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Changes in the ACCME Standards for Commercial Support

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The acceptance or use of commercial support for continuing education in the Indian health system is rare. There are several reasons for this. First, the Federal Standards for Ethical Conduct make it difficult, if not impossible for federal employees to accept such support from prohibited sources, such as pharmaceutical companies. Certainly any facility or individual wanting to attempt to use commercial support following these Federal Standards should do so in consultation with the Program Integrity and Ethics Office (PIES; telephone (301) 443-4137).

Second, the requirements imposed by the Accreditation Council for Continuing Medical Education (ACCME) on those who wish to pursue commercial support make the practice complicated, at best, in the federal setting. Among these requirements are the following: 1) the funds from the pharmaceutical company must go to the coordinator or facility hosting the activity, and not directly to the presenter, 2) there must be a written, signed contract between the recipient of the commercial support and the pharmaceutical company, and 3) the coordinator, and not the drug company, must control the choice of the topic and speaker. Most pharmaceutical companies do not want to abide by the requirements that they give up this control.

Finally, most service units have found that the practice is not very useful or rewarding. Public opinion, clinician attitudes, recent medical literature, and the lay press have all swung to the opinion that the practice is costly to the consumer and leads to poor prescribing decisions by physicians (see, most recently, "Drug Makers Pay for Lunch as They Pitch" in the July 28, 2006 issue of The New York Times, *http://www.nytimes.com/2006/07/28/business/28lunch.html*).

Even though commercial support isn't used much, nevertheless, we are obligated to complete the "disclosure process." This is a process required by the ACCME, the organization that accredits the Clinical Support Center (CSC) to sponsor continuing medical education (CME), whereby steps are taken to find out if there are any potential "conflicts of interest." For the most part, since there is little commercial support in Indian Country, and since most of our speakers do not have any conflicts of interest, things have been simple. By letting those attending know that the speakers have completed the disclosure process and that they have no conflicts of interest to disclose, the requirements have been met.

There are two new requirements, now, that make this a little more complex.

The New Rules About Who Must Complete the Disclosure Process

In the past, only faculty members had to complete the disclosure process. The new ACCME requirements state that

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"everyone who is in a position to control the content of an educational activity" must complete the process. **This means that all course coordinators and planning committee members must also do so.** Those who are unable or unwilling to do so must be excluded from participating. An easy way to meet this requirement is for all planning committee member complete and sign a CSC Disclosure Form at the beginning of the planning process (go to *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/continuingEducation.cfm* for forms and detailed instructions).

The New Rules about Resolution of Conflict of Interest

The new ACCME standard requires that we 1) identify all relevant financial relationships with any commercial interest; 2) have a mechanism to determine whether these relationships create a conflict of interest with the individual's control of the content; and 3) have a mechanism to **resolve** all conflicts of interest before the activity occurs. For a number of years, we have been meeting the first requirement.

What Needs to be Done with the Information Learned from the Disclosure Process?

If the person states that he or she has nothing to disclose, then nothing more needs to be done other than letting the audience know that the process has taken place and that there is nothing to disclose, using the prescribed disclosure statements on the preconference publicity and on the course materials distributed at the meeting (see below). If, however, there is something significant to disclose, then the new requirements state that not only must the audience be informed, but that there must be "resolution of the conflict of interest."

How Does One Determine if There is a Conflict of Interest?

The ACCME has listed on its website and other educational materials the various types of relationships that might constitute a conflict of interest, such as receipt of an honorarium, service on a speakers bureau, acceptance of research funds, ownership of equity on the company, and so on. The Standards for Commercial Support have always required that these relationships be disclosed to the audience. Now, however, we have to examine those relationships in the context of the role that the person plays in the design and execution of the activity, and the scope of the educational content of the activity. An easy way to do this is to contact the CSC whenever there is any potential conflict of interest to discuss the matter and what needs to be done.

What is Resolution of Conflict of Interest?

The ACCME doesn't often spell out exactly how things must be done, so this permits a great deal of flexibility. Some examples of how this might be accomplished are as follows: 1) prior review of the content of a presentation with special attention to the best available evidence, and requirements for revision as need be; 2) asking a speaker or a planning committee member to recuse him- or herself from this activity; 3) asking the person in question to divest themselves of the financial relationship; or 4) assigning the speaker a different topic. There are obviously many other ways to resolve conflicts of interest. ACCME has made it clear, however, that simply monitoring the activity will not suffice, and some concrete **action** must be taken **before** the activity takes place. As with anything else, it is critical to document what was done, for the file.

What Must be Disclosed?

This has not changed. The disclosure must include the name of the individual, the name of the commercial interest, and the nature of the relationship. Such relationships might include grant or research support, being a consultant or on the speaker's bureau, being a stock shareholder, or anything else that seems relevant. Relationships with government or non-profit organizations are not considered relevant.

How Does One Complete the Disclosure Process?

All coordinators, planning committee members, and speakers should complete and sign the "Disclosure of Conflict of Interest" Form that can be found at our website at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/ceChecklist.cfm*. The form must be filled out before the activity takes place. If no conflicts of interest are found, then this information should be included on the preconference publicity and on the course materials handed out at the activity (usually on the faculty list) using the prescribed statements, as follows:

> The course coordinator, all planning committee members, and all speakers have completed the disclosure process and have indicated that they have no financial relationships with any company or product that may be discussed in this activity.

The completed forms must then be sent to CSC for inclusion in the permanent records for the activity. Please be sure that the file number for the activity in on each form so that they may be kept with the appropriate file.

Summary

Two new, important steps have been added to the disclosure process. First, in addition to all speakers, now all course coordinators and planning committee members must complete and sign a Disclosure Form. Second, if any financial relationship is discovered, steps must be taken to resolve any conflict of interest. Since there are few instances if financial conflicts for speakers or planners in the Indian health system, there will likely be few situations when such steps to resolve conflicts of interest will need to be taken. The complete text of the ACCME Standards for Commercial Support and supplemental answers to frequently asked questions on this topic can be found on the ACCME website at *http://www.accme.org/*.

Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 4, No. 7, July 2006) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month
Point/Counterpoint
Refusals by pharmacists to dispense emergency contraception

I wanted to take the opportunity to respond to one of the articles in the June 2006 issue of CCC Corner. The article "Refusals by pharmacists to dispense emergency contraception: a critique" addresses an issue that has been in the news off and on for the last couple of years. Many of the leading pharmacy organizations issued a response to the *Obstetrics and Gynecology* article (see references).

Over the past 30 years, the IHS Pharmacy Program has worked with physicians and other providers to assure that our patients receive the medications they need. On April 8, 2005, an e-mail was sent out on the pharmacist and physician listservs discussing this issue. The e-mail is provided below.

> **Subject: Dispensing Birth Control and Emergency Contraception**
>
> Many of you may have read the articles this week (see below) about the Governor of Illinois directing pharmacists to fill prescriptions for birth control and emergency contraception. This issue was also discussed this week at the American Pharmacists Association Annual Meeting in Orlando, Florida.
>
> Over the years, the IHS has tried whenever possible to accommodate pharmacists who do not feel they can ethically dispense birth control or emergency contraception while still meeting our mission of providing needed pharmaceutical services to our patients.
>
> At most sites, this issue is resolved by having another pharmacist who is willing to dispense the medication fill the prescription and counsel the patient. This solution is acceptable if the workload volume does not place an undue burden on the dispensing pharmacist. In clinics with only one pharmacist, the pharmacist can discuss this issue with the Clinical Director and see if there is a physician or other prescriber who would be available to dispense these medications. Policies and procedures need to be in place for when the pharmacist or prescriber is on vacation or unavailable so that patients can receive medications without delay.
>
> Other sites have looked at how they can assure that these medications are available 24/7 without violating any employee's ethical concerns nor causing any embarrassment for the patient (especially at sites that do not have 24 hour pharmacy coverage). Some sites provide pre-packed, pre-labeled emergency contraception in a controlled (for example Omnicell) location for providers who might be prescribing this medication. This allows the 24/7 option, allows first dose administration by the provider in the clinic or ER if desired, and automatically provides a work around for any pharmacist with ethical concerns. Most providers were very willing to work with us on this issue, and patients are getting the care they are seeking.
>
> Please discuss this issue at your site and if needed come up with a workable solution. If you have any questions, please contact me at the address below.
>
> RADM Robert E. Pittman
> PHS Chief Pharmacist Officer

OB/GYN CCC Editorial comment

This is another in our series of Point/Counterpoint topics that allows our readers to fully explore various sides of complex issues. I want to thank James Bresette, HQE, for helping facilitate this Point/Counterpoint.

