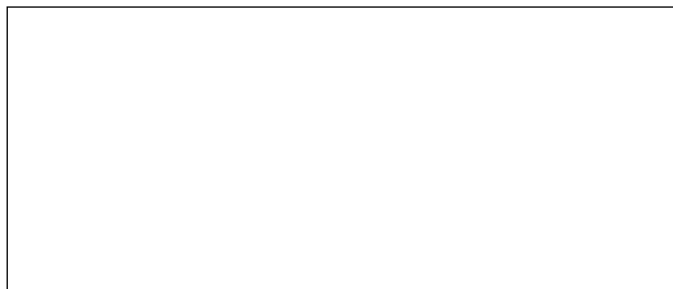




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Lā'au lapa'au and Western Medicine in Hawai'i: Experiences and Perspectives of Patients Who Use Both

Natalie N. Young BA and Kathryn L. Braun DrPH



Natalie N. Young BA



Kathryn L. Braun DrPH

This research was conducted as part of an honors thesis at Stanford University, Palo Alto, CA by the first author. (N.N.Y.)

Authors' Affiliations:

- John A. Burns School of Medicine, University of Hawai'i, Honolulu, HI 96813 (N.N.Y.)
- School of Public Health and Social Work, University of Hawai'i, Honolulu, HI 96822 (K.L.B.)
- 'Imi Hale Cancer Network, Honolulu, HI 96813 (N.N.Y., K.L.B.)

Natalie N. Young BA
'Imi Hale Cancer Network
894 Queen Street
Honolulu, HI 96813
Email: young.natalie@gmail.com

Abstract

Using qualitative methods, we examined 12 patients' experiences with combining lā'au lapa'au (Hawaiian herbal healing) and Western medicine. Participants felt a higher degree of connectedness and understanding in their relationship with their healer than with their physician, and they felt that healers took more time to listen and clearly explain diagnoses. Lā'au lapa'au was more likely than Western medicine to incorporate a spiritual and prayer component, lead to improvements in cultural and personal identity, and foster feelings of connectedness to the land and Hawaiian values.

Introduction

Throughout history, cultures have developed healing practices to safeguard health and guide daily living. The traditional practices of many indigenous groups in the United States, however, were repressed following Western contact. Recently, there has been a growing awareness of potential benefits of traditional healing approaches alone or in combination with Western medicine.^{1,2} This research sought to understand why people in Hawai'i use both traditional and Western medicine.

Native Hawaiians trace their ancestry directly to the Polynesians who peopled and governed the Hawaiian archipelago prior to the arrival of Westerners in 1778.³ Lā'au lapa'au is a traditional Native Hawaiian healing practice employing herbs and other plants.^{4,5} The practitioner was known as a *kahuna* (expert or master teacher) lā'au lapa'au.⁶ Prayer was integral to the practice. Special *oli* (chants) accompanied harvesting and replanting of herbs. *Kahuna lā'au lapa'au* needed to be *pono* (righteous, balanced), and *pule* (prayers) were offered during the preparation and administration of medicines. Patients needed to participate in spiritual cleansing as well, and continued prayer was important to their healing process.^{7,8}

In 1893, the Hawaiian monarchy was overthrown, and Hawai'i was annexed by the United States in 1898. Within a century of Western contact, Hawaiians had lost their land, spirituality, and culture.⁹ Although the 1919 Territorial Legislature established a Hawaiian Medicine Board to license lā'au lapa'au practitioners, 2 out of the 3 members were white, and the board discouraged lā'au

lapa'au practitioners by requiring them to use Western scientific names for Hawaiian medicinal plants. Within 6 years of statehood (1959), the Hawaiian Medicine Board was abolished; lā'au lapa'au practitioners were no longer licensed.¹⁰

With the Hawaiian cultural renaissance in the 1970s, Hawaiian practices began to re-emerge. Lā'au lapa'au was re-recognized in 1988 when Congress passed the Native Hawaiian Health Care Act,¹¹ which sought to improve the health status of Native Hawaiians by funding culturally based health promotion, disease prevention, and primary care services.^{12,13} Although many of the details of Hawaiian herbal medicine were lost, lā'au lapa'au traditions have been revived through information passed on through families and *kūpuna* (elders),¹⁴ and many of today's healers are training students.^{5,6} The practice continues to evolve to meet the health needs of Native Hawaiians. Based on findings from a population-based survey, an estimated 10-15% of Native Hawaiians used lā'au lapa'au in 2001-2002.¹⁵

Many studies on traditional Hawaiian healing focus on interviews with healers.^{5,6,14} To complement these, this study examined patients' experiences with lā'au lapa'au and Western medicine. The idea for this study stemmed from earlier interviews by the first author with lā'au lapa'au healers, who revealed that most of their patients used a combination of traditional and Western medicine (Young, 2002).

Materials and Methods

In this phenomenological¹⁶ qualitative study, data were collected through in-depth interviews with people currently using the specific combination of lā'au lapa'au and Western medicine. Participation was limited to individuals responding to fliers or referred by friends. During the study period (June-August 2004), 12 individuals contacted the researcher. All 12 signed consent forms and completed interviews.

All participants came from Native Hawaiian families; 58% were woman and 91.7% were age 45 or older. For 33.3% the highest level of education was high school, 25.0% had attended or completed college, and 41.7% had attended graduate school. During the interview,

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patients freely disclosed their medical problems, which included diabetes (n=6), asthma (n=4), cancer (n=4), arthritis (n=3), heart conditions (n=3), depression (n=2), kidney damage (n=2), and bipolar disorder (n=1).

Interviews included 20 open-ended questions in 4 categories identified in the literature and previous study: 1) decision about care, 2) comparison of treatments, 3) trust with physician and healer, and 4) cultural and spiritual importance (Young, 2002). Each interview lasted approximately 1 hour. Because most participants declined to be audio-taped, detailed notes were made during the interview. These were analyzed using the constant-comparative method.¹⁷ Data were sorted by question. The most informative and all-encompassing question under each of the 4 categories was micro-analyzed. For each question, the response of a randomly chosen participant was selected, and responses were analyzed in random order. Units within a participant's response that did not address the question under analysis were moved to the appropriate question or to the end of the transcript. Remaining units were separated by theme then labeled with the participant code and question number. Each participant's response to a question contained 3-10 units, depending on the length and content of the response. Units per theme were summarized.

Results

Decision about Care

Participants began to use *lā'au lapa'au* because of recommendation (n=8), personal values (n=5) (including interest in Hawaiian culture), and dissatisfaction with Western medicine (n=4). Among those expressing dissatisfaction with Western medicine, 3 spoke of a medical problem that was not being addressed by Western medicine. For example, P10 sought out a *lā'au lapa'au* healer "out of desperation" because his laceration would not heal.

The costs of the 2 treatments differed greatly. Participants reported that *lā'au lapa'au* cost little or nothing (n=11), while Western medicine was very expensive (n=8). Surprisingly, most participants (n=11) indicated that cost was not the primary factor in their decision to use *lā'au lapa'au*. P8 and her husband, P7, explained, "We use *lā'au* because it works."

In discussing their use of both types of care, study participants spent far more time commenting on *lā'au lapa'au* than on Western medicine. Their statements uniformly expressed positive views towards their Native Hawaiian healers: "The healers do it for the love of the participant" (P11), "Help one another. Hawaiian medicine is to help" (P5), "My *kumu* (teacher) is helping more people know about it. She wants to serve" (P1).

Comparison of Treatments

Participants described 3 main differences between the 2 treatments: process (n=8), timing (n=5), and effects (n=5). The process for Western medicine was seen as clinical and general, while *lā'au lapa'au* was holistic and individualized. P6 recounted that "with Western treatments, everything is generalized by age, etc. With Hawaiian treatments, healing is way more specific with each person." Participants noted that their healers used less invasive methods to diagnose them, including odor and touch, rather than blood tests. Participants felt that Western medicine was used more for particular symptoms and was event-based. Contrarily, *lā'au lapa'au* was long-term and addressed underlying causes of symptoms.

Participants reported that Western medicine was more convenient than *lā'au lapa'au*, which involved detailed preparation of sometimes strong tasting herbal teas and often required strict dietary restrictions. But, *lā'au lapa'au* was seen as more efficient and having less adverse side effects than Western medicine. P7 explained, "*Lā'au* doesn't attack other parts of the body like Western medicine. It starts by building your immune system and cleaning you out."

Additionally, participants commented that *lā'au lapa'au* offered results of higher quality. One participant even stated, "If I hadn't done *lā'au*, I'd be dead" (P5). She went on to explain that *lā'au lapa'au* incorporates more than just physical health benefits. "[My healer] helps me with forgiveness for self, helps me to start seeing the bigger picture." P4 stated that Western medicine "helps [him] with life, but not the quality of life."

Trust with Physician and Healer

Participants identified that trust-building required communication (n=9) and relationship (n=9). Regarding communication, participants said it was easier to explain symptoms to their healer than to their physician. They noted the rushed atmosphere about the physician, which precluded the chance for the patient to provide a full health background, inclusive of personal and cultural factors. Participants expressed dissatisfaction with physicians' diagnoses, claiming they were hard to understand. In contrast, participants felt that healers took the time to fully explain why particular medications were used and how they worked. P9 explained, "The [Western] doctors always were rush, rush, rush. Never really get a chance to talk. With the healer, he takes the time to find out what's really wrong."

Participants reported negative views of *lā'au lapa'au* by their physicians. P10's physicians forbade him to use *lā'au lapa'au* for his foot laceration, recommending amputation. Against the physicians' advice, P10 used *lā'au*, faith, and prayer. Initially, he took herbs to improve his immune system, digestive system, and blood circulation. Then he received herbs to use for foot-soaking. To the surprise of P10's physicians, the laceration healed, and amputation was avoided. P7 and P12 also described physician disapproval of *lā'au lapa'au*. Both participants said that they no longer tell their physicians that they see healers, although they tell their healers about their physician visits.

Regarding relationship, participants stressed the importance of mutual respect between patient and provider (n=9). The majority of the participants referred to an "intrinsic" understanding with their healers. "My healer is less intrusive" (P5), "My healer understands me a little more" (P10), "My healer comes on the same level as me. She relates to me ...she's already connected with me" (P4).

Other factors influencing participants' relationships with their physician or healer were emotional connectedness (n=5) and approach to healing (n=4). Participants reported a lack of emotional connection with their physician: "My physician can help me physically but can't reach [my] emotional or spiritual level...Western medicine is not holistic treatment. It just deals with the illness, not the individual. My healer is holistic. She helps me, not just my symptoms" (P4).

Cultural and Spiritual Importance

Participants reported 3 ways that *lā'au lapa'au* emphasizes cultural and spiritual importance: incorporating a spiritual and prayer component (n=10), improving cultural and personal identity (n=7), and forming a connection to other elements (n=9).

