

THE IHS PRIMARY CARE PROVIDER



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

July 1996

Published by the IHS Clinical Support Center

Volume 21, Number 7

Perceptions of Caring Behaviors in Health Providers

Susan Fifer, RN, MS, Psychiatric Nurse Specialist, Northern Idaho Indian Health Center, Lapwai, Idaho.

Abstract

An ethnographic study of American Indians' perceptions of caring behaviors was completed. Twelve key informants were selected from among tribal members living on a reservation in the Southwest. All identified themselves as American Indian and agreed to be interviewed. Interviewing continued until no new responses were elicited from informants. Findings were validated with key informants.

Rogers¹ and other scholars²⁻⁴ point out that caring about others is a universal phenomenon. However, the expressions, processes, and patterns of caring behaviors vary among cultures.^{5,6}

In order to provide more effective, culturally sensitive, care, health care providers need knowledge of the caring values of the people they are working with. This requires exploration and description of the meaning of caring from the individual's cultural perspective.

An ethnographic study was designed to examine what behaviors of health care providers are perceived by American Indians in the Southwest as demonstrating a caring attitude.

Ethnography

Ethnography has its roots in the social sciences and, in particular, the field of anthropology. Ethnography is a study of culture which looks at an individual's perception as it relates to his culture.⁷ It uses qualitative tools to study human phenomena that are not objectively measurable. It often includes prolonged, direct, personal involvement with the

group being studied and interviewing of selected group members. Ethnography provides insights about a group of people and offers us an opportunity to understand their world.

One approach to ethnography uses precise ways of asking questions in order to frame responses so that perceptions and meanings are elicited. This linguistic approach requires that each informant is asked the same set of questions, in the same context, with further questions prescribed. The interviewer may ask for further information by eliciting stories, and then ask for clarification or further description. In other words, the interview is structured the same way for each informant.

Methods

The researcher attended three formal tribal meetings to present the purpose, procedure, implications, and potential

In This Issue...

- 89 Perceptions of Caring Behaviors in Health Providers
- 95 Qualitative Research
- 100 The Shutdown Message
- 102 Continuing Education Materials Available
- 103 Special Announcements

benefits of the study and answer any questions that members posed. The Tribal Council approved the study, giving the author permission to approach potential key informants.

Following a review of the literature, interview questions were developed; a pilot study was then conducted with three tribal members. As a result of the pilot study, the interview questions were revised. The revised questions were easier to understand and elicited more information from informants about the concept of caring than did the original questions. These questions were used as a guide by the researcher to elicit comments and stories about caring from informants. One of these questions addressed behaviors in health care providers that are perceived as demonstrating caring.

Sample. The sample consisted of American Indian informants who identified themselves as members of the tribe. These informants were selected for their knowledge of the culture of the community, their willingness to share information, and their ability to communicate in a nonanalytic manner. As the researcher described the nature of the study to various tribal members, suggestions for key informants were spontaneously offered. Many of these contacts made additional suggestions for key informants to interview.

Additional key informants were interviewed until no new responses were elicited; this yielded a sample size of 12.

The sample included eight women and four men, ranging in age from 39 to 75 years (mean age of 54). Education achieved ranged from 7 to 18 years, and all had worked at many jobs and fulfilled many roles during their lives. Individuals were selected from various areas on the reservation, to reduce bias by omitting attention to regional differences. While all informants identified themselves as tribal members, at the time of the interview two reported that their heritage included another local tribe.

Setting. The reservation under study was located in the southwestern part of the United States, approximately 35 miles from a large metropolitan area. At the time of the study, the tribal population was 11,700. The setting was rural with a major highway running through the reservation and two paved secondary roads bisecting the area. Most of the roads on the reservation were unpaved. There were few street signs or addresses and few residents had telephones.

Medical facilities on the reservation, staffed by the Indian Health Service, included inpatient, outpatient, and long-term care services. The Tribal Department of Health Services provided health care through five divisions: public health nursing; health education; behavioral health; nutrition and support services, such as medical transportation; and environmental health.

Over the last 20 years residents have moved into villages, whereas they formerly lived on small farms where they traditionally raised both wild and cultivated foods. Gradual acculturation, with significant modifications in lifestyle and diet, has been accompanied by higher rates of diabetes, heart disease, and alcoholism.

Results

To answer the research question, What do American Indians on this reservation identify as important caring behaviors in health care providers? informants responded to the following question: "When you have seen a doctor or nurse for a health problem or sickness, what have they said or done that showed you they care?" Many caring behaviors by health professionals were identified, including touch, voice, attitude, visibility, availability, presence, respect, treatment, consistency, acceptance, visiting, and time perception. While only caring behaviors were solicited, informants volunteered and described both caring and noncaring behavior and actions, and offered suggestions about how to be a caring health provider in their community (see Table 1).

The health providers mentioned included doctors, nurses, a pharmacist, a psychiatrist, and a dentist. These health providers were employed by the Indian Health Service, the tribe, and private hospitals. Inpatient, outpatient, and community health services were the settings where these informants had received health care. Inpatient hospital experiences accounted for one-half of the informants' stories.

Examples of caring and non-caring behaviors.

Examples of caring shown by doctors included giving medications, giving follow-up clinic appointments, being gentle during treatments and examinations, talking with patients, and being ready to help during an emergency. One informant said, "The doctors in intensive care were always friendly to me, they just tell me to 'hang on, you're all right, we're taking care of you . . . We're not letting you die.'"

Physicians perceived as non-caring handled people roughly, "talked down at patients," used "big" words that were not understood, and rushed in and out of the room without "visiting." According to one informant, a doctor was asked by the Tribal Health Board and the Tribal Council to leave the Indian hospital because of non-caring remarks and behavior. The informant recalled, "He came out from back East during the Vietnam War and told people, 'I took the lesser of the two evils and came out here to work, instead of going to war.' That really hurt people here."

The informants gave the following examples of caring shown by hospital nurses: assistance with bathing, feeding, ambulation, and cleaning their beds; talking, being friendly, and telling stories, and jokes. One informant said, ". . . the nurses stood over me, told me I'll be better soon, and held my hand awhile. I know I was really sick, so they held my hand." Another informant described a caring nurse who prepared their family to view a relative's body by using a soft tone of voice and comforting words. One informant responded, "I suppose in the hospital when I had surgery, some of the nurses were kind, were nice, treated me like a person, not just a patient." After describing a negative experience with nurses, one person said, "I think the ones we have now are caring, they're encouraging to everybody, just their presence makes a difference."

Table 1. Behaviors perceived by members of one tribe of American Indians in the Southwest as demonstrating ‘caring’ and ‘non-caring’ in health care providers.

