occurs during the second trimester. Some obstetric providers include symptomatic cholelithiasis as an indication for elective induction of labor in appropriate candidates. Successful induction of labor anecdotally relieves the symptoms and shortens the time to potential surgical therapy. The author believes that induction of labor at term in properly selected patients is a viable option for those with symptomatic cholelithiasis.

Surgical intervention remains a viable option even in the pregnant patient with symptomatic gall bladder disease. As noted above, surgical management is indicated in cholecystitis and pancreatitis. Several studies have shown that laparoscopic cholecystectomy is just as safe as open cholecystectomy and even has a number of advantages as well, e.g., shorter hospital stay, lower post-op pain, better cosmesis, etc. Furthermore, several case studies note that the use of the laparoscopic technique is safe and effective even in the third trimester. No strict recommendations exist regarding the obstetric aspects with patients undergoing cholecystectomy but some factors should be considered:

- Perioperative fetal monitoring, especially in gestational age past 14 weeks
- Adequate maternal hydration prior to surgery
- Use of the open (Hassan) technique for insufflation
- Placement of the patient in the left lateral recumbent position
- Pneumoperitoneum pressure less than 15 mm Hg
- Corticosteroid injection for fetal maturity in appropriate patients
- Prophylactic tocolytic therapy

Other sources cite the use of other interventions to include percutaneous cholecystostomy and endoscopic retrograde

cholangiopancreatography (ERCP) in selected patients.

Several studies have been published comparing the outcomes of medical versus surgical management of symptomatic cholelithiasis (with no evidence of cholecystitis or pancreatitis) during pregnancy. One such study concluded that surgical management is safe, decreases days in the hospital, and reduced the rate of labor induction and preterm deliveries. Furthermore, the rate of relapse of symptoms in those managed medically was significantly higher. Maternal and fetal mortality in both groups was shown to be similar. The patient's obstetric provider should ensure that she receives an adequate consultation regarding the data and risks regarding surgical intervention.

This review highlighted several salient factors in the role of the obstetric provider in the care of pregnant patients with biliary gallstone disease. The author would like to summarize a few points that are felt to be especially important:

1. Pregnancy is a risk factor for cholelithiasis.
2. Asymptomatic cholelithiasis does not warrant intervention.
3. Symptomatic cholelithiasis can safely be managed medically or surgically.
4. There is a significant recurrence rate for symptomatic cholelithiasis in pregnancy.
5. Induction of labor for appropriately selected term patients with symptomatic cholelithiasis is a viable option.
6. Cholecystitis and pancreatitis increase the risk for maternal and fetal morbidity and mortality and therefore should be treated aggressively.
7. The obstetric provider should provide specific recommendations regarding the obstetric aspects in patients undergoing surgical intervention.

Reference: Online

Women's Health Headlines
Carolyn Aoyama, HQE
Women's Leadership Scholarship

Women's Leadership Scholarship is a program of the Channel Foundation, a small, private foundation based in Seattle, Washington, that promotes leadership in women's human rights around the globe. Channel's mission is to fund and create opportunities for groups working in many regions of the world to ensure that women's human rights are respected, protected, and fulfilled.

Eligible candidates include women leaders from the Global South and/or from indigenous groups who also meet all the following criteria:

1. They are committed to grassroots organizing and the needs of their communities or indigenous group.
2. They have proof of a bachelor's or a higher degree.
3. They have at least three years of work experience dealing with critical human rights concerns, and other social, educational, environmental, health or economic conditions that negatively affect their communities.
4. They have been accepted into a non-doctoral graduate program at an accredited university for full-time study/research related to their work experience in human rights, sustainable development, and/or public health.
5. They can show evidence of financial need for educational support.
6. They intend to return to their home countries to work, utilizing training and research acquired in the study program.

Contact *http://www.nativeleaders.org:80/how.html*.

MEETINGS OF INTEREST ☐

Available EHR Courses

EHR is the Indian Health Service's Electronic Health Record software that is based on the Resource and Patient Management System (RPMS) clinical information system. For more information about any of these courses described below, please visit the EHR website at *http://www.ihs.gov/CIO/EHR/index.cfm?module=rpms_ehr_training*. To see registration information for any of these courses, go to *http://www.ihs.gov/Cio/RPMS/index.cfm?module=Training&option=index.*

2008 Education in Palliative and End-Of-Life Care-Oncology/IHS (EPEC-O/IHS)
March 25 - 27, 2008; Bloomington, Minnesota

The 2008 Education in Palliative and End-Of-Life Care-Oncology/IHS (EPEC-O/IHS) will be held March 25 - 27, 2008 in Bloomington, Minnesota. This intensive, interactive training course is a joint effort between the IHS and the National Cancer Institute and is evolving into one of the best opportunities available to develop specific skills related to caring for patients and families who are facing cancer and other serious chronic illnesses, and those facing the end of life.

The faculty features the top clinicians in the field. Participation is open to all physicians, nurses, social workers, and pharmacists across the Indian health system. All Indian health facilities are encouraged to support interested physicians, nurses, social workers, pharmacists, and others to attend this course. If a facility wishes to send a team, that would be ideal.

The National Cancer Institute has provided funds to cover travel costs and the *per diem* for about 35 attendees for this course. We will accept applications on a first request, first served basis. Please contact Timothy Domer, MD by e-mail at *timothy.domer@ihs.gov*.

A second training session will be held in Flagstaff, Arizona April 22 - 24. The location of that training will be forthcoming shortly. You may apply to attend that course using the same e-mail address.

The March training will be held at the Holiday Inn Select International Airport, 3 Appletree Square, Bloomington, Minnesota 55425. Please make your hotel room reservations by March 3, 2008 by calling 1-800-465-4329 or (952) 854-9000. Be sure to ask for the "Indian Health Service" group rate. For online registration and the most current conference agenda, please visit the Clinical Support Center web page at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*.

The IHS Clinical Support Center is the accredited sponsor for this meeting. The Indian Health Service (IHS) 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 up to 18¾ hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spent in the educational activity. The American Academy of Physician Assistants (AAPA) accepts this AMA Category 1 credit for physician assistants. The Indian Health Service is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center Commission on Accreditation, and designates this program for 18.75 contact hours for nurses. For more information on CME/CEU, contact Gigi Holmes or CDR Dora Bradley at (602) 364-7777 or e-mail *gigi.holmes@ihs.gov*.

Cardiovascular Disease Update
April 4, 2008; Scottsdale, Arizona

The Native American Cardiology Program is organizing a one-day conference for primary care providers in the Indian Health Service. The conference agenda and registration will be going out by e-mail and fax soon. We are excited to have a group of topnotch faculty to discuss the most up-to-date clinical recommendations for the diagnosis and management of cardiovascular disease. Conference topics include advances in the management of stroke, peripheral vascular disease, and acute MI; evaluation and treatment of atrial fibrillation and heart failure; who needs defibrillators; brief updates on guidelines changes, and advances in cardiac resuscitation. The target audience includes all medical staff with an interest in cardiovascular disease. The IHS Clinical Support Center is the accredited sponsor. The meeting is free to IHS personnel; it will be held at the Chaparral Suites in Scottsdale. For more information, please contact *bmalasky@umcaz.edu* or call our office at (520) 694-7000 or fax requests to (520) 694-6712.

Lifesavers 2008 National Conference on Highway Safety Priorities
April 13 - 15, 2008; Portland, Oregon

Lifesavers is the premier national highway safety meeting in the United States dedicated to reducing the tragic toll of deaths and injuries on our nation's roadways. The conference addresses a wide range of safety topics, from child passenger safety and occupant protection to roadway and vehicle safety and technology. It offers the state-of-the-art information on advances in highway safety, highlights successful programs, and draws attention to emerging safety. Conference attendees come from the public and private sectors representing a

multidisciplinary audience including child passenger safety professionals, EMS, nurses, physicians, social workers, injury prevention advocates, researchers, law enforcement, judicial officials, and consumers. Each year, the Lifesavers Conference has become even more relevant and timely, providing a forum that delivers common-sense solutions to today's critical highway safety problems.