Participants explained that their healers recognized the importance of spirit in their approach. This most commonly entailed prayer and chanting, but could include touch and energy transfer. P10 stated, "When [my healer] would touch you, everything had to be awoken in you... He taught us that his healing is 20% *lā'au* and 80% faith." For 10 participants, the spiritual and faith component of *lā'au lapa'au* healing was one of its most important aspects.

Seven participants said use of *lā'au lapa'au* had an effect on their cultural and/or personal identity. Three participants (P6, P1, and P2) stated that one does not have to be Hawaiian to benefit from this approach. P6 explained, "*Lā'au* puts you more in touch with who you are." Similarly, one participant who married into a Native Hawaiian family explains her positive experience, "I'm very grateful for the gifts given to me by the Hawaiian culture" (P5). P10 and P11 stated that their use of *lā'au lapa'au* is not due to culture, but rather their health.

Lastly, participants described how *lā'au lapa'au* typically requires more patient involvement than Western medicine, enhancing feelings of connectedness and significance. P9 explained that learning how to use *lā'au* gives people wisdom. P5 added, "There's a hidden meaning. It's being able to ask for help; receiving and giving without just taking." P10 and P11 described *lā'au lapa'au* as providing them with hope. P5 and P9 also spoke about Hawaiian values learned through the use of *lā'au lapa'au*. P9 stated, "You learn respect for the *āina* (land). You ask the plant's permission before you use them." P5 added, "[*lā'au lapa'au*] has taught me *ho'ihi* (respect) and to be *pono* by doing the right things. Values always go back to baseline foundation. You need a strong foundation."

Discussion

As other researchers have found, this study's respondents identified important differences between traditional and Western medicine.⁶ The differences are summarized these into 3 dichotomies: Personal versus Professional, Holistic versus Segmented, and Spiritual/Cultural versus Scientific (Table 1).

Personal versus Professional

In the practice of *lā'au lapa'au*, there is a more personal setting for healer and patient interactions. Healers usually take more time than physicians with patients when diagnosing and treating. Contrastingly, Western physicians are restricted in time and relationship due

Table 1.— Major differences between *Lā'au lapa'au* and Western medicine as perceived by patients.

Themes (<i>Lā'au lapa'au</i> vs. Western Medicine)	Explanations		Implications
	<i>Lā'au lapa'au</i>	Western Medicine	
Personal vs. Professional	<ul style="list-style-type: none"> - Intimate relationship - Long conversations 	<ul style="list-style-type: none"> - Economic and liability concerns - Shorter time allotted for each patient (15 minutes or less) 	Expand training on establishing a good patient-provider relationship and interpersonal communication
Holistic vs. Segmented	<ul style="list-style-type: none"> - Pro-active/ Preventive, focuses on cause of problems 	<ul style="list-style-type: none"> - Reactive, symptom based - Treatments segmented by specialty 	Look at examples of providers offering integrative medicine, e.g., the Indian Health Service, Ke Ola Mamo, Waimanalo Health Center, and Waiānae Coast Comprehensive Health Center
Spiritual/Cultural vs. Scientific	<ul style="list-style-type: none"> - Incorporates prayer/ chants, faith - Hawaiian values and culture 	<ul style="list-style-type: none"> - Relies mainly on scientific methods; no spiritual component 	Enhance cultural competence training of providers

to economic and liability concerns. Thus, patients reported feeling closer and more connected to healers than to Western physicians.

This finding suggests that Western medicine may be improved by recognizing the importance of the patient-physician relationship. It is recommended that training of Western physicians place greater emphasis on interpersonal communication and interaction with patients. This can help decrease patients' anxiety or fear of the health care system and help physicians engage their clients more effectively in treatment.¹⁴ As Americans live longer with multiple co-morbidities, more time will be needed to effectively interact with and treat patients.

Holistic versus Segmented

Western medicine oftentimes addresses health care delivery through the treatment of symptoms in a reactive, need-based system, and treatments are segmented by a growing number of specialties. *Lā'au lapa'au* employs a holistic approach, which proactively focuses on underlying causes rather than symptoms.⁵

Through their differences, these two practices can complement each other. Already, some US Indian Health Service (IHS) health facilities offer both American Indian traditional medicine and Western medicine, emphasizing an alliance between the community's traditional healers and Western-trained providers. A study conducted in 2004 observed the effects of this integrative medical approach in a reservation-based sample of American Indians and found that both the Western and traditional healing practices were important sources of treatment for these patients.¹⁸

Although research in Hawai'i suggests that *lā'au lapa'au* is not necessarily known to or sanctioned by most Western physicians, some programs in Hawai'i now promote a blended approach and validate the use of *lā'au lapa'au*. *Ke Ola Mamo* (KOM) is a program whose mission is to remove barriers to health care and improve the health status of Native Hawaiians. One of KOM's outreach sites, Waimanalo Health Center, is a community-based nonprofit corporation that specializes in integrating Native Hawaiian cultural healing with Western medical practices. Another site, Waiānae Coast Comprehensive Health Center, offers a range of health services such as family practice, specialty services, and Native Hawaiian healing, including *lā'au lapa'au*.

Spiritual/Cultural versus Scientific

While Western medicine relies mainly on a scientific approach to medicine, *lā'au lapa'au* also incorporates cultural and spiritual components in its healing methods. The increasing popularity of complementary medicine reflects the changing needs and values in modern society. As more people supplement Western medicine with alternative therapies, the need to understand and recognize these practices increases.¹⁹ Physicians' ignorance about these practices risks broadening the doctor-patient communication gap. Healers also need to be aware of which Western medicines their patients are taking to avoid any conflicting treatments.¹

Cultural competence and, more importantly, cultural humility are needed to bridge the gap currently separating the two approaches to patient care.²⁰ Because decisions about health promotion and illness prevention are made within a cultural context, it is important to adopt culturally congruent methods of maintaining health.²¹ Thus, recognizing patients' health beliefs and working with them from their perspectives become imperative to the caring relationship. Ignoring the significance of culture may even be harmful to the health of the patient since the health care provider may be unaware of important decision-making behaviors of the patient that may directly affect his or her health.^{12,22,23}

Limitations and Future Research

Although sample size was small, the authors are confident thematic saturation was achieved because of the many similarities in participants' reports of their experiences. This study's findings led the authors to develop a closed-ended questionnaire about the combined use of Western medicine and *lā'au lapa'au* for use in future research (contact lead author for a copy of the questionnaire). A survey will allow the authors to collect data from a larger sample and use quantitative analysis to determine frequencies of use and experiences. It also could expand options for multi-site research on the combination of Western and traditional healing approaches.

Conclusion

Patients who use *lā'au lapa'au* in combination with Western medicine do so because this traditional method emphasizes factors perceived as important to health that are ignored (or at least not emphasized) by Western medicine. A more thorough investigation of the benefits of concurrently using Western and traditional practices is warranted. The authors also urge Western and traditional healers to increase their awareness of each other's approach, and to work together to optimize healthcare provided to people of all backgrounds and cultures.

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Factors associated with Organ Donation in Filipino Americans: Results from Hawai'i's Bayanihan Project

Cheryl L. Albright PhD, MPH, Linda L. Wong MD, May Rose Dela Cruz BS, Laurie Abe MS, and Tony Sagayadoro BA



Cheryl L. Albright PhD, MPH



Linda L. Wong MD



May Rose Dela Cruz BS

Abstract

Results from mailed surveys (n = 424) showed that 28% of adult Filipinos were a designated organ donor on their driver's license. In logistic regression analyses respondents who were born in the United States were 3.5 times more likely to be a designated donor compared with foreign-born Filipinos. Future programs should emphasize the need for Filipinos, especially immigrants, to become organ donors.

Introduction

The United States Public Health Service has described the lack of organs for transplant as a "public health crisis." Over 90,000 Americans are currently waiting for donated organs, but only about 28,000 transplant operations are completed annually.¹⁻³ As a result, many seriously ill patients often wait years for a transplant, and over 6,000 die annually while waiting for an available organ.^{3,4} Although deceased organ donations have increased 11% since 2003,⁵ more whites compared to all other races donate their organs after death.^{2,6,7} Asian Americans, including Filipino Americans, have particularly low rates of organ donation following death and their attitudes about organ donation are often different compared to other ethnic minorities.⁸⁻¹²

Due to insufficient numbers of deceased ethnic minority donors, there are often discrepancies between the ethnicity of the organ donor and the ethnicity of the organ recipient. Matching a recipient with a donor from the same ethnic group increases the chances of long-term survival.¹²⁻¹⁴ If family members know the donation preference of a deceased family member, either because they had a discussion with them or the person was a designated donor on their state-issued drivers license, almost all will agree to have their loved one's organs donated.^{15,16} The purpose of this study was to investigate the sociodemographic factors associated with being a designated organ donor or having a family discussion among Filipino Americans, an ethnic group for whom these factors are not well understood. For example, analyses will determine if education, country of birth, gender, age, and religious preference predicted organ donor status in Filipinos.

Methods

The University of Hawai'i and the Organ Donor Center of Hawai'i (ODCH) are collaborating to investigate issues related to deceased donor organ donation in Filipinos. These efforts occur within the National Institutes of Health funded Bayanihan Project, which has as its primary goals to increase deceased-donor organ donations in Filipino Americans in Hawai'i, to encourage Filipino Americans to become a designated donor, and to promote family discussions about organ donation prior to a medical crisis. "Bayanihan" is a Filipino cultural concept that literally translated means "working together to help" and refers to a communal spirit which makes seemingly impossible feats possible through the power of unity and cooperation. The project conducts community-based outreach efforts through a network of religious groups, civic/social organizations, business groups, youth organizations, and health professional organizations (e.g. nurses), and representatives from the state government and local media.

A survey was developed that included questions from a 1993 Gallup survey conducted by the Partnership for Organ Donation.¹⁷ Demographic questions were included as were questions assessing general support for organ donation, designated organ donor status on state-issued driver's license/identification card or an organ donor card, discussion of organ donation with family members, and barriers to the latter 2 issues.

A stratified random sample (n = 1450) was selected from a directory of Filipino households on all 6 Hawaiian islands. In addition to the mailings, staff from ODCH distributed surveys at Filipino health fairs and community events on the island of Oahu. The surveys were anonymous and study protocols were approved by the University of Hawai'i's Institutional Review Board.