Contrast	Non-Caring	Caring
Touch	Doesn't touch person or sore; rough handling of people.	Shakes hands, hugs, touches person while examining sore; gentle touch; "professional touch."
Voice	"Talks down" or "talks over" people. Uses "big" words; angry voice; yells at people.	Talks at same level; soft, concerned voice.
Attitude	Pushy, demanding; treats people like "little children"; acts like "know it all."	Willing to wait for person to make decisions; patient in teaching people; willing to learn from people.
Visibility	Never seen outside clinic or hospital setting.	Seen at community functions, "Fun Runs," Feast Days, funerals, church sales.
Availability	"Can only get sick between hours of 8 am and 3 pm", only seen if person has an appointment	On call 24 hours a day; available whenever person is sick or needs help.
Presence	Ignores people, avoids spending time with people; does their duties, then leaves.	"Being there" for a person who is sick; spends time with person; willing to listen.
Respect	Criticizes or shames elders; belittles people; "acts like they're better than us."m	Elders treated kindly, revered, learn from elders; understand differences between people, extended family.
Visiting	Visits only when there's a problem; visits on "hit or miss" basis; "doesn't talk about or share his/herself.	Visits people regularly, often, in health and in illness; shares things about themselves, tells stories, jokes.
Time Perception	Always in a hurry; rushes in and out of room; rushes through home visit; "do it now!" Only spends six months or a year in job, then leaves.	Spends time talking, listening, examining person; sits down; has coffee, shares a meal; spends hours with person; is patient, gives person time to accept illness; works several years in community; "Dedicate yourselves to people for a long time."

Two examples of non-caring by hospital nurses were given. One informant said, "Some of the nurses don't do their work, they just go and sit, drink coffee, talk loud, and make noise. We hear them laughing and talking . . . we have our lights on to get help, but they don't come." Another informant noticed that when he was in the hospital, some nurses gave patients unequal treatment. He explained:

I was treated good, maybe because of who I was, what I am, or who I'm related to, but others weren't. . . . There was unequal treatment. Maybe it has to do with the type of illness, if you've got the runs and mess the bed, can't walk, . . . or have a big, smelly sore on your arm, they [the nurses] stay away from you . . . rather than if you are just there for a check-up. You can hear them down the hall, talking to an

elderly man or woman saying, 'What did you do now? Shame on you!' Or some of them come in, not say a word, do their thing and walk out.

Later this informant contrasted non-caring nurses with a nurse he perceived as caring:

There is one nurse I really admired . . . that really went overboard in terms of treating everybody the same. She didn't care what happened or what you did. . . . It didn't make a difference to her with the care she provided. When this nurse was on duty, the feeling throughout the ward changed, it was a warm feeling. She had a different aura than the others. . . . She worked hard but would talk, joke, tell stories while she was doing her necessary duties.

Some of the informants gave examples of caring and non-caring by health professionals in an outpatient setting. One informant described his dialysis nurse:

I can't thank her enough. I call her 'My Little Angel of Mercy'. . . . She taught me everything about kidney disease, how to mix my exchanges, how to cure peritonitis, what heparin is, all that is caring. When I get sick, she's on-call 24 hours a day. She's always there whenever I go to the hospital, that shows she cares.

Another informant who regularly attends clinic shared her opinion of the nurses, "The nurses I've known, I don't see them as nurses, they're just friends of mine. . . . It's hard to explain, I just feel they do care about me, they say so at times and show me with their hugs."

One informant admitted she refused to have a gynecology exam for a long time because she was uncomfortable with the male doctors and didn't trust them. However, she described a recent clinic visit with a caring doctor:

This doctor was different. . . . He had a soft tone of voice, nice expressions; he was serious, but smiled at times. He sat there, spent time talking to me about himself. I felt comfortable with him. I trusted him, so I agreed to have him do the exam. He had a gentle touch, but very professional. I felt like I was the only person he was examining that day, and I was so thankful that he came to our hospital. When the time came for me to go back, I was anxious to see him, to talk with him, to listen to him. After that I came home and told other women, 'Go see Dr. So and So. He's very nice.'

One informant spoke highly of the public health nurses, their reservation regional clinics, and their clinic and home services:

The elderly are checked more often since the nurses started this elderly clinic. They go to each [regional clinic] to see the elderly. It's much easier for people to come there for care, and they help people recover quicker from different things. These nurses check your blood pressure, blood sugar, and check your feet for sores. They also check if you're taking your medicines or need a refill. These nurses also go to people's homes if they can't come in, change their dressings, watch over them, make sure they're all right. . . . These nurses are caring, no more hit and miss. Just their presence makes a difference. . . . Everybody knows the nurses in their district.

Problems identified. One problem noted by three infor-

nants was the frequent and/or cyclic turnover of hospital and clinic staff.

What is so devastating to our people is the change in doctors and nurses every two or so years. You get to know them and they're gone, so you have to start all over again. . . . The people are left in limbo, left hanging, and this happens so many times.

Another informant added, "It seems like the good doctors and nurses never stay long. . . . We always have to get used to new people . . . to trust again."

Another problem identified by informants was that hospital and clinic staff "ignore people who have been waiting for hours," and "no one says, 'Are you still here? What happened? Have you been seen yet?'" One informant noted that the clinic hours are too rigid, "We are told that we have better services now, but they're saying, 'Don't come now. Make an appointment.' Seems like you have to get sick between 8 am and 3 pm." Another informant complained that "They treat us like we are children, or we are lazy, or that we don't know how to care for our own children." Several of the informants had observed or heard these complaints from people in the community, but they reported that it is rare for people to discuss their complaints directly with the hospital staff.

Two informants shared that health care providers are not visible at community functions and as a result are unable to establish linkages with the community and miss an opportunity to establish trust. One informant said,

Nowadays they [doctors] are starting at least to greet you in the hallway, before I don't know what they thought we were. There doesn't seem to be a wall between us. I wish they would make themselves more available to the community, be more open, get involved in community activities.

One informant remembered a public health nurse who used to visit his home when he was young:

Mrs. _____, a reservation nurse, I still remember her name, used to visit my mother after I was born at home. She used to come to the feasts, come to different things on the reservation so people could see her, know she was a part of the community. We never see the doctors or nurses at any of the community functions we have. They're welcome all the time but I suppose they want a special invitation. You never see them, they sneak in, do their work, and sneak out. You only see them when you go to the clinic, you don't see them any other time. You'd be lucky to see the same doctor twice.

Four informants described non-caring actions by health providers as “not keeping promises” and “not following through with what they said they would do.”

We hear promises from these doctors and nurses, ‘We’re going to do this and that, everything will be better.’ I’ve never heard anybody say, ‘I have skills and experience, and we’ll integrate this with what you have here already.’ They’re always saying, ‘I went to school, I’m going to do this for you, this way, no other way.’ And, that closes a lot of doors because we’ve heard this too many years.