For more information visit *www.lifesaversconference.org*; telephone (703) 922-7944; fax (703) 922-7780.

8th Annual Advances in Indian Health
April 29 - May 2, 2008; Albuquerque, New Mexico

The 8th Annual Advances in Indian Health Conference is offered for primary care physicians, nurses, and physician assistants who work with American Indian and Alaskan Native populations at Federal, tribal, and urban sites. Medical students and residents who are interested in serving these populations are also welcome.

Both new and experienced attendees will learn about advances in clinical care specifically relevant to American Indian populations with an emphasis on southwestern tribes. Opportunities to learn from experienced clinicians who are experts in American Indian health will be emphasized. Indian Health Service Chief Clinical Consultants and disease control program directors will be available for consultation and program development.

The conference format includes three and a half days (Tuesday, Wednesday, Thursday, and Friday morning) of lectures and case discussion workshops. In early spring, the brochure will be posted on the UNM CME website at *http://hsc.unm.edu/cme*. For additional information, please contact Kathy Breckenridge, University of New Mexico Office of Continuing Medical Education at (505) 272-3942, or e-mail the UNM CME Office to request at brochure at *CMEWeb@salud.unm.edu*.

If you would like to review a sample program, you can find it on the National Council of Chief Clinical Consultant's website at *http://www.ihs.gov/NonMedicalPrograms/NC4/nc4-fpAdvances.asp*.

2008 Nurse Leadership in Native Care (NLiNC) Conference
"New Directions in the New Frontier: Education, Evidence, and Empowerment"
May 12 - 15, 2008; Anchorage, Alaska

IHS, tribal, and urban nurses are encouraged to attend the NLiNC (Nurse Leadership in Native Care) Conference to be held at the Hotel Captain Cook, 939 West 5th Avenue, Anchorage, Alaska 99501; *www.captaincook.com*. Please make your room reservations by **April 11, 2008** by calling the toll-free number, 1-800-843-1950, or call the Hotel Captain Cook directly at (907) 276-6000; ask for the "Alaska Native Medical Center" to secure the special rate of $105 + tax single or double occupancy per night. Please remember to book early –regularly priced hotel rooms in Anchorage can average nearly $200/night + tax in the summer! This rate is available three days before and three days after the conference, on a space available basis.

Alaska Native Medical Center is an approved provider of continuing education by the Alaska Nurses Association, an accredited approver by the American Nurses Association Credentialing Centers' Commission on Accreditation; Provider Number AP-06-002. For more information about this event, contact Casie Williams, Nurse Educator, Alaska Native Medical Center, at *cwilliams@anmc.org*; or telephone (907) 729-2936. You can also visit the NNLC website at *http://www.ihs.gov/MedicalPrograms/nnlc/*.

Keeping the Circle Strong: Celebrating Native Women's Health and Well Being
June 9 - 11, 2008; Albuquerque, New Mexico

The National Indian Women's Health Resource Center, directed by Pamela Iron, will hold their 10th year anniversary celebration conference June 9 - 11, 2008 in Albuquerque, New Mexico. An exciting and informative program is planned to address the physical, mental, social, and spiritual well being of our Native women by keeping the circle of our traditions strong and celebrating what we were taught from those who came before us. Health educators, nurse practitioners, health administrators, and health care providers interested in women's health should attend. Dr. Kathleen Annette, Bemidji Area Indian Health Service Director, will be the keynote speaker. Other noted speakers include Dr. Cynthia Lindquist Mala, a health and education activist, and Dr. Billie Kipp, University of New Mexico Center for Native American Health. Vanessa Shortbull will provide the entertainment. For more information regarding the agenda, please go to our website at *www.niwhrc.org*.

The meeting will be held at the Marriott Hotel, 2101 Louisiana Blvd. NE, Albuquerque New Mexico 87110. Please make your room reservations by calling 1-(800)-334-2086. You can go online at *www.marrott.com/abqnm* to register for the hotel using the group code NIWNIWA. If you call in your registration, the group code is NIWHRC. The room rates are $75.00 for a single or double. The conference rates are $100 with a NIWHRC membership and $150 without. To register for the conference and become a member, visit *www.niwhrc.org*. For further information on how to register by check or Purchase Order, please call (918) 456-6094 or e-mail *Donita@niwhrc.org*. If you would like to be an exhibitor or arts and crafts vendor, please contact our office. The conference will be accredited by the National Council of Health Education Credentialing (NCHES).

POSITION VACANCIES ☐

Editor's note: As a service to our readers, THE IHS PROVIDER *will publish notices of clinical positions available. Indian health program employers should send brief announcements on an organizational letterhead to: Editor,* THE IHS PROVIDER, *The IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004. Submissions will be run for two months, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service. The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.*

Internal Medicine, Family Practice, and ER Physicians
Pharmacists
Dentists
Medical Technologists
ER, OR, OB Nurses
Crow Service Unit, Crow Agency, Montana

The Crow Service Unit is seeking health practitioners to come work with their dedicated staff on the Crow Indian Reservation. The Crow Service Unit consists of a small 24-bed hospital located in Crow Agency and two satellite clinics, Lodge Grass Health Center, located approximately 20 miles south of Crow Agency, and Pryor Health Station, located about 70 miles northwest of Crow Agency.

The hospital is a multidisciplinary facility that includes inpatient, outpatient, urgent care, emergency room, dental, behavioral health, substance abuse, public health nursing, physical therapy, pharmacy, dietary, obstetrics, surgery, and optometry services. Our medical staff includes nine family practice positions, two ER physician positions, one general surgeon, two obstetrician/gynecologists, one podiatrist, one internist/pediatrician, one pediatrician, one radiologist, one nurse midwife, and six mid-level provider positions (NP or PA). Family practice physicians and the internist share the hospitalist responsibilities, and each primary care physician shares the daytime ER call duties. The staff is complemented by contract locum tenens physicians for nighttime, weekend, and holiday coverage. OB call is shared between the obstetrician/gynecologists, the midwife and the FP physicians. The two outlying clinics in Lodge Grass and Pryor are primarily staffed by midlevel providers.

The Crow Tribe is a close, proud people. They maintain their own buffalo herd and proudly display their cultural heritage during events such as the well-known Crow Fair. Other points of cultural interest in the "Tipi Capital of the World" are The Little Big Horn Battlefield National Monument, Chief Plenty Coup State Park, and the Little Big Horn College.

For those who enjoy the outdoors, Red Lodge Mountain Resort offers great skiing. The Big Horn Canyon National Recreation Area offers great fishing, camping, and boating fun. The area offers spectacular mountains and mountain activities, and world class hunting and fishing. Billings, Montana, a city of 100,000, is less than an hour away.

For additional information, please contact Audrey Jones, Physician Recruiter, at *Audrey.jones@ihs.gov*; telephone (406) 247-7126; or Dr. Michael Wilcox at *Michael.wilcox@ihs.gov*; telephone (406) 638-3309.

Family Practice Physician
Warm Springs Health and Wellness Center; Warm Springs, Oregon

The Warm Springs Health and Wellness Center has an immediate opening for a board certified/eligible family physician. We have a clinic that we are very proud of. Our facility has been known for innovation and providing high quality care. We have positions for five family physicians, of which one position is open. Our remaining four doctors have a combined 79 years of experience in Warm Springs. This makes us one of the most stable physician staffs in IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs in Central Oregon. We have a moderately busy outpatient practice with our doctors seeing about 16 - 18 patients per day under an open access appointment system. Currently we are a pilot site for the IHS Director's Initiative on Chronic Disease Management. We fully utilize the IHS Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626.

Primary Care Physicians (Family Medicine/Internal Medicine)
Santa Fe Indian Hospital; Santa Fe, New Mexico

The Santa Fe Indian Hospital is expanding its primary care department and is currently seeking three to four board certified family physicians and general internists to join its outstanding medical staff. We provide care to a diverse population of nine Pueblo communities in north central New Mexico, as well as an urban population in and around Santa Fe, New Mexico. The current primary care staff of five family physicians, three pediatricians, one internist, and three PA/CNP providers work closely with one another to give full

spectrum ambulatory and inpatient services. Three nurse midwives, one OB-Gyn, one general surgeon, one podiatrist, one psychiatrist, and one psychologist are also on site.