The June 2006 CCC Corner noted increasingly numerous instances reported in the national media of pharmacists refusing to fill prescriptions written for emergency postcoital contraceptives. These pharmacists have asserted a "professional right of conscience" not to participate in what they interpret as an immoral act. Above, the PHS Chief Pharmacist Officer in a simple, yet elegantly worded response makes it clear that policies and procedures need to be in place for when the pharmacist or prescriber is on vacation or unavailable so that the patients can receive medications without delay. The PHS Chief Pharmacist Officer's comments are especially important because some of our AI/AN patients may be a thousand miles by airplane away from the nearest alternative pharmacy provider.

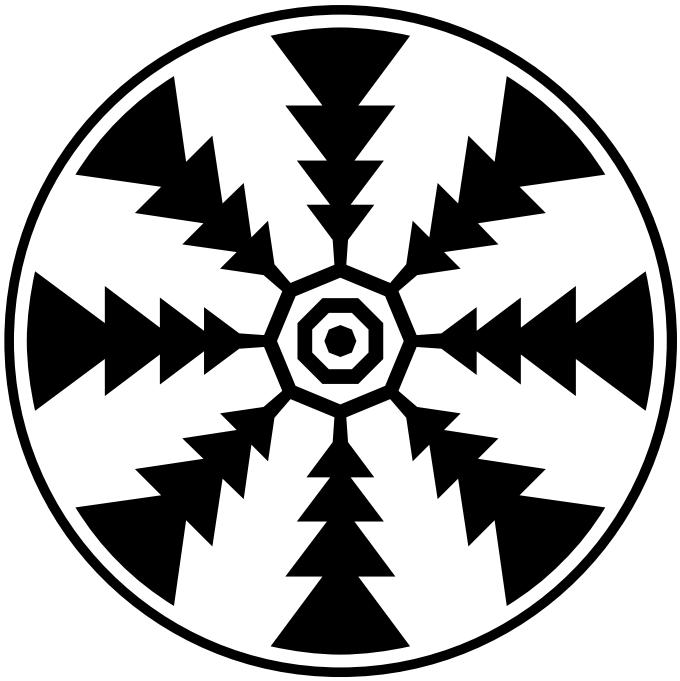
The American Pharmacists Association (APhA), the national professional society of pharmacists, has been a strong advocate for women. The APhA has been active in facilitating pharmacists to prescribe emergency contraception directly to women in need in a number of states. Please see the APhA Special Report below.

It may not only be the individual provider or pharmacist's approach that creates barriers to our patients. In some cases there can be system issues that also lead to impaired access. Another article posted in the CCC Corner on this topic was co-authored by two former Indian health staff who are now on the faculty of the University of New Mexico. Espey et al reported that Plan B and Preven were not in stock at the majority of pharmacies in a moderately sized metropolitan area. Lack of availability at the pharmacy constitutes a major barrier to emergency contraception access.

Lastly, it is my experience that pharmacists tend to be much more organized than most providers, and hence are much more likely to have an effective policy and procedure for something like this. I think an individual patient is much more likely to have her choices limited by a provider. The Indian Health Primary Care Discussion Forum referenced below provides a variety of views on this topic. If a provider does not feel she/he can offer the full range of services to a patient, then they should make similar arrangements to those described by our pharmacy colleagues. Just like our pharmacy colleagues, we should honor that provider's opinion while we continue to provide the highest level of care to our patients.

I encourage continued dialogue on this and other topics. I find we can learn best if we can truly listen to those we think we disagree with the most. Please consider the "walk a mile in my shoes" concept before you begin to you make any final decision. Once we completely understand all the variables, then we can better serve our patients.

References: see the online version of the Ob/Gyn CCCC newsletter.



From Your Colleagues: Mark Traeger, Whiteriver
How to address health disparities? One story of success — Whiteriver, Arizona

We recently published our influenza vaccination rates, showing how Whiteriver bridged the disparity often seen in influenza vaccination rates on reservations. The rates quoted are from 2002 - 2003; since then we have increased our rates another 10% or so (see abstract below).

Objectives: The Whiteriver Service Unit (WRSU) used proven effective methods to conduct an influenza vaccination campaign during the 2002 - 2003 influenza season to bridge the vaccination gap between American Indians and Alaska Natives and the US population as a whole.

Methods: In our vaccination program, we used a multidisciplinary approach that included staff and community education, standing orders, vaccination of hospitalized patients, and employee, outpatient, community, and home vaccinations without financial barriers.

Results: WRSU influenza vaccination coverage rates among persons age 65 years and older, those age 50 to 64 years, and those with diabetes were 71.8%, 49.6%, and 70.2%, respectively, during the 2002 - 2003 influenza season. We administered most vaccinations to persons age 65 years and older through the outpatient clinics (63.6%) and public health nurses (30.0%). The WRSU employee influenza vaccination rate was 72.8%.

Conclusions: We achieved influenza vaccination rates in targeted groups of an American Indian population that are comparable to or higher than rates in other US populations. Our system may be a useful model for other facilities attempting to bridge disparity for influenza vaccination.

Traeger M, et al. Bridging disparity: a multidisciplinary approach for influenza vaccination in an American Indian community. *Am J Public Health.* 2006 May;96(5):921-5.

Hot Topics: Obstetrics
The return of the vaginal breech delivery

Abstract: In light of recent studies that further clarify the long-term risks of vaginal breech delivery, the American College of Obstetricians and Gynecologists recommends that the decision regarding mode of delivery should depend on the experience of the health care provider. Cesarean delivery will be the preferred mode for most physicians because of the diminishing expertise in vaginal breech delivery. Planned vaginal delivery of a term singleton breech fetus may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management. Before a vaginal breech delivery is planned, women should be informed that the risk of

perinatal or neonatal mortality or short-term serious neonatal morbidity may be higher than if a cesarean delivery is planned, and the patient's informed consent should be documented.

OB/GYN CCC Editorial comment:

This is a significant shift in opinion, based on the increasing literature supporting the return to vaginal breech delivery in those centers with providers who can display current competence and in which the facility has hospital-specific protocol guidelines. Oxytocin induction or augmentation was not offered. Here are some of the criteria used in the studies analyzed:

- gestational age greater than 37 weeks
- frank or complete breech presentation
- no fetal anomalies on ultrasound examination
- adequate maternal pelvis
- estimated fetal weight between 2,500 g and 4,000 g.
- fetal head flexion
- adequate amniotic fluid volume, defined as a 3-cm vertical pocket
- normal labor progress

ACOG has issued the following recommendations

- The decision regarding the mode of delivery should depend on the experience of the health care provider. Cesarean delivery will be the preferred mode of delivery for most physicians because of the diminishing expertise in vaginal breech delivery.
- Obstetricians should offer and perform external cephalic version whenever possible.
- Planned vaginal delivery of a term singleton breech fetus may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management.
- In those instances in which breech vaginal deliveries are pursued, great caution should be exercised, and detailed patient informed consent should be documented.
- Before embarking on a plan for a vaginal breech delivery, women should be informed that the risk of perinatal or neonatal mortality or short-term serious neonatal morbidity may be higher than if a cesarean delivery is planned.
- There are no recent data to support the recommendation of cesarean delivery to patients whose second twin is in a nonvertex presentation, although a large multicenter randomized controlled trial is in progress

Mode of term singleton breech delivery. ACOG Committee Opinion No. 340. American College of Obstetricians and Gynecologists. Obstet Gynecol 2006;108:235–7.