When I had my leg cut off, they [doctors] said they’re going to work on getting me a prosthesis, but they were just pretending. I kept asking them, ‘How are you coming along?’ ‘When am I going to get my leg?’ and they said, ‘We’re working on it.’ After so many months, I just gave up. Nothing’s going to get done, they don’t care. Yesterday when I went in the doctor said, ‘Haven’t you got your prosthesis yet?’ I said no. He said, ‘It’s been too long a time.’ He started calling around and told me, ‘I’m not giving up, I’ll have some news next time you come.’ When I came out, I said, ‘There’s someone that cares.’ I was really surprised this doctor wanted to help. . . . It was a new experience for me.

The minute you [doctors and nurses] promise a lot of things and don’t do it, that’s where it hurts. That’s when people here turn against you. That’s what people are doing today, promising, promising and never go through with it.

One informant contrasted caring and non-caring behaviors of public health nurses she had known:

Once I came across a man who was completely helpless, he was so sick, high fever, ulcers on his leg. I referred him to this nurse but she refused to go see him, just told us to take him to the hospital. He refused, because he feared going to a nursing home. It was appalling to me that this nurse wouldn’t even go see him or touch him. I think if she had just come to his house, bathed him, and said, ‘We’ve got to take you,’ he would have gone. Another time this same nurse came to my house to see my dad after his amputation and his stump needed care. This nurse told my mother how to care for him, but didn’t show her. A different nurse came later, touched his wound, acknowledged it, and said, ‘That’s healing well.’ She didn’t find him disgusting, but the other nurse did.

Suggestions for health care providers. During the

interviews, several informants offered suggestions to the researcher about how to show caring towards them and others in their community. Suggestions for health providers included being a role model, being visible in the community, visiting people, sharing things about yourself, speaking truthfully, speaking from the heart, and learning about their culture. As one informant explained, “For you to work with people, is to live that life, show them that you care. Never discourage anybody, never talk against what they’re doing, but try to show them by your example what they need to do.” Another informant explained, “If you volunteer to do things for the people and help them, that’s a sign of your caring.”

Visiting and spending time with people was mentioned often by informants:

Go and visit people, ask them ‘How are you doing?’ or ‘How are you feeling?’ Share some of your problems, you don’t always have to talk about health or illness things. People here often say the staff is so involved with their work, that they feel ignored.

In addition to visiting, three informants emphasized listening to people. “Listen to whatever they have to say, no matter if it’s in the medical field, or whatever their problems are, stay and listen even if it takes all day.” “Too often they [nurses] just stop, give me medicine, give me instructions, then they go off and don’t come back for several weeks or months.”

In addition to visiting and listening, two informants believed encouragement to be a sign of caring. “Lots of health people don’t encourage you to do things, or get well, it’s like you’re just there, taking up space.”

One informant advised, “Show caring from the heart, not the head, it’s your actions that speak louder than the words. . . . When somebody says, ‘I care for you’ and all that, those are just things people say to butter us up.” Another informant emphasized, “People have a way of seeing if you don’t care for them; you talk way above them or talk down to them; you’re looking over them; you’re not focusing on the middle part where everybody is.” Attitudes of public health nurses were addressed by one informant: “Nurses should stop by, just to say hello, or touch the person, or look at their health problem.” “I’m embarrassed when non-Indian people come to my house, if it’s messy, seems like they are looking at how I live, my environment, rather than focusing their attention on me.”

Three informants advised health providers to learn about the culture, history, legends, and traditions from community people. One informant emphasized that health providers should be aware of and work with traditional Indian medicine people. “Some nurses and doctors will say, ‘He’s my patient and I’ll provide all the care,’ instead of being willing to let go. Maybe they could also suggest people going to see a [Medicine Man].” He further explained, “Health people should try to work with the system that’s already in place here,

instead of trying to change it, to use what they know to better the system.”

Discussion

After completion of the study, the author presented the findings and implications at a meeting of health care professionals and other interested persons (some of whom were tribal members) held at the reservation hospital. This presentation was videotaped, and a copy of the videotape and the author's thesis was left at the hospital for future reference. During discussion of the results of the study with various other tribal members, the findings were often spontaneously validated with comments such as “That holds true for me” and “That makes sense to me.”

The author believes that the results of this study are applicable in most settings throughout Indian country. The findings provide insight into what caring behaviors in health providers are considered important by these American Indian informants, and probably by most American Indians and Alaska Natives.

Ethnographic interviews allowed the author to learn about the culture of this Southwestern tribe from an “insider's” point of view. Even though these informants reported that health providers need to work with their community a long time to really know them, they readily shared with the author many insights about what was important to them, their families, and their community in a single interview.

There was tremendous diversity among the 12 informants regarding their school, work, and family experiences; their religious beliefs; and their knowledge and use of traditional American Indian cultural practices. Their unique life experiences have influenced their beliefs, knowledge, and rules of caring. Health care providers need to understand that there is no “typical American Indian,” and that rather than making assumptions, it would be wiser to individualize their care. An essential part of the health history is an assessment of the psychological and sociological status of the individual.⁹⁻¹¹ Health care providers cannot effectively communicate with patients or meet their health care needs without first perceiving the patient as a whole person and achieving an appreciation for cultural differences and understanding the patient's beliefs relevant to health, illness, and treatment.

Informants stressed the importance of extended family and community members in their lives in response to other questions in this study (not described in this paper). Health care was delivered to informants not only by doctors and nurses but also by parents, grandparents, children, siblings, other extended kin, and by American Indian healers. Therefore, health care providers should consider including the client's family and concerned community members when planning and providing their health care.

Providers who are culturally sensitive will appreciate the potential role that Indian medicine and healing practices may have in achieving an optimal response to health care. Three

informants mentioned the use of Indian medicine, others used a combination of Indian and Western medicine, and some did not know or believe in the “old ways.” While health care providers cannot assume that all American Indians believe in Indian medicine or, for those who do, practice it in the same way, sensitivity towards non-Western health beliefs and practices is invaluable in meeting the needs of the whole person.

Providers also need sensitivity towards a person's spiritual beliefs because all of these American Indian informants described the significance of religion and prayer in their lives. Religious activities among informants were perceived as caring.

American Indian informants in this study indicated that they believed it was important for health care providers to learn about their culture through participation in community, church, school, and family activities on the reservation, including attendance at family funerals and making home visits. Health care professionals should enhance their understanding of the culture and demonstrate caring and respect by increasing their visibility and participation in the Indian communities where they work. Administrators have an obligation to provide opportunities for new health care professionals to be oriented to the values and beliefs of the community. This responsibility could be shared with tribal leadership.

Informants voiced concern about health providers who do not involve them in planning their health programs. Informants emphasized the need for health providers to work with their cultural values, instead of trying to change traditional ideas and force new programs on them. This is especially important in view of the short employment period and high turnover rate; providers often try to make changes long before they have any understanding of the culture and the community with whom they are working.

