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Navajo Use of Native Healers

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Abstract

Background: Although the Indian Health Service provides extensive health care service to Navajo people, the role of native healers, or medicine men, has not been quantitatively described.

Objective: To determine the prevalence of native healer use, the reasons for use, cost of use, and the nature of any conflict with conventional medicine.

Methods: We conducted a cross-sectional interview of 300 Navajo patients seen consecutively in an ambulatory care clinic at a rural Indian Health Service hospital.

Results: Sixty-two percent of Navajo patients had used native healers and 39% used native healers on a regular basis; users were not distinguishable from nonusers by age, education, income, fluency in English, identification of a primary provider, or compliance, but Pentecostal patients used native healers less than patients of other faiths. Patients consulted native healers for common medical conditions such as arthritis, depression, and diabetes mellitus as well as "bad luck." Perceived conflict between native healer advice and medical provider advice was rare. Cost was the main barrier to seeking native healer care.

Conclusions: Among the Navajo, use of native healers for medical conditions is common and is not related to age, sex, or income but is inversely correlated with the Pentecostal faith; use of healers overlaps with use of medical providers for common medical conditions. Patients are willing to discuss use of native healers and rarely perceive conflict between native healer and conventional medicine. This corroborates

other research suggesting that alternative medicine is widely used by many cultural groups for common diseases. *Arch Intern Med.* 1998;158:2245-2249

Introduction

Navajo traditionally received treatment for illness from native healers or "medicine men." As in a conventional medical care system, many different types of practitioner exist; these range from diagnosticians such as hand tremblers, crystal gazers, and "listeners," to individuals who perform healing ceremonies involving herbs, balms, and purgatives.¹ Native healers have been the focus of extensive ethnographic study by anthropologists, psychiatrists, and physicians¹⁻⁵ but the prevalence and frequency of use of native healers among Navajo have not been described. The Navajo are also eligible for extensive free health care services through the Indian Health Service (IHS). It is not clear if conventional medical care provided by IHS physicians conflicts with the recommendations of native healers.

To improve understanding of the use of native healers and its interaction with conventional medicine, an interview was conducted of Navajo IHS patients to determine the prevalence

In This Issue...

- 1 Navajo Use of Native Healers
- 6 Spotlight on Violence Prevention: The Phoenix Area Injury Prevention Program Approach
- 7 Continuing Education for Physicians and Nurses in MMWR
- 8 The USPSTF Recommendations
- 9 Call for Nominations for the Physicians Professional Advisory Committee 1999 Awards
- 10 Focus on Elders and Meetings of Interest
- 13 Position Vacancies
- 15 NCME Videotapes Available

of use, reasons for use, characteristics of those who use native healers, cost of care, and whether native healer care conflicts with care provided by conventional physicians.

Methods

Between June 23, 1997, and September 1, 1997, consecutive adult patients seen in the ambulatory care clinic at a rural IHS hospital were interviewed. The hospital is a 39-bed hospital located on the eastern edge of the Navajo reservation in New Mexico. Its catchment area contains roughly 10,000 of the 25,351 square miles of the Navajo Nation, which is roughly the size of West Virginia. Despite its location on the edge of the reservation and the access that patients have to other non-governmental health care facilities, almost 47,000 outpatient visits were made to the hospital during the 1992 fiscal year.⁶

Eligibility was limited to consenting patients 18 years or older who did not have cognitive or physical impairment that prevented completion of the interview. An interview rather than a self-administered questionnaire was necessary because many eligible participants cannot read or cannot speak English and therefore require a translator. The overall response rate among eligible individuals was 99%; 2 patients refused to participate and 1 patient chose to respond only to demographic questions and issues related to hospital care. Three patients were excluded secondary to dementia.

The Interview

A questionnaire was developed in focus groups consisting of the English-speaking Navajo hospital staff and a native healer. The questionnaire was then pilot tested among Navajo nursing assistants to ensure that questions were understandable, nonoffensive, and informative. The Navajo Nation Research Board, which acts as the institutional review board for research involving the Navajo tribe, reviewed and approved the study.

Two non-Navajo interviewers who were medical providers conducted the surveys in the ambulatory care clinic. The medical providers had worked at the hospital for 1 year in the continuity clinics, ambulatory care clinics, and the emergency department. The interviewer addressed the reason for the outpatient visit then asked if the patient was willing to participate in the interview. The purpose of the interview was described to potential respondents and they were assured that their responses would be kept confidential and not be entered into their medical record.