Data were compiled using Excel and SAS software. Univariate analyses (Chi-Square analyses) were used to test for significant differences between categorical sociodemographic characteristics, and t-tests were used to test for significant differences in continuous variables. Logistic regression analyses were conducted to assess the

Correspondence to:
Cheryl Albright PhD, MPH
Prevention and Control
Program
Cancer Research Center of
Hawai'i
University of Hawai'i
1960 East-West Road
Biomedical Sciences Bldg.
Room C-105
Honolulu, HI 96822
Fax: (808) 586-3077
Email: calbright@crch.
hawaii.edu



Laurie Abe MS



Tony Sagayadoro BA

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Authors' Affiliations:

- Cancer Research Center of Hawai'i, University of Hawai'i, Honolulu, HI 96822 (C.L.A., M.R.D.C., L.A.)
- Department of Surgery, John A. Burns School of Medicine, University of Hawai'i, Honolulu, HI 96813 (L.L.W.)
- Organ Donor Center of Hawai'i, Honolulu, HI 96813 (T.S.)

relative contribution of the sociodemographic factors in predicting designated organ donor status and family discussion about organ donation.

Results

Of the 1450 surveys that were mailed in 2004 and 2005, 414 (28%) were returned as undeliverable, and of the 1036 delivered surveys, 119 (11%) were completed and returned. Of the 600 surveys handed out at community events in 2005, 329 (55%) were completed and returned (total sample = 448, 95% were Filipino $n=424$). There were no significant differences between these distribution methods in respondents' years of education, the percent reporting they were likely to donate their organs following death, and the percentage that reported being a designated donor or who had discussed organ donation with their family. However, there were significant differences for gender (more women completed the handed-out surveys, Chi Square = 25.81 (df = 1), $p < .0001$), age (more adults over the age of 55 completed the mailed survey, Chi Square = 24.64 (df = 4), $p < .0001$), and immigrant status (more immigrants completed the handed-out survey, Chi Square = 34.19 (df = 1), $p < .0001$). Of the total sample 65.8% were women, 54.9% were over 45 years of age, 73.3% were born in the Philippines, 66.6% were married, 58% had a college/post-graduate degree, 73% had children, and 74.5% were Catholic.

Most (76.5%) of the respondents supported the concept of organ donation, 4.4% were opposed to organ donation and 19% were uncertain. There were no differences in the responses to this question by gender, age, marital status, immigrant status, or if the respondent had children. However, significantly more people who supported the concept of organ donation had a college degree (Chi Square = 19.1 (df = 8), $p < .01$). Over half (57.3%) of the respondents reported they would accept a donated organ if needed; however, there were significant differences by age, marital status, and education. Of those who would accept a donated organ (compared to those who would not) if medically necessary, significantly more were younger (Chi Square = 17.3 (df = 8), $p < .03$), married (Chi Square = 19.4 (df = 4), $p < .001$), or had a college degree (Chi Square = 27.2 (df = 8), $p < .0006$).

The sample was divided into 2 groups: those who reported they were "somewhat likely" or "very likely" to donate following death ($n=227$, 57.0%) and those who were "not likely" or "not very likely" to donate ($n=171$, 42.9%). Chi Square analysis of differences between these 2 subgroups showed significantly more immigrants and people who had children were in the "not likely/ not very likely to donate" subgroup ($p < .001$). Age, mean years in the United States for immigrants, marital status, education, and religious preference were not significantly different for these 2 subgroups. The most frequently reported reasons why they were not

likely to donate their organs after their death included: I don't want my body cut up (42.6%), I don't know anything about organ donation (22.2%), I never thought about it (21.1%), medical reasons (16.4%), I don't feel right about it (12.2%), and I am unsure/undecided (9.3%) (note: respondents could select more than one reason).

In terms of designated donor status, 28.1% ($n=115$) of the sample reported being a designated donor on their Hawai'i issued driver's license/ID card or had signed a donor card from ODCH, 63.8% ($n=261$) were not a designated donor, and 8.1% ($n=33$) could not remember. Analyses comparing designated donors to non-designated donors found significant differences for marital status ($\chi^2_{(4)} = 14.01$, $p < .01$ - a higher percentage of non-designated donors were married), immigrant status ($\chi^2_{(2)} = 13.41$, $p < .01$ - 79.5% of non-designated donors were born in the Philippines compared to 60.3% of designated donors), and immigrants who were designated organ donors had lived significantly longer in the United States ($t(373) = 2.48$, $p < .01$). There were no statistical differences by gender, age, having children, number of children, education, or religious preference.

About a third (30.6%) of the respondents had told a member of their family about their decision to donate or not to donate organs after their death and 26.4% stated that another family member had told them about their wish to donate or not to donate. There were no significant differences between those who had a family discussion about organ donation and those who had not, for any of the sociodemographic factors. Most respondents (58.2%) were very willing or somewhat willing to discuss their wishes about organ donation with their family, but 22.3% were not willing to have such a discussion and 19.5% were not sure. Reasons listed by those who were unwilling to talk to a family member included: 35% hadn't given it much thought, 26.1% it makes my family nervous to talk about death or dying, 18.2% I don't discuss death with my family, and 11.5% I don't need to talk about it, it is their decision to make, not mine. Having a family discussion about organ donation was reported by significantly more respondents who were a designated donor (72.6%), while only 14.1% of non-designated donors had discussed organ donation with their family ($\chi^2_{(4)} = 176.16$; $p < .00001$).

The results of the logistic regression analyses showed that immigrant status significantly predicted designation as an organ donor with an Odds ratio = 3.54 (CI = 1.5-8.0, $p < .003$); thus, US born Filipino Americans were 3.5 times more likely to be a donor. And among immigrants, years in the United States was significant (Odds Ratio = 1.03; CI = 1.01-1.06, $p < .01$); thus, for every year an immigrant lived in the United States there was a 3% increase in the probability they were a designated donor. The logistic regression for family

discussion revealed that immigrant status had an Odds ratio=2.3 (CI= 1.1-5.1, $p < .04$); thus, US born respondents were twice as likely to have talked to their family. Also, marital status was a significant predictor (Odds ratio=1.96 CI=1.06 -3.57, $p<.03$), such that married respondents were twice as likely to have had a family discussion as unmarried respondents.

Since the Bayanihan survey contained questions that were very similar to those used in a national survey done by Gallup in 1993 ($n=6,127$), its results could be compared to the ethnic minority results (blacks and Hispanics) reported for the Gallup survey. The survey methods for these 2 studies were different, the Gallup survey was a telephone survey and the Bayanihan survey was a self-administered print survey. Also, the sampling frameworks were different for the 2 studies, as were the target populations (the Gallup sample included 23% ethnic minorities, while 100% of this data was from Filipino Americans). These differences may have contributed to differences between the two samples on sociodemographic factors. Seventy-five percent of this Filipino sample was Catholic compared with 26% of the entire Gallup sample. The Filipino sample was predominately an immigrant population but 58% had graduated from college compared with 15% of the ethnic minorities in the Gallup sample. The distribution of respondents' age and gender ratios were similar for the ethnic minorities in both surveys. Given these sociodemographic differences, it could be informative to compare each sample's responses regarding being a designated organ donor and having a family discussion about organ donation (see Table 1).

As for barriers to being a designated organ donor or having a discussion with their family about organ donation, the most prevalent barrier to being a designated donor in our survey was "not wanting their body cut up" (43%), while overall in the Gallup survey only 9% reported this barrier. Although no percentages are provided, the Gallup survey reported that black and Hispanic respondents were "more likely" than whites to indicate a desire to be buried "intact". Both surveys had similar percentages of respondents reporting they didn't know anything about organ donation or had never thought about it (43% in Bayanihan and 47% in Gallup). The reasons listed by respondents who were unwilling to discuss organ donation with their family members were somewhat different for each sample. In this survey the most common reasons were that the person had not thought about talking to their family (35%) and that it would make their family nervous to talk about death (26%). The primary reason listed in the overall Gallup survey was the respondent had not thought about having a family discussion or he/she didn't know or didn't report a reason why (73%); however 21% of Hispanics indicated they did not discuss death with their family.

Table 1.— Comparison between 2005 Bayanihan survey and 1993 Gallup survey

Survey Question:	2005 Bayanihan survey	1993 Gallup survey*
Support organ donation, in general	77%	72%
Somewhat likely to donate organs after death	57%	55%
Would accept an organ transplant, if necessary	57%	72.5%
Designated donor on driver's license/organ card	28.1%	20.5%
Discussed organ donation with family	72.5% in designated donors 14.1% in non donors	40% in those likely to donate 39% in those unlikely to donate
Very Willing to discuss organ donation with family	83% in those likely to donate 26% in those unlikely to donate	89% in those likely to donate 58% in those not likely to donate

* = the percentage listed is an average of the percentage reported for Blacks and Hispanics in the Gallup survey ($n = 1463$)

Discussion

Filipino Americans are the second largest and fastest growing Asian ethnicity in the United States.¹⁸ The United States Census in 2000 indicated that within the Asian population there were 2.3 million Filipino Americans, which was second only to 2.8 million Chinese Americans.¹⁹ Over half of all Filipino Americans live in 3 states: California, New Jersey, and Hawai'i.²⁰ Health information on Filipino Americans is often difficult to determine due to inconsistencies in coding of race and ethnicity. For example, national data on Filipinos is typically classified within data reported for Asian Americans, but sometimes Filipino information can be reported within "other Pacific Islander".²¹ It is known, however, that Filipino immigrants are at a high risk for hypertension, coronary heart disease, diabetes, and other metabolic problems.²²⁻²⁴ All of these diseases are risk factors for developing renal failure and end-stage renal disease. Although 15% of Hawai'i's population is Filipino, they comprise 48% of the patients who are on renal replacement therapy (hemodialysis or peritoneal dialysis) and 36% of the patients who are waiting for deceased donor renal transplant. In 1999, 6.5% of the organs, eyes, and tissues transplanted in Hawai'i were from a Filipino donor and this rate had increased to 14% by 2005. Referral rates for approaching Filipino families to obtain consent for organ donation are appropriate (95%), but only 58% consented to donation (7/2005-6/2006).²⁵ Conducting a survey to quantify the prevalence rate among Filipinos of designated donors and identifying reasons for not being a designated donor is, thus, justified.

The Bayanihan survey revealed that Filipinos are supportive of organ donation and most would be willing to accept an organ, if necessary; but only 28% have actually signed an organ donor card or were a designated donor on their Hawai'i driver's license. This self-reported rate is 11% lower than the percentage of people in Hawai'i, regardless of ethnicity, who agree to be listed as a designated donor on their Department of Motor Vehicles (DMV) issued Hawai'i driver's license. The Hawai'i DMV rate for designated donors (38.1% in 2006) is lower than rates reported by mostly-white states (e.g., 50% designated donor rate in Ohio).²⁶ Our survey data is, however, consistent with the 6,127 ethnic minorities surveyed in the 1993 Gallup survey, 72% supported organ donation, 55% were somewhat/very likely to donate their organs after death, but only 20.5% had signed an organ donor card.¹⁷ Our designated donor rate is also similar to the designated donor rates for black women (25%) living in Maryland.²⁷ However, our Filipino rate is much lower than rates reported in studies with largely white samples, for example a 67% designated donor rate was reported for a sample that was 98% white,²⁸ and 43% in a sample that was 75% white.²⁹ Clearly little progress has been made over the past decade in the designated organ donor rate for ethnic minorities.