Informants viewed health providers as caring when they spent time visiting and getting acquainted with them in the hospital, clinic, and home setting. These caring providers respected the informant's beliefs and cultural practices, and willingly shared information and stories about their own lives.

Recommendations and Conclusions

Further ethnographic research among other American Indian or Alaska Native groups might be useful to determine if similar themes emerge related to what behaviors are perceived as evidence of “caring.” Similar studies utilizing health providers as the “informants,” and then comparing and contrasting the results, might be both interesting and enlightening. Additionally, ethnographic studies of American Indian health beliefs and practices are needed to promote further understanding of how to provide culturally sensitive care.

To enhance more culturally sensitive health care, professional school curricula should include classes on transcultural care and cultural diversity. Especially important to reaching this goal of culturally sensitive care is to increase efforts to provide training in the health care professions for greater

numbers of American Indians and Alaska Natives.

This exploratory study provides cultural insight into those behaviors of health professionals that are perceived by members of an American Indian tribe in the Southwest as demonstrating caring. The informants stated that incorporation of these caring behaviors into the hospital, clinic, or home setting will enhance culturally sensitive care, facilitate client receptiveness to new information or counseling, and improve the effectiveness of client encounters.

References

1. Rogers ME. Space age paradigm for health. Presented at the Region I meeting of The Society of Rogerian Scholars; November 1990; Phoenix, AZ.
2. Aamodt AM. Themes and issues in conceptualizing care. In: Leininger MM, ed. *Care: The Essence of Nursing and Health*. Thorofare, NJ: SLACK Incorporated; 1984:75-79.
3. Leininger MM. Leininger's theory of nursing: cultural care diversity and universality. *Nurs Science Quarterly*. 1988;1(4):152-160.
4. Watson J. *Nursing: Human Science and Human Care*. A Theory of Nursing. Norwalk, CT: Appleton-Century-Crofts; 1985.
5. Aamodt AM. The care component in a health and healing system. In: Bauwens EE, ed. *The Anthropology of Health*. St. Louis, MO: C.V. Mosby; 1978:37-45.
6. Leininger MM, ed. *Care: The Essence of Nursing and Health*. Thorofare, NJ: SLACK Incorporated; 1984.
7. Spradley JP. *The Ethnographic Interview*. New York, NY: Holt, Rinehart & Winston; 1979.
8. PHS Workforce Online Data System. September 30, 1995.
9. Bates B. *A Guide to Physical Examination*. 2nd ed. Philadelphia, PA: J.B. Lippincott Company; 1979.

Qualitative Research What is it? Is it important?

William L. Freeman, MD, MPH, Director, IHS Research Program; and Timothy L. Taylor, MPH, PhD, Behavioral Health Researcher, IHS Alcohol and Substance Abuse Branch; Albuquerque, New Mexico.

Comparing Quantitative and Qualitative Research

Sophisticated readers of research reports expect all papers to include statistical *P* values, randomized comparison groups, placebo controls, and 95% Confidence Intervals (CIs). These are all methods to assist in ensuring that the body of scientific knowledge about health care is not based on anecdotes or subjective impressions. What, then, is one to make of Susan Fifer's article in this issue (page 89) that reports her subjective analysis of conversations with 12 people, and which contains not one statistical test?

Randomization, *P* values, CIs, etc. are methods of "quantitative research." Ms. Fifer did ethnographic research, one type of "qualitative research." Qualitative research has been accepted

as legitimate research in the health sciences, and has been published in prestigious journals such as the *Journal of the American Medical Association*,¹ the *British Medical Journal (BMJ)*,² *Nursing Research*,³ the *American Journal of Public Health*,⁴ and the *Canadian Journal of Public Health*.⁵ The BMJ recently published a series of seven articles and an editorial covering qualitative research: what it is and how to read it.⁶⁻¹³ And, the National Institutes of Health, that embodiment of hard science, even funds it.¹⁴

Recent articles and reports document that American Indian, Alaska Natives, Canadian First Nations, and Inuit (AI/AN/CFN/I) peoples have participated in qualitative research useful to them. Such research has examined, for example, evaluation of a Community Health Representative program,¹⁵ occupational therapy,¹⁶ experience of loss of land,⁵ depression and alcohol abuse,¹⁷ diabetes,^{14,18,19} advance directives by patients and "Do-Not-Resuscitate" orders by physicians,^{1,20} the meaning of death to adolescents,²¹ and the development of health education material and preventive programs

"Qualitative research has been accepted as legitimate research in the health sciences...."

for diabetes¹⁴ and fetal alcohol syndrome.²²

To read reports of qualitative research, one must be familiar with its purposes and methods. It has been described as research from and of the “perspectives of the subjects under [study].”²³ It studies questions for which quantitative research is ill-suited, such as “What meanings do people give to [item]?” or “What kinds and content of health education material do the patients themselves think would be educational and motivational for them?” Qualitative research sometimes produces results valued in their own right; other times, the results are exploratory, to develop or guide a subsequent research project that may itself be quantitative, qualitative, or both. Major characteristics of qualitative and quantitative research are outlined in Table 1.

The data in qualitative research are people’s own written or spoken words or their observed behavior. Those data often come from detailed, extended interviews with a few people, similar to but longer than the medical history, or “Subjective” part of our SOAP notes. The interviews may follow a planned format, or may be open-ended and follow the subject’s path of thinking. Data may also come from focus groups; written his-

tories, such as diaries; extended observation of public or private behavior and interaction; or many other sources.

Measurements

Quantitative research does measurements of or surveys specific subpopulations of people (e.g., 10% of adults in the community, all women with newly diagnosed ovarian cancer at the hospital); rigorous statistical sampling procedures and calculations of sample size and statistical power help ensure reliable and replicable results. Qualitative research interviews or observes only a few people, but usually in depth or for extended periods; purposeful sampling and seeking contrary views help ensure reliable and replicable results by maximizing the likelihood that the subjects *represent the range* of opinions, values, or behaviors found in the community/group about the research question. Purposeful sampling may solicit people to interview from specific segments in the community, or from the entire spectrum of each characteristic likely related to the study. Such characteristics in Ms. Fifer’s study might include satisfaction or dissatisfaction with care, extent of traditionality, and training and employment as a health care

Table 1. Characteristics of qualitative versus quantitative research.*

Characteristic	Qualitative Research	Quantitative Research
Typical questions	What is going on? What does this mean to the subject?	What causes____? Which treatment is more effective?
Methods to obtain data	Observation; Interviews; focus groups; etc.	Measurement; formal surveys.
Domain and people studied	One or a few people in a community.	Subpopulation
Sampling	Purposeful	Statistical
Means of analysis	Interpretation	Statistics
Logic of analysis	Creative induction first; sometimes deduction also	Deduction
Description by:	Range of values or findings	Statistics: mode, mean, etc.
Explanatory models	Patterns; circles; webs	One or a few lines
Reliability, replicability, consistency	Purposeful sampling; seeking contrary views	Rigorous statistical sampling procedures
Internal validity, credibility, accuracy	Subject review; check interpretations with community people; detailed quotations	Masking; objective measurements; accurate instruments
External validity, applicability	Transferability	Generalizability; transferability

*Adapted and expanded from Krefting L,³³ Kuzell et al,³⁴ Mays N, Pope C.⁸

provider. The researcher may also ask subjects and informants to identify other people, with views contrary to those already expressed. The researcher should not quantitate the qualitative research interviews. (Ms. Fifer appropriately did not report what percentage of the 12 subjects reported one or another value or feeling.)