Family physicians and general internists at the Santa Fe Indian Hospital all have continuity clinics, and are collectively responsible for covering a moderately busy urgent care and same day clinic seven days a week. They also participate in a rotating hospitalist schedule. When fully staffed, these providers will take one in eight night call and will work approximately two federal holidays per year. In our "work hard, play hard" approach to scheduling, hospitalist weeks are followed by scheduled long weekends off, with scheduled days off during the week in compensation for other weekend shifts.

This is an opportunity for experienced primary care physicians to have the best of two worlds: providing care to a fantastic community of patients *and* living in one of the country's most spectacular settings. Santa Fe has long been recognized as a world-class destination for the arts and southwestern culture, with nearly unlimited outdoor activities in the immediate area. As a consequence, our staff tends to be very stable, with very little turnover. Ideal candidates are those with previous experience in IHS or tribal programs who are looking for a long-term commitment. For more information, please contact Dr. Bret Smoker, Clinical Director, at (505) 946-9279 (e-mail at *bret.smoker@ihs.gov*), or Dr. Lucy Boulanger, Chief of Staff, at (505) 946-9273 (e-mail at *lucy.boulanger@ihs.gov*).

Chief Pharmacist
Staff Pharmacist
Zuni Comprehensive Healthcare Center; Zuni, New Mexico

The ZCHCC, within the Indian Health Service, is located on the Zuni Indian Reservation in beautiful western New Mexico. ZCHCC is a critical access hospital with an inpatient unit consisting of 30 plus beds, labor and delivery suites, emergency department, and a large outpatient clinic. The center serves the Zuni and Navajo Tribes. Housing and moving expenses available for eligible applicants. The Zuni are a Pueblo people with rich culture, customs, and traditions. Applicants may contact Cordy Tsadiasi at (505) 782-7516 or CDR David Bates at (505) 782-7517.

Psychiatrist
SouthEast Alaska Regional Health Consortium; Sitka, Alaska

Cross cultural psychiatry in beautiful southeastern Alaska. Positions available in Sitka for BE/BC psychiatrist in our innovative Native Alaskan Tribal Health Consortium with a state-of-the-art EHR in the coming year. Join a team of committed professionals. Inpatient, general outpatient, telepsychiatric, C/L, and child/adolescent work available. Excellent salary and benefit pkg. Loan repayment option. Live, hike, and kayak among snow capped mountains, an island studded coastline, whales, and bald eagles. CV and questions to *tina.lee@searhc.org* or (907) 966-8611. Visit us at *www.searhc.org*.

Family Practice Physician
Sonoma County Indian Health Project; Santa Rosa, California

The Sonoma County Indian Health Project (SCIHP) in Santa Rosa, California is seeking a full-time BC/BE Family Practice Physician to join our team. SCIHP is a comprehensive community care clinic located in the northern Californian wine country. Candidates must currently hold a California Physician/Surgeon license. Inpatient care at the hospital is required. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. For more information, please contact Bob Orr at (707) 521-4654; or by e-mail at *Bob.Orr@crihb.net*.

Family Practice Physician/Medical Director
American Indian Health and Family Services of Southeastern Michigan; Dearborn, Michigan

American Indian Health and Family Services of Southeastern Michigan (*Minobinmaadziwin*) (AIHFS) is a non-profit ambulatory health center, founded 1978. AIHFS provides quality, culturally integrated, medical and preventative dental care in addition to comprehensive diabetes prevention and treatment. All of AIHFS programs integrate traditional Native American healing and spiritual practices with contemporary western medicine in both treatment and prevention.

AIHFS is seeking a full time primary care and family practice physician/medical director. This involves the delivery of family oriented medical care services as well as general professional guidance of primary care staff. The incumbent will also function as the Medical Director, who will collaborate with fellow physicians and the Executive Director on administrative operations of the medical, dental, and behavioral health services.

Please send a cover letter (include the position that you are applying for, a summary of your interests and qualifications for position), minimum salary requirement, resume, and a list of three professional references with contact information to American Indian Health and Family Services of Southeastern Michigan, Inc., Attn: Jerilyn Church, Executive Director, P.O. Box 810, Dearborn, Michigan; fax: (313) 846-0150 or e-mail *humanresources@aihfs.org*.

Pediatrician
Nooksack Community Clinic; Everson, Washington

The Nooksack Community Clinic in Everson, Washington is seeking an experienced pediatrician to take over the successful practice of a retiring physician. The clinic provides outpatient care to approximately 2,000 members of the

Nooksack Indian Tribe and their families. The position includes some administrative/supervisory duties as well as part-time direct patient care. We are seeking a dedicated, experienced pediatrician with a special interest in child advocacy and complex psychosocial issues. This is a full time position with a competitive salary and benefits. There are no on-call, no inpatient duties, and no obstetrics. We currently are staffed with one family practitioner, one internist, one pediatrician, and one nurse practitioner. Additionally we have three mental health counselors, a state-of-the-art four-chair dental clinic, a nutritionist, a diabetic nurse educator, and an exercise counselor. We provide high quality care in an environment that prides itself on treating our patients like family.

The clinic is located in a very desirable semi-rural area of Northwest Washington, renown for its scenic beauty, quality of life, and year 'round outdoor recreation. The beautiful city of Bellingham is 20 minutes away. Vancouver, Canada is less than 90 minutes away, and Seattle is approximately a two-hour drive away. St. Joseph Hospital in nearby Bellingham offers a wide range of specialist and inpatient services, an excellent hospitalist program, as well as emergency care, lab, and imaging services, all easily accessible for our patients.

For further information, please send your CV or contact Dr. MaryEllen Shields at *nooksackclinic a,gmail.com*, or write c/o Nooksack Community Health Center, PO Box 647, Everson, Washington 98247; telephone (360) 966-2106; fax (360) 966-2304.

Nurse Executive
Santa Fe Indian Health Hospital; Santa Fe, New Mexico

The Santa Fe Indian Hospital is recruiting for a quality, experienced nurse executive. The 39-bed Santa Fe Indian Hospital is part of the Santa Fe Service Unit providing services in the clinical areas of general medical and surgical care, operating room, urgent care, progressive care, and preventive health. The purpose of this position is to serve as the top level nurse executive for all aspects of the nursing care delivery. As Director of Nursing (DON) services, manages costs, productivity, responsibility of subordinate staff, and programs, as well as providing leadership and vision for nursing development and advancement within the organizational goals and Agency mission.

The Nurse Executive is a key member of the SFSU Executive Leadership Team and has the opportunity to coordinate clinical services with an outstanding, stable, and experienced Clinical Director and Medical Staff. The SFSU includes the hospital and four ambulatory field clinics primarily serving nine tribes. The SFSU earned 2006 Roadrunner Recognition from Quality New Mexico. The hospital is located in beautiful Santa Fe, New Mexico, filled with cultural and artistic opportunities.

Contact CAPT Jim Lyon, CEO at (505) 946-9204 for additional information.

Director of Nursing
Acoma-Canoncito Laguna Hospital; San Fidel, New Mexico

Acoma-Canoncito Laguna Hospital has an opening for a director of nursing. The Acoma-Cononcito Laguna Service Unit (ACL) serves three tribal groups in the immediate area: the Acoma Pueblo (population 3,500), the Laguna Pueblo (5,500) and the Canoncito Navajos (1,100). The ACL Hospital is located approximately 60 miles west of Albuquerque, New Mexico. The hospital provides general medical, pediatric, and obstetric care with 25 beds. The director of nursing is responsible for planning, organizing, managing, and evaluating all nursing services at ACL. This includes both the inpatient and outpatient areas of the service unit. The director of nursing participates in executive level decision making regarding nursing services and serves as the chief advisor to the chief executive officer (CEO) on nursing issues. Other responsibilities include management of the budget for nursing services. For more information about the area and community, go to *http://home.Abuquerque.ihs.gov/serviceunit/ACLSU.html*. For details regarding this great employment opportunity, please contact Dr. Martin Kileen at (505) 552-5300; or e-mail *martin.kileen@ihs.gov*.