Family discussions about a person's wishes regarding donation of his or her organs following death is an integral part of the organ donation process. Minorities have been shown to be less likely to have a family discussion about organ donation. Minniefeld and colleagues surveyed 892 people and their results showed that 54% of whites and 32% of African Americans had a family discussion about organ donation.³⁰ The Bayanihan study showed that only 31% of Filipinos had a discussion with family members about organ donation. Filipino households tend to be multigenerational so initiation of a family discussion may be more complicated. These discussions could involve family members with large gaps in age, multiple different languages, and potentially widely spread opinions from traditional views of their native country to Western views. All Filipino families should be encouraged to discuss their wishes with respect to organ donation with their family, but the discussion itself could be much more complex compared to a non-minority family.

A limitation of this study is its use of 2 methods for distributing the survey. One was a random sample of Filipino households, the other was a sample of convenience that included Filipinos attending community events. Although no significant differences were found between the responses collected via these methods with respect to the questions relevant to organ donation, there were significant differences in the demographic characteristics of their respective respondents. Such differences in methods could have led to differential response biases for the survey. Due to the low response rate for the mailed survey, the method for distributing surveys was changed in order to collect adequate numbers of questionnaires. Thus, the results may not be generalizable to all Filipinos living in Hawai'i, and the designated donor rate could be an over- or under- estimate of the true number of Filipinos who are designated donors. If it is an overestimate, it is disconcerting that the true rate would be lower than rates found for ethnic minorities surveyed across the United States over a decade ago. Another limitation is this study's focus on only 1 ethnic group in 1 state — Filipino Americans living in Hawai'i. Our results may not be applicable to other Asian Americans living in Hawai'i or Filipinos living in other states. However, Asia is the second most common region of birth for people in the United States who were born in a foreign country.³¹ Other than Hawai'i's proximity to Asia, there is no substantial evidence that foreign-born Filipino Americans in Hawai'i have attitudes or preferences with respect to deceased organ donation that are dramatically different from Filipino immigrants living in other states.

In summary, to improve organ donation in the Filipino population, the Bayanihan project needs to continue its media campaigns and efforts to educate people about becoming a designated organ donor. Specifically, programs that address the attitudes and needs of immigrant Filipinos and unmarried Filipino adults should be developed. Not only should family discussions be encouraged, but Filipinos should be informed about what information should be exchanged with family members and how to initiate this discussion in a culturally-sensitive, multigenerational fashion.

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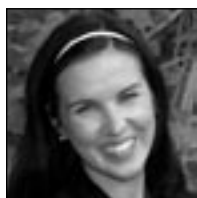
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Underdiagnosis and Under-treatment of Osteoporosis Following Fragility Fracture

Mohamed Aboyoussef MD and Koah R. Vierkoetter BA



Mohamed Aboyoussef MD



Koah R. Vierkoetter BA

Abstract

Aim: Assess the treatment and diagnosis rates for osteoporosis following a fragility fracture.

Design: A retrospective chart review.

Findings: Out of 93 patients with fragility fractures, 26.9% received an osteoporosis or osteopenia diagnosis within 6 months after the time of fracture.

Conclusion: Despite availability of clinical tools and therapeutic options of the treatment of low bone density, osteoporosis remains underdiagnosed and under-treated.

Introduction

Osteoporosis is a progressive and chronic disease with potentially life threatening complications. Principal of which is an increased risk of fracture. There are approximately 1.5 million fragility fractures annually in the United States.¹ Fragility fractures are fractures that occur without a trauma or with minor traumas, such as falling in the same plane or from a height less than 12 inches. Some fractures are associated with disability and death.² One in 4 hip fracture patients over the age of 50 will die in the year following their fracture. Following fracture, 20% of patients who were previously ambulatory will necessitate long-term care.¹ The decrease in activities of daily living following a fracture greatly impacts patients and burdens families. Furthermore, a previous fracture is strongly associated with subsequent fracture.³ From a broader perspective, the impact of the disease reaches beyond the individual, with repercussions at social and economic levels as well, including direct costs of \$18 billion annually.⁴

The lifetime risk of an osteoporotic fracture is high, about 40–50% in women and 13–22% in men.⁵ Although incidence is lower in men, the risk cannot be understated, considering that the occurrence of hip fracture in men approaches that of women with age.⁶ Areas most susceptible to osteoporotic fracture include the hip, vertebral body, and distal forearm.⁷ In 1994, the World Health Organization established guidelines upon which the diagnosis of osteoporosis is based. These include either the occurrence of a fragility fracture and/or measurement of low bone mass density, predominantly by dual-energy X-ray absorptiometry (DXA).⁸

Yet, despite the significant consequences of osteoporosis, several studies have shown that treatment rates following a fragility fracture are low. Andrade et

al.⁹ examined the records of 3492 women over age 60 who were identified with a fragility fracture. Of these, 24% received pharmaceutical treatment for low bone density within a year of fracture. Similar studies have shown treatment rates for osteoporosis with prescription medication for low bone density to be 22% (n=60),¹⁰ 17% (n=343),¹¹ and 13% (n=422).¹² Other studies have shown rates of diagnosis for osteoporosis following a fragility fracture to be 18.5% (n=108)¹³ and 11.2% (n=226),¹⁴ and the incidence of receipt of a test for bone density to be 9.6% (n=227),¹⁵ 7% (n=658),¹⁶ and 2.8% (n=1162).¹⁷

The aim of this study was to assess the treatment and diagnosis rates for osteoporosis following a fragility fracture at Straub Hospital and Clinic in Honolulu, Hawai'i. In light of previous studies, the authors hypothesized that diagnosis and treatment rates would be in the range of 20%.

Methods

Research Setting & Design

A retrospective chart review was conducted of patients presenting to the Bone and Joint Clinic of Straub Hospital in Honolulu, Hawai'i. All fractures over the course of 2005 with the ICD-9 (The International Classification of Diseases, 9th Revision) coded diagnoses of 733.93–733.95 (stress fractures), 805–806 (vertebral column) 807 (ribs), 808 (pelvis), 812–821, 823–825, and 828 (upper and lower limbs) were identified through the hospital's computerized database. Study approval was obtained by the Hawai'i Pacific Health Institutional Review Board.

Study Participants

The inpatient, outpatient, emergency, and radiological records of identified women and men over age 65 were reviewed. An initial group of exclusions included patients with incomplete primary care records, with no fracture or a non-fragility fracture, or fractures that did not occur in 2005. Patients with a diagnosis of osteoporosis/osteopenia or treatment for these conditions before the time of fracture were excluded. Participant selection and exclusion criteria are outlined in figure 1.

Analysis Variables

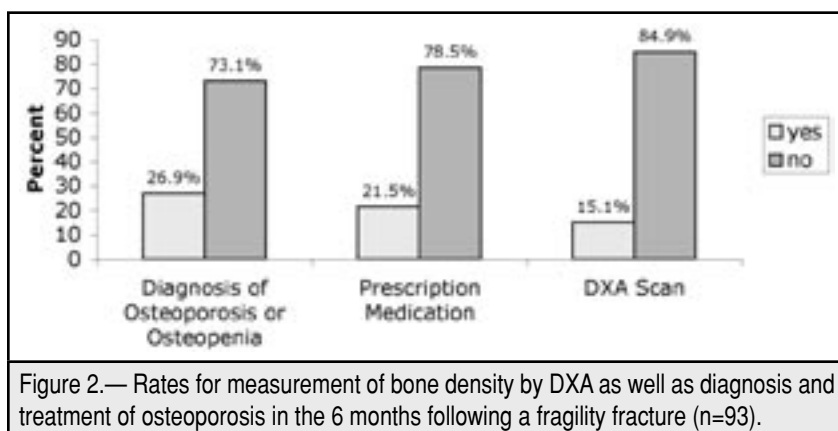
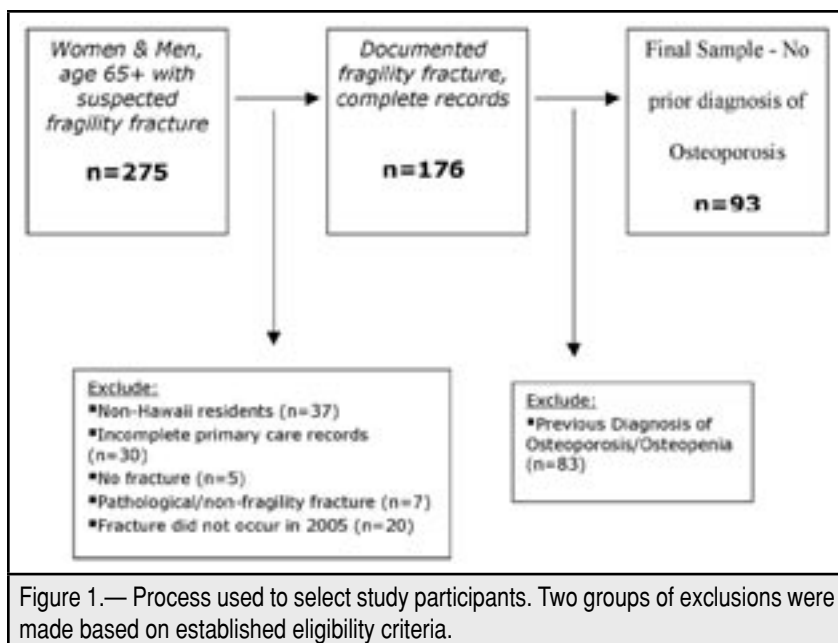
Data collected included the age of the patient at time of

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Authors' Affiliations:

- Department of Rheumatology, Straub Clinic & Hospitals, Honolulu, HI 96813 (M.A.)
- John A. Burns School of Medicine University of Hawai'i, Honolulu, HI 96813 (K.R.V.)

Mohamed Aboyoussef MD
Rheumatology
Straub Clinic & Hospitals
888 South King Street
Honolulu, HI 96813
Ph: (808) 522-4522
Fax: (808) 522-3408
Email: mohamed.aboyoussef@straub.net



fracture, gender, location of fracture, diagnosis of low bone density (osteoporosis or osteopenia), date of diagnosis, medication for low bone density, bone densitometry results, and date. Diagnosis was defined as the explicit notation within a patient's chart of osteoporosis. Osteoporosis treatment was defined as the receipt of medication for low bone density and included the use of both prescription medication including raloxifene, alendronate, risedronate, ibandronate, calcitonin, teriparatide, and hormone replacement therapy as well as nonprescription use of calcium and vitamin D. Dual-energy X-ray absorptiometry was utilized for bone densitometry measurements. Statistical analyses are primarily descriptive and were performed with SPSS for windows.