Subjectivity

The two types of research handle subjectivity differently. In quantitative research, subjectivity is taboo because it may include intentional or unintentional bias to an unknown extent. Quantitative research strives to eliminate subjectivity by several methods (e.g., placebo control, double-masking [double-blinding] or single-masking, and minimizing inter- and intra-observer differences).

Qualitative research, on the other hand, uses, and thus must manage subjectivity. The researcher “is his or her own ‘instrument’ of observation,”²⁴ and interprets the textual or observational data with a creative (subjective) step of seeing patterns or relationships in the data. Researchers minimize (manage) personal bias or self-deception by several methods. To avoid making idiosyncratic interpretations unrelated to reality, they develop their interpretation with other community people, and hold “feedback sessions” to check their interpretation with community members and even with the subjects themselves. If it is likely that different researchers would develop markedly different interpretations of the same material, the “Rashomon effect,”²⁵ they may ask other experts to interpret the data independently. They report details, including extended quotations by the subjects, especially those that give different or even contrary views, so that the readers can themselves compare the researchers’ interpretations with the basic data on which they are based. They may also explicitly state their own biases, values, and judgements, to help the reader be alert for their possible influence on the researchers’ interpretations.

Sampling

Since it is impossible to study every individual to identify information that would apply to them all, most quantitative and qualitative research is done on limited numbers of individuals and the results then applied to people other than just the individual subjects studied. What is labeled “generalizability” of research results is often actually “applicability” or “transferability.” Quantitative research can *statistically generalize* only to the group from whom the subjects were selected by rigorous sampling; unfortunately, that group is often quite small or narrow. For instance, a randomized, controlled trial, “The Physicians’ Health Study,” showed that one aspirin every other day prevented deaths from heart attacks in the

22,000 physicians studied.²⁶ Those results *statistically generalize* only to all U.S. male physicians age 40 to 84 (the group from whom the sample was obtained), yet they *apply* or *transfer* with confidence to all adult males in Europe and North America, but perhaps not to women. The AI/AN Youth Health Survey did not obtain its group of 13,000 reservation adolescents by statistical sampling at all.²⁷ The results thus cannot *statistically generalize* to any larger group, yet they probably roughly *apply* or *transfer* to the adolescents of most reservations. Because qualitative research usually does not use statistical sampling, its results usually cannot *statistically generalize* to a larger group. However, as with the two examples of quantitative research, qualitative research results often may *apply* or *transfer* to other settings if careful judgment is used.

Standards

Just as methods have become more defined and standards have risen for quantitative research in the past 45 years, so too for qualitative research in the past 15 years.²⁸⁻³² Readers now have guidance to assess the quality of qualitative research.^{8,24,33,34} Two recent articles about American Indians demonstrate state-of-the-art qualitative research.^{1,21} A description of several methods qualitative researchers often now use to ensure quality can be found in the box on pages 98-99.

“Quantitative research, on the other hand, uses, and thus must manage, subjectivity.”

Evaluation of Ms. Fifer’s Article

What do the authors make of Ms. Fifer’s article? She asked a specific, well-developed question of the 12 subjects to define behaviors that demonstrate caring by health professionals. Not surprisingly, some people volunteered examples of non-caring as well as caring. The people she selected to interview were quite diverse in their religious orientation and knowledge of traditional practices. The sample number of 12 was large enough that no additional ideas were being elicited, suggesting that she had obtained the range of views, values, and feelings that existed in the community. She checked her interpretations with peers and health care coworkers who were themselves members of the community studied. The article contains a rich set of detailed quotations from the people interviewed; her interpretations are tightly related to the quotations. Although she did not conduct feedback sessions with the subjects themselves, she did do a report and feedback session with community members and the staff of the health facility serving the tribal community. She even left a copy of that session on videotape and of her thesis with the health facility and tribe. Finally, her article has strong “face validity,” as suggested by the following question readers should ask themselves: “Is it likely that the people in the tribal community studied define caring behavior differently than what Ms.

Fifer reported (e.g., that ‘caring’ means ‘listening to us’ and ‘spending time with us’)?” In summary, although she did her research seven years ago and thus may not have included some methods that have since become state-of-art, the quality of her qualitative research was quite high nevertheless.

Ms. Fifer’s article applies or transfers to most other AI/AN/CFN/I communities. However, there might be limited transfer for those communities that are markedly different with regard to one or more important characteristic(s). For instance, one person said that the staff should “get involved in community activities,” a feeling that several people shared; that component of “caring” might transfer only with modification to tribal communities that are quite private about many religious community events. While some tribal communities might have a few additional components or aspects of caring not mentioned in Ms. Fifer’s article, very few or no communities will substantially contradict her results.

Our final comments reflect our subjective judgment, not scientific analysis. In the article’s last sentence, the subjects of the study spoke directly to the readers. We (WLF and TLT) feel that the entire Fifer article spoke directly to us, as to how we can be more caring in our roles of providing health care. We also feel that the article spoke for us, when we or our family members are patients.

Ms. Fifer’s article in this issue, and the articles cited above, demonstrate that qualitative research is especially relevant when the perspectives of patients and families are markedly different than those of the professional caregivers, as in our setting. Therefore, qualitative research is especially important to improve the health of, and the health services to, AI/AN/CFN/I people. We hope that *The IHS Primary Care Provider* will publish more high quality articles that use the methods of qualitative research.

Internal Validity, Reliability, and External Validity in Qualitative Research*

A qualitative study is systematic research conducted with demanding, though not necessarily routinized, procedures. These procedures help ensure the internal validity, reliability, and external validity of the research. In qualitative research, “internal validity” would mean that the results accurately represent both the world (i.e., range of values, behaviors, or feelings) of the subject interviewed or observed, and the world of the community that the research is about and from which the subjects were selected. “Reliability” or “replicability” would mean that roughly the same results would be obtained if the same research were done by another qualitative researcher who followed the same procedures in the same community but, by chance, started with other initial informant[s]. “External validity” would mean that it is known to what types of communities the results apply or transfer. As with quantitative research, it is not possible for qualitative research to achieve perfect internal validity and reliability, or to know with complete certainty the external validity of the results. However, the set of strategies below help ensure that the internal validity and reliability are quite high, and that the external validity is reasonably known.