Navajo nurses and nursing assistants who knew the purpose of the interview and who spoke Navajo translated for non-English-speaking patients. The responsibilities of the Navajo nursing staff include translation between patients and health care providers. Each translator was trained to administer the interview. The interview was reviewed with each assistant individually. The questions were primarily phrased in yes/no format with open-ended questions afterward to decrease variability between translators.⁷ In 3 cases, family members served

as translators.

The interviews averaged 15 minutes in length and began with demographic questions on age, educational level, income, and religion. Next, respondents were asked about their interactions with medical doctors, nurse practitioners, and physician assistants. From the patients' medical charts, the number of outpatient visits, inpatient stays made to the hospital in the last year, and the reasons for the visits were recorded. Use of conventional medicine at other locations in the last year was inquired about and the number of visits and the reasons for these visits were recorded. Patients were also asked about their satisfaction with conventional medical care for these problems. Next, patients were asked if they followed medical provider instructions all the time, most of the time, some of the time, or never.

At this point, respondents were asked about their use of native healers: whether they had ever consulted a medicine man and if so, how many times in the last year. However, no inquiry was made about the type of native healer sought or the type of ceremony performed since the native healer consultant advised that such questions might be considered intrusive. The time of their last visit to a native healer, the reasons for the visits, and satisfaction with these visits was recorded.

Then, questions were asked about barriers to medicine man care; patients were asked if the cost of native healer care, religious reasons, or trust in native healers deterred them from seeking native healer care. They were also asked if there were any other deterrents.

Finally, patients were asked about the interaction between conventional medicine and native healers: whether they had been given significant conflicting instructions about an ailment, what the nature of this conflict was, and whose instructions they chose to follow.

Statistical Analysis

The demographic characteristics of the population, prevalence and frequency of native healer use, and reasons for visits to medical providers and native healers were described using percentages for dichotomous variables and the mean and SD for continuous variables. The characteristics of patients who used a native healer were compared with those who did not, using χ^2 tests for dichotomous and categorical variables and t tests for continuous variables. To adjust for potential confounding, a multivariate logistic model was used to evaluate variables associated with use of a native healer. All statistical tests were carried out using STATA software.⁸

Results

Predictors of Use of Native Healers

Sixty-two percent of individuals interviewed had used a native healer at least once in their lifetime and 39% had used a native healer during the last year. Those who had seen a native healer in the past averaged 2 visits per year although the number of visits ranged widely. Among those who had used a

native healer at some time but not during the past year had a mean time of 11 years elapsed from their last visit although the number of years also ranged widely.

Characteristics of the subjects interviewed are shown in Table 1. The age and sex distributions of subjects are similar to that of all patients seen at the Crownpoint Healthcare Facility, Crownpoint, NM, between June 23, 1997, and September 1, 1997. The median income calculated was similar to that listed by the Navajo Nation,⁶ meaning 56% live below the poverty line. The rates of lifetime and recent use were not correlated with age, sex, education, income, fluency in English, identification of a primary provider, number of clinic visits or hospitalizations, or compliance with medical provider instructions in univariate analysis and multiple logistic regression analysis.

Table 1. Characteristics of the 300 Navajo interviewed*

Characteristic	Used a Native Healer at least once	Never Used a Native Healer
Age, y		
18-29	46 (25)	29 (25)
30-49	64 (35)	45 (39)
50-65	44 (24)	30 (26)
66-90	31 (17)	10 (9)
Sex		
Female	108 (58)	72 (63)
Income, \$		
< 5,000	60 (32)	36 (32)
5,000- 9,999	35 (19)	27 (24)
10,000 - 19,999	54 (29)	32 (28)
>20,000	35 (19)	16 (14)
Education		
< High school	51 (28)	34 (30)
Some high school	22 (12)	25 (22)
High school	67 (36)	37 (32)
Some college	36 (19)	15 (13)
College or graduate school	9 (5)	3 (3)
Requires a translator	31 (17)	14 (12)
Religion		
Christian, not specified	25 (14)	28 (24)
Traditional Navajo, only	46 (25)	6 (5)
Native American Church	41 (22)	9 (8)
Pentecostal	13 (7)	36 (31)
Mormon	27 (15)	7 (6)
Baptist	10 (5)	13 (11)
Catholic	14 (8)	1 (1)
Other	9 (5)	14 (12)
No primary medical provider	96 (52)	54 (47)
Outpatient visits in prior year		
1 - 5	69 (37)	42 (37)
6 - 10	52 (32)	34 (30)
11 - 20	38 (21)	25 (22)
21 - 50	19 (10)	13 (11)

* Values are number (percentage). Because some patient(s) chose not to respond to certain questions, numbers do not total 300.

