Insights Gained From Teaching and Working With Apache Nursing Assistants

GRACE CHICKADONZ, RN, MS, LOIS EVANS, RN, MS, and NORBERT HIRSCHHORN, MD

IT WAS with eagerness, curiosity, and some apprehension that 14 Anglo professionals arrived on the Fort Apache Indian Reservation in June 1971. Our task was to study the causes of diarrhea in Apache children and to devise practical methods of treatment during a 3-month, hospital-based project (under a contract by the National Institute of Arthritis, Metabolism, and Digestive Diseases with Johns Hopkins University). From teaching and working with the 12 young Apache women who were hired to assist us came the insights we share here.

The Fort Apache Reservation, home of the White Mountain Apache Tribe, covers 1.8 million acres in the White Mountains of eastern Arizona. The population of between 6 and 7 thousand live in eight scattered communities that lie along creeks and rivers. Whiteriver, the largest community, is the seat of the tribal government and the location of the major facilities of the Public Health Service and the Bureau of Indian Affairs. The median age of the population is 15 years. Its per capita income is low, and nearly half the adults are unemployed. Most of the people are bilingual, although English is generally not learned until school.

With the recent appearance of subsidized and mutual help housing, the people's home environments are rapidly improving, but more than half the tribe still live under less than ideal conditions (*1*).

Diarrhea is a major health problem. It is most prevalent in the summer months. Each summer it affects about half of the children under 2 years of age and prompts the hospitalization of one-fourth of those children stricken. During the past decade it has been associated with about one-third of all post neonatal deaths.

Our project included (*a*) a search for diarrhea-causing toxins, which was carried out by culturing bacteria from the stool and upper intestine during acute diarrhea and (*b*) a demonstration of a simplified method of estimating the fluid loss and of replacing such loss with an oral glucose-electrolyte mixture, techniques that can be readily performed by nursing assistants and which have been described elsewhere (*2–4*).

The professional team—three physicians, six nurses and five technicians—had done teaching and research in inner-city and Asian communities and had worked on health teams. Twelve Apache

Ms. Chickadonz is an assistant professor of nursing and Ms. Evans an instructor, Georgetown University School of Nursing. Dr. Hirshhorn, who at the time of the study was an assistant professor of medicine, Johns Hopkins University, serving in the Baltimore (Md.) City Hospitals, is now with Management Sciences for Health, Cambridge, Mass.

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women, ranging in age from 16 to 25, completed our staff. They had been hired before our arrival by the Bureau of Indian Affairs under its summer "work and learn" program. Five were high school students, six were high school graduates, and one was in college. Two of the women had received previous nurse-aid training elsewhere; five had never worked before.

We were determined that our project should not burden or inconvenience the existing Public Health Service hospital staff. Thus our immediate need was for nursing assistants who would help us provide 24-hour-a-day care for the children hospitalized with diarrhea and gather the data needed for our studies. In addition we appreciated the fact that assistants drawn from the local community reflected the language, attitudes, and customs of their people and were often insightful interpreters for both resident and visiting professionals (5,6).

To add to our personal resources, before our arrival we had consulted persons experienced in the teaching of nursing assistants, had scanned the literature on the subject (references *5–11* are representative) and had also begun to learn about the Apache people (*12–14*). Most important, members of our group shared the belief that people from different cultural backgrounds and life experiences could learn to relate to one another, to work together, and to teach each other.

Because of our responsibilities back home, we arrived in Whiteriver only a week before we were scheduled to begin the teaching program. We were dismayed both by our adverse physical responses to the changes in altitude and the quality of the water supply and by our first emotional response to the immediately obvious environmental difficulties. Talking about and sharing these reactions among members of our own group was essential, and the support we gave each other enabled us to go on. Maslow has taught that creativity and learning proceed with difficulty if physical and emotional needs are unsatisfied (*15*), and our experiences made us subsequently more sensitive to events in the lives of the Apache women that could impede learning.

Teaching Program

The teaching program began with an intensive 1-week course, followed by 4 to 8 hours weekly in classroom sessions and regular on-the-job instruction.

As individuals, the assistants, the majority of

whom were adolescents and members of a cultural group different from our own, presented many unknowns as we began the program. Thus we sought to create an informal atmosphere, provided refreshments, and often just talked and tried to get to know each other. We frequently changed our class plans in line with our growing sensitivity to the assistants' ways of communicating and responding.

Several methods of teaching proved effective:

1. Demonstrations with explanations, filmstrips on nursing procedures, and practice sessions by the assistants with one another, with professional staff, and with patients were most useful initially.