Strategies to Ensure Internal Validity and Reliability

Purposeful sampling. Qualitative researchers typically focus their data collection efforts on in-depth explorations of a small number of people, even single cases, selected purposefully. Purposeful sampling selects people whose information will illuminate the question[s] under study. There are at least 15 methods in purposeful sampling. For example, maximum variation sampling tries to interview or observe the diversity in a setting, in order to describe the entire range of values or behavior and the patterns within that range. Disconfirming case sampling seeks to interview or observe people who do not fit the hypothesis (e.g., in a community in which explicit discussion of advance directives violates norms of behavior, interviewing patients and families who found such explicit discussion valuable and desirable).

Triangulation of data. Data are collected through multiple sources (e.g., interviews, observations, and document analysis). Triangulation compares and collates the data from the different sources. For example, patient interviews that include tests done and diagnoses can be compared with patient charts; provider interviews about what they told certain patients can be compared with patient interviews about the same encounter.

Member checking. Informants serve as checks throughout the research process. Purposes include: (a) to check inconsistencies or other problems contained in field notes with the informants; (b) to ask informants for feedback about accuracy of reporting and the researcher’s interpretations, and (c) to develop an

References

1. Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation: benefit or harm? *JAMA*. 1995;274:826-829. (See also comments in: *JAMA* 1995; 274:844-845 and 1996;275:107-110.)
2. Gantley M, Davies DP, Murcott A. Sudden infant death syndrome: links with infant care practices. *BMJ*. 1993;306:16-20.
3. Brown MA, Powell-Cope GM. AIDS family caregiving: transitions

(continued)

understanding shared by subjects and researcher.

Repeat observations over time. Especially in observational research, repeating observations during an extended period will minimize the chance that the observed behavior was just an aberrant example.

Peer examination. Have colleagues, research associates, and other appropriate people independently examine the research.

Participatory research. Involve informants and other research stakeholders in most phases of the study, from the design of the project to developing interpretations to writing the results.

Clarify researcher bias. Reporting possible researcher biases both helps minimize the effects of the bias and lets the readers assess if the bias adversely affected the quality of the research.

Strategies to Ensure External Validity

“External validity” (i.e., “applicability” or “transferability” to other settings) refers to what the researchers and readers do with the results. Four commonly utilized techniques help readers assess the transferability of the study to other settings.

Detailed quotations or descriptions. The most common method is to provide rich, thick, detailed descriptions or quotations, and also detailed backgrounds of the subjects studied, so that anyone interested in transferability will have a solid framework for comparison.

Detailed research methods. Provide a detailed account of the focus of the study, the researcher’s role, the informants’ positions and method for selection, data collection methods, the context from which data are gathered, and analysis strategies.

Purposeful sampling. Interview or observe people from the entire spectrum or range of people to whom the researcher will want to transfer the results. For instance, a qualitative study about all intravenous drug use would interview or observe people from several ethnic groups (including European Americans), both genders, all drugs, all socio-economic levels, etc.; a study of binge-drinking alcoholism in a tribal community would interview or observe a range of severity and frequency, both genders, all socio-economic levels, etc.; a study of hospice care would include families of patients who had stayed with hospice, had left, had varying degrees of control of pain and nausea and of satisfaction with the services.

Check representativeness. Member checking can ask the people studied if the behavior observed by the researcher was “typical” or “usual” behavior for the context, or if what was discussed in the interview was “usual” or “typical.” All phases of a study should be subject to scrutiny by an external auditor who is experienced in qualitative research methods.

* Adapted and expanded from Taylor SJ, Bogdan R²⁸, Patton MQ²⁹, Kuzel AJ, Like RC,³⁰ Crabtree BF, Miller WL³¹, Creswell JW³²; and Krefting L.³³

7. Pope C, Mays N. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ*. 1995; 311:42-45.
8. Mays N, Pope C. Rigour and qualitative research. *BMJ*. 1995;311:109-112.
9. Mays N, Pope C. Observational methods in health care settings. *BMJ*. 1995; 311:182-184.
10. Britten N. Qualitative interviews in medical research. *BMJ*. 1995;311:251-253.
11. Kitzinger J. Introducing focus groups. *BMJ*. 1995;311:299-302.
12. Jones J, Hunter D. Consensus methods for medical and health services research. *BMJ*. 1995;311:376-380.
13. Keen J, Packwood T. Case study evaluation. *BMJ*. 1995;311:444-446.
14. Gittelsjohn J, Harris SB, Whitehead S, et al. Developing diabetes interventions in an Ojibwa-Cree community in northern Ontario: linking qualitative and quantitative data. *Chronic Dis Canada*. 1995;16:157-164.
15. Lavallee C, James CA, Robinson EJ. Evaluation of a community health representative program among the Cree of northern Quebec. *Can J Public Health*. 1991;82:181-184.
16. DeMars PA. An occupational therapy life skills curriculum model for a Native American tribe: a health promotion program based on ethnographic field research. *Am J Occup Ther*. 1992;46:727-736.
17. O’Nell TD. Feeling worthless: an ethnographic investigation of depression and problem drinking at the Flathead reservation. *Cult Med Psychiatry*. 1992-1993;16:447-469.
18. Huttlinger K, Krefting L, Drevdahl D, Tree P, Baca E, Benally A. “Doing battle”: a metaphorical analysis of diabetes mellitus among Navajo people. *Am J Occup Ther*. 1992;46:706-712.
19. Parker JG. The lived experience of Native Americans with diabetes within a transcultural nursing perspective. *J Transcult Nurs*. 1994;6:5-11.
20. Ventres W, Nichter M, Reed R, Frankel R. Limitation of medical care: an ethnographic analysis. *J Clin Ethics*. 1993;4:134-145.
21. Grossman DC, Putsch RW, Inui TS. The meaning of death to adolescents in an American Indian community. *Fam Med*. 1993;25:593-597.
22. McCarthy P. Opinions of American Indian and Alaska Native women on prevention of fetal alcohol syndrome/effect (FAS/FAE). *American Indian Health Care Association*. Feb 2 1994.
23. Schmid H. American Occupational Therapy Foundation: qualitative research and occupational therapy. *Am J Occup Ther*. 1981;35:105-106.
24. Inui TS, Frankel RM. Evaluating the quality of qualitative research: a proposal pro tem. *J Gen Intern Med*. 1991;6:485-486.
25. Heider KG. The Rashomon effect: ethnographers disagree. *Am Anthropology*. 1988;90:73-81.
26. Steering Committee of the Physicians’ Health Study Research Group.