There were significant differences in the rates of use among religions; use of medicine men was significantly less common among members of the Pentecostal faith ($P<.001$) than among those who identified themselves as Catholic, traditional Navajo, Native American Church, Mormon, Protestant, Christian, no religion, or Baptist. In a multivariate logistic analysis that included all variables in Table 1 as predictors, only religion was significantly associated with use of native healers (odds ratio, 0.16; 95% confidence interval, 0.057-0.483).

Patterns of Use of Native Healers

Table 2 summarizes the most common reasons for visits to a medical provider and the frequency of concomitant use of native healers. Among these conditions, the use of native healers was highest for arthritis, abdominal pain, depression/anxiety, and chest pain. No patient saw a native healer for upper respiratory tract infections, health care maintenance, pregnancy, or allergies.

Table 2. Most common conditions for which treatment is sought*

Condition	Saw a medical provider	Saw a native healer also	Saw a native healer	Saw a medical provider also
Upper respiratory infection	83 (28)	0 (0)	...	...
Arthritis	75 (25)	18 (6)	24 (21)	18 (16)
Hypertension	70 (23)	2 (1)	...	...
Diabetes Mellitus	68 (23)	8 (3)	8 (7)	8 (7)
Health care maintenance	58 (19)	0 (0)	...	...
Abdominal pain	32 (11)	9 (3)	7 (6)	5 (4)
Urinary tract infection	31 (10)	2 (1)	...	...
Back pain	23 (8)	4 (1)	10 (9)	4 (3)
Chest pain	20 (7)	5 (2)	...	...
Depression/Anxiety	17 (6)	5 (2)	17 (15)	5 (4)
Pregnancy	17 (6)	0 (0)	...	...
Allergies	16 (5)	0 (0)	...	...
Skin problems	16 (5)	2 (1)	...	...
Headache	13 (4)	2 (1)	8 (7)	2 (2)
Blessing	...	...	30 (26)	0 (0)
Bad luck	...	...	20 (17)	0 (0)
"Sick"	...	...	12 (10)	0 (0)
Insomnia	...	...	9 (8)	2 (2)
Headache	...	...	8 (7)	2 (2)
Abdominal pain	...	...	7 (6)	5 (4)
Family problems	...	...	7 (6)	0 (0)

* Values are number (percentage). Because patients often had more than one reason per visit, percentages do not total 100. Ellipses indicate not applicable.

Table 2 also summarizes the most common reasons for visits to a native healer and the frequency of concomitant use of a medical provider. These reasons overlapped with the most common reasons for seeing a medical provider, such as arthritis, depression/anxiety, back pain, and diabetes mellitus, but certain complaints such as family problems and insomnia were much more common reasons for visits to native healers than medical providers. Patients who saw native healers for arthritis and diabetes mellitus commonly consulted a medical provider in addition. Those who consulted a native healer for depression/anxiety and arthritis were less likely to also consult a medical provider, and medical providers were never consulted for "sickness," "blessing," "bad luck," or family problems.

Patients' ratings of self-compliance were high. Only 2 patients (1%) said they were never compliant. Seventy-eight patients (26%) stated they were sometimes compliant, 115 patients (38%) said they were usually compliant, and 104 patients (35%) said they were always compliant. Compliance did not correlate with use of native healers.

Dissatisfaction was reported infrequently for both medical provider and native healer use; roughly 10% of patients reported they were dissatisfied with care. Twenty patients (6.6%) reported being dissatisfied with the medical treatment of arthritis, but only 7 (2.3%) reported seeking native healer care due to dissatisfaction. Six patients (2%) reported being dissatisfied with the native healer treatment of arthritis, and 5 (1.6%) reported seeking medical care because of this. Dissatisfaction with the treatment of other complaints occurred only 1% of the time for both medical providers and native healers. Satisfaction with conventional medical care did not correlate with use of native healers.

Perceived conflict in medical provider and native healer instructions occurred infrequently. Twenty-one patients stated that their medical provider and the native healer gave them conflicting recommendations. When faced with conflicting advice, 15 patients stated they attempted to follow both sets of advice, 1 patient followed the medical provider's advice only, and 5 patients followed the native healer's advice only.