Results

Sample Characteristics

Of the 275 men and women identified with applicable fractures by ICD-9 code, 176 had complete medical records and sustained a fragility fracture. Of the remaining participants, half of these (n=93) had not received a diagnosis of osteoporosis or osteopenia nor treatment for low bone density at the time of their fracture. Of these 93 patients, the mean age was 80.3 + 8.6 years (min. 65; max. 97), 61 (65.6%) were women and 32 (34.4%) were men. Fracture locations included the hip (n=18), vertebrae (n=16), wrist (n=16), shoulder (n=13), foot (n=9), ankle (n=6), arm (n=5), elbow (n=5), metacarpal (n=3), and rib (n=2).

Diagnosis and Treatment of Osteoporosis

Of the 93 patients, 25 (26.9%) received an osteoporosis or osteopenia diagnosis within 6 months after the time of fracture; of these, 88% received the diagnosis of osteoporosis and 12% received the diagnosis of osteopenia. Medication for the treatment of low bone density was prescribed to 20 patients (21.5%) in the 6 months following a fracture; alendronate was prescribed for 13, risedronate for 4, raloxifene for 2, and alendronate and calcitonin for 1. Bone density was measured by DXA in 14 patients (15.1%) 6 months subsequent to fracture. In all, 32.3% of patients received 1 or more of a diagnosis, a prescription medication for the treatment of low bone density, or a DXA scan within 6 months of their fracture.

Discussion

As the world's population continues to age, osteoporosis will likely become more prevalent. This presents a significant and potentially severe public health problem with imminent socioeconomic burdens. The 1.5 million fractures ascribed to osteoporosis yearly in the United States are associated with increased mortality as well as disability and lowered quality of life.¹ Nevertheless, the rates of diagnosis and treatment of osteoporosis following a fragility fracture have been shown to be low in a number of studies.¹⁰⁻¹⁷ This analysis was designed to determine the diagnosis and treatment of osteoporosis in patients over 65 without a prior diagnosis of low bone density at Straub Hospital and Clinic in Honolulu, Hawai'i.

In this study, 34% of participants were men. This is greater than the national proportion of male osteoporosis cases, which is generally cited at approximately 20%.¹ The under-treatment of osteoporosis in males has been well documented.^{18,19} Moreover, men exhibit higher mortality and morbidity rates than women following fracture.^{20,21} Considering these poor outcomes for men, the relatively high number of men experiencing fragility fracture in this study points to a need for a heightened awareness of osteoporosis in men.

The hip was the most common location of fracture (19%), followed by the vertebrae (17%), and distal forearm (17%). These data reflect global osteoporotic fracture trends of 1.6 million hip, 1.4 million vertebral, and 1.7 million forearm fractures in 2000.²² Although fractures at all locations have been shown to be related to heightened morbidity and mortality, hip fractures have the greatest associated death and disability rates.²³ For instance, 1 in 5 of hip fracture patients will end up in a nursing home.¹ Vertebral compression type fractures are also associated with increased mortality²⁴ and fractures of the spine are associated with back pain and disability.²⁵ Furthermore, in spite of the fact that the incidence of distal forearm fragility fracture is similar to hip and vertebral fracture, Cuddihy et al.¹¹ suggest that the nature of wrist fractures may not provoke the

recognition of underlying osteoporosis by either the physician or patient.

In the present study, the percentage of patients whose osteoporosis was addressed by a diagnosis of osteoporosis or osteopenia, a prescription medication for the treatment of low bone density, a bone density scan, or combination of the above was 32%. Considered alone, 27% were given an osteoporosis/osteopenia diagnosis, 22% prescription medication, and 15% a DXA scan. These rates, similar to or slightly higher than those in the osteoporosis literature,²⁶ indicate that the needs for diagnosis and treatment of osteoporosis following fracture are not being met. Such care remains inadequate in view of the increased risk for a consecutive fracture.

The incidence of fracture is a timely opportunity for the identification and treatment of low bone density. Treatment options for osteoporosis have been outlined by the US Surgeon General and include lifestyle changes, including nutrition, calcium and vitamin D intake, physical activity, and fall prevention as well as pharmacotherapy.⁴ Bisphosphonates, calcitonin, teriparatide, selective estrogen receptor modulators, and estrogen have all shown to be effective in increasing bone mineral density and reducing the risk of fracture when used in combination with calcium and vitamin D.^{27,28}

That such low diagnosis and treatment rates occur despite available and proven treatment options has been explained by a disjunction between the orthopedic surgeon treating the fracture and the primary care physician.²⁹ In addition, Kaufman et al.³⁰ outline a number of plausible barriers to diagnosis and treatment including issues of dementia, reimbursement, or reluctance on the part of the patient or family to pursue treatment after fracture.

Various groups have advanced suggestions for improvement. Sidwell et al.³¹ found significant improvements in the rate of measurement of bone mineral density following the implementation of a post-fracture protocol (11% to 93%, $p < 0.01$). In another assessment, 42% of patients received a DXA and/or prescription medication after a discussion regarding osteoporosis, its treatment, and DXA testing. In addition they received 5 questions regarding osteoporosis to address with their PCP, as well as a reminder phone call. This 42% was compared to 19% in a control group ($p = 0.036$).³²

A limitation of the present study is the potential inaccuracy and/or incompleteness of electronic medical records including ICD-9 codes, diagnosis notations, medication lists, or DXA scans. The study was limited to patients who received their primary care and followed medically in the Straub clinic in order to eliminate patients who seek care at other offices or hospitals in Hawai'i. Additionally, although medical records did in some instances note the use of over-the-counter calcium and vitamin D, documentation of calcium and vitamin D intake was incomplete. For this reason, the definition of treatment included pharmaceuticals alone. Stringent consistency with National Osteoporosis Foundation recommendations for treatment would require the supplementation of calcium and vitamin D in addition to pharmaceutical intervention. Finally, considering that Asian women have the lowest bone mineral density among ethnic groups,³³ an area of interest for further study would take into consideration ethnicity in the treatment of osteoporosis. Within the research setting, the metropolitan city of Honolulu, resides a multiethnic and largely Asian³⁴ population and thus unique opportunity to examine patterns of disease.

In conclusion, despite the personal and societal consequences of osteoporotic fractures and known treatment for low bone density, osteoporosis is underdiagnosed and under-treated. These findings suggest the need to increase diagnosis and treatment of osteoporosis to meet nationally proposed guidelines.

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Family Centered Rounds: A New Twist on an Old Concept

Lora Bergert MD and Shilpa Patel MD

Department of Pediatrics, John A. Burns School of Medicine, University of Hawai'i

The Committee on Quality of Health Care in America in 2001 focused on patient centered care. Patient centered care was defined as providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.¹ In pediatrics the addition of the family into this concept is vital. In 2003 the American Academy of Pediatrics (AAP) wrote the policy statement, Family Centered Care and the Pediatrician's Role, and recommended that physician rounds occur in the room with the family.² A recent article was published in Pediatrics by the pediatric hospitalist group at Cincinnati Children's Hospital that focused on the concept and implementation of family centered rounds (FCR) at their institution.³ Family centered rounds (FCR) are when the physician team rounds in the hospital room with the patient, family, and nursing staff.

The need for improved interdisciplinary communication is becoming more important throughout medicine. The Accreditation Council for Graduate Medical Education (ACGME) now mandates all residents to demonstrate competence in interpersonal and communication skills.⁴ With increased use of electronic medical records, more medically complex patients, and less resident continuity, there is an increasing need to improve and evaluate interdisciplinary communication. The opportunity to teach and model communication skills starts at the medical student level.

In an effort to examine communication concerns on the pediatric inpatient unit at Kapi'olani Medical Center for Women and Children in Honolulu, a needs assessment survey was administered to nurses and attendings. The needs assessment showed that both attending physicians and nurses had common concerns about communication. The greatest concern among attendings and nurses were the nurses feeling "out of the loop." A majority of the attendings and all of the nurses felt communication challenges delayed discharge. This information led to examining different options to improve communication.

In September 2006, the Pediatric Hospitalist Division at Kapiolani Medical Center for Women and Children adopted the concept of Family Centered Rounds. Previously rounds were held in a conference room where the case was discussed in detail with the ward team. The attending physician would then examine the patient and speak with the family independently. Medical student communication with the family and nursing staff was variable and often not observed by the attending physician or the supervising resident. In the FCR model the team sees the patient together. The process of FCR includes:


- During the initial history and physical examination the intern or medical student explains the process of family centered rounds to the family and gives the family the option of not participating.
 - The medical student or intern sees the patient first in the morning and again talks with the family about FCR. They then discuss the patient and plan with their senior resident during senior work rounds.
 - Introductions are made to the family each day by the team and include writing the names of the physicians and students involved in the case on the white board in the room.
 - Nurses are invited to participate and are paged prior to going into the room.
 - The medical student or intern presents the patient's overnight course, physical exam, and then discusses an assessment and plan that was formulated during senior work rounds.
 - Both the nurse and family are encouraged to participate in the rounds; clarifying terminology and asking questions.
 - Prior to leaving the room the senior resident or attending summarizes in layman's terms the plan of the day.
 - The attending physician often performs their exam while in the room with the team – modeling and teaching physical exam skills.
- In terms of implementation of FCR the hospitalist faculty were concerned about the potential loss of teaching time, length of work rounds, and discussion of sensitive issues with the family/patient present. A 1-hour training session/curriculum around facilitation of FCR was developed and addressed the issues mentioned above. The training session included patient vignettes on DVD from Cincinnati Children's Hospital.
- A protocol for attendings, residents, and students was written to help facilitate the change to FCR. Challenges found during the implementation included timing of rounds, resident team composition, nurse participation, and ease of bringing the computer on rounds. The faculty continues to work to find good solutions to these challenges while facilitating learning for the residents and students.
- After almost a year after the change to FCR, the faculty has found that FCR provides many opportunities to teach. FCR has increased bedside clinical teaching as the team is observing the patient together. The attending physician can observe not only the medical students' knowledge of the case, but their personal communication skills, both with the family and the medical team. Additional teaching can be conducted in the room that includes focus on physical exam skills, evidence based medicine, and general pediatric knowledge. The division emphasizes the use of layman's terms to help families

understand the medical disease and to explain the daily plan for families. Modeling is done by both the resident and attending physicians for the medical student. With FCR, medical students learn from all the patients and from different role models. They also receive immediate and specific feedback regarding patient encounters.

FCR has encouraged the division to broaden its teaching, the incorporation of more modeling for both residents and medical students, and provided opportunities for direct observation. Evaluations are not only for resident or medical student's general knowledge, but their communication skills with immediate feedback can be accurately evaluated. Training physicians to focus on patient centered care that includes the patient/family/physician relationship helps residents and medical students understand the art of medicine.