- through uncertainty. *Nurs Res*. 1991;40:338-345.
4. Grund JP, Kaplan CD, Adriaans NF. Needle sharing in The Netherlands: an ethnographic analysis. *Am J Public Health*. 1991;81:1602-1607.
5. Willms DG, Lange P, Bayfield D, et al. A lament by women for “The People, The Land” [Nishnawbi-Aski Nation]: an experience of loss. *Can J Public Health*. 1992;83:331-334.
6. Jones R. Why do qualitative research? *BMJ*. 1995;311:2. Editorial.

- Final report on the aspirin component of the ongoing Physicians' Health Study. *NEJM*. 1989;321:129-135.
27. Blum RW, Harmon B, Harris L, Bergeisen L, Resnick MD. American Indian/Alaska Native youth health. *JAMA*. 1992;267:1637-1644.
 28. Taylor SJ, Bogdan R. *Introduction to Qualitative Research Methods*. New York, NY: John Wiley & Sons; 1984.
 29. Patton MQ. *Qualitative Evaluation and Research Methods*. Newbury Park, CA: Sage; 1990.
 30. Kuzel AJ, Like RC. Standards for trustworthiness of qualitative inquiry. In: Norton PG, Stewart M, Tudiver F, Bass MJ, Dunn EV. *Primary Care Research: Traditional and Innovative Approaches*. Newbury Park, CA: Sage; 1990:138-158.
 31. Crabtree BF, Miller WL. *Doing qualitative research*. Newbury Park, CA: Sage; 1991.
 32. Creswell JW. *Research Design: Qualitative and Quantitative Approaches*. Newbury Park, CA: Sage; 1994.
 33. Krefting L. Rigor in qualitative research: the assessment of trustworthiness. *Am J Occup Ther*. 1991;45:214-222.
 34. Kuzel AJ, Engel JD, Addison RB, Bogdewic SP. Desirable features of qualitative research. *Fam Pract Res J*. 1994;14:369-378. ®

The Shutdown Message Putting a "Face" on the Federal Employee

Tony Kendrick, Acting Communications Director, Indian Health Service, Rockville, Maryland.

Government employees are the best spokespersons for their agency. When employees are underrated as spokespersons, the agency loses a significant communication channel to the public.

There were many different messages that went out about the impact of the series of federal shutdowns that began November 14, 1995. The messages were given by congressional and government leaders in response to questions asked by media representatives and to polls taken of public perception.

I believe the overriding message of the shutdown was that there was stoppage, disruption, or curtailment of services. The message of the disruption of services, which was wider than just federally administered services, was delivered by senior spokespersons, Cabinet Secretaries, and members of Congress. They were the few taking the message to the potential many. Their communication channels were the national media, including CNN, C-SPAN, major newspapers, talk shows, and other communication outlets. There is never any guarantee that those who are exposed to a message will hear it, understand it, or even care about it. However, if the message comes from local sources and is personalized, there is a better chance that the message will be heard.

Government employees have access to the local media, and are easier for the media to contact than senior government

officials. When a local reporter cannot reach a Cabinet Secretary or an 'inside the beltway' spokesperson, he/she will select a local, senior official or an employee for a response. A service that government communicators, such as the Director of Communications for the Indian Health Service or Area Office public affairs liaisons, can provide for the local media is access to employees who can localize, personalize, and reinforce messages from national offices.

In the recent shutdowns, the communication role of local employees of most agencies appeared to have been relegated to describing how employees were personally affected. Instead of putting a 'face' on the government employee, the government employees (and other spokespersons) should have been putting a 'face' on the customer of their particular service or agency. An opportunity was missed by some government communicators to engage employees in educating the public about the value of services their agency provides and the potential detrimental effects that might result (or did result) as a consequence of losing those services.

One purpose of government is to provide services established by elected officials. Managers and employees must understand how their work contributes to the mission, goals, and objectives of their agency. It is a responsibility of every government employee to help the public, and even one another, understand the value of the agency and its employees. Government employees must recognize their responsibility for communication that is inherent in their government service job.

Messages about the impact of shutdowns should always reflect the reason for the existence of the government agency.

For example, to provide health services, to control communicable diseases, to process mortgage applications, to feed the elderly, to enforce import regulations, to clean up toxic waste, etc. If the only impact of a government shutdown is that federal employees cannot pay their bills, then it could be assumed that the main purpose for the agency is to provide employment for the workers and not services for the public.

Essential services, such as direct patient care, were provided during the shutdown. The customers of these services may not have perceived a disruption of service. If there is another shutdown, perhaps government employees still on the job should provide the customer a “pink slip” along with the service. The “pink slip” would explain how the services they are receiving are or will be affected by a shutdown. The customer can then understand and articulate the value of the services they are receiving and the potential impact a shutdown would have on them, their families, and their community.

The schism between the messages of senior officials and employees was unfortunate. While senior officials talked about “how disruption of services affects you, the customer,” employees were talking about “how the shutdown affects me.” Employees should have been provided guidance by government communicators to reinforce the message from the leaders: that is, “how the shutdown affects my ability to provide vital services to the customer.”

The guidance provided to Indian Health Service employees was to use the opportunity of speaking with reporters to explain the services being provided, and how the shutdown was having an impact on these services. Messages about the value of the services provided by the Indian Health Service conveyed to the media by employees were consistent with and also reinforced and validated the messages being received and sent by members of Congress, tribal leaders, Indian organizations, and the Department of Health and Human Services. Wherever the media went for a news source, they received the same message in response to their questions. As a result, there were no claims that the Indian Health Service was an unnecessary agency or that its budget should be reduced. Employee spokespersons proved to be an effective and credible source of information about the Indian Health Service for the media.

For agencies that did not provide similar guidance, their employee responses to questions from the media did not provide any information about their agency. For example, in one Good Morning America segment, the messages delivered by some federal employees were self-serving: “I can’t pay my bills”; “Federal employees are human, too”; or “I can’t carry out my duties as a prosecutor” (without any additional explanation about what effect this might have on the public being served, or the individual customer). The two individuals who were not government employees in the group were the only ones who discussed the impact of the shutdown as it related to services they were contracted to provide. It is my belief that the culture of government service lets senior officials or

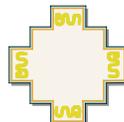
spokespersons speak for the government or agency and allows employees to believe they can only speak for themselves, even to the point of not explaining the value of their job within the agency’s mission, unless they get specific permission from their organization.

We should begin now to prepare in the event of another funding impasse. Government communicators should immediately work with officials and agency employees to identify the primary services provided by the agency. The challenge, which is easily met, will be

“The challenge, which is easily met, will be for each employee to be able to briefly explain the mission of the agency, identify its customers, and describe the vital services provided to these customers.”

for each employee to be able to briefly explain the mission of the agency, identify its customers, and describe the vital services provided to these customers. This would be the message that one would want every employee to include in their personal responses, and there would be no need for any preclearance. Employees need to be prepared to respond to questions, even personal ones, with answers that address “what my agency does, what role I play in helping the agency do what it does, and how the customer is affected by what I do.”