Primary Care Physician
(Family Practice Physician/General Internist)
Family Practice Physician Assistant/Nurse Practitioner
Kyle Health Center; Kyle South, Dakota

Kyle Health Center, a PHS/IHS outpatient clinic, is recruiting for the position of general internal medicine/family practice physician and a position of family practice physician assistant/nurse practitioner. The clinic is south of Rapid City, South Dakota, and is located in the heart of the Badlands and the Black Hills – an area that is a favorite tourist destination. It is currently staffed with physicians and mid-level practitioners. It provides comprehensive chronic and acute primary and preventive care. In-house services include radiology, laboratory, pharmacy, optometry, podiatry, primary obstetrics/gynecology, diabetic program, and dentistry. There is no call duty for practitioners. We offer competitive salary, federal employee benefits package, CME leave and allowance, and loan repayment. For further information, please contact K.T Tran, MD, MHA, at (605) 455-8244 or 455-8211.

Internist
Northern Navajo Medical Center; Shiprock, New Mexico

The Department of Internal Medicine at Northern Navajo Medical Center (NNMC) invites board-certified or board-eligible internists to interview for an opening in our eight-member department. NNMC is a 75-bed hospital in Shiprock, New Mexico serving Native American patients from the northeastern part of the Navajo Nation and the greater Four

Corners area. Clinical services include anesthesia, dentistry, emergency medicine, family practice, general surgery, internal medicine, neurology, OB/Gyn, optometry, orthopedics, ENT, pediatrics, physical therapy, and psychiatry. Vigorous programs in health promotion and disease prevention, as well as public health nursing, complement the inpatient services.

The staff here is very collegial and unusually well trained. A vigorous CME program, interdepartmental rounds, and journal clubs lend a decidedly academic atmosphere to NNMC. Every six weeks, the departments of internal medicine and pediatrics host two medical students from Columbia University's College of Physicians and Surgeons on a primary care rotation. In addition, we have occasional rotating residents to provide further opportunities for teaching.

There are currently eight internists on staff, with call being about one in every seven weeknights and one in every seven weekends. We typically work four 10-hour days each week. The daily schedule is divided into half-days of continuity clinic, walk-in clinic for established patients, exercise treadmill testing, float for our patients on the ward or new admissions, and administrative time. On call, there are typically between 1 and 4 admissions per night. We also run a very active five-bed intensive care unit, where there is the capability for managing patients in need of mechanical ventilation, invasive cardiopulmonary monitoring, and transvenous pacing. The radiology department provides 24-hour plain film and CT radiography, with MRI available weekly.

The Navajo people suffer a large amount of diabetes, hypertension, and coronary artery disease. There is also a high incidence of rheumatologic disease, tuberculosis, restrictive lung disease from uranium mining, and biliary tract and gastric disorders. There is very little smoking or IVDU among the Navajo population, and HIV is quite rare.

Permanent staff usually live next to the hospital in government-subsidized housing or in the nearby communities of Farmington, New Mexico or Cortez, Coloado, each about 40 minutes from the hospital. Major airlines service airports in Farmington, Cortez, or nearby Durango, Colorado. Albuquerque is approximately 3½ hours away by car.

The great Four Corners area encompasses an unparalleled variety of landscapes and unlimited outdoor recreational activities, including mountain biking, hiking, downhill and cross-country skiing, whitewater rafting, rock climbing, and fly fishing. Mesa Verde, Arches, and Canyonlands National Parks are within a 2 - 3 hour drive of Shiprock, as are Telluride, Durango, and Moab. The Grand Canyon, Capitol Reef National Park, Flagstaff, Taos, and Santa Fe are 4 - 5 hours away.

If interested, please contact Thomas Kelly, MD, by e-mail at *Thomas.Kelly@ihs.gov* or call (505) 368-7037.

Physician Assistant
Native American Community Health Center, Inc.; Phoenix, Arizona

The Native American Community Health Center, Inc. (dba Native Health) is a non-profit, community focused health care center centrally located in the heart of Phoenix, Arizona. Native Health has been providing health care services to the urban Indian community in metro Phoenix, since it was incorporated in 1978. Native Health is currently seeking a physician assistant (PA). The PA is a key element in providing quality health care services to patients of all ages. Native Health offers competitive and excellent benefits. For more information, contact the HR Coordinator, Matilda Duran, at (602) 279-5262 or *mduran@nachci.com*.

Family Practice Physicians
Medical Clinic Manager
North Olympic Peninsula, Washington State

The Jamestown Family Health Clinic is seeking two BC/BE full spectrum family practice physicians with or without obstetrical skills. The clinic group consists of five FP physicians, two OB/GYN physicians, and five mid-level providers. The clinic is owned by the Jamestown S'Klallam Tribe and serves tribal members and approximately 9,000 residents of the north Olympic Peninsula. The practice includes four days per week in the clinic and inpatient care at Olympic Medical Center. OMC is family medicine friendly with hospitalists who cover nighttime call and are available to assist with most hospital rounding. Our practice fully utilizes an electronic medical record system (Practice Partner) and participates in the PPRI net research affiliated with Medical University of South Carolina. The clinic serves as a rural training site for the University of Washington Family Medicine residency.

The Jamestown S'Klallam Tribe provides a competitive salary and unbeatable benefit package including fully paid medical, dental, and vision coverage of the physician and family. The north Olympic Peninsula provides boating opportunities on the Strait of San Juan de Fuca, and hiking, fishing, and skiing opportunities in the Olympic Mountains and Olympic National Park. Our communities are a short distance from Pacific Ocean beaches, a short ferry ride away from Victoria, BC, and two hours from Seattle.

Send CV to Bill Riley, Jamestown S'Klallam Tribe, 1033 Old Blyn Highway, Sequim, Washington 98382, or e-mail *briley@jamestowntribe.org*.

The Medical Clinic Manager is responsible for management and staff supervision of the multiple provider clinic in Sequim, Washington. Clinic services include primary care and OB/GYN. Send cover letter and resume to Jamestown S'Klallam Tribe, 1033 Old Blyn Highway; Sequim Washington 98382, Attn: Bill Riley; or fax to (360) 681-3402; or e-mail *briley@jamestowntribe.org*. Job description available at (360) 681-4627.

Chief Pharmacist
Deputy Chief Pharmacist
Staff Pharmacists (2)
Hopi Health Center; Polacca, Arizona

The Hopi Health Care Center, PHS Indian Health Service, is located on the Hopi Indian Reservation in beautiful northeastern Arizona. HHCC is a critical access hospital with an inpatient unit consisting of four patient beds plus two labor and delivery suites, emergency room, and a large outpatient clinic. The HHCC serves the Hopi, Navajo and Kiabab/Paiute Tribes. Housing, sign-on bonus and/or moving expenses are available for eligible applicants. The Hopi people are rich in culture, customs, and traditions and live atop the peaceful mesas. Applications are available on-line at *www.ihs.gov*, or contact Ms. April Tree at the Phoenix Area Office at (602) 364-5227.

Nurse Practitioners
Physician Assistant
Aleutian Pribilof Islands Association (APIA), St. Paul and Unalaska, Alaska

Renown bird watcher's paradise! Provide health care services to whole generations of families. We are recruiting for mid-level providers for both sites, and a Medical Director for St. Paul and a Clinical Director for Unalaska, Alaska.

Duties include primary care, walk-in urgent care, and emergency services; treatment and management of diabetes a plus. Must have the ability to make independent clinical decisions and work in a team setting in collaboration with referral physicians and onsite Community Health Aide/Practitioners. Sub-regional travel to other APIA clinics based on need or request. Graduate of an accredited ANP or FNP, or PA-C program. Requires a registration/license to practice in the State of Alaska. Credentialing process to practice required. Knowledge of related accreditation and certification requirements. Minimum experience 2 - 3 years in a remote clinical setting to include emergency care services and supervisory experience. Indian Health Service experience a plus. Will be credentialed through Alaska Native Tribal health Consortium. Positions available immediately. Work 37.5 hours per week.