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Prophylactic HPV Vaccination for the Prevention of Cervical Cancer

Brenda Y. Hernandez PhD, MPH, Cancer Research Center of Hawai'i, University of Hawai'i

Human papillomavirus (HPV) is one of the most common sexually transmitted infections and the major cause of cervical cancer worldwide.¹ In a Cancer Research Center study of over 2,300 adult women in Hawai'i, researchers found that 29% had cervical HPV infection.² While the vast majority of cervical infections clear on their own and never progress into clinical disease, a small number of women who are persistently infected with oncogenic HPV genotypes develop cervical cancer.³ The incidence of invasive cervical cancer in Hawai'i and the rest of the United States has decreased substantially over the past several decades⁴ a trend attributed to increased cytologic (Pap) screening. Each year in Hawai'i, fewer than 70 women are diagnosed with invasive cervical cancer.⁵ Cervical cancer, however, remains the second leading cancer in women worldwide with over 80% of cases occurring in developing countries⁶ where Pap screening is not readily available.

The recent availability of a prophylactic vaccine against human papillomavirus (HPV) has the potential to substantially reduce the incidence of cervical cancer. *Gardasil*, from Merck, is a recombinant, quadrivalent vaccine comprised of virus-like particles (empty viral capsids) of HPV genotypes 6, 11, 16, and 18. HPV 6 and 11 are non-oncogenic types responsible for up to 90% of genital warts.⁷ HPV 16 and 18 are oncogenic types responsible for approximately 70% of cervical cancers worldwide.⁸ A second vaccine, *Cervarix*, from GlaxoSmith-Kline, a bivalent vaccine against HPV 16 and 18, was submitted for FDA approval earlier this year.

Gardasil has been evaluated in randomized, double-blinded placebo-controlled studies conducted in over 20,000 women in 30 countries including the United States. Overall, the vaccine demonstrated 100% efficacy against HPV 16- and 18- related cervical cancer precursors and 99% efficacy against HPV 6/11/16/18-related genital warts.⁹ Protection was limited, however, to women not previously or currently infected with these virus types. Although evaluation of vaccine efficacy was limited to women ages 16-26 years, immunologic bridging studies demonstrated the ability of the vaccine to generate high-titer antibody responses among women ages 9-15 years.

Gardasil was approved for use in the United States in June 2006 and has been recommended by the Advisory Committee on Immune Practices (ACIP) for routine vaccination among young women ages 11-12 years, although vaccination may be given as young as 9 years old at the discretion of physicians.⁹ Catch-up vaccination is recommended for women ages 13-26 who have not yet received the vaccine.

These age-based recommendations are intended to target women before they are likely to have been exposed to HPV. According to national figures, approximately 25% of girls and boys have initiated sexual activity by age 15.¹⁰ HPV is typically acquired soon after initial sexual activity and incident infections peak among women under age 25.¹¹ Even young women who are already sexually active may benefit from vaccination as it is possible that they have

not been infected with all 4 vaccine-covered types. HPV testing is not a prerequisite for HPV vaccination as serologic and DNA-based tests cannot reliably determine genotype-specific infection history. Currently, the only clinically-indicated use for HPV testing is for triage of women with equivocal Pap test results and as an adjunct to Pap tests in women ages 30 years and older.

The long-term impact of HPV vaccines on the incidence of cervical cancer will not be known for at least several decades. Factors that will influence the success of the HPV vaccines include vaccine coverage or the proportion of the eligible population that will be vaccinated and the duration of vaccine-induced immunity. In an ideal scenario where vaccine coverage is 100% and the vaccine-induced immunity lifelong, prophylactic HPV vaccination could theoretically reduce the incidence of invasive cervical cancer by 70%, or the proportion of carcinomas attributed to HPV 16 and 18.

Nevertheless, past experiences of other vaccines teach us that vaccine coverage rarely reaches 100% due to political, economic, logistic, as well as socio-cultural issues, and these may be particularly salient for prophylactic HPV vaccines. Since its release in the United States in 2006, controversy has been stirred in some states and municipalities around the country where school-based mandatory HPV vaccination policies have been proposed. While mandatory vaccination will increase coverage in the population, a number of ethical concerns have been raised including parental autonomy in child health care decisions and the possibility that vaccination for an STD may be a disincentive for abstinence among adolescents. Compulsory HPV vaccination has not been proposed in Hawai'i.

As with other childhood vaccinations, pediatricians and parents will be the major gatekeepers in any voluntary vaccination program. Preadolescents and teens, however, may be particularly difficult to reach with respect to preventive health care. Furthermore, HPV may be a particularly sensitive issue among parents of preadolescents and adolescents because of its sexually transmitted nature. Compliance with the 3-dose vaccination schedule required for full immunologic protection may also be problematic.

Gardasil is expensive to manufacture such that the costs to consumers are not trivial, with the 3-shot series retailing for \$360. Hawai'i's major third-party medical providers have been proactive in promoting access to *Gardasil*. Most of the state's major third-party medical providers cover the costs of the vaccine in part or in full for age-eligible women. The federal Vaccines for Children program covers the vaccine for children up to age 18 without adequate insurance coverage. Access, however, may remain an issue for medically underserved and uninsured women ages 19-26 a group who is also of particularly high-risk for cervical cancer due to low rates of Pap screening.

In addition to vaccine coverage, the second key factor that will determine the long-term effectiveness of HPV vaccinations is the duration of vaccine-induced immunity. The duration of protection against the 4 HPV types (6/11/16/18) covered by *Gardasil* has only

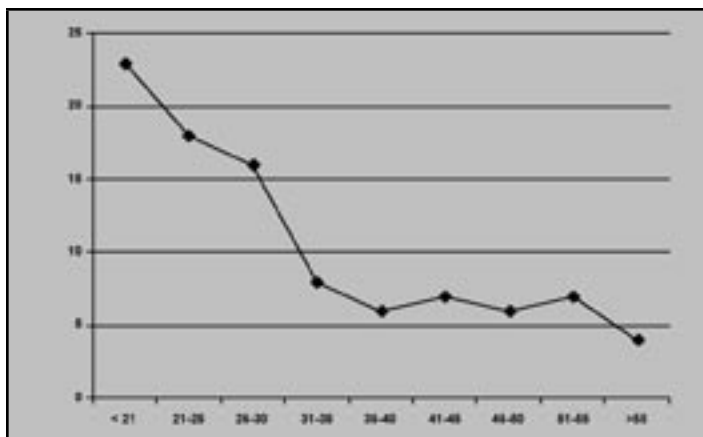


Figure.— HPV prevalence by age, Hawai'i Female HPV Cohort, 1999-2004

been demonstrated up to 5 years.⁹ Invasive cervical cancer typically takes several decades to develop; the average age of diagnosis in the United States is approximately 50 years.⁴ An effective HPV vaccine would therefore induce high antibody titers that are maintained for at least 30 years, if not lifelong. Ongoing clinical trials will continue to evaluate the duration of immunity in order to address key questions regarding vaccine-induced immunity including the need for booster vaccinations. Should booster HPV vaccinations become necessary, issues of access and compliance will be even more critical.

Men are the main source of HPV infection in women. The Cancer Research Center study of men found genital HPV infection in over 50% of adult men at study entry.¹² The efficacy of prophylactic HPV vaccines has not yet been demonstrated in men, although clinical trials are ongoing. Herd immunity would be facilitated by vaccination of men by reducing the transmission of vaccine-covered HPV types to women. This may result in greater reductions in cervical cancer incidence, particularly if vaccine coverage is relatively limited among women.

Prophylactic HPV vaccines have the greatest potential to reduce the morbidity and mortality from cervical cancer in developing countries. Needless to say, the same issues of limited resources and infrastructure that prevent effective Pap screening in these areas will also limit the ability to implement widespread HPV vaccination programs in these countries.

HPV vaccination alone will not eradicate cervical cancer. The current HPV vaccines do not protect against infection with the other oncogenic HPV types that cause 30% of cervical malignancies. Furthermore, condoms do not afford complete protection against HPV infection.¹³ Consequently, comprehensive cervical cancer control programs must continue to include routine Pap screening to detect early cervical neoplasias. It is imperative that women who are vaccinated continue to follow age-specific guidelines for cytologic screening.

HPV also plays an etiologic role in other cancers including 90% of anal cancers, 40% of vaginal and vulvar cancers, 40% of penile cancers, and up to 12% of cancers of the oral cavity and pharynx.¹⁴ Consequently, in addition to its impact on cervical cancers, HPV vaccines have the potential to reduce the incidence of other HPV-associated malignancies in both men and women.

For more information about the Cancer Research Center of Hawai'i, please visit its web site at www.crch.org.

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Issues in Medical Malpractice XIII

S.Y. Tan MD, JD, Professor of Medicine and Adjunct Professor of Law, University of Hawai'i

Question: Mrs. Sonnenberg sustained multiple fractures after her car was struck by a drunk driver. The orthopedic surgeon accidentally nicked her femoral artery during surgery, which resulted in profuse hemorrhage requiring six units of packed red blood cells. Although she survived, Mrs. Sonnenberg was left with irreversible renal failure and she now requires lifelong dialysis. Which of the following are correct?

- A. Drunk Driver is liable for all injuries that resulted from his negligent driving.
- B. Drunk Driver cannot be liable for bleeding and renal complications since he did not cause them.
- C. If surgeon's action is a superseding cause, this would free Drunk Driver from such liability.
- D. Surgeon will be successfully sued for malpractice.
- E. If Mrs. Sonnenberg did not survive the operation, both Drunk Driver and Surgeon could be charged with homicide.

Answer: A and C are correct

Surgeon's mishap will most likely be construed as a foreseeable event, and in law this is said to constitute a concurring, not a superseding, cause. This makes Drunk Driver liable for all injuries including bleeding and renal complications. If Surgeon's "negligence" were deemed to be unforeseeable (it has been stated however, that a doctor's malpractice is always a foreseeable event), then his/her conduct becomes a superseding intervening act, and this will free Drunk Driver from the additional liability arising from Surgeon's negligence. Therefore A and C, but not B, are correct.

Surgeon may be successfully sued for malpractice if the nicking of the artery is shown to be a negligent act. However, Surgeon may well prevail in such a lawsuit. The measure of negligence is what is to be ordinarily expected of a surgeon under the circumstances. There may have been extenuating circumstances such as an obscured surgical field, anomalous anatomy, etc., and Surgeon in this case may have met the duty of due care. A mal-occurrence is not necessarily negligence. D is therefore incorrect.

If Mrs. Sonnenberg died, Drunk Driver will be charged with vehicular homicide. Homicide is an act that causes the death of a person with criminal intent and without legal justification. Driving while drunk amounts gross negligence or reckless disregard, which meets the criminal intent ("*mens rea*") requirement. Surgeon on the other hand would not be so charged, as there was no criminal intent on his part to cause death, and the surgical mishap was at worst ordinary negligence. E is therefore incorrect.