Gynecology

CDC's Advisory Committee recommends human papillomavirus vaccination

Vaccine considered highly effective in preventing infections that are the cause of most cervical cancers.

The Advisory Committee on Immunization Practices (ACIP) voted to recommend that a newly licensed vaccine designed to protect against human papillomavirus (HPV) be routinely given to girls when they are 11 - 12 years old. The ACIP recommendation also allows for vaccination of girls beginning at nine years old as well as vaccination of girls and women 13 - 26 years old. HPV is the leading cause of cervical cancer in women.

According to the ACIP's recommendation, three doses of the new vaccine should be routinely given to girls when they are 11 or 12 years old. The advisory committee, however, noted that the vaccination series can be started as early as nine years old at the discretion of the physician or health care provider.

OB/GYN CCC Editorial comment

ACIPs recommendations: Some of the final steps before roll out of this HPV vaccine

Each Indian Health Service, tribal, and urban facility should be making active plans now on how best to implement this vaccine for their clientele. In general most states will make the quadravalent vaccine available to our AI/AN patients at no cost in January 2007. There are many major issues to anticipate while we maintain a highly effective screening program in the meantime. Here are just a few:

- how to implement this as a cancer vaccine while addressing the sexually transmitted infection issues head on
- how to address "catch up" vaccination for those patients over the age of 19 years who will not qualify for Vaccines For Children coverage
- how to monitor the quadravalent vaccine effectiveness (patients may be infected with more than one HPV sub-type), and possible adverse vaccine reactions.

Child Health

Boyfriends, girlfriends, and adolescents' risk of sexual involvement

We have found that having had a boyfriend or girlfriend by seventh grade is both a predictor of having sex in the ninth grade and a marker of prior risks for sex.

- Males who reported a girlfriend by seventh grade were more likely than those who had not to be sexually active in ninth grade.
- Females who reported a same-age boyfriend in seventh grade were more likely than those reporting no boyfriend in seventh grade to be sexually active in ninth grade, and those reporting an older boyfriend in seventh grade were more likely than those reporting a same-age boyfriend to be sexually active in ninth grade.

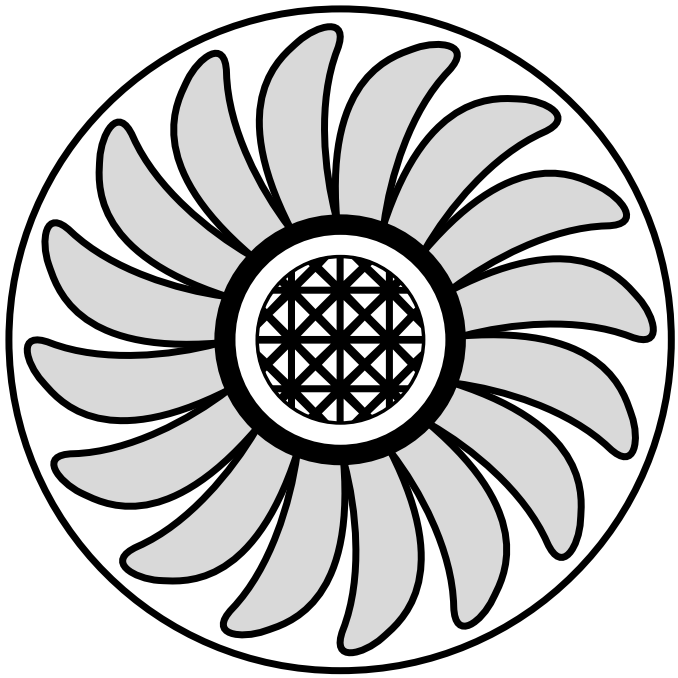
- For males, sixth-grade peer norms favoring sex, Hispanic ethnicity, and eighth-grade situations that could lead to sex predicted ninth-grade reports of sexual activity.
- For females, menarche in sixth grade was associated with ninth-grade reports of sexual activity, as were peer norms favoring sex and situations that could lead to sex in eighth grade.
- Helping girls to handle the social changes related to early pubertal development, deemphasizing social activities that may pave the way for risky behavior and encouraging parental supervision may help reduce early involvement with a boyfriend or girlfriend.

Marin BV, Kirby DB, Hudes ES, et al. 2006. Boyfriends, girlfriends and teenagers' risk of sexual involvement. *Perspectives on Sexual and Reproductive Health*. 38(2):76-83.

OB/GYN CCC Editorial Comment

Lori de Ravello, National IHS STD Program, offers a focus on adolescent sexual behavior this month in the STD Corner. Lori highlights five articles from the June 2006 *Perspectives on Sexual and Reproductive Health* on findings and strategies in adolescent reproductive health. In addition Sulak et al report a successful sex education program in an academic center.

Sulak PJ, Herbelin SJ, Fix DDA, et al. 2006. Impact of an adolescent sex education program that was implemented by an academic medical center. *American Journal of Obstetrics and Gynecology*. 195(1):78-84.



Chronic disease and Illness

Driving, other erratic behaviors reported after taking zolpidem (Ambien)

Zolpidem (Ambien), a nonbenzodiazepine, sedative-hypnotic prescribed for the short-term treatment of insomnia, has been associated with increased numbers of impaired driving incidents in Wisconsin during the past several years. Although the label directs patients to take zolpidem only when able to devote a full eight hours to sleep, and cautions against operating heavy machinery or motor vehicles, the patients involved in these incidents have driven while under the influence of zolpidem. Some of these drivers have expressed their belief that they were "sleep-driving," saying they have no memory of the driving incident.

A "typical" Ambien driver will demonstrate erratic, unsafe driving, often with wide lane deviations, many crashes or near-head on collisions, or unpredictable, bizarre driving maneuvers according to staff at the Toxicology Section at the Wisconsin State Laboratory of Hygiene (WSLH) in Madison.

Erratic behaviors reported after taking zolpidem are not limited to impaired driving, but have included sleepwalking, eating, drinking alcohol, belligerent outbursts, urinating in inappropriate places, agitation, confusion, dazed appearance, slurred speech, incoordination, and poor balance. Usually patients have no memory of these incidents and are at a loss to explain subsequent events, such as why food is missing from the refrigerator or why alcohol bottles are half empty.

Factors associated with zolpidem-impaired driving include not going to bed immediately after taking the drug, attempting to drive too soon after taking it, high blood levels, or ingestion with other drugs and/or alcohol. Special concerns that patients should be aware of include memory loss or amnesia. Patients are advised to take Ambien only when they are able to get a full night's sleep (7 - 8 hours) before they need to be active again.

Features: ACOG

William H. J. Haffner American Indian/Alaska Native Women's Health Award

The ACOG Committee on American Indian Affairs would like to establish the William H. J. Haffner American Indian/Alaska Native Women's Health Award. This award recognizes an individual who has made a major contribution to raising the level of health and/or improving AI/AN women's health care.

In the Committee's role of visiting IHS Areas and providing on-site reviews, it has a first hand look at the many dedicated clinicians working in the field in the IHS. These are men and women who have found innovative ways to provide excellent maternal and child health care with exceedingly limited resources and often in isolated and remote areas. They continue to show incredible fortitude and hope in trying circumstances. The committee felt that it should be commending these heroic efforts and shining a light on the many ways in which the IHS is succeeding.

The Committee wanted to name the award after someone who has been the living example of what the award stands for. The committee felt that Dr. William Haffner epitomizes this dedication and exceptional service to AI/AN women's health care. Dr. Haffner had a long career in the IHS and also has been involved with the ACOG Indian health programs from the beginning. In many cases, he has been the link between ACOG and the IHS in the long history of cooperative efforts to improve the health and welfare of AI/AN woman. While Dr. Haffner enjoys recognition and service within the College through his years of service on many committees, he also brings recognition and legitimacy to the role that ACOG has played within the IHS. He is someone who has and does move between both worlds with ease. He therefore brings a certain prestige to the award for the IHS as well. The committee foresees the honoree being recognized at ACOG's ACM and also being recognized at the IHS's Annual National Combined Councils awards banquet. This increases the awareness of the role ACOG continues to play in increasing access and quality of health care for AI/AN women within the Indian health system.

The criteria are as follows:

- A clinician who has been outstanding in AI/AN women's health care.
- The clinician could be but does not have to be an obsetrician/gynecologist. Any health care professional such as family physicians, certified nurse midwives, nurse practitioners, registered nurses, etc. could be eligible for the award.
- Awardees must demonstrate a commitment and dedication to providing exceptional health care to AI/AN women.
- They must be currently working within an IHS or tribal position or recently retired.

Contact Yvonne Malloy at *YMalloy@acog.org*.

Breastfeeding
Suzan Murphy, PIMC
Pain is one of the reasons that moms quit breastfeeding in the first two weeks

For common sore nipples, there are quick fixes that can help reverse the problem.

For early sore nipples, look for the root problem.

Check positioning points

- The baby is "belly to belly" so the baby's face and body face the mom's body.
- The baby's mouth is open wide, on the breast, and snuggled close. The baby's nose can be squished up against the mom's breast – it is okay, the baby will pull back or let go if breathing is hard.

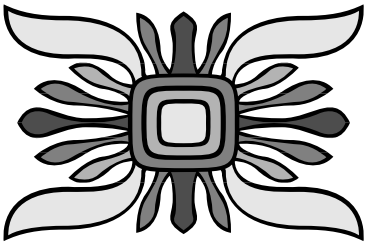
Latch

- Check that both lips are out and at least 1/2 inch past the nipple onto the areola (more is better).
- Check the internal mouth and nipple connection:
  - o Is the baby's lower lip folded under?
  - o Does the mom feel the baby's lower gum bumping her when the baby sucks?
  - o Is the sucking rhythm jerky, snappy, not smooth?
  - o "Yes" to any of these usually means the nipple isn't deep enough in the mouth and the baby's tongue isn't out far enough to cover the gums and effectively milk the nipple.

So, show the mom how to gently push the chin down through a couple suck cycles. The baby's mouth will open a little more, the lower lip pops out, and the tongue will drop down to cover the gums – viola! Less pain and the baby gets more milk — and it usually takes just a couple "fixed" feedings for the baby to automatically latch appropriately.

- Sometimes in the first couple days, as the baby is learning how to suck effectively, the baby will chomp on mom enough to cause tender nipples. Moms usually describe it as pain at the beginning of the feeding that goes away after the first 15 - 30 seconds. It usually helps for the mom to know that the discomfort will get better each day.
- If the mom is compressing or pushing down on the breast — so she can see the baby breath – it can disrupt latching and lead to sore nipples. It can help to reassure her that the baby instinctively knows that breathing is important and will pull away if breathing is hard.
- If the baby is using a pacifier often, it can alter the sucking process and lead to sore nipples. Encourage the mom to use the pacifier carefully – less (and later) is better.
- To help the mom while the nipples are healing, encouragement is magic. She will feel better soon – a day or two, sometimes less. Also consider suggesting:
  - o Let the nipple air dry before putting the bra flap or breast pad on.
  - o If the nipple sticks to clothing or a breast pad, wet it first so it peels off gently without new skin.
  - o Topical treatments like lanolin ointment, gel pads, and tea bags. Moms often say they help. Effective positioning/latch and time help too.
- If the mom says that it hurts all the time and nothing seems to help, check with a breastfeeding consultant.

If the pain starts after the first couple weeks, thrush is likely. Both mom and baby need to be treated.



References:

Schanler R et al. Breastfeeding Handbook for Physicians, American Academy of Pediatrics and American college of Obstetricians and Gynecologists. 2006

Biancuzzo M. Breastfeeding the Newborn: Clinical Strategies for Nurses, Mosby Publishing, 2003.

Information Technology

Hospital computer keyboards should be disinfected daily

Conclusions: Our data suggest that microbial contamination of keyboards is prevalent and that keyboards may be successfully decontaminated with disinfectants. Keyboards should be disinfected daily or when visibly soiled, or if they become contaminated with blood.

Rutala WA, et al. Bacterial contamination of keyboards: efficacy and functional impact of disinfectants. *Infect Control Hosp Epidemiol.* 2006 Apr;27(4):372-7.

International Health Update

Claire Wendland, Madison, Wisconsin

Where There is No Doctor and *A Book for Midwives*

Most of us have likely seen or used *Where There is No Doctor*, the community health worker's manual that is a staple of Peace Corps volunteers and others — and that has had ninety translations and adaptations made to date! The Hesperian Foundation, a non-profit organization famous for its publication of this and other low-cost low-technology health manuals, has now made several manuals available on line in English-language versions. OB providers will be especially interested in *A Book for Midwives*, just named "Notable Book of 2006" by the American College of Nurse-Midwives.

Medical Mystery Tour

Copious post operative mucous secretions: The rest of the story

Let's review last month's case history . . ..

A 60 year-old female, a heavy smoker, underwent a staging laparotomy that ultimately revealed bilateral hydrosalpinges without complication. The patient developed a left lung collapse due to tenacious secretions and had a successful re-inflation of the lung by bronchoscopy. The afebrile patient was then noted to have several dry, small, fatty nodules between her midline staples, but she was otherwise tolerating an advancing diet, voiding, and had bowel movements. The patient was encouraged to stop smoking and the nature of chronic obstructive pulmonary was discussed with the patient. On the day of discharge, the provider began to replace the slightly prolapsed subcutaneous fat and to place Steristrips over the otherwise clean and dry incision.

Did you think of any further discharge/wound care instructions you would give this patient? If you said something along the lines of "take two hydrocodone and call me in the morning," then you would have been half correct. If you had said "take a little general anesthesia and call me in the morning," then you would have been closer. Let me explain.

The provider removed the lower one half of the staples at the bedside and was surprised to find that the adipose protruding through the staples for the last three days had actually been the omentum. The patient was taken to the operating room and received general anesthesia. The subcutaneous tissue was opened. There was omentum in the subcutaneous tissue with some omentum that was dried, indicating that it had been there for a while. Most of the tissue was fresh in appearance and moist. There was no odor, discharge, or purulent material. There was no devitalized tissue. The skin edges and the subcutaneous tissues looked normal and without significant need for debridement. At the fascial edge, the suture was identified and was in place, but had pulled through the fascia in the upper 1/2 of the wound, allowing the omentum to herniate through.

The total area of dried omentum is less than 2 square inches. This was immediately moved away from the incision and a small partial omentectomy was performed by sequentially clamping, dividing, and ligating the omentum away from the bowel. There was no bowel extravasated from the abdominal cavity. The prolapsed omentum was excised and the abdomen explored without further findings. The fascia was closed with a mass closure technique. The patient did well and was discharged five days later without further complication. The patient was re-admitted two weeks later with a partial small bowel obstruction that resolved with conservative therapy.

Of note, the patient went home with inhalers, an incentive spirometer, and a pulmonary appointment, but she did stop smoking.

What can we learn from this case?

There are a number of facets to this case, but let's start with incidence, risk factors, and signs/symptoms. Please review what UpToDate says about "Surgical incisions: prevention and treatment of complications" for complete details.

The incidence of fascial disruption is 1 percent overall and 0.4 percent in gynecologic surgery. By comparison, incisional hernia develops in approximately 1 percent of uncomplicated surgical cases, 10 percent of patients with wound infection, and 30 percent of patients who underwent repair of dehiscence. More than one-half of hernias appear within six months of the original operation, approximately three-quarters are present by two years, and 97 percent are present by five years.

Wound disruption results from increased intraabdominal pressure or abdominal wall muscle tension overcoming suture strength, knot security, and tissue strength or holding power. Factors that enable mature collagen to stretch and allow incisional hernia after apparently adequate healing remain obscure. Often no obvious cause or precipitating factors are identified. Problems with slow or delayed healing are rare in young and healthy patients, while a number of factors contribute to the problem of fascial failure in other patients.

Underlying conditions and risk factors for fascial disruption are numerous, but excessive coughing is listed along with poor nutrition, advanced age, pulmonary disease, obesity, and several others.

Signs and symptoms of a complete dehiscence include profuse serosanguinous drainage, often preceded by a popping sensation and an incisional bulge exacerbated by Valsalva maneuvers. The absence of a healing ridge in a laparotomy incision by postoperative day five can be a sign of impaired healing and impending disruption. In one series, none of 17 patients with dehiscence had a palpable ridge prior to rupture, whereas 1,240 of 1,249 patients without dehiscence had a palpable ridge. Most dehiscences occur four to 14 days after surgery, with a mean of eight days. The diagnosis can be made based upon clinical grounds in the majority of cases. Imaging studies, such as ultrasonography, magnetic resonance imaging, or computed tomography, have been used when the diagnosis was unclear.

OB/GYN CCC Editorial comment
Appropriate wound reclosure will improve the care of our AI/AN patients

While the above wound dehiscence is a relatively uncommon event, superficial wound disruption is much more common. The American Board of Obstetricians and Gynecologists Annual Board Certification materials recently referenced a systematic reviewed on the reclosure of the disrupted laparotomy wound by Wechter et al 2005.

The review found that reclosure of disrupted laparotomy wounds was successful in over 80% of patients. Failed reclosure resulted in no life-threatening complications. Reclosure of disrupted laparotomy wounds is safe and decreases healing times. Compared with healing by secondary intention, reclosure resulted in faster healing times (16 - 23 days versus 61 - 72 days), and in the one study that evaluated it, 6.4 fewer office visits. The optimal timing and technique for reclosure and the utility of antibiotics were inconclusive.

Wechter ME, et al. Reclosure of the disrupted laparotomy wound: a systematic review. *Obstet Gynecol.* 2005 Aug;106(2):376-83.

Midwives Corner
Lisa Allee, CNM, Chinle
Nuchal cords, somersaults, and the value of a pulsing cord: nuchal cord management

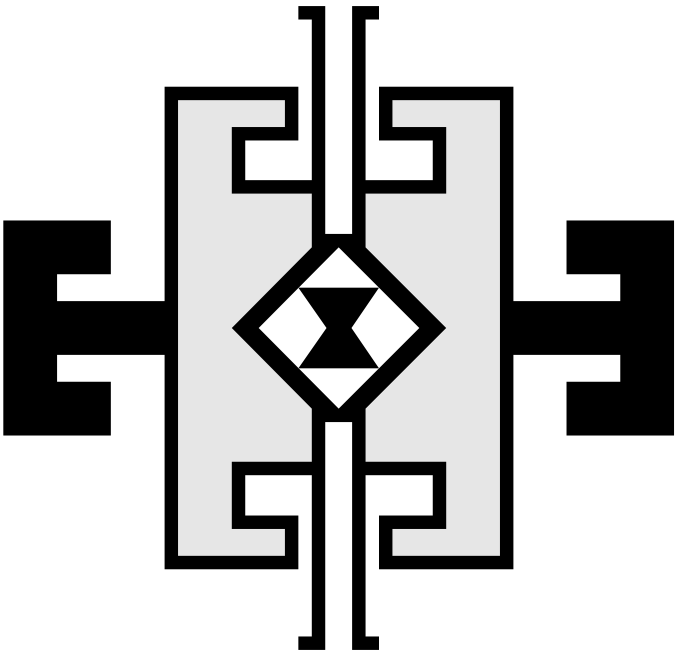
Abstract: Nuchal cord, or cord around the neck of an infant at birth, is a common finding that has implications for labor, management at birth, and subsequent neonatal status. A nuchal cord occurs in 20% to 30% of births. All obstetric providers need to learn management techniques to handle the birth of an infant with a nuchal cord. Management of a nuchal cord can vary from clamping the cord immediately after the birth of the head and before the shoulders to not clamping at all, depending on the provider's learned practices. Evidence for specific management techniques is lacking. Cutting the umbilical cord before birth is an intervention that has been associated with hypovolemia, anemia, shock, hypoxic-ischemic encephalopathy, and cerebral palsy. This article proposes use of the somersault maneuver followed by delayed cord clamping for management of nuchal cord at birth and presents a new rationale based on the available current evidence.

Mercer J, Skovgaard R, Peareara-Eaves J, Bowman T. Nuchal cord management and nurse-midwifery practice. *Journal of Midwifery & Women's Health*. 2005;50(5):373-379.

Editorial Comment by Lisa Allee, CNM

Judith Mercer, et al, present excellent evidence that leaving a nuchal cord alone and delivering the baby by the somersault maneuver is preferred over clamping and cutting the cord before the shoulders deliver. They also provide nice drawings showing how to do the somersault. I first learned the somersault many years ago from a *locum tenens* midwife while I was working as an RN. Soon after, on a very, very busy shift, I walked into a room where two nurses were busily getting gloves on, but the head was crowning, so I stepped in and caught the baby, noting a nuchal cord as he came out. I pointed him toward his mother's thigh and out he somersaulted! First baby I ever caught.

I have used the somersault ever since, except once when I mistakenly thought that a baby was slow to deliver due to the nuchal cord and clamped and cut it — it wasn't the cord, it was the shoulders. Needless to say the seconds it took to get that baby out were long and the baby needed some help getting going. Lesson learned — the baby needs the cord intact.



Mercer, et al, present research that shows cutting a nuchal cord can lead to problems (see above) and that in a survey of nurse-midwives, 40% selected somersaulting as their best option for nuchal cords, and 96% avoid immediate clamping and cutting of nuchal cords. They also provide a clearly stated description of cord anatomy and physiology and the "blood volume model of neonatal transition" that not only supports the suggested management of nuchal cords, but also the benefits of delayed cord clamping in general.

Judith Mercer has written elsewhere about delayed cord clamping and its beneficial role in neonatal resuscitation. This is based on the blood volume the baby gets from the placenta, preventing hypovolemia, and this thinking is consistent with the new changes in CPR that emphasize circulation. She proposes letting the cord pulse while giving PPV with the baby between mom's legs. I know this is very different than the rush to the warmer, and change is hard, but read and think about it — it makes sense. I highly recommend her chapter, "Fetal to Neonatal Transition: First, do no Harm," in *Normal Childbirth: Evidence and Debate*, edited by Su Downe. Actually, read the whole book.

Navajo News

Kathleen Harner, Tuba City

Methamphetamine abuse among women on the Navajo Reservation: Part IV: the "drop-in" gravida

A 24 year-old G3A2 presents to labor and delivery at 34 weeks gestation having received no prenatal care. She is contracting every 5 – 6 minutes and is complaining of excruciating pain. She is very dramatic. She denies health problems or surgeries; she has had one elective and one spontaneous abortion. She denies drug or alcohol use and does not use any medications regularly. Her fetal monitoring strip is reactive and without decelerations. You order routine prenatal labs and a urine toxicology screen, which is positive for methamphetamine. Her fetal fibronectin test is negative, ultrasound confirms her dating, and her contractions stop with hydration. Now what are you to do with her?

This is the "drop-in" gravida, positive for methamphetamine, and having had no prenatal care. You are far more likely to see a gravida positive for meth in labor and delivery than in your prenatal care clinic. She comes in not because she is concerned about her pregnancy, but because she is in excruciating pain. Meth abusers do not perceive pain, joy, or sadness the same way non abusers do. At TCRHCC this patient would be immediately identified as being at risk for drug or alcohol abuse, and she would be informed that a urine toxicology screen would be performed.

Our clinical guideline on drug screening in labor and delivery includes the following conditions:

- Positive substance abuse questionnaire
- No prenatal care
- Late prenatal care
- Scant prenatal care
- Multiple missed appointments
- Abruptio placenta
- Intrauterine fetal demise
- Prior history of substance abuse
- Preterm labor
- Intrauterine growth restriction
- Unexplained congenital abnormalities
- Current signs and symptoms of acute intoxication
- Domestic violence

Patients should be informed that screening will be performed based on clinical guidelines. Written consent is not required. Providers should strive to protect the integrity of the provider-patient relationship, treating patients with dignity and respect. Providers should communicate honestly and directly about what information can and cannot be protected. Positive screens are reported to child protective services and the staff pediatricians are notified.

The patients are offered counseling services prior to discharge from the hospital. If the patient is undelivered at discharge, she is offered the same combination of regular drug screening, continuity of prenatal care, and mental health counseling that drug dependant mothers identified in the clinic setting are offered. If the patient is delivered and either she or the baby have a positive urine drug screen, child protective services are notified, and they determine the appropriate disposition of the infant. The mother is still offered counseling services and close follow-up.

Unfortunately, we often don't see these moms until late in their prenatal course, as with the gravida in the example. Ideally, these patients should receive extra support from their prenatal care providers, but this is impossible when they are not identified until late in pregnancy. However and whenever they are identified, they must be offered comfort, hope, and support.

References: see the online version of the Ob/Gyn CCCC newsletter.

OB/GYN CCC Editorial comment

I want to offer special thanks to Kathleen Harner, MD, from Tuba City for this very helpful four-part series on methamphetamine abuse among women on the Navajo Reservation. The previous three editions can be found in the CCCC dating from April 2006.

In addition, the Primary Care Discussion Forum had a particularly helpful discussion on the topic of methamphetamine abuse in Indian Country moderated by Steve Holve, MD, also from Tuba City. Please find that captured discussion, as well as many other resources, at this site: *http://www.ihs.gov/MedicalPrograms/MCH/F/PCdiscForumMod.cfm#meth*.

Perinatology Picks
George Gilson, MFM, ANMC
Only 29% of ACOG recommendations are level A: good and consistent evidence

Results: The 55 practice bulletins contained 438 recommendations of which 29% are level A, 33% level B, and 38% level C. The 55 bulletins cite 3953 references, of which 17% are level I, 46% level II, 34% level III, and 3% others. Level A recommendations were significantly more likely among the 23 gynecologic than 32 obstetric bulletins (37% versus 23%, odds ratios 1.95, 95% confidence intervals 1.28, 2.96). The study types referenced in obstetric and gynecologic bulletins were similar (P > .05 for comparison of levels I, II, and III and meta-analysis references).

Conclusion: Only 29% of the American College of Obstetricians and Gynecologists recommendations are level A, based on good and consistent scientific evidence.

Chauhan SP et al. American College of Obstetricians and Gynecologists practice bulletins: an overview. *Am J Obstet Gynecol*. 2006 Jun;194(6):1564-72; discussion 1072-5.

Editorial comment:

Please note this article is not meant to criticize ACOG's Practice Bulletin process, which is actually quite robust and which we all appreciate. Rather, it is a reflection of what level of studies are available in the literature for ACOG to review. When in doubt, remember the Cochrane Library was initially a maternity oriented database and only reviews randomized clinical trials.

STD Corner
Lori de Ravello, National IHS STD Program
Focus on adolescent sexual behavior

Boyfriends, Girlfriends and Teenagers' Risk of Sexual Involvement.

Conclusions: To reduce the risk of adolescent sexual activity, parents and communities should encourage youth in middle school, especially females who experience early menarche, to delay serious romantic relationships.

Marin BV, et al. *Perspectives on Sexual and Reproductive Health*. June 2006;38(2):76-83.

Four other related articles are available on the online version of the Ob/Gyn CCCC newsletter.

Barbara Stillwater, Alaska State Diabetes Program

Diabetes is the clinical equivalent of aging 15 years.

Interpretation: Diabetes confers an equivalent risk to aging 15 years. However, in general, younger people with diabetes (age 40 or younger) do not seem to be at high risk of CVD. Age should be taken into account in targeting of risk reduction in people with diabetes.

Booth GL, et al. Relation between age and cardiovascular disease in men and women with diabetes compared with non-diabetic people: a population-based retrospective cohort study. *Lancet*. 2006; 368:29-36.

Escaping the tyranny of the urgent by delivering planned care

Bottom Line: Planned care is a powerful vehicle to help us close the gaps and improve patient care in the US. In addition, it makes the practice of medicine feel more organized and more satisfying. Rather than feeling caught in the tyranny of the urgent, we can feel confident that we have provided high-quality care that meets the needs of our patients and ultimately makes our work more rewarding.

Moore LG. Escaping the tyranny of the urgent by delivering planned care. *Fam Pract Manag*. 2006;13(5):37-40.

Correction

The new url address for The Provider, where you can find back issues and other information, is *http://www.ihs.gov/PublicInfo/Publications/HealthProvider/Provider.asp*.

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

IHS Child Health Notes

Quote of the month

"Of course, it is important to be a good listener – but it also pays sometimes to be a little deaf."

Yiddish Proverb for newlyweds

Articles of Interest

Outcomes among newborns with total serum bilirubin levels of 25 mg per deciliter or more. *N Engl J Med*. 2006 May 4;354(18):1889-900. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed*

Neonatal hyperbilirubinemia — what are the risks? *N Engl J Med*. 2006 May 4;354(18):1947-9. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed*

An assessment of neurodevelopmental outcome in 140 infants at term or near term with total serum bilirubin levels > 25mg/dl; 130 patients had bilirubin levels > 25 mg/dl and <30 mg/dl while 10 infants had bilirubin levels > 30 mg/dl. One hundred and thirty-five patients were treated with phototherapy alone, and five patients received exchange transfusions.

No patient had kernicterus. There was no increase in the number of patients with abnormal neurological findings on exam, or documented diagnoses of neurological abnormalities compared to control infants. Patients with positive direct antiglobulin tests had lower scores on cognitive tests but no more neurologic or behavioral problems.

Editorial Comment

This study is reassuring that bilirubin levels of < 30 mg/dl are unlikely to put an infant at risk for kernicterus or adverse neurologic outcome. The one subgroup at higher risk are those with hemolytic disease, and these patients should be treated more aggressively with phototherapy and exchange transfusion if indicated. This is consistent with the newest AAP guidelines on hyperbilirubinemia from 2004.

The editorial also notes that the biological risk for hyperbilirubinemia is genetically based. It is already known that the risk is higher in Asians and also in American Indians of the southwest. American Indian/Alaskan Native infants in general may be at higher risk than the general population for hyperbilirubinemia and deserve our extra attention.

For further reading:

Management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatrics*. 2004 114: 297-316. *http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;94/4/558*

Jaundice in Navajo neonates. *Clin Pediatr (Phila)*. 1992 Dec;31(12):716-8. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed*

Exaggerated jaundice in Navajo neonates. The role of bilirubin production. *Am J Dis Child*. 1986 Sep;140(9):889-90. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed*

Infectious Disease Update
Rosalyn Singleton, MD, MPH
Vaccines: Update on New Recommendations

There have been so many new vaccine recommendations pouring out of the Advisory Committee on Immunization Practices (ACIP) that I decided a general update was in order (I can barely keep these all straight and this is my job!):

1. Menactra® (meningococcal conjugate) vaccine was in the news because of a vaccine shortage. The ACIP recommends deferring the doses in 11 - 12 year olds and concentrating on the 15 year olds and college freshmen entering dorms. *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm55d520a1.htm?s_cid=mm55d520a1_e*. We are changing the RPMS forecasting in late summer so that it only forecasts for 15 year olds.
2. RotaTeq® (rotavirus) vaccine provisional recommendations have been published: *http://www.cdc.gov/nip/recs/provisional_recs/rotavirus-child.pdf*. RotaTeq is recommended as a three dose oral vaccine for children 6 - 32 weeks. The first dose must be given before 13 weeks of age, or you don't start the series, and the last dose must be given by 32 weeks of age. The unique forecasting for this vaccine will be included in the late summer RPMS patch.
3. Gardasil® (Human papillomavirus – HPV) vaccine is licensed for 9 - 26 year old females, and the ACIP has recommended HPV vaccine for routine vaccination of 11 - 12 year olds with catch-up for older ages. *http://www.cdc.gov/od/oc/media/pressrel/r060629.htm*. Gardasil will eventually be covered under Vaccine

for Children Program; however, we are still waiting for news of a federal contract for this vaccine (anticipated in fall, 2006), and ACIP recommendations have not yet been published.

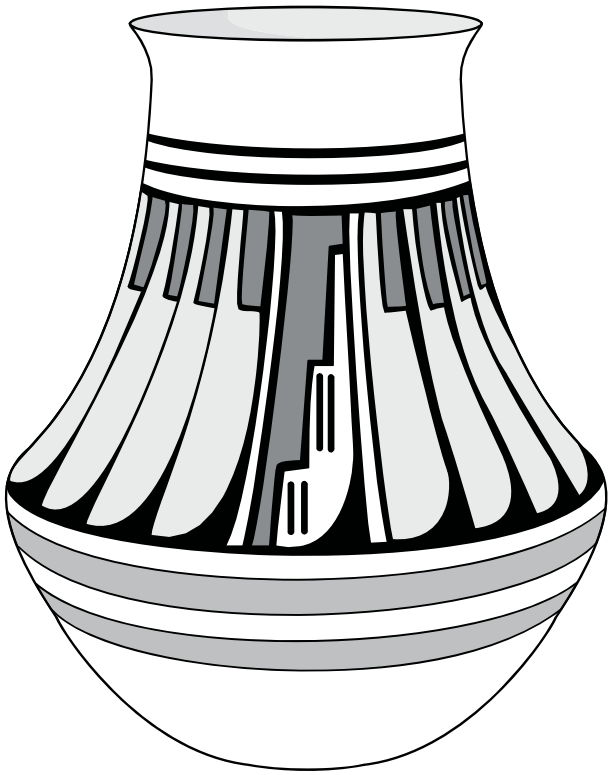
4. Varicella vaccine – the ACIP just voted for a routine second dose of Varicella to be given at school entry (4 - 6 years of age). This recommendation will be included in the RPMS forecasting in the late summer RPMS Immunization patch. *http://www.cdc.gov/od/oc/media/pressrel/r060629-b.htm*.

Recent literature on American Indian/Alaskan Native Health

Doug Esposito, MD

Mental disorders among parents/caretakers of American Indian early adolescents in the northern midwest. *Soc Psychiatry Psychiatr Epidemiol*. 2006 Jun 15; [Epub ahead of print] *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=Abstract&list_uids=16779502&query_hl=1&itool=pubmed_DocSum*

This study employed a culturally modified version of the University of Michigan Composite International Diagnostic Interview (UM-CIDI) to investigate the 12-month and lifetime prevalence of five DSM-III-R diagnoses among 861 northern midwest American Indian and Canada First Nations parents and caretakers of 10 - 12 year-old children. The five conditions assessed were alcohol abuse, alcohol dependence, drug abuse, major depressive disorder, and generalized anxiety disorder. Prevalence rates were then compared to rates reported from studies of a northern plains and a southwest American Indian culture, and to the general U.S. adult population. The authors discuss their findings in the context of the inherent difficulties faced when studying small, culturally distinct, and often geographically isolated Native populations in the U.S. and Canada. They scrutinize method variance as a possible source for divergent prevalence rates for some psychiatric disorders reported in studies of different cultural groups.



Study subjects were from four American Indian reservations in the northern midwest and five Canada First Nation reserves, all of whom share a common cultural tradition and language. The authors report a lifetime prevalence of 74.6% of at least one of the five conditions assessed, with males being more likely than females to meet these criteria. Nearly 32% of the adult parents and caretakers satisfied criteria for two or more of the surveyed conditions. Females were almost twice as likely as males to be without any of the five surveyed conditions over their lifetimes in this study.

As expected, substance abuse disorder rates were high, with 49.6% of respondents meeting criteria for alcohol abuse, 20.9% for alcohol dependence, and 22.4% for drug abuse. Statistically significant male to female differences were identified for alcohol dependence and drug abuse only, with the prevalence in males exceeding females.

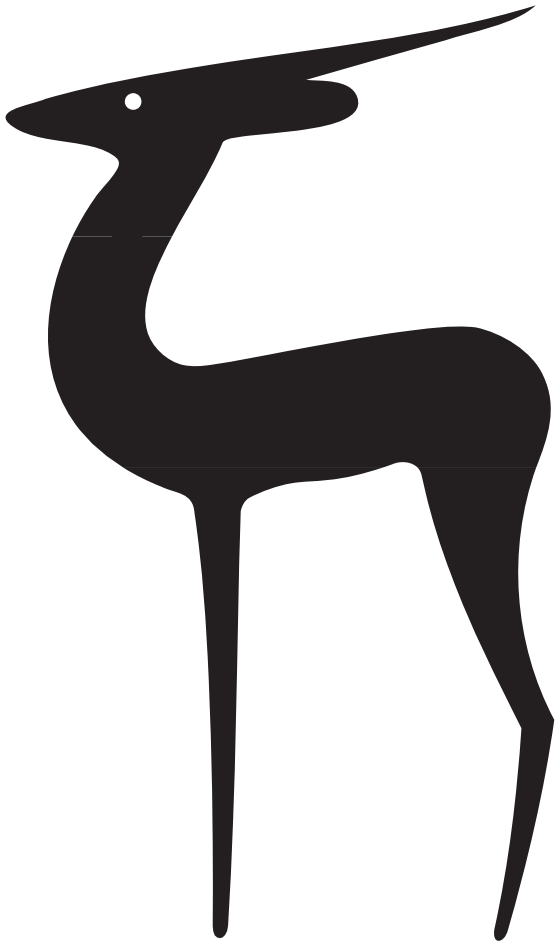
A lifetime prevalence of 17.1% for major depressive disorder and 4.5% for generalized anxiety disorder was found. Both conditions were more prevalent in females than males in this study.

Comparisons were made to the National Comorbidity Survey (NCS) and the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP). These assessment tools were similar, but not identical, to the methodology used to survey the study population. Suffice it to say that there were inter-study differences in prevalence rates for four of the five DSM-III-R diagnoses surveyed. A thorough review of the methodological issues that might account for these inter-study differences is offered, but is beyond the scope of this review. The interested reader is encouraged to review the paper in its entirety.

Editorial Comment

The findings reported by the authors of this study are concerning. The high lifetime prevalence rates for the five diagnoses surveyed reflect the distress of our American Indian and Canada First Nations families. What's more, these are only five out of the total universe of diagnoses that might have been investigated.

Correctly, the authors state, "These findings have serious implications for effective parenting and family functioning.



The prevalence rates also call attention to the need to improve access, identify and eliminate cultural barriers, and improve funding for mental health service among northern midwest and Canadian First Nations people." I suggest this is true for essentially all AI/AN and Canada First Nations populations, both rural and urban.