Salary DOE + benefits. Contractual two year commitment with relocation and housing allowance. Job description available upon request. Please send resumes with at least three professional references to Nancy Bonin, Personnel Director, via email at *nancyb@apiai.org*.

Family Practice Physician
Dentist
Northeastern Tribal Health Center; Miami, Oklahoma

The Northeastern Tribal Health Center is seeking a full-time Family Practice Dentist and a Family Practice Physician to provide ambulatory health care to eligible Native American beneficiaries. The Health Care Center is located in close proximity to the Grand Lake area, also with thirty minute interstate access to Joplin, Missouri. The facility offers expanded salaries, excellent benefits, loan repayment options, no weekends, and no call. To apply please submit a current resume, certifications, and current state license. Applicants claiming Indian preference must submit proof with their resume. Applicants will be required to pass a pre-employment drug screen and complete a background check. To apply, send requested documents to Northeastern Tribal Health Center, P.O. Box 1498, Miami, Oklahoma 74355, attention: Personnel. The phone number is (918) 542-1655; or fax (918) 540-1685.

Internal Medicine and Family Practice Physicians
Yakama Indian Health Center; Toppenish, Washington

Yakama Indian Health Center in Toppenish, WA will soon have openings for internal medicine and family practice physicians. The current staff includes four family physicians, two pediatricians, one internist, five nurse practitioners, and a physician assistant. The clinic serves the 14,000 American Indians living in the Yakima Valley of south central Washington. Night call is taken at a local private hospital with 24/7 ER coverage. The on-call frequency is about 1 out of 7 nights/weekends. The area is a rural, agricultural one with close proximity to mountains, lakes, and streams that provide an abundance of recreational opportunities. The weather offers considerable sunshine, resulting in the nearest city, Yakima, being dubbed the "Palm Springs of Washington." Yakima is about 16 miles from Toppenish, with a population of 80,000 people. There you can find cultural activities and a college. For further information, please call or clinical director, Danial Hocson, at (509) 865-2102, ext. 240.

Family Practice Physician
Ilanka Community Health Center; Cordova, Alaska

The Ilanka Community Health Center has an immediate opening for a board certified/eligible family practice physician. Position is full-time or part-time with flexible hours.

Ilanka is a tribally-owned clinic that also receives federal Community Health Center funding. We serve all members of the community. Cordova also has a 10-bed Critical Access Hospital with on-site long-term care beds. Physicians and physician assistants provide services in the clinic and in the hospital emergency department, as well as inpatient and long-term care.

This is a very satisfying practice with a nice mix of outpatient, ER, and inpatient medicine. Sicker patients tend to be transferred to Anchorage. The clinic provides prenatal care to about 20 patients a year, but the hospital is currently not doing deliveries.

Cordova is a small, beautiful community situated in southeast Prince William Sound. It is a very friendly town. The population of Cordova is 2,500 in the winter and around

5,000 in the summer. The population is 70% Caucasion, 15% Alaska Native, and 10% Filipino, with an influx of Hispanic patients in the summer.

Most of the town is within easy walking distance to the clinic/hospital. The community is off the road system, but connects to roads by ferry and has daily flights to Anchorage and Juneau. This offers the advantages of remoteness with the benefits of connectivity.

We have tremendous access to outdoor sports and activities including excellent hiking, cross country skiing, alpine skiing, ice skating, boating, world class kayaking, heli-skiing, fishing, and hunting. This is the source of Copper River Salmon!

We offer flexible schedules, competitive salary and benefits, and loan repayment options. We would like to hear from you if you are excited about being an old style, small-town, family doctor.

Get more information about Cordova at *www.cordovaalaska.com*, *www.cordovachamber.com*, and *www.cordovaalaska.net/cordovarealty/*. For more information, please contact Gale Taylor, at (907) 424-3622; or gale@ilanka.org

Emergency Department Physician/Director
Kayenta Health Center; Kayenta, Arizona

Kayenta is unique in many ways. We are located in the Four Corners area on the Navajo Indian Reservation as part of the Indian Health Service/DHHS. We have challenging assignments, beautiful rock formations, movie nostalgia, ancient ruins, and wonderful clientele to care for. We are within one hundred and fifty miles from the Grand Canyon and one hundred miles from Lake Powell, which offers boating, fishing, water skiing, and camping. World class skiing resorts and winter sports are just a few hours away in Colorado and Utah. Kayenta is a great place to raise a family with stress free living in a small hometown setting.

Working for Kayenta Health Center provides a unique opportunity. Because of our remote location and underserved population, you may be eligible for loan repayment and can be making a real difference in the world.

We are currently recruiting for a BC/BE emergency department physician and director to work in our 24-hour, eight bed facility. This is a great opportunity to join our multi-specialty ten member medical staff and nursing team. This position will be supported by dynamic outpatient clinical services, including dental, optometry, mental health, public heath nursing, pharmacy, radiology, environmental health services, and nutrition.

If interested in this exciting employment opportunity, please contact Stellar Anonye Achampong, MD, Clinical Director, at (928) 697-4001; e-mail *stellar.anonye@ihs.gov*; or send CV to Human Resources/Melissa Stanley, PO Box 368, Kayenta, Arizona 86033; telephone (928) 697-4236.

Multiple Positions
Riverside-San Bernardino County Indian Health Inc.; Banning, California

Internal medicine physician: two years experience in an ambulatory care patient setting. MD degree, current California medical license, current DEA license, board certified.

Public health nurse: bachelor of science degree in nursing from an accredited school of nursing. Must possess a current California nursing license and public health nurse certificate; valid California driver's license and safe driving record.

RN charge nurse: current California RN license, current CPR certification, current California driver's license. Experience with computerized medical management system desirable. Two years experience in ambulatory care, urgent care, or similar setting.

Registered Dietitian & Public Health Nutritionist: bachelor of science degree in foods and nutrition, applicable master's degree in nutrition or masters in public health or RD. At least two years professional experience required. A California driver's license and a current DMV printout are required.

Quality management/credentialing assistant: applicant must possess a high school diploma or equivalent. Must have two years experience in the coordination of quality management and credentialing services for the professional staff. Must have strong written and oral communications skills.

All applicants must be able to work with the Indian community and be sensitive to the Indian culture and its needs. Please fax resumes to Human Resource Department at (951) 849-3581; or e-mail *msouvenir@rsbcihi.org*.

Multiple Professions
Pit River Health Service, Inc.; Burney, California

Pit River Health Service is an IHS funded rural health clinic under P.L.93-638 in northern California that provides medical, dental, outreach, and behavioral health. We are seeking several professional positions to be filled. We are looking for a Health Director to administer and direct the program to fulfill the Pit River Health Service, Inc.'s primary mission of delivering the highest possible quality of preventative, curative and rehabilitative health care to the Indian people served; a Dental Director to plan and implement the dental program and supervise dental staff; a Public Health Nurse or Registered nurse seeking a PHN license to provide public health nursing and to coordinate and supervise Community Health Services program; a Behavioral Health Director/LCSW as an active member of an interdisciplinary team providing prevention, intervention, and mental health treatment services to clients; and a Registered Dental Assistant.

Burney is located about 50 miles northeast of Redding, California in the Intermountain Area. The Intermountain Area offers plenty of recreational opportunities such as fishing,

hiking, camping, boating, and hunting, with a beautiful landscape. Snow skiing is within an hour's drive away. The Intermountain Area is a buyers market for homes, as well. All available positions require a California license and/or certification. To apply for employment opportunities and for more information, please contact John Cunningham; e-mail *johnc@pitriverhealthservice.org*; or telephone (530) 335-5090, ext. 132.