Barriers to Seeking Native Healer Care

Medical care provided by the IHS is free, with the exception of certain procedures such as cosmetic surgery and certain items such as dentures. In contrast, the cost of visiting a native healer was reported to vary from \$1 to \$3000, with an average cost per visit of \$388. The average annual cost of native healer use as a proportion of the patient's self-reported annual income was 0.21, or roughly one fifth. Cost was cited by 108 patients (36%) as the reason for not seeking native healer care more frequently and was the most common barrier to native healer care. Costs are a conservative estimate as they may exclude such customary expenses as transportation, feeding all those who participate in a ceremony, and costs of materials needed such as buckskin or herbs. Cost charged to

the patient did not correlate with the patient's income.

Other patients stated that lack of trust in native healers (76 patients [25%]), their religion (70 patients [23%]), unsupportive families (37 patients [12%]), lack of belief in traditional Navajo medicine (33 patients [11%]), lack of knowledge about traditional Navajo medicine (20 patients [7%]), good health (11 patients [4%]), and lack of local native healers (10 patients [3%]) also acted as deterrents to native healer care.

Comment

Patients use unconventional medicine extensively. In their 1993 national survey, Eisenberg et al⁹ discovered that roughly 34% of respondents used unconventional therapy at an expense of \$13.7 billion dollars per year. The rate of unconventional therapy use is as high as 50% among patients who use conventional medical care.¹⁰ Smaller studies¹¹⁻¹³ have also determined that the use of unconventional therapy is widespread and used primarily for common chronic or self-limiting illnesses, but also used for diseases such as cancer, human immunodeficiency virus infection, and asthma.

We also found high rates of alternative medicine use in the Navajo population. Most patients interviewed had used native healers at some point and almost 40% used native healers on a regular basis. Those who had not used native healers within the last year generally had not used them for more than a decade. Cost was the main barrier to using native healers.

Religion was the only predictor of native healer use. Patients who belonged to an organized religion generally held traditional beliefs as well, but religion was a barrier to seeking native healer care, particularly if they were of the Pentecostal faith. "I'm a Christian now, so I don't go so much, but I used to go more often," stated one patient.

Patients consulted both native healers and medical providers for a wide range of health problems. Common conditions among the Navajo such as diabetes mellitus, arthritis, and depression or anxiety were common reasons for consulting both the medical provider and the native healer. However, certain diseases such as upper respiratory tract infections and allergies were recognized as the exclusive domain of the medical provider and other problems such as bad luck, blessings, and family difficulties were recognized as the exclusive domain of the native healer. This may reflect the fact that family problem is not a medical diagnosis and sickness and bad luck are also categorized differently in medical terminology. For diseases such as diabetes, native healer care was viewed as an adjunct rather than a substitute for medical provider care. The patients using native healers consulted native healers for depression or anxiety a greater proportion of the time than patients only using medical providers consulted medical providers for depression or anxiety. As one patient stated, "The doctors give me pills for my body, the medicine man gives me songs for my spirit."

Patients' satisfaction with care provided by the native healer or the medical provider did not seem to serve as a

driving force to seeking alternate care because most patients were satisfied with the care they received. Patients who expressed dissatisfaction with medical care did not always seek native healer care for their health problems and vice versa.

The cost of visiting a native healer was the main barrier to use. More than one third of patients stated they would use native healers more often except for the cost. The costs listed may underestimate the costs actually involved as no inquiry was made regarding materials and ancillary costs of the ceremonies. Even so, native healer cost is high, sometimes exceeding 20% of the patient's annual income. The cost may vary for several reasons, particularly regarding the type of ceremony performed and the complexity of the ceremony. Certain diagnostic ceremonies such as hand trembling tend to cost significantly less than "treatment" ceremonies, which may involve the patient's entire extended family and last for days.

Many patients reported that they did not trust certain individuals claiming to be native healers. While these patients still believed in traditional Navajo medicine, they stated that they could not find a trustworthy practitioner; one patient stated, "There are a lot of quacks out there," applying the term quacks to those masquerading as native healers. Several patients stated that certain individuals claiming to be native healers did not bother to learn the intricacies of their trade but rather charged patients for inadequately performed services. The longer ceremonies can last as long as 9 days with different chants and rituals performed throughout, and can take years of apprenticeship to learn.² Patients who cited lack of trust were concerned that the quality of native healer care varied substantially from practitioner to practitioner. "I know a good one, so I use him a lot," stated one patient.

Lack of availability of local healers also acted as a barrier. No exact tally exists of the number and location of native healers, but several patients stated that the number of local healers varies at different locations on the Navajo reservation. "All the good medicine men are far away," stated one patient. "I would have to drive 3 hours to get the ceremony I need."