If government employees cannot explain the purpose of their agency and champion its existence, then the agency will be perceived not as one of service but as one of employment. That is an unfortunate perception for members of the local community and local officials to express to their elected representatives in the Congress, who then will debate the value of the agency during the government budgetary process. ®



IHS Research Conference

Announcement and Call for Papers

August 28-30, 1996 (please note new date)

The Eighth Annual Indian Health Service (IHS) Research Conference, sponsored by the IHS Research Program and the IHS Clinical Support Center (accredited sponsor) will be held August 28-30, 1996 at the Best Western Rio Grande 1015 Rio Grande Boulevard in Albuquerque, New Mexico. The Best Western Rio Grande has reserved a block of rooms for \$63.31 for single and \$72.36 for double. Please make your reservations before August 9, 1996 at 505-843-9500: to get this special room rate, tell them you are attending the IHS Research Conference.

The conference will feature "lessons from the past." Papers are invited for oral or poster presentation in the following categories: Aging, AIDS, Alcohol and Substance Abuse, Cancer, Cardiovascular Disease, Diabetes, Environmental Health, Epidemiology, Health Care Administration, Health Promotion and Disease Prevention, Health Services Research, Injury Prevention, Mental Health, Nutrition, Oral Health, and Women's Health. Research measuring the effectiveness of innovative health care delivery interventions or research that demonstrates partnerships between researchers and tribes is especially welcome.

Abstracts must be received no later than close of business on July 15, 1996 to be considered for review (see "Instructions for Preparing Abstracts" below). Notice of acceptance of abstracts will be mailed by July 19, 1996.

For abstract consultation, contact one of the following Research Conference Planning Committee members: Linda Arviso-Miller at 505-837-4142 or Cherie Thomas at 505-837-4145.

Instructions for Preparing Abstracts

1. Use the abstract form on the next page to prepare your

abstract. All copy must fit within the frame. This form may be copied.

2. Accepted abstracts will be reduced and printed in the conference program. Remember that you are producing camera-ready copy. Submit your abstract in a type size no smaller than 12 pitch typewriter type or a 10 cpi font on a word processor. Single space all copies. Do not include figures, tables, equations, mathematical signs or symbols, or references in the abstract.
3. The abstract content should be structured as follows; title, author and affiliation, purpose/background, methods, results, and conclusions. Place an asterisk next to the name of the presenting author. Conclude your abstract with the sentence: "For further information: [Name and address of author serving as point of contact]." The abstract must fit within the frame on a single abstract form and be no more than 250 words in length.
4. Check the desired form of presentation: oral, poster, or either.
5. All abstracts should be sent to: Conference Coordinator, IHS Research Program, 5300 Homestead Road, N.E., Albuquerque, New Mexico 87110 (phone: 505-837-4142). Submit one original signed by the primary author.
6. A biographical sketch must accompany the original abstract. Use the form below. Do not submit a curriculum vitae or resume.
7. Abstracts must be received by close of business July 15, 1996.
8. We will notify authors of the acceptance or rejection of their papers by July 19, 1996.

Any questions about style should be directed to Linda Arviso-Miller, Conference Coordinator, at (505) 837-4142.

Biographical Sketch

(Please Type)

Primary Author/Presenter:

(As you would like it printed in the Final Conference Program)

Mailing Address: _____

City/State/Zip: _____

Telephone Number: Work _____

Home _____

Position Title: _____

Secondary Authors: (Name, Title, Degree, Place of Employment) _____

Send abstract and biographical sketch to: Linda Arviso-Miller, Conference Coordinator, IHS Research Program, 5300 Homestead Road, N.E., Albuquerque, NM 87110.

Indian Health Service, OHPRD, Research Program
8th Annual Conference
Call for Papers
ABSTRACT FORM

Submitted for:

- Oral Presentation Poster Presentation Either

If this abstract is not accepted for oral presentation, would you consider a poster?

- Yes No

Indicate the major content area of your abstract:

- Nursing Medicine Environmental Health
 Community Health Nutrition Behavioral/Mental Health
 Dentistry Epidemiology Other_____

Abstracts must be received by July 15, 1996.

Primary Author: _____
Date: _____

Wellness Conference

July 31-August 2, 1996 Fort Defiance

“Walking in Beauty with Good Health,” a wellness conference for men and women, is sponsored by the Navajo Tribe, the Window Rock United School District, and the Indian Health Service. For more information, call the Social Service Department at 520-729-3294, the Navajo Health Education Program at 520-729-3417, or the Department of Behavioral Health Services at 520-729-4012.

Honoring Indian Elders

August 29-30, 1996 Albuquerque, NM

The National Indian Council on Aging (NICOA), celebrating its 20th anniversary of advocacy for Indian elders, is sponsoring this two-day conference, which will bring together Indian elders, tribal leaders, health care experts, legislators, policy makers, and service providers. Sessions will examine the health, economic, and political status of the nation’s Indian elders as the nation approaches the beginning of a new century.

For more information, contact NICOA, 6400 Uptown Boulevard, N.E., Suite 510W, Albuquerque, NM 87110 (phone: 505-888-3302; fax: 505-888-3276).

THE IHS PRIMARY CARE PROVIDER



The Provider is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 640-2140; Fax: (602) 640-2138; e-mail: provide@ihs.ssw.dhhs.gov. Previous issues of *The Provider* (beginning with the December 1994 issue) can be found on the IHS health care provider home page (<http://www.ihs.gov>)

Wesley J. Picciotti, MPA.....*Director, CSC*

Wilma L. Morgan, MSN, FNP
E. Y. Hooper, MD, MPH
John F. Saari, MD*Editors*

Thomas J. Ambrose, RPh
Stephan L. Foster, PharmD
M. Kitty Rogers, MS, RN-C.....*Contributing Editors*

Opinions expressed in articles are those of the authors and do not necessarily reflect those of the Indian Health Service or the Editors.

Circulation: *The Provider* (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for IHS and tribal health programs, to medical and nursing schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive *The Provider*, free of charge, send your name, address, professional title, and place of employment to the address listed below.

Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3,000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred.

Authors should submit at least one hard copy with each electronic copy. Manuscripts may be received via the IHS Banyan electronic mail system. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities/Area Publications Committees to publish manuscripts rests with the author. For those who would like some guidance with manuscripts, a packet entitled “Information for Authors” is available by contacting the CSC at the address below.

Dept. of Health and Human Services
Indian Health Service
Clinical Support Center
1616 East Indian School Road, Suite 375
Phoenix, Arizona 85016

BULK RATE
Postage and Fees Paid
U.S. Dept. of Health & Human Services
Permit No. G-290

ADDRESS CORRECTION REQUESTED

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE \$300