Proximate Causation

There are two types of causation, and the plaintiff must prove both. They are factual cause and proximate cause. Whether the defendant's conduct was a proximate cause of the plaintiff's harm is often at issue

in malpractice litigation. The basic idea behind proximate causation is to show a reasonable causal connection between negligence and harm. In the words of a Court of Appeals of Arizona:

*"A plaintiff proves proximate cause, also referred to as legal cause, by demonstrating a natural and continuous sequence of events stemming from the defendant's act or omission, unbroken by any efficient intervening cause, that produces an injury, in whole or in part, and without which the injury would not have occurred."*¹

The key inquiry in proximate cause analysis is whether the injury was foreseeable rather than remote. If the defendant could not reasonably have foreseen such harm resulting, then the defendant escapes liability. When intervening factors come into play, they create uncertainty over whether there is proximate causation. Suppose D negligently broke the leg of a pedestrian as the result of careless driving. Unfortunately, the injury was worsened by a rescuer's negligence. Because rescuers can be foreseen to act negligently in emergency situations, the aggravation of the injury will most likely be deemed foreseeable. The rescuer's act is said to be a concurring cause, and D becomes liable to the pedestrian for both the original and the aggravated injury.

In a recent Florida case, the District Court of Appeals found several doctors liable in the case of a child whose tuberculous meningitis was missed despite being symptomatic and having seen several different physicians. The Court held that since there were multiple doctors involved, i.e., concurring causes, the plaintiff was entitled to concurring cause jury instruction. The purpose of such instruction was to negate the idea that a defendant is excused from the consequences of his or her negligence by reason of some other cause concurring in time and contributing to the same damage.²

On the other hand, an event may develop between the defendant's act and the plaintiff's injury that breaks the chain of causation. The law does not hold such a defendant liable when an unforeseeable intervening factor has led to an unforeseeable injury. The term used is superseding cause, which is defined as

*"an act of a third person or other force which by its intervention prevents the actor from being liable for harm to another which his antecedent negligence is a substantial factor in bringing about."*³

Suppose an emergency room (ER) doctor missed a fracture on an X-ray, and sent the patient home without benefit of surgical intervention. The next day, the attending physician, upon discovering the error, informed the on-call ER doctor, who was not the original doctor. This second ER doctor unfortunately failed to notify the patient. Did the second ER doctor's negligence free the first ER doctor from liability? In a case presenting with similar facts, the Sixth Circuit Court held that this was a superseding cause relieving the first doctor of liability.⁴

To analyze causation issues systematically, one has to separately identify factual cause issues from proximate cause issues. To make matters worse, the term “legal cause” is sometimes used interchangeably with the term “proximate cause.” And of course, there can be more than one proximate cause for any given injury. Reflecting this complexity, the California Supreme Court now disallows confusing jury instructions regarding proximate cause, suggesting instead that the jury be simply directed to determine whether the defendant’s conduct was a contributory factor in the plaintiff’s injury.⁵

This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is excerpted from the author’s book, *“Medical Malpractice: Understanding the Law, Managing the Risk”* published in 2006 by World Scientific Publishing Co., and available at Amazon.com. You may contact the author, S.Y. Tan MD, JD, at email: siang@hawaii.edu or call (808) 526-9784 for more information.

References

1. *Barrett v. Harris*, 86 P.3d 954 (Ariz. 2004).
2. *Hadley v. Terwilliger*, 873 So.2d 378 (Fl. 2004).
3. Restatement (Second) of Torts §440.
4. *Siggers v. Barlow*, 906 F.2d 241 (6th Cir. 1990).
5. *Mitchell v. Gonzales*, 819 P.2d 872 (Cal. 1991).

HMSA Lawsuit Settlement Alert

HMA’s lawsuit against Blue Cross Blue Shield has resulted in a \$129.2 million settlement. Important things Hawaii physicians need to know:

- You can file a claim for your share of the settlement monies. You must submit a claim form, which will be mailed to Hawaii physicians in July 2007;
- Only HMA members will have the benefit of HMA representation for the enforcement of settlement terms;
- HMA will report to the Compliance Facilitator systemic issues and violation of settlement terms.

For its members only, HMA will liaison with the court appointed Compliance Facilitator to ensure HMSA follows the settlement terms. Members are encouraged to alert the HMA to HMSA actions they believe violate settlement terms.

Settlement terms include:

1. Coding – HMSA is prohibited from automatically reducing the intensity coding of evaluation and management codes billed for covered services;
2. Fee Schedule – HMSA must provide fee schedules to physicians;
3. Medical Necessity – HMSA must allow medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice;
4. Reimbursement for Vaccines and Injectables – HMSA must pay for the cost and administration of recommended vaccines and injectables;
5. Physician Input – HMSA must establish and maintain physician advisory committees of which HMA will appoint four members; and
6. Timely Notice – HMSA must give ninety (90) days’ notice of changes in practices and policies and annual changes to fee schedules.

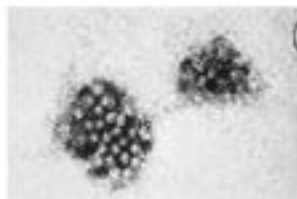
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Prevent and Control Viral Gastroenteritis Outbreaks in your Healthcare Facility

Clinical Presentation

Viral gastroenteritis usually presents as acute onset of vomiting (more common in children), watery non-bloody diarrhea, abdominal cramps, and nausea. Low-grade fever occasionally occurs. Symptoms usually last from 24-60 hours. The most common complication is dehydration, which may require medical attention for intravenous fluids. The agent most commonly implicated are small non-enveloped single-stranded RNA viruses called noroviruses (picture, upper left).

Transmission

Noroviruses are highly communicable and primarily transmitted through the fecal-oral route – either by consumption of contaminated food or water or by direct person-to-person spread. The Centers for Disease Control and Prevention estimate that more than 50% of all foodborne disease outbreaks in the United States are caused by noroviruses.

Diagnostic Testing

Diagnosis of norovirus infection relies on the use of reverse-transcription polymerase chain reaction (RT-PCR) assays. A specimen of walnut-sized (semi-solid) or at least 1 ml (liquid) stool without any preservatives, unmixed with urine, and collected within 7 days of onset is preferred. This testing is available at the Hawaii State Health Department, State Laboratories Division (SLD) and must be requested by calling one of the phone numbers listed below. Bacterial culture to rule out enteric bacterial pathogens should also be requested.

Outbreak Control Measures

- Cohort or isolate symptomatic individuals. Exclude ill staff until 48 hours symptom-free.
- Wear gloves and apron for contact with affected patients and for environmental cleaning.
- Wash hands with soap and water after contact with affected patients or contaminated environment (after removing gloves and apron).
- Clean and disinfect vomit and feces spillage areas with a 5000 parts per million (ppm) chlorine bleach solution (1 and 2/3 cup bleach in one gallon of water).
- Clean and disinfect surfaces like countertops, rails, and doorknobs with a 200ppm chlorine bleach solution (1 tablespoon bleach in one gallon of water).
- Leave bleach on the surface for 10-20 minutes, then rinse with clean water.

Outbreaks of gastroenteritis are reportable events

Report 2 or more cases in your facility to the Department of Health,
Disease Outbreak Control Division

Norovirus gastroenteritis will soon be a reportable condition in Hawaii

Oahu: (808) 586-4586
Maui: (808) 984-8213
Kauai: (808) 241-3563

East Hawaii: (808) 933-0912
West Hawaii: (808) 322-4877

For more information about viral gastroenteritis, visit the Department of Health Website: www.hawaii.gov/health, on the left side click on *Family/Child Health and Contagious Disease*, then click on the *Epidemiology Fact Sheet* link and select *Norovirus*.



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Date	Specialty	Sponsor	Location	Meeting Topic	Contact
August 2007					
8/1-8/4	N	Mayo Clinic College of Medicine	Hapuna Beach Prince Hotel, Kohala Coast	Mayo Clinic Practical 21st Century Clinical Neurology Review	Tel: (480) 301-8323 Web: www.mayo.edu/cme/
8/4	ON	Hawai'i Chapter of the American College of Surgeons	JW Marriott Ihilani	2007 Summer Meeting	Tel: (808) 586-7446
8/4-8/9	Multi	National Medical Association	Hawai'i Convention Center, Honolulu	2007 National Medical Assn. Annual Convention and Scientific Assembly: Collaboration of Health Professionals at the Point of Practice	Web: www.NMAnet.org
8/5-8/11	IM, FM	Keck School of Medicine of USC	Ritz-Carlton Kapalua, Maui	50th Annual Refresher Course in Medicine	Tel: (800) 872-1119
8/9-8/10	Multi	Kaiser Permanente	Ihilani Resort & Spa, Honolulu	6th Annual Pai Symposium	Tel: (808) 432-7931
8/13-8/15	R	Stanford University School of Medicine	Hyatt Regency, Maui	LAVA: Latest Advances in Interventional Techniques	Tel: (888) 556-2230 Web: med.stanford.edu
8/15-8/18	EM	University of California - Davis	Waikoloa Beach Resort & Spa, Hawai'i	Emergency Medicine Update: Hot Topics 2007	Tel: (866) 263-4338 Web: cme.ucdavis.edu
September 2007					
9/7-9/8	ON, SO	Cancer Research Center of Hawai'i	Four Seasons Resort, Hualalai, Kailua-Kona, Hawaii	10th Annual West Hawai'i Cancer Symposium	Tel: (808) 987-3707
9/13	Multi	Grand Hyatt Kauai Resort & Spa	Grand Hyatt Kaua'i	Creating a Healthy Community	Tel: (808) 742-1234
9/14	P	Adult Mental Health Division, Hawaii State Department of Health	Windward Community College	2007 Forensic Mental Health Examiner Training	Tel: (808) 586-4686
9/24-9/29	END	Mayo Clinic College of Continuing Medical Education	Hyatt Regency, Maui	20th Annual Techniques in Advanced Gynecologic, Endoscopic & Laparoscopic Surgery	Tel: (480) 301-4580 Web: www.mayo.edu/cme/
October 2007					
10/6-10/12	PD	University Children's Medical Group	Hyatt Regency Maui Resort, Maui	"Aloha Update" Pediatrics 2007	Tel: (800) 354-3263 Web: www.ucmg.org/cme.html
10/10-10/13	OMF	American Association of Oral and Maxillofacial Surgeons (AAOMS)	Hawai'i Convention Center, Honolulu	89th Annual Meeting & Scientific Sessions	Tel: (847) 678-6200 Web: www.aaoms.org
10/16-10/20	Multi	American Society for Bone and Mineral Research	Hawai'i Convention Center, Honolulu	29th Annual Meeting	Tel: (202) 367-1161 Web: www.asbmr.org
10/17-10/19	Multi	University of California - Davis	Waikoloa Beach Resort & Spa, Hawai'i	27th Annual Current Concepts in Primary Care Cardiology	Tel: (916) 734-5390 Web: cme.ucdavis.edu
10/18-10/20	GE	Stanford Hospital & Clinics	Mauna Lani Bay Resort, Kohala Coast	GI Cancers	Tel: (650) 724-7166 Web: www.cme.stanfordhospital.com
10/19-10/21	Multi	Guam Memorial Hospital	Hyatt Regency, Guam	3rd Micronesian Medical Symposium	Tel: (671) 647-2349 Web: www.micronesianmedical-symposium.org
10/20-10/24	ORS	Orthopaedic Research Society	Hawai'i Convention Center, Honolulu	6th Combined Meeting of the Orthopaedic Research Societies	Tel: (847) 698-1625 Web: www.ors.org