Participants in the survey may not accurately represent Navajo patients, as patients interviewed were exclusively drawn from those who seek care at an IHS hospital; the use of native healers may be much higher for those who do not seek conventional medical care or who seek care at a nongovernmental hospital. Also, as previously mentioned, the reservation is large and the IHS site where the interview was conducted is located at the edge of the reservation. Thus, patients interviewed may have easier access to non-Navajo sources of health care than patients who are located in the interior of the reservation. Conversely, patients located in the interior of the reservation may have easier access to native healers than the patients interviewed if there is a higher concentration of healers in the interior of the reservation. Finally, not all Navajo live on the reservation, and it is unknown how this population's access to conventional or native healer care differs from the populations mentioned above.

The fact that 2 non-Navajo medical providers conducted the interview in a hospital clinic may have led to an underestimate of patients' use of native healers. Patients may have felt uncomfortable divulging the frequency or history of use for fear of how this might influence their medical care due to the misperception that the interviewers, being non-Navajo, might be prejudiced against native healer care. Also, since patients had just received medical provider care, they may have been reluctant to state they were dissatisfied with their medical care. Similarly, they may have overestimated their compliance rates with medical care.

As with many other subpopulations in the multicultural society that composes the United States, the use of alternative medicine is common among Navajo patients. Patients usually do not perceive conflict between different health system beliefs and may use remedies prescribed by several practitioners for a single health care problem; they may perceive such an approach as more effective than using a single system. This may be rooted in the belief that disease is multifaceted, and different health care systems treat different facets effectively.⁵ As one patient succinctly stated, "It is better to stand on two legs than on one." Therefore, inquiring about patients' use of native healers can significantly enhance understanding of the patients' health.

Even though use of native healers can be a religious and private issue, patients are willing to discuss their use of native healers if asked in a sensitive manner. Increased understanding of this deeply rooted system can improve communications between providers and patients and, therefore, can help medical providers improve the quality of care provided. Further research is needed to elucidate how extensive native healer use is across various areas of the Navajo reservation, what patients' expectations of their various health care providers are, their view of the success of the care provided, and how conventional care and native healer care can interact with each other to increase the overall effectiveness of care provided to the patient. □

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References

1. Sandner D. *Navajo Symbols of Healing*. Orlando, Fla: Harcourt Brace &

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- Co; 1979
 2. Reichard GA. *Navajo Religion: A Story of Symbolism*. 2nd ed. Tuscon: University of Arizona Press; 1983
 3. Hammerschlag C. *The Dancing Healers*. New York, NY: HarperCollins Publications Inc; 1988
 4. Kelly KB, Francis H. *Navajo Sacred Places*. Bloomington: Indiana University Press; 1994
 5. Coulehan JL. Navajo Indian medicine: implications for healing. *J Fam Pract*. 1980;10:55-61
 6. Etcitty D. *Navajo Nation FAX 1993*. Window Rock, Ariz: Division of Economic Development, Navajo Nation; 1994
 7. Hully SB, Cummings SR. *Designing Clinical Research*. Baltimore, Md: Williams & Wilkins; 1988
 8. *Stata Statistical Software*. College Station, Tex: Stata Corp; 1997
 9. Eisenberg D, Kessler R, Foster C, Norlock FE, Calkins DR, DeBanco TL. Unconventional medicine in the United States. *N Engl J Med*. 1993;328:246-252
 10. Elder NC, Gillchrist A, Minz R. Use of alternative health care by family practice patients. *Arch Fam Med*. 1997;6:181-184
 11. Cook C, Baiseden D. Ancillary use of folk medicine by patients in primary care clinics in southwestern West Virginia. *South Med J*. 1986;79:1098-1101
 12. MacIntyre RC, Holzemer WL. Complementary and alternative medicine and human immune deficiency virus and AIDS. *J Assoc Nurses AIDS Care*. 1997;8:25-38
 13. Hackman RM, Stern JS, Gershwin ME. Complementary and alternative medicine and asthma. *Clin Rev Allergy Immunol*. 1996;14:321-336
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Spotlight On Violence Prevention: The Phoenix Area Injury Prevention Program Approach

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Violence has emerged as a major health problem facing American Indians in recent years. During the past decade, violence-related injuries have overtaken motor vehicle-related injuries as the leading cause of injury death and hospitalization in many Phoenix Area service units. The problem of violence is being addressed with a variety of approaches by many different interests, including primary care providers, behavioral health staff, law enforcement and judicial authorities, tribal councils, and victim's groups. This brief article will offer an overview of some of the public health-oriented efforts that the Phoenix Area Injury Prevention Program has utilized to address this important health issue.