Family Practice Physician
Internal Medicine Physician
Psychiatrist
Winslow Indian Health Care Center; Winslow, Arizona

The Winslow Indian Health Care Center (WIHCC) in northern Arizona is currently looking for primary care physicians in family practice, internal medicine, and psychiatry. We have a staff of 12 physicians, including a surgeon, and nine family nurse practitioners and physician assistants. We offer comprehensive ambulatory and urgent/emergent care to patients at our health center in Winslow, which includes a state-of-the-art, seven-bed Urgent Care Center completed in 2006. WIHCC also operates two field clinics five days a week on the Navajo Reservation, at Leupp and Dilkon. Our FPs and internist also provide inpatient care at the local community hospital, the Little Colorado Medical Center, where the FPs provide obstetrical deliveries with excellent back-up from the local OB-Gyn group. The psychiatrist works as part of a team consisting of one full-time psychiatric nurse practitioner, another (part-time) psychiatrist, and five Navajo counselors, providing primarily outpatient services with occasional hospital consults.

WIHCC offers an awesome mix of professional, cultural, and recreational opportunities. It is located just seven miles from the breathtaking beauty of Navajoland and its people, and 50 miles from Flagstaff – a university town with extensive downhill and cross-country skiing, where several of our employees choose to live. Attractive salary and benefits, as well as a team oriented, supportive work environment are key to our mission to recruit and retain high quality professional staff.

WIHCC became an ISDA 638 contracted site in 2002, and has experienced steady growth and enhancement of programs and opportunities since the transition from a direct IHS program. Please contact Frank Armao, MD, Clinical Director, if you are interested in pursuing an opportunity here, at *frank.armao@wihcc.org*; telephone (928) 289-6233.

Family Practice Physician
Peter Christensen Health Center; Lac du Flambeau, Wisconsin

The Peter Christensen Health Center has an immediate opening for a board certified family practice physician; obstetrics is optional, and call will be 1/6. The facility offers competitive salaries, excellent benefits, and loan repayment options; all within a family oriented work atmosphere.

The Lac du Flambeau Indian Reservation is located in the heart of beautiful northern Wisconsin. The area's lakes, rivers, and woodlands teem with abundant wildlife, making it one of the most popular recreational areas in northern Wisconsin. The area boasts fabulous fishing, excellent snowmobiling, skiing, hunting, golf, and much more. Four seasons of family fun will attract you; a great practice will keep you.

For specific questions pertaining to the job description, call Randy Samuelson, Clinic Director, at (715) 588-4272. Applications can be obtained by writing to William Wildcat Community Center, Human Resource Department, P.O. Box 67, Lac du Flambeau, Wisconsin 54538, Attn: Tara La Barge, or by calling (715) 588-3303. Applications may also be obtained at *www.lacduflambeautribe.com*.

Primary Care Physician
Zuni Comprehensive Community Health Center; Zuni, New Mexico

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has an opening for a full-time primary care physician starting in January 2008. This is a family medicine model hospital and clinic providing the full range of primary care -- including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics -- with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 14 physicians, one PA, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

Zuni Pueblo is one of the oldest continuously inhabited Native American villages in the US, estimated to be at least 800 - 900 years old. It is located in the northwestern region of New Mexico, along the Arizona border. It is high desert, ranging from 6000 - 7000 feet elevation and surrounded by beautiful sandstone mesas, canyons, and scattered sage, juniper, and pinon pine trees. Half of our medical staff has been with us for more than seven years, reflecting the high job and lifestyle satisfaction we enjoy in this community.

For more information, contact John Bettler, MD at (505) 782-7453 (voice mail), (505) 782-4431 (to page), or by e-mail at *john.bettler@ihs.gov*. CVs can be faxed to (505) 782-4502, attn: John Bettler.

Primary Care Physicians (Family Practice, Internal Medicine, Med-Peds, Peds)
Psychiatrists
Pharmacists
Nurses
Chinle Service Unit; Chinle, Arizona

Got Hózhó? That's the Navajo word for joy. Here on the

Navajo Reservation, there's a great mix of challenging work and quality of life. No rush hour traffic, no long commutes, no stressors of urban life. We walk to work (naanish) and enjoy living in our small, collegial community. Our 60-bed acute care hospital is located in Chinle, Arizona, the heart of the Navajo Nation. At work we see unique pathology, practice evidence-based medicine, and are able to utilize the full scope of our medical training. Together, we enjoy learning in an atmosphere of interdepartmental collaboration, supported by an established network of consulting specialists across the southwest. A comprehensive system of preventive programs and ancillary services allows us to provide the best possible care for our patients. During our time off, many of us explore the beautiful southwest, bike on amazing slick rock, and ski the slopes of the Rocky Mountains. It's a great life – combining challenging and interesting work with the peaceful culture of the Navajo people and the beautiful land of the southwest.

We're looking for highly qualified health care professionals to join our team. If you're interested in learning more about a place where "naanish baa hózhó" (work is joyful), contact Heidi Arnholm, Medical Staff Recruiter, Chinle Service Unit, telephone (970) 882-1550 or (928) 674-7607; e-mail *heidi.arnholm@ihs.gov*.

Family Practice Physician
Family Practice Medical Director
Tanana Chiefs Conference, Chief Andrew Isaac Health Center; Fairbanks, Alaska

We are seeking a board certified family practice physician, preferably with obstetrics skills for a full-time position. We will have openings in the summers of 2007 and 2008.

The facility is a multispecialty clinic providing services in obstetric/gynecology, internal medicine, and family practice. It also includes dental, optometry, pharmacy, behavioral health, community health aides, and other services. Our referral region includes 43 villages in interior Alaska covering an area the size of Texas. Fairbanks has an outstanding school system and university. We offer a very competitive salary with a great benefits package and a loan repayment plan. Commissioned Corps positions are also available. Contact Jim Kohler at (907) 459-3806 or *james.kohler@tananachiefs.org*.

Family Practice Physician
Seattle Indian Health Board; Seattle, Washington

Full Time, Fantastic Benefits! We are recruiting for a family practice physician to join our team at the Seattle Indian Health Board in Seattle, Washington. We are a multiservice community health center for medical, dental, mental health, substance abuse, and community education services. We are looking for a physician who is familiar with health and social issues facing American Indians/Alaska Natives and a desire to promote the delivery of appropriate health services to this population.

Seattle Indian Health Board (SIHB) physicians are responsible for the delivery of quality, culturally sensitive primary medical care to the SIHB's patient population. This position provides general medical care (including diagnosis, treatment, management, and referral) to SIHB patients with acute, chronic, and maintenance health care needs. The physician chosen will also participate in the medical on-call rotation schedule and other responsibilities such as consulting and coordinating care with other practitioners, nursing, pharmacy, laboratory, and outside referral sites. He or she will provide clinic preceptorship of mid-level practitioners and patient care instruction to nurses, pharmacists, and other SIHB clinical staff. The incumbent will precept for residents for the outpatient continuity family practice clinics. In addition to supervising patient care, preceptors engage in didactic activity to enhance resident learning. The physician will also participate in quality assurance, program development, community health education/screening, and related activities. He or she will document all patient care information/treatment in problem-oriented format in the patient's medical records, as well as complete and submit encounter forms and related materials according to established procedure. Finally, the person selected will comply with SIHB policies and procedures, and the AAAHC Standards of Care.

Qualifications include board certification in family medicine and a Washington State medical license. All applicants will be required to complete a background check. Please visit our website at *www.sihb.org* for more information, or you can call Human Resources at (206) 324-9360, ext. 1123.

Primary Care Physicians
USPHS Claremore Comprehensive Indian Health Facility; Claremore, Oklahoma

The USPHS Claremore Comprehensive Indian Health Facility has openings for full-time positions for an emergency medicine physician, a surgeon, an anesthesiologist (or nurse anesthetist), an OB/GYN physician, and an internal medicine physician.

The Claremore hospital is a 50-bed specialty based comprehensive care facility, providing care through nine organized clinical services: community health, dentistry, optometry, emergency medical services, general surgery, internal medicine, obstetrics and gynecology, pediatrics, and radiology. In addition, the hospital has a six-bed intensive and coronary care unit and CAT scan equipment with 24 hour teleradiology support. The facility maintains several academic affiliations, and has a professional staff consisting of 36 staff physicians, approximately 60 contract physicians, five dentists, three nurse practitioners, a physician assistant, an optometrist, and an audiologist.