2. The nurse's example in the actual clinical situation was more useful after patient care by the assistants began.

3. Frequent changes in teaching method, site, and topic stimulated interest and participation. The sessions lasted from 30 minutes to 2 hours.

4. A satisfactory textbook was distributed (*16*).

5. Use of lay terms enhanced clarity and understanding. (Because of the difficulty that the professional team had in speaking spontaneously without recourse to medical jargon, carefully prepared presentations were used, although not without some loss of spontaneity).

6. Seminar discussions were successful when the more outgoing assistants acted as spokemen, after conducting whispered consultations with their group; we also sat among the assistants and amplified their whispered answers and ideas. Teaching seemed most effective with groups of

three or four. Discussions improved as the summer progressed.

7. We scheduled visits for the assistants to patients' homes with the Public Health Service nurse so as to focus on the environment from which the children in the study came. The discussions that followed provided a way for the assistants to begin to teach us about their culture, their people, and the health and social problems that affected their lives.

A preceptor system evolved as the same nurses and assistants worked together on the ward; each nurse developed a close relationship with two or three assistants that enabled her to determine their interests and assess their learning needs more accurately.

By the end of the teaching program the assistants learned to give physical and emotional nursing care to children with diarrhea, to participate in the collection of data and specimens, to estimate fluid requirements and administer the oral solutions needed, and to carry out certain hospital routines (see box).

Initially shy, the assistants progressively displayed inquisitiveness, good humor, perceptiveness, and sensitivity. In working together and enjoying the same picnics, parties, and visits, some warm, communicative relationships developed between the nurses and the assistants, relationships that were gradually extended to the assistants' families. We believe that these friendships were of major importance in achieving effective teaching, supervision, and evaluations of performance. For us, they were valuable personally and offered countless insights into the lifestyles and values of the Apache people, whom we came to admire and respect.

CONTENTS OF THE TEACHING PROGRAM

Orientation to the project
- staff introduction
- job description
- hospital tour
- employee responsibilities

Work environment
- germ theory
- handwashing
- disinfection, sterilization
- cleaning toys, equipment
- wearing gowns
- isolation
- safety
- supplies

Patients' unit
- admission supplies
- discharge procedures
- bedmaking

Body mechanics

Personal care of patients
- oral care
- bathing infants and children
- shampoo
- morning care
- diaper rash care
- diapering
- pacifiers
- cradle cap care

Food services
- nutrition
- digestive system
- formula preparation
- feeding
- nasogastric tubes

Fluids and waste
- fluid intake and output, measuring, describing and recording
- forcing fluids
- IV therapy and care
- oro-duodenal tubes
- collecting stool and urine specimens

Body signs
- temperature, pulse, respiration
- blood pressure
- weight and height

Physical examinations
- assisting physician and supporting child during examination and tests

Special care
- temperature elevation—sponges
- croupette
- restraints

Environmental and emotional needs
- holding, cuddling
- playing, toys
- talking
- field visits and discussion
- separation due to illness

Growth and development
- maternity cycle
- labor and delivery
- stages and development

Problems Encountered

We had been warned to expect considerable absenteeism among the assistants. Some Public Health Service "old timers" doubted that our project would succeed if we had to depend on the assistants. Absenteeism was in fact a problem, but the causes for it were often valid. Several assistants had to walk considerable distances to work, and telephones were scarce. Severe personal, health, and social problems regularly affected some of the women. Also, the assistants apparently often regarded significant social, religious, and family gatherings—common in the summer —as more important than the income they would lose by being absent.

Because of our special need for the assistants' help, we were not rigid in enforcing attendance. We clearly stated our expectations for meeting patient-care needs, and the entire group developed reasonable alternatives to absences; for example, schedules were juggled, days off were traded, permission was given to make up time when extra staff was needed, and help was provided with transportation. Nonetheless, to meet our obligations to the children, the professional staff worked many extra hours, often to our exasperation. Gradually the assistants learned to use the alternatives and became better able to solve the problems they encountered in getting to work.

The importance of social, religious, and family gatherings cannot be overemphasized. These are the customs that maintain the cohesiveness of the Indian culture and that carry with them family and clan obligations which the individual must meet. While such obligations, as well as severe personal problems, can and do interfere with job responsibilities that are Anglo-oriented, to ignore the significance of these obligations and problems and expect the individual to fulfill all work demands is only to guarantee failure for the employee and severe problems for the program. Working together, reasonable alternatives can be found.