The Phoenix Area Injury Prevention Program has been successful in applying basic public health and epidemiologic principles to injury control in American Indian communities. Program components include maintenance of community-based severe injury surveillance to monitor the trends and patterns of severe injury in communities; conducting epidemiologic studies of certain injury problems to determine specific causative factors; development of comprehensive, community-based epidemiologic interventions; development of community-based coalitions to develop interventions; and consultation and training by technical experts in injury prevention.

Since the mid-1990s, we have applied these strategies to violence-related injury. From our ongoing severe injury surveillance systems, multi-year retrospective studies of severe

assault injury have been conducted on three reservations. The purpose of the studies was to determine the causes of assault injury. The sources of data for these studies were patients' medical records, mental health and social services records, and tribal police department records. The studies were designed to examine things like victim/offender relationships, demographic characteristics of victims and offenders, method of assault, weapons used, medical care provided, alcohol involvement, treatment, and services to which victims were referred. The studies have helped quantify some of the patterns and trends of injury. One of the consistent findings of the three studies is a low level of referral of hospitalized assault victims to behavioral health programs or law enforcement agencies. There also appeared to be inadequate coordination of basic intervention and treatment services for severely injured assault victims.

In October 1997, an epidemiologist with experience in the field of violence prevention visited two service units in the Area. The purpose of the visits was to provide consultation and advice on programmatic direction in violence prevention. The visits included a review of data and existing efforts in violence prevention, meetings with focus groups to gain insight about the communities' perspective of the issue, and providing violence prevention training to IHS and tribal medical staff and other primary care providers. The visits resulted in a detailed consultative report with numerous useful programmatic recommendations.

An effort to stimulate community interest in, and share information about violence prevention was conducted in August 1998 with the presentation of "Mending the Spirit: A Conference to Address Violence Among Native Americans."

This meeting attracted over 330 representatives of tribes and agencies from the southwestern US. At the conference, participants shared strategies and successes in violence prevention with national experts and other attendees. The conference was a first step in establishing violence prevention as a specific policy issue and public health problem that warrants special attention within Native American communities.

The Phoenix Area Injury Prevention Program plans to continue applying a public health approach to the growing problem of violence among Native Americans. The participation of other interested programs, professions, and individuals is welcomed and encouraged. Multidisciplinary team work is one of the best ways to address this difficult public health problem. □

Continuing Education for Physicians and Nurses in MMWR

Continuing medical education (CME), continuing nursing education (CNE), and continuing education units (CEU) are available in the paper and electronic versions of three recent issues of *Recommendations and Reports (RR)* of *Morbidity and Mortality Weekly Reviews (MMWR)*. A CME component was produced for the article entitled "Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease" (Vol 47, No. RR-19), CME and CNE components were created for "Prevention and Treatment of Tuberculosis Among Patients Infected with Human Immunodeficiency Virus: Principles of Therapy and Revised Recommendations" (Vol 47, No. RR-20), and CME, CNE, and CEU components were created for "Human Rabies Prevention -- United States, 1999: Recommendations of the Advisory Committee for Immunization Practices (ACIP) (RR-1).

The CME activities were planned and implemented by the Centers for Disease Control and Prevention (CDC) according to the "Essentials and Standards" of the Accreditation Council for Continuing Medical Education (ACCME). The CDC is accredited by ACCME to provide continuing medical education for physicians. The CDC designates the two educational activities in RR-19 and RR-20 for a maximum of 2.0 hours each in category 1 credit toward the American Medical

Association's Physician's Recognition Award. The CDC designates the educational activities in RR-1 for a maximum of 1.0 hour in category 1 credit.

The CDC is also accredited by the American Nurses Credentialing Center's Commission on Accreditation to provide continuing education for nurses. The CDC designates the educational activity in RR-20 for a maximum of 2.4 contact hours of CNE credit, and the activity in RR-1 for 1.2 contact hours. In addition, the CDC is accredited by the International Association for Continuing Education and Training (IACET) to award CEUs, a nationally recognized unit designed to provide a record of a person's continuing educational accomplishments. The CDC designates the educational activities in RR-1 for a maximum of 0.1 hours of CEU credit.

To register and receive credit, physicians, nurses, and others may return their responses electronically to <http://www2.cdc.gov/cep/>. Responses may also be returned by a card or letter sent by fax (404-639-4198) or mail no later than one year from the publication date of these reports. No fee is charged for participating in these continuing education activities.