Claremore is a town of 18,000 just 21 miles northeast of the very metropolitan city of Tulsa, with a US Census county

population of 560,431. Tulsa has a major airport with international flights and destinations in most major US cities, and was ranked in the top 10 southern cities in Southern Living magazine and Fodor's Travel Publications as one of its outstanding travel destinations. Tulsa's cost of living is 8 percent below the national average and has a county per capita income 11 percent above the national average. If you prefer rural living, there are many opportunities nearby. The facility is located 10 minutes from a major lake, and only one hour from a lake with over 1,100 miles of shoreline.

For more information, contact Paul Mobley, DO at (918)342-6433, or by e-mail at *paul.mobley@ihs.hhs.gov*. CVs may be faxed to (918) 342-6517, Attn: Paul Mobley, DO.

Family Practice Physician
Hopi Health Care Center; Polacca, Arizona

The Hopi Health Care Center currently has openings for family practice physicians and family nurse practitioner or physician assistants. The Hopi Health Care Center is a small, rural IHS hospital providing full spectrum family practice medical services including ambulatory care, adult/peds inpatient care, low risk obstetrics, and ER care. We currently staff for 12 full time physicians, and four full time FNP/PA positions. Our facility is located in northern Arizona, 90 miles northeast of Flagstaff and 70 miles north of Winslow, on the Hopi Indian Reservation. Services are provided to both Hopi and Navajo reservation communities. The reservation is located in the heart of the southwest; within a 90 mile radius are abundant mountain areas, lakes, forests, and archeological sites. The Hopi Health Care Center is a new facility established in 2000 with a full ambulatory care center environment including a dental clinic, physical therapy, optometry, and behavioral health services. We are a designated NHSC site, and qualify for the IHS Loan Repayment Program.

For more information, please contact Darren Vicenti, MD, Clinical Director at (928) 737-6141 or *darren.vicenti@ihs.gov*. CVs can be faxed to (928) 737-6001.

Family Practice Physician
Chief Redstone Health Clinic, Fort Peck Service Unit, Wolf Point, Montana

We are announcing a job opportunity for a family practice physician at the Chief Redstone Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. This is a unique opportunity for a physician to care for individuals and families, including newborns, their parents, grandparents, and extended family. Applicants must be culturally conscious and work well within a team environment. The Fort Peck Service Unit is located in the northeast corner of Montana along the Missouri river. Fort Peck Service Unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point.

Our Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social work, radiology, lab, public health nursing, and a very active Diabetes Department. These are ambulatory clinics; however our providers have privileges in the local community hospital. We have approximately 80,000 patient contacts per year. We work very closely with the private sector. IHS and the private hospital have a cardiac rehabilitation center. By cooperating with IHS, the hospital has been able to get a CT scanner and a mammography unit. Tribal Health has a dialysis unit attached to the Poplar IHS clinic. Customer service is our priority. The IHS has excellent benefits for Civil Service and Commissioned Corps employees. There are loan repayment options, and we are a designated NHSC site. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being closely involved in our population to encourage a "Healthier Community."

There are many opportunities for recreation, as we are a short distance from the Fort Peck Dam and Reservoir. For more information about our area and community please go to the website at *http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp*. Fort Peck tribes also can be found on *www.fortpecktribes.org*, and the Fort Peck Community College on *www.fpcc.edu*. Northeast Montana offers many amenities one might not expect this far off the beaten path. If you are interested please contact our provider recruiter, CDR Karen Kajiwara-Nelson, MS, CCC-A, at (406) 768-3491 or by e-mail at *karen.kajiwara@ihs.gov*. Alternatively, you can contact Dr. Craig Levy at (406) 768-3491, or e-mail *craig.levy@ihs.gov*, or the Billings Area Physician Recruiter, Audrey Jones, at (406) 247-7126 or e-mail *audrey.iones@ihs.gov*. We look forward to communicating with you.

Pediatrician
Family Practice Physician
Pharmacist
Obstetrician/Gynecologist
PHS Indian Hospital; Browning, Montana

The Blackfeet Service Unit is recruiting for health practitioners who want to join the staff at the PHS Indian Hospital, Browning, Montana. The Blackfeet Service Unit is home to the Blackfeet Community Hospital, a 27-bed hospital, active outpatient clinic, and well-equipped emergency department. Inpatient care includes obstetrics and elective general surgery. We also offer community health nursing, an active diabetes program, optometry, laboratory, dental, and ENT services along with behavioral and social services and women's health. We are seeking candidates who are committed to improving the health of the local community and being part of a team approach to medicine. The hospital is located 13 miles from Glacier National Park. This area offers spectacular mountains and incredible outdoor activities year round. There

are loan repayment options, excellent benefits, and we are a designated NHSC site. If you are interested in joining our medical team, contact Dr. Peter Reuman at *peter.reuman@ihs.gov* or telephone (406) 338-6150; or contact the Physician Recruiter, Audrey Jones, at *audrey.jones@ihs.gov* or telephone (406) 247-7126. We look forward to hearing from interested candidates.

Family Practice Physician
Pharmacists
PHS Indian Hospital, Harlem, Montana

The Fort Belknap Service Unit is seeking family practice physician and pharmacist candidates to join their dedicated staff. The service unit is home to a critical access hospital (CAH) with six inpatient beds, two observation beds, and a 24-hour emergency room, as well as an 8 am to 5 pm outpatient clinic. The service unit also operates another outpatient clinic 35 miles south of Fort Belknap Agency in Hays. The Fort Belknap CAH outpatient visits average 39,000 per year. The new clinic in Hays, the Eagle Child Health Center, can adequately serve 13,000 per year. The medical staff includes four family practice positions, two physician assistants, and one nurse practitioner, and has implemented the Electronic Health Record in the outpatient clinic. The service unit also has a full-time staffed emergency medical services program. The staff is complemented by contract *locum tenens* physicians for weekend emergency room coverage.

The medical staff is supported by and works with a staff of nurses, behavior health personnel, physical therapist, lab and x-ray personnel, pharmacists, dentists, administrators, housekeepers, supply specialists, and contract practitioners to provide the best possible care to patients. The staff works as a team to make a difference. Contract (private) hospitals are from 45 to 210 miles from the facility.

There are loan repayment options, excellent benefits, and we are a designated NHSC site. The area is primarily rural, and a friendly small-town atmosphere prevails here. The reservation communities promote various local activities such as rodeos, church socials, and basketball. The tribe also manages its own buffalo herd. Bigger events fill in the calendar as well, such as the Milk River Indian Days, Hays Powwow, and the Chief Joseph Memorial Days, featuring cultural activities and traditional dancing. The Fort Belknap Tribe has hunting and fishing available both on and off the reservation. The Little Rocky Mountains and the Missouri River provides scenic and enjoyable areas for the outdoor-minded. If you are interested in joining our medical team, contact Dr. Robert Andrews at *robert.andrews@ihs.gov* or telephone (406) 353-3195; or contact the Physician Recruiter, Audrey Jones, at *audrev.jones@.gov;* telephone (406) 247-7126.

Family Nurse Practitioner or Physician Assistant
Fort Peck Service Unit; Poplar, Montana

We are announcing a job opportunity for a family nurse practitioner and/or physician assistant at the Verne E Gibbs Health Center in Poplar, Montana and the Chief Redstone Health Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. The Fort Peck Service Unit is located in the northeast corner of Montana along the Missouri river. Fort Peck Service Unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point. The Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social work, radiology, lab, public health nursing, and a very active Diabetes Department that includes one nurse educator, one FNP, and one nutritionist. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being involved in the community to encourage a "Healthier Community."