10/22-10/27	GYN	Mayo Clinic College of Continuing Medical Education	Hyatt Regency, Maui	20th Annual Techniques in Advanced Gynecologic, Endoscopic & Laparoscopic Surgery	Tel: (480) 301-4580 Web: www.mayo.edu/cme/
10/28-11/2	R	University of California, San Francisco	Hyatt Regency Resort & Spa, Maui	Diagnostic Radiology Seminar	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
November 2007					
11/8-11/10	Multi	Mayo Clinic College of Continuing Medical Education	Grand Hyatt Kauai Resort & Spa, Koloa, Hawai'i	Parkinson's Disease and Other Movement Disorders for the Practitioner, 2007	Tel: (480) 301-4580 Web: www.mayo.edu/cme/
11/10-11/13	Multi	American Medical Association	Hawai'i Convention Center, Honolulu	AMA Interim Meeting	Web: http://www.ama-assn.org/
January 2008					
1/13-1/18	R	University of California, San Francisco	The Fairmont Orchid, Kona	Breast Imaging in Paradise	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
1/19-1/21	Multi	Pan-Pacific Surgical Association	Sheraton Waikiki, Honolulu	28th Annual Congress: Connecting Surgeons Throughout the Pacific	Tel: (808) 941-1010 Web: www.panpacificsurgical.org
1/20-1/25	R	University of California, San Francisco	The Fairmont Orchid, Kona	Body Imaging in Paradise	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
1/21-1/25	AN	California Society of Anesthesiologists	Hyatt Regency Maui Resort & Spa, Ka'anapali Beach, Maui	CSA Hawaiian Seminar	Web: www.csaqh.org
February 2008					
2/6-2/9	Multi	Society of Laparoendoscopic Surgeons	Hilton Hawaiian Village, Honolulu	Asian-American MultiSpecialty Summit III: Laparoscopy and Minimally Invasive Surgery	Tel: (800) 872-1119
2/9-2/15	OBG	Keck School of Medicine of USC	West Maui, Maui	Perinatal Medicine 2008	Tel: (800) 872-1119
2/16-2/19	OTO, HNS	Tripler Army Medical Center and the University of California, San Francisco	Hilton Hawaiian Village, Honolulu	Pacific Rim Otolaryngology - Head and Neck Surgery Update	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
2/17-2/22	R	University of California, San Francisco	The Fairmont Orchid, Kona	Neuro and Musculoskeletal Imaging	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
2/17-2/22	IM	University of California, San Francisco	Grand Hyatt, Kaua'i	Infectious Diseases in Clinical Practice	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
2/21-2/26	GE	Keck School of Medicine of USC	Kaua'i Marriott Resort, Kaua'i	Medical and Surgical Aspects of Esophageal and Foregut Disorders: Pathophysiology and Treatment	Tel: (800) 872-1119
March 2008					
3/30-4/4	IM	University of California, San Francisco	Wailea Beach Marriott Resort & Spa, Wailea, Maui	Primary Care Medicine: Update 2008	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
May 2008					
5/2-5/6	PD	Pediatric Academic Societies	TBA	Annual Meeting 2008	Tel: (281) 419-0052 Web: www.pas-meeting.org

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THE WEATHERVANE

RUSSELL T. STODD MD, CONTRIBUTING EDITOR



Russell T. Stodd MD

❖ BEING GOOD DOES NOT ALWAYS PAY OFF, AND THERE IS NO COMPENSATION FOR MISFORTUNE.

Bausch and Lomb is a Rochester, N.Y., medical company first organized in 1853 by two German immigrants, John Bausch and Henry Lomb. They opened a business dealing in optical equipment. Today the company has grown into a major ophthalmic supplier employing 13,000 people. In recent years the company has been heavily into contact lenses and various solutions as well as fixed implements. The company stock traded at more than \$80/share in 2005, but then was shocked by the disclosure of fungus infections implicating B&L solutions.

Sales dropped 21% in 2006, and share prices dropped to \$41.20 but have partially rebounded. Now this solid old company is stumbling badly and the directors have agreed to sell to a private equity firm *Warburg Pincus*. Pretty sad to see an ancient stalwart forced out of the business by mold.

❖ CATCH 22, OR DAMNED EITHER DIRECTION.

In Boise, Idaho, a mother brought her 5-week-old daughter to the hospital emergency department with a temperature of 101.3 F. The ER doc feared a bacterial infection of meningitis and planned a spinal tap, consistent with the hospital's standard of care. The mother refused the procedure believing that it was too risky. The doctor called the hospital social worker, who called the police, who took possession of the baby, and the spinal tap was accomplished (it was negative). Now the parents are suing the doctor, the hospital, the social workers, and the police for depriving them of their constitutional right to make a medical decision for their child. I smell a lawyer in the background looking for an easy settlement.

❖ HAVE SOME VICODIN! IT'S NO MORE ADDICTIVE THAN ASPIRIN. NOT!

It was the largest drug-company criminal settlement in history when Purdue Frederick Co. and three executives agreed to pay \$634.5 million for misbranding OxyContin with the intent to defraud and mislead the public. According to US Attorney John Brownlee, the drug was promoted as less addictive and less likely to be abused than it really is. Moreover, the sales force was trained to inform physicians and pharmacists that it was difficult to extract oxycodone, the active ingredient, for purposes of abuse. Naturally, these three drug pushing executives, CEO Michael Friedman, General Counsel Howard Udell and former Chief Medical Officer Paul Goldenheim will simply pay fines and none will do jail time; never mind the lives and careers disrupted or destroyed by the addiction these three overpaid hot shots promoted. Only small time distributors do jail time.

❖ ANOTHER ATTACK OF POLLSTERGEIST.

A survey conducted by PNC Financial Services Group determined that almost one-third of health care dollars are spent on the bloated error-prone claims processing system in this country. Twenty percent of claims are denied or delayed, and a massive 96% must be submitted more than once, according to the 200 hospital executives and 1,000 consumers who participated in the study. Twenty-five percent of consumers claimed that their health plan denied coverage of a legitimate claim, and one in five of that group ultimately paid the bill out of pocket. Is this system screwed up, or what? And how long are physicians going to continue working in this swamp of paper?

❖ THE SEARCH FOR SOMEONE TO BLAME IS ALWAYS SUCCESSFUL.

A physician in Massachusetts allegedly discharged a diabetic patient from the hospital without warning him about the dangers of hypoglycemia. About 45 minutes after leaving the hospital he became unconscious as a result of low blood sugar, lost control of his car and struck a man riding

a motorcycle. The injured man is suing the physician for negligence. The physician asked the court to dismiss the lawsuit because he did not have a physician/patient relationship with the motorcyclist and did not owe him a duty of care. The judge denied the motion and ruled that there was a "special relationship" and the lawsuit should go to trial. To date, five states, Missouri, Texas, Iowa, Kansas, and Florida have refused to impose a "special relationship" while three states, California, Michigan, and Delaware ruled that the physician has such a duty. The issue could be analogous for eye surgeons – what is the doctor's duty in insuring highway safety when a patient has failing eyesight? And most importantly, carefully document any warnings or special instructions.

❖ CHOOSING A POLITICIAN IS DECIDING BETWEEN THE DISASTROUS AND THE UNPALATABLE.

In sorting out the two major parties' potential nominees, it is hard to exaggerate the hypocritical "man-of-the-people" factor – Mitt Romney, net worth \$250 million with a different political jacket for every gathering, or Rudy Giuliani who is averaging a million dollars per month on the speaking circuit, or John Edwards who invests in Cayman Islands assets which he attacks from the podium, or the Billary ticket where she was advanced \$8 million on her next book and Bill was advanced \$10 million for his. Oh, the suffering of poor Barack Obama whose estate is a mere \$1 million. John Edwards, the tort lawyer probably takes the blue ribbon four-flusher award. He has now been enriched to an estimated \$40 million, built a \$5 million 102 acre estate, was paid almost \$500,000 as a consultant (and investor) with a Cayman Islands hedge fund of sub prime mortgage lenders while he runs his campaign on helping the down trodden working man. What a guy!

❖ NOW YOU CAN BE ALL YOU ARE CRACKED UP TO BE!

The Roxbury Spa in Beverly Hills is now offering the "Butt Facial." Yes, you can call for an appointment and have your neglected heinie polished, de-blemished, massaged, toned-up and glamorized. It begins with a vigorous scrub followed by action with the cellulite-reducing machine, then a bottom-bra is applied. In some cases a little tissue extraction may help to leave customers with firm, mobile and gorgeous cheeks. Cost: \$650 to \$800. I couldn't make this up.

❖ TALK IS CHEAP BECAUSE THE SUPPLY EXCEEDS THE DEMAND.

The relative peace and tranquility of air travel with a welcome hiatus from ground-bound business is likely to end within twelve months. US airlines will soon offer in-flight internet connections with text-messaging and e-mail. Moreover, airborne cell phone chatter will likely come along as well despite the Federal Communications Commission (FCC) claim that it will keep a ban in place. The FCC has already auctioned off radio spectrum for cell phone use on aircraft.

❖ THESE STUDENTS ARE NOT COMPLETE IDIOTS. SOME PARTS ARE MISSING.

The University of Minnesota campus newspaper reported that some students who donated blood to the local blood bank, promptly headed for the nearest bar after the needle was removed. Supposedly, the relative anemia made the blood alcohol concentration (BAC) considerably more potent. "The rest of the night is a real turn on," or possibly even a turn off.

ADDENDA

- ❖ The department of Veterans Affairs sends a monthly check to 124,000 veterans to care for their hemorrhoids.
- ❖ In Singapore an increasingly popular cosmetic procedure is plucking the eyebrows and tattooing a new artistically curved brow.
- ❖ The average desk top has more bacteria than any surface in the bathroom. Toilet seats and photocopier surfaces were the least contaminated sites in all offices tested.
- ❖ A fanny fetish is perilously close to asphyxiation.

ALOHA AND KEEP THE FAITH — rts■

Contents of this column do not necessarily reflect the opinion or position of the Hawai'i Ophthalmological Society and the Hawai'i Medical Association. Editorial comment is strictly that of the writer.

OLA PONO IKE

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