Other CME, CNE, and CEU components are planned for future MMWR publications. For more information, contact John W. Ward, MD, Editor, MMWR, at jww4@cdc.gov. □

The USPSTF Recommendations

Interventions Considered and Recommended for the Periodic Health Examination Age 65 and Older

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The United States Preventive Services Task Force (USPSTF) issued age-specific, evidenced-based preventive services guidelines in the 2nd edition of their report published in 1996.¹ These guidelines are comprised of preventive services that have been demonstrated to be efficacious. The following table is a summary of the USPSTF 1996 recommendations for persons age 65 and older. The reader is referred to their Guide to Clinical Preventive Services, 2nd Edition, for details.

Screening

- Blood pressure
- Height and weight
- Fecal occult blood test (annually) and/or sigmoidoscopy
- Mammogram (every 1-2 years; for women <70) ± annual clinical breast exam
- Pap smear (for all women who are or have been sexually active and who have a cervix; consider discontinuation of testing after age 65 if previous regular screening with normal results)
- Vision screening
- Assess for hearing impairment
- Assess for problem drinking

Immunizations

- Pneumococcal vaccine
- Influenza (annually)
- Tetanus-Diphtheria (Td) booster

Chemoprophylaxis

- Discuss hormone prophylaxis (peri- and postmenopausal women)

Interventions for high-risk populations

<u>Population</u>	<u>Potential Interventions</u>
Institutionalized persons	PPD, Hep A vaccine, Amantadine, Rimantadine
Chronic medical conditions, TB contacts, low income, immigrants, alcoholics	PPD

Persons >74, or >69 with risk factors for falls	Fall prevention intervention
Cardiovascular disease risk factors	Consider cholesterol screening
Native Americans/ Alaska Natives	PPD, Hepatitis A vaccine
Blood products recipients	HIV screen, Hepatitis B vaccine
High risk sexual behavior	Hepatitis A vaccine, HIV screen, Hepatitis B vaccine, RPR/VDRL
Health care/lab workers	PPD, Hepatitis A vaccine, Amantadine, Rimantadine, Hepatitis B vaccine

Counseling

Substance Use

- Tobacco cessation
- Avoid alcohol/drug use while driving, etc.

Diet and Exercise

- Limit fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables
- Adequate calcium intake (women)
- Regular physical activity

Injury Prevention

- Lap/shoulder belts
- Motorcycle and bicycle helmets
- Fall prevention
- Safe storage/removal of firearms
- Smoke detector
- Set hot water heater to <120-130 degrees F
- CPR training for household members

Dental Health

- Regular visits to dentist
- Floss, brush with fluoride toothpaste daily

Sexual Behavior

- STD prevention, avoid high risk sexual behavior, use condoms

Reference

1. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*, 2nd ed. Baltimore:Williams & Wilkins, 1996

Call for Nominations for the Physicians Professional Advisory Committee 1999 Awards

The Physicians Professional Advisory Committee (PPAC) to the Surgeon General of the United States Public Health Service (USPHS) is seeking nominations for three physician awards to be presented at the upcoming USPHS Professional Meeting in Alexandria, Virginia on June 6-9, 1999. Both Civil Service and Commissioned Officer USPHS physicians are eligible for these awards.

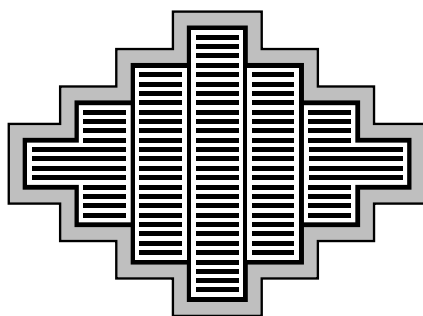
The first award is the Clinical Physician of the Year. This award will recognize a clinical physician who consistently achieves high standards in the practice of medicine. He/she is able to find innovative ways of delivering quality medical care despite the constraints of budget and personnel. This individual is consistently looked upon as a role model by his/her peers and is a valuable resource person due to the extended length of his/her service.

The second award is the Physician Researcher of the Year, which recognizes individual initiative, accomplishment, and accountability for actions that increase the overall effectiveness of the USPHS through research. This individual has established research programs or approaches that enhance health care delivery or has improved existing research programs. In addition, he/she has developed and implemented research programs that have raised the health and safety consciousness of the public or resulted in significant cost savings or cost avoidance.