Last month, I reviewed an article authored by researchers from The National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center. This institution continues to offer an important body of information regarding the mental health status of American Indian groups. Though not the authors of the article currently under review, they are the originators of the AI-SUPERPFP and the litany of related reports and articles that are extensively referenced.

The authors of this month's article pay homage to the originators of the AI-SUPERPFP by stating, "The first publications from the AI-SUPERPFP data are radically changing the landscape of American Indian psychiatric epidemiology by providing the first population sample that can be compared to national psychiatric epidemiological surveys. This important study will become the benchmark for future research on psychiatric disorders in American Indian populations . . .. Researchers are now in a position to replicate AI-SUPERPFP work with other Native cultures to provide cumulative and comparable information that will inform policy makers and service providers regarding potential systematic differences in prevalence rates across cultures."

The importance of this comment cannot be overstated. There is a cumulative value for each and every published report related to the health of AI/AN and Canada First Nations peoples. One-by-one, greater light is shed on the socioeconomic and health issues and disparities burdening these populations, bringing into crisper focus exactly what needs to be done. Someday, we will find a way to use this knowledge to achieve equity in health status for North American Native populations and once and for all end the injustice.

Additional Reading

Social epidemiology of trauma between two American Indian reservation populations. *Am J Public Health*. 2005 May;95(5):851-9.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=Abstract&list_uids=15855465&query_hl=10&itool=pubmed_docsum.

Cultural specificity and comparison in psychiatric epidemiology: walking the tightrope in American Indian research. *Cult Med Psychiatry*. 2003 Sep;27(3):259-89.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=Abstract&list_uids=14510095&query_hl=8&itool=pubmed_DocSum.

Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: mental health disparities in a national context. *Am J Psychiatry*. 2005 Sep;162(9):1723-32.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=Abstract&list_uids=16135633&query_hl=8&itool=pubmed_docsum.

Announcements from the AAP Indian Health Special Interest Group

Sunnah Kim, MS

Locums Tenens and Job Opportunities

If you have a short or long term opportunity in an IHS, tribal or urban facility that you'd like to publicize (i.e., on the AAP website or a complimentary ad on *Ped Jobs*, the official AAP on-line job board), please forward the information to *indianhealth@aap.org* or complete the on-line *locum tenens* form at *http://www.aap.org/nach/locumtenens.htm*.

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Indian Health Service History Project

The Indian Health Service has initiated a project to document the 50 years of work since the federal health responsibilities for American Indians and Alaska Natives was transferred to the US Public Health Service. The project includes collecting historic documents, photos, and oral histories relating to the history of the Indian Health Service. We are researching records at the National Archives, Library of Congress, National Library of Medicine, and university archives with Indian health related records.

The records tell a fascinating, but at times incomplete story. Much of the work of the Indian Health Service was carried out in distant, rural locations by government and tribal programs whose work may not have reached the official record system.

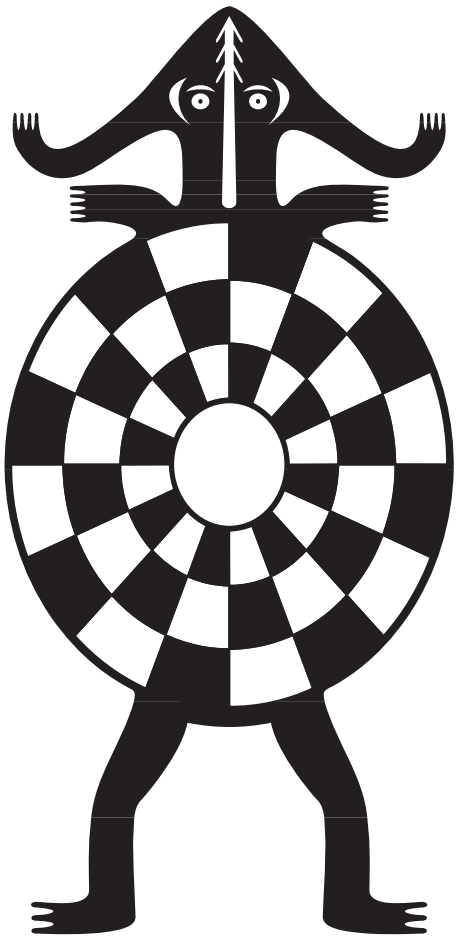
We are interested in finding people who would be willing to share photos, documents, and memories of their time in the Indian Health Service. Do you have old photos, reports, or documents that you have been saving for years, and are you unsure what to do with them? This is your opportunity. If you are willing to share items from your time in the Indian Health Service, we would like to hear from you. We can accept the donation of items to add to our collection, or we can take them on loan to return to you after viewing and copying.

If you are interested in this unique opportunity or have questions about the project, please contact:

CAPT Alan Dellapenna, Jr.,
Gold Book Project Coordinator
Office of Public Health Support
Indian Health Service
801 Thompson, Suite 200, TMP 450
Rockville, Maryland 20852
Telephone (301) 443-0097
E-mail *alan.dellapenna@ihs.gov*

You can see some items related to the history of the Indian Health Service on the IHS website; the items include the executive summary of the history of the Indian Health Service, *The First 50 Years of the Indian Health Service: Caring and Curing*, which can be viewed and downloaded at *http://info.ihs.gov/*. Go to the grey box at the top of the page and select "IHS Gold Book - Part 1" through "IHS Gold Book - Part 4"

A collection of historic IHS photos is located at *http://www.ihs.gov/publicinfo/photogallery/index.cfm*. Follow the instructions to view the photos in the collection.



NICE Evidence-Based Medicine Resource

Diane Cooper, Biomedical Librarian/Informationist, Health Services Research Library, National Institutes of Health Library, Bethesda, Maryland

It's not only NICE, but it's nice, as well. It's the National Institute for Health and Clinical Excellence (NICE), a new evidence-based medicine resource. NICE guidelines are developed by independent advisory groups made up of health professionals, patients, their caregivers, and the public.

NICE supports England's National Health System, and provides guidance in the promotion of good health and patient care. The guidelines they produce are based on the "best available evidence of medical effectiveness and cost effectiveness."

NICE produces guidance in three areas of health, as follows:

Public health: the promotion of good health and the prevention of ill health

Health technologies: the use of new and existing medicines, treatments, and procedures

Clinical practice: the appropriate treatment and care of people with specific diseases and conditions

Up-to-date and to-the-point guidelines are a NICE specialty. The "Postnatal Care Quick Reference Guide" was posted July 2006, and is a colorful, well-organized, and easy-to-use web pamphlet with tips for nurses, doctors, and the public. Another July 2006 guideline deals with the use of etanercept (Enbrel) and infliximab (Remicade) for psoriatic arthritis. The guidelines are crisp and focused. For example, use Enbrel if the patient has three or more involved joints, and at least two other DMARDs have not worked.

For hypertension treatment, a June 2006 guideline suggests starting with an ACE inhibitor in patients younger than 55, but start with either a thiazide diuretic or calcium channel blocker for those over 55, and for black patients of any age. A brief discussion of the use of beta blockers follows the flow diagram.

The database is very easy to use. To search, go to the homepage at *http://www.nice.org.uk*. On the right side of the homepage is an orange search box. Type your subject in the box for a simple and broad search. For a refined search, click on advanced search. You'll go to a page where you can enter a keyword; select different health topics from a dropdown box; select the type of information you want (e.g., clinical guidelines, technology appraisals, public health intervention, etc.); and select publication years of interest.

Although these guidelines are based on health care in England, this evidence based database is a useful and friendly resource to add to your EBM resource list. It lives up to its NICE name. It's even easy to remember its website, "nice.org.uk." For questions and help, e-mail me at *cooperd@mail.nih.gov*.

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THE IHS PRIMARY CARE PROVIDER

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

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

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