There are many opportunities for recreation, as we are a short distance from the Fort Peck Dam and Reservoir. For more information about our area and community please go to the website at *http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp*. We are looking for an applicant with well rounded clinical skills. Two years experience is preferred but new graduates are welcome to apply. Northeast Montana offers many amenities one might not expect this far off the beaten path. If you are interested please contact our provider recruiter, CDR Karen Kajiwara-Nelson, MS, CCC-A at (406) 768-3491 or by e-mail at *karen.kajiwara@ihs.gov*.

Family Practice Physicians
Dentists
Pharmacists
Crownpoint Comprehensive Healthcare Facility; Crownpoint, New Mexico

The Crownpoint IHS facility has openings for two family practitioners with low risk obstetric skills (we will consider candidates without OB skills), two pharmacists, and two general dentists. Our service unit follows a family medicine model for providing full-spectrum care to our patients, with a dynamic medical staff that finds the work here quite rewarding. With a high HPSA rating, we are a NHSC-eligible site for payback and loan repayment.

Crownpoint is a town of about 2,500 people in the Four Corners region of New Mexico. We serve a traditional community of 25,000 Navajo people, many of whom speak only Navajo and live in traditional homes with no running water, electricity, or phone service. Our hospital has a six bed ER, a 17 bed med/peds unit, a labor and delivery/post-partum unit, and a large outpatient clinic. We have a total of 16 dental chairs, optometry, and mental health services, as well as on-site pharmacy, laboratory, radiology, and ultrasonography. Our medical/dental staff is a collegial and supportive group

including ten family physicians, two pediatricians, an obstetrician/gynecologist, a psychiatrist, three PAs, three FNPs, four dentists, and a podiatrist. We have a very exciting, full-spectrum medical practice that includes high-risk prenatal care, low-risk labor and delivery, emergency room care with management of trauma and orthopedics, and an interesting inpatient medicine and pediatric service.

As primary care physicians in a rural setting, we manage a wide variety of medical problems. We care for many patients with diabetes and hypertension, but we also see some unusual illnesses such as plague, Hantavirus, and snake bites. There are many opportunities for outpatient and ER procedures including suturing, therapeutic injections, closed reductions of fractures and dislocations, para/thoracentesis, chest tubes, LPs, colposcopy, sigmoidoscopy, and OB ultrasound.

While Crownpoint is small, there is a lot to do in the surrounding area. There are two junior colleges in town where many of us have taken Navajo language, weaving, and history classes. Some have gotten involved with local churches and children's activities. Outdoor activities are plentiful, with downhill and cross-country skiing, camping, and fishing all nearby. There are several excellent mountain biking and hiking trails, as well as Anasazi ruins that are right in Crownpoint. Albuquerque is two hours away and is our nearest large city with an international airport. Other destinations that are within an afternoon's drive include Santa Fe (three hours), Durango and the Rocky Mountains (two hours), Taos (four hours), Southern Utah's Moab and Arches/Canyonlands National Parks (four hours), Flagstaff (three hours) and the Grand Canyon (five hours).

For more information, contact Harry Goldenberg, MD, Clinical Director, at (505)786-5291, ext.46354; e-mail *harry.goldenberg@ihs.gov*; or Lex Vujan at (505) 786-6241; e-mail *Alexander.vujan@ihs.gov*.

Family Practice Physician
Pediatrician
Bristol Bay Area Health Corporation, Dillingham, Alaska

Bristol Bay Area Health Corporation (BBAHC) is a mature tribal compact located in scenic southwestern Alaska. The Bristol Bay Area Service Unit encompasses 44,000 square miles of Alaska country bordering the Bristol Bay region of the state. Over 400 employees provide primary care to 28 villages including two sub-regional villages, and a primary care hospital, Kanakanak, located in Dillingham, Alaska. The Medical Staff consists of nine family physicians, a pediatrician, a nurse midwife, four dentists, a physical therapist and an optometrist, all providing primary care. The patient population consists of Yupik Eskimo, Aleut, and Athabascans who have been residents of the area for hundreds of years. Family physicians provide a broad spectrum of practice including obstetrics, inpatient medicine, emergency care and procedures such as colonoscopy, EGD, flexible sigmoidoscopy, colposcopy, and treadmill services in a very collegial and supportive atmosphere. Our solo pediatrician is allowed to practice full spectrum pediatrics with an extremely interesting patient mix and some very high risk and rare genetic disorders unique to this area. The pediatrician works in a collegial manner with family physicians and is not required to perform any adult medicine or obstetrics, but solely pediatrics.

BBAHC was the first hospital in the country to establish a 638 contract and has an extremely good working relationship with their Board of Directors. Of note, the practice here in Alaska is unique, and air travel to outlying villages is required, since continuity care to the villages is very important to our care here and is uniquely rewarding. BBAHC has an extremely competitive salary and benefits package.

If interested, please contact Arnie Loera, MD, Corporate Medical Director, at (907) 842-9218, Kanakanak Hospital/Bristol Bay Area Health Corporation, PO Box 130, Dillingham, Alaska 99576. You may also contact him by e-mail at *aloera@bbahc.org*. CVs can be faxed to (907) 842-9250, attn: Arnie Loera, MD. You may also view our website for information about our corporation at *www.bbahc.orq*.

Medical Technologist
Tuba City Regional Health Care Corporation; Tuba City, Arizona

The Tuba City Regional Health Care Corporation, a 73-bed hospital with outpatient clinics serving 70,000 residents of northern Arizona, is recruiting for full-time generalist medical technologists.

The laboratory has state-of-the-art equipment. We offer competitive salary, based on experience. Relocation benefits are available. New graduates are encouraged to apply for this position. Tuba City is located on the western part of the Navajo reservation approximately 75 miles north of Flagstaff, Arizona, with opportunities for outdoor recreation and cultural experiences with interesting and adventurous people.

For more information, please contact Minnie Tsingine, Laboratory Supervisor, at (928) 283-2716 or *minnie.tsingine@tcimc.ihs.gov*. For an application, please contact Human Resources at (928) 283-2041/2432 or *mfrancis@tcimc.ihs.gov*.

Family Medicine Physicians
Phoenix Indian Medical Center, Phoenix, Arizona

The Family Medicine Department is recruiting for BC/BE family physicians at the Phoenix Indian Medical Center and the satellite clinic at Salt River. The positions are predominantly outpatient with limited hospital inpatient activity; OB optional. Join eight physicians, one nurse practitioner, one physician's assistant, and a number of part-time providers. PIMC is one of the largest IHS sites, with over 100 providers and 70 active beds. We have been using PCC+ and in part EMR. There are great opportunities socially, culturally, professionally, and educationally living in the

Phoenix metropolitan area. The IHS has a great benefits package for Civil Service and Commissioned Corps. Loan payback is an option. For more information, please contact/send CV to Eric Ossowski MD, Family Medicine Department, Phoenix Indian Medical Center, 4212 N. 16th Street, Phoenix Indian Medical Center, Phoenix, Arizona 85016. Telephone (602) 263-1537; fax (602) 263-1593; or e-mail *eric.ossowski@ihs.gov*.

Family Practice Physician
Gallup Indian Medical Center; Gallup, New Mexico

The Gallup Indian Medical Center has an immediate opening for a family medicine physician. GIMC is one of the largest Indian Health Service sites. The IHS has great benefits packages for both Civil Service and Commissioned Corps providers. We are an NHSC scholarship and an IHS Loan Repayment site as well. The Department of Family Medicine offers the opportunity for full spectrum family medicine care. There are currently nine physicians, two physician assistants, and one pharmacist clinician in the department. Chronic disease management and prevention are the focus for continued development and expansion of this department and program. The hospital has a multi-specialty group, and family medicine physicians have inpatient privileges at GIMC as well as at the community hospital, Rehoboth McKinley Christian Hospital.

Please contact Dr. Alma Alford, Chief of Family Medicine, if you are interested in pursuing an opportunity here. The address is Gallup Indian Medical Center, 516 E. Nizhoni Blvd., P.O. Box 1337, Gallup, New Mexico 87301-1337; telephone (505) 722-1000; fax (505) 726-8740; office number (505) 722-1280 or 722-1775; e-mail *alma.alford@ihs.gov*.

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THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

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