The third award is the Physician Executive of the Year,

which recognizes a physician executive who plays a key role in the successful administration or management of an office or program activity in the PHS. This individual makes exceptional contributions to the accomplishments, goals, and objectives of the PHS while serving as a manager, administrator, or supervisor. He/she exercises exceptional judgement in making managerial decisions and developing innovations that provide increased effectiveness in the management of programs. He/she makes choices that maximize the use of available resources and enhance the goodwill between the United States Government and the public.

The PPAC Awards Committee will consider all nominations that are received by April 16, 1999. Submissions sent by facsimile machine or e-mail will not be accepted. Each nomination package should include a brief narrative (1 to 2 pages) explaining how the physician meets the award criteria, the nominee's title, Agency, address, and fax and telephone numbers. The nominee's current *curriculum vitae* should also be attached. A brief, one sentence statement as to the reason this nominee deserves this award should be included in the nomination package. This information can also be found on the Physicians Professional Advisory Committee's web site at www2.ihs.gov/ppac. All nominations should be addressed to CAPT Timothy D. Mayhew, MD, Chair, PPAC Awards Committee, Dzilth-Na-O-Dith-Hle PHS Indian Health Center, 6 Rd 7586, Bloomfield, NM 87413. □



The Interdisciplinary Elder Care Team: The Initial Process

Bruce Finke, MD, Director, Elder Care Initiative, and Staff Physician, Zuni-Ramah Service Unit, Zuni, New Mexico

Previous articles in this series appeared in the November and December 1998 issues of The Provider outlining the proposal to set aside time in May, 1999 to establish interdisciplinary elder care teams at IHS, tribal, and urban program clinics and hospitals.

You have assembled the interdisciplinary elder care team and the time has come to start the work. In this article we will make some suggestions that will help your team get started.

The first step is to list the elder care work already being done by team members. You may be surprised (and pleased) by the significant work you are already doing to improve the care of elders. We all need to recognize what we are doing well.

The next step is to begin brainstorming about needs and projects. Think about the “problems” you see in your hospital, clinic, or community with regard to elder care. What needs to be done to improve the care of elders? Most of us notice these things on a daily basis; what we need is time and help addressing them. The problems you identify will obviously depend to some degree on the folks sitting around the table. A

team with more community involvement will generate a different list than a team localized to the hospital or clinic. Once you identify the problems, then begin to discuss possible approaches.

You may find it easier to think about specific projects first. It often happens that a project or program that a team member has heard or read about will be appealing. In those situations, it is very important that you identify the problem that the particular program is meant to address. A program that is very attractive in someone else’s institution or community will disappoint you in yours if it doesn’t address a very real need.

Now your team has created a list of programs already under way and a list of potential projects. Your team may decide to rededicate itself to the programs already in process rather than to embark on new activities. In doing so, team members should look at those activities with fresh eyes, and think creatively about how to use all the members of the team.

For teams that decide to embark on a new project, the choice of project can be a critical one. It will be the test of the team and can generate enthusiasm for future efforts. Choose a project that requires the skills of as many of the team members as possible. Above all, choose an initial project that can be accomplished, and within a reasonable amount of time. This is terribly important. We need to see that our hard work can pay off in a meaningful way, by improving the care of our elders. □

MEETINGS OF INTEREST □

Midwinter Ob/Peds Conference February 5-7, 1999; Telluride, Colorado

The annual Midwinter Ob/Peds Conference will be held in Telluride, Colorado, February 5-7, 1999. This conference will offer continuing education to providers interested in new developments in health care for women and children. A special focus this year will be on maternal screening and prevention of vertical transmission of sexually transmitted diseases. Other presentations will include gestational diabetes, neonatal seizures, counseling the parents of premature infants, treatment of fecal incontinence, and complementary and alternative medicine. The IHS Clinical Support Center is the accredited sponsor; the CSC is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. For more information contact Alan

Waxman, MD at (505) 722-1000, or Diana Hu, MD at (520) 283-2501.

Fetal Alcohol Syndrome Two identical sessions: February 10-12, 1999, and June 2-4, 1999; Seattle, Washington

This conference is cosponsored by the University of Washington Fetal Alcohol and Drug Unit, the University of Washington FAS Diagnostic and Prevention Network, and the Indian Health Service. Native Americans or those working with Native Americans are eligible, including professionals (physicians, psychiatrists, psychologists, social workers, nurses, teachers, CHNs, chemical dependency counselors, lawyers, judges, etc.) as well as advocates and parent activists. Six trainees will be selected for each session by the IHS



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Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via the IHS Banyan electronic mail system.

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or through our fax retrieval service. Call 602-640-2140, ask for the fax retrieval service, and request document #3005. After business hours, press 8, and follow the instructions.

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