Absenteeism began to increase again toward the end of the program, perhaps because of the psychological effects of the imminent breaking off of the brief, yet intense, personal friendships. We tried to cope with the feelings that we all were experiencing by conveying our own feelings about leaving, by exchanging gifts, and indicating our plans to return for an expanded field study the following summer. We do not believe, however,

Nursing assistant bathing a patient

that we were very successful in these efforts. We were doing what we had heard people in the community make so many comments about during our stay—"Just as you get used to the doctors at the hospital, they leave and you have to start all over again." (In the summer of 1972, however, 3 physicians, 3 nurses, and 10 of the assistants from the 1971 group did work together again.)

The process of becoming sensitive to the assistants' way of interacting with us took time (for instance, their custom was to avoid meeting a person's eyes even while listening intently). The differences between us and the assistants in culture, language, professionalism, and age were major blocks to communication for both groups. Again, the personal relationships between the nurses and assistants seemed an effective way to begin to overcome these barriers.

Outcome

We regularly evaluated the program through our own and the regular hospital staff's judgments as to the accuracy of procedures carried out by the assistants and by eliciting from the assistants ideas about the content of training needed, about the methods of presentation they preferred, and about the performance of actual ward procedures.

The assistants' involvement in the project increased as we more and more shared our thoughts and feelings with them and gained their advice and participation. We interpreted their joking and teasing as signs of their acceptance of us (see also reference *11*). They delighted in seeing the physicians feed and wash babies so that they could be off duty for Career Day (described in

the next section). We saw their involvement reflected also in progressively warmer relationships between them and the patients; there was more cuddling, comforting, holding for feeding, talking, teasing, and playing. All assistants identified a favorite child they had cared for. They also often assisted in explaining procedures to the children and their parents and in facilitating relationships between the parents and staff.

By the end of the summer the nine remaining assistants participated in individual evaluation conferences. We found that they had performed all assigned tasks; six of the nine required only minimal supervision. One of the three who did not complete the summer with us had gone away for relocation training, and the other two had missed a great deal of work because of family problems. The efforts and accuracy of the work of the nine assistants were judged to be good; four of the assistants were able to make independent observations of patients' conditions.

In retrospect, the times when all of us worked well together were when we were learning mutually, sharing ourselves, and accepting each other as persons (*17*). When things became difficult it was often due to a lack of understanding of one's self or a failure to share one's feelings and reactions.

Career Opportunities

With the help of Public Health Service and Bureau of Indian Affairs people, we all were enabled to observe Indian and Anglo health personnel in a variety of roles and settings, including the Indian Medical Center in Phoenix. We concluded the training program with a career day, at which knowledgeable people discussed training for health careers and the existing resources for providing help through educational programs. At the end of the summer all nine assistants indicated they would like to do similar work again; four stated that their career plans had been influenced by the summer's work experiences, field trips, and the career day.

At this time, however, there are many obstacles preventing realization of such plans—an extreme shortage of jobs on the reservation, cutbacks in funded programs that provide work, and various barriers to happy and successful employment off the reservation. As the assistants shared with us their family and social problems, health needs, and educational plans, we wanted to help. But the severity of the problems and an awareness of the shortness of our stay created feelings of helplessness in us. We sought local resources and encouraged the assistants to use them, but we became aware of their inadequacy to fulfill the tremendous needs despite their provision of some excellent services.

Providers of health services must become more sensitive to the needs and customs of Indian people (*18,19*). Given the shortage of jobs, we believe that recruitment of Indians for professional and auxiliary health careers should be intensified. Finally, innovative health care programs that include Indians as full participating members of health teams are urgently needed. Such programs should aim to teach all workers—Indian and non-Indian, professional and nonprofessional—how to understand and share their feelings with others so that they can work together effectively (*20*).

Conclusions

Nine of the 12 young Apache women in our program successfully learned skills and techniques as nursing assistants and played a key role in our 13-week study of diarrhea in children. At the conclusion of the study, simplified methods of treating diarrhea were adopted by the hospital (*4*).

The friendships that developed between the nurses and the assistants were reflected in the cohesiveness of the staff as it worked together to provide patient care. As nurses and assistants learned from each other, the teaching program became more effective. Frustrations and satisfactions were experienced by everyone. The effects of cultural differences were extensive and required a great deal of time to understand. We found solutions to problems, however, as we developed a greater awareness of motivating forces within the Indian culture. While most of the assistants returned to school at the end of the summer, several needed jobs, and there were none.

The paucity of jobs on the reservation, the tenuous nature of many Anglo-Indian relationships (especially in the existing health care system), and the urgent need for health care that reflects the culture of the people it serves place heavy demands on those seeking to design effective health programs. We believe that Indians should be prepared to fill roles in health care at all levels and should become increasingly responsible for the design of their health care system.

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One of the social activities shared by professional staff and nursing assistants