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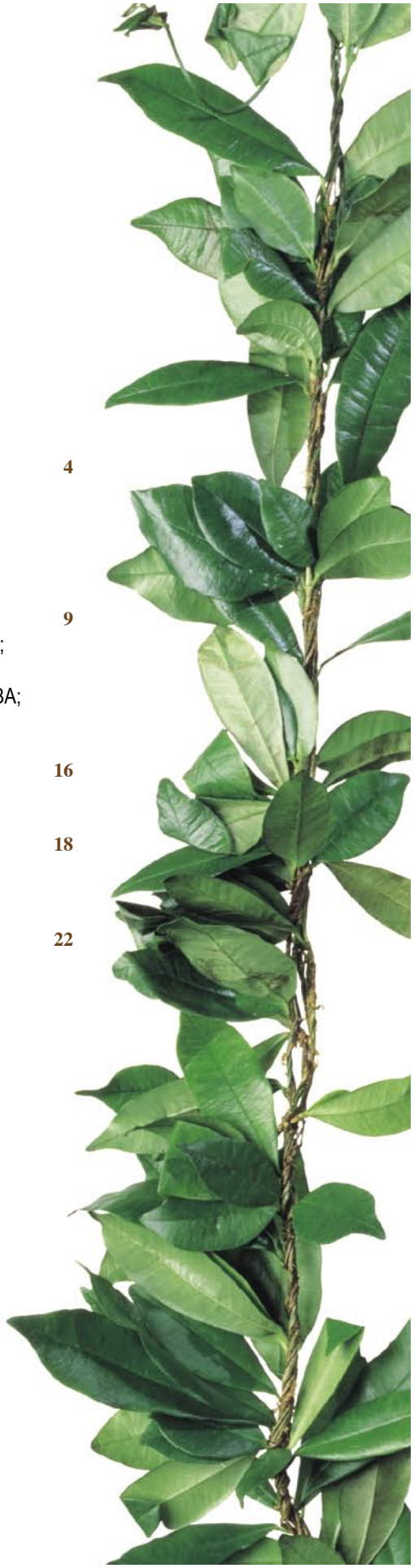

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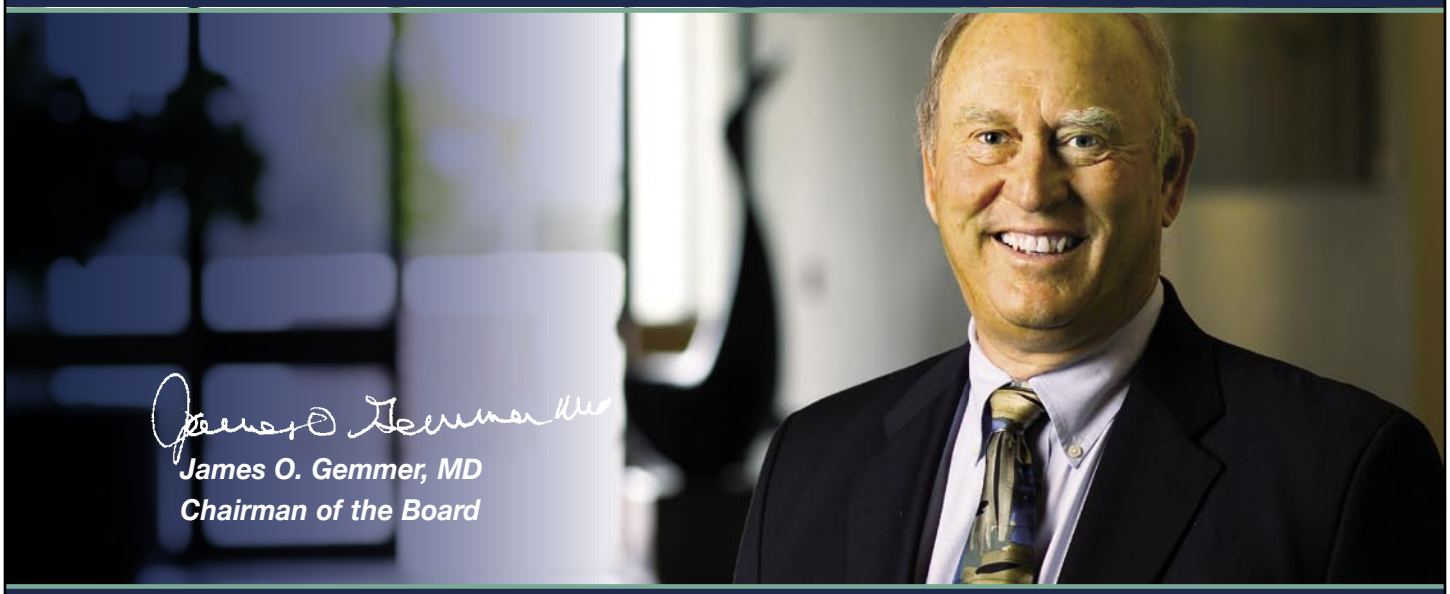

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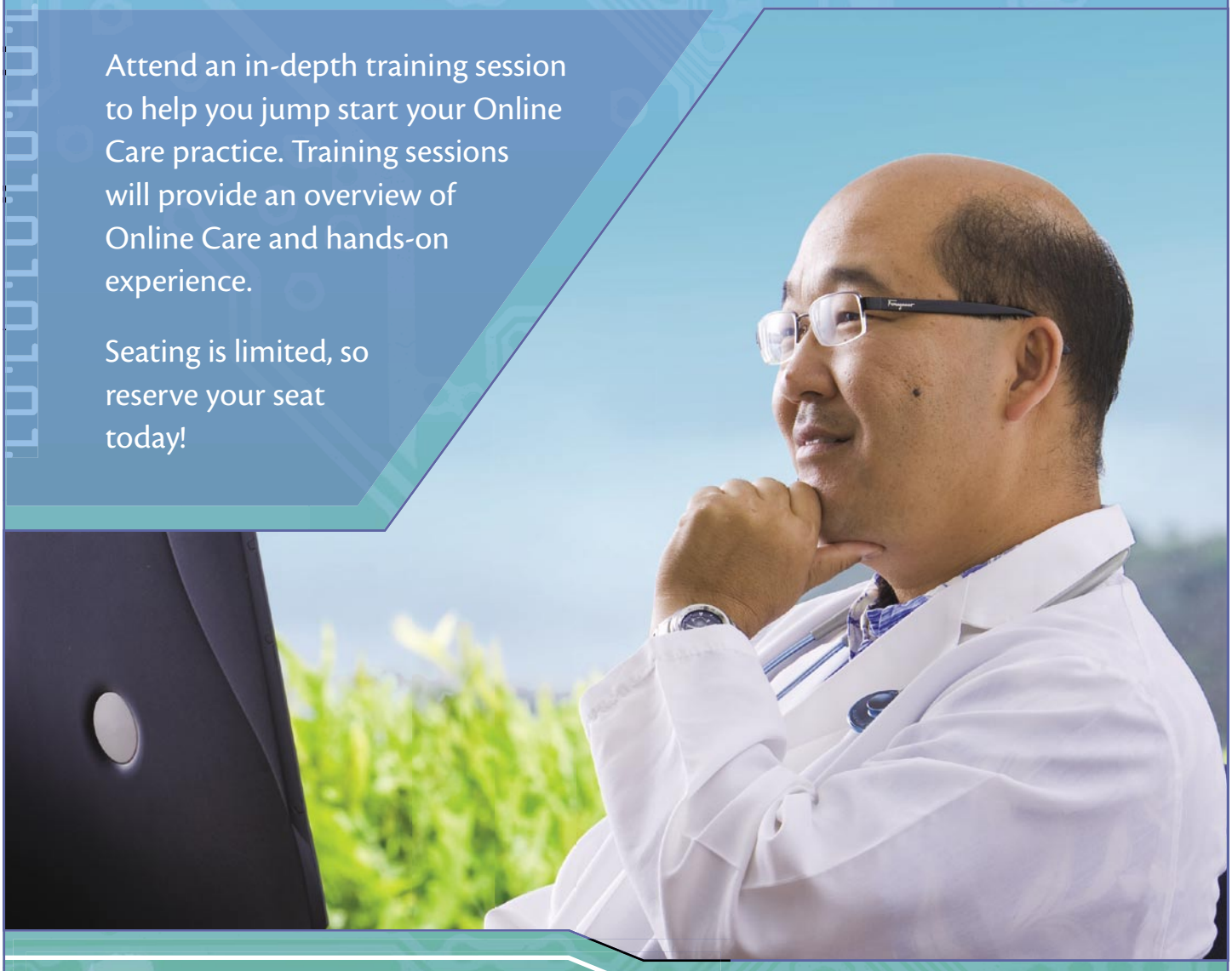

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A Center for Self-Management of Chronic Illnesses in Diverse Groups

Jillian Inouye PhD, APRN; Mary G. Boland DrPH, RN, FAAN; Claudio R. Nigg PhD; Kathleen Sullivan PhD, RN; Anne Leake PhD, APRN-Rx; Debra Mark PhD, RN; and Cheryl L. Albright PhD

Abstract

Prevention and successful treatment of chronic disease require a scientific understanding of the impacts and interactions of ethnicity, culture, and illness on self-management interventions. This article presents one approach to developing effective methods to address the needs of ethnic minorities living with chronic illnesses. Described is the University of Hawai'i Center for 'Ohana Self-Management of Chronic Illnesses (COSMCI) located in the School of Nursing & Dental Hygiene and funded by the National Institute of Nursing Research (Award Number P20NR010671). The interdisciplinary center focuses on family and community self-management interventions in ethnically diverse populations with chronic illnesses. Areas discussed are: 1) the operational structure for creating an environment conducive to interdisciplinary 'ohana self-management chronic illness research in ethnically diverse populations; and 2) the development of sustainable interdisciplinary, biobehavioral research capacity. The COSMCI uses a social cognitive theory framework to guide the application of established self-management interventions to Asian and Pacific Island populations (API) through three conceptually linked research projects on HIV infection, type 2 diabetes, and chronic obstructive pulmonary disease. COSMI addresses the feasibility of sharing of lessons learned among the approaches taken. The interdisciplinary nature of COSMCI increases the potential success of the intervention efforts.

Introduction

Data indicates that Asian and Pacific Islanders (API) are at increased risk of chronic illness. As theoretical understanding of self-management increases and standard interventions emerge, there is a need to ensure that such interventions are both effective and culturally competent across populations and, when necessary, to modify them. Few studies currently exist on self-management strategies specifically focusing on API ethnic subgroups. The Center for 'Ohana Self-Management of Chronic Illnesses (COSMCI) is one of three Exploratory Centers on Self-Management funded by the National Institute of Nursing Research (NINR). The interdisciplinary Centers provide the venue for such research via their ability to provide access to research interventions for ethnic minorities with chronic illnesses. This article describes the University of Hawai'i (UH) Center's effort to develop effective intervention strategies that address the chronic health needs of ethnic minorities.

The UH responded to NINR's request for proposals to develop exploratory centers focusing on self-management in chronic illness. The requirement for applicants to have at least one RO1 (Established Investigator) type funding in the area of self-management was met by the School of Nursing and Dental Hygiene's (SONDH) active NINR funded project studying self-management in persons with type 2 diabetes (T2D). The UH submitted an application to establish COSMCI and received funding for 5 years. The unique contribution of the Center is the focus on interdisciplinary research and translation provided by the core co-investigators and co-leaders of the participating units: nursing, psychology, public health, and medicine.

Hawai'i's Population and Chronic Illness

The 2008 Hawai'i Health Survey (N = 16,895) ranked self-reported chronic conditions from highest to lowest prevalence in this order: high blood cholesterol, hypertension, asthma, arthritis, and diabetes.[1] Native Hawaiians had the highest vulnerability for chronic conditions and were significantly higher than all other ethnic groups in prevalence of obesity, asthma, and diabetes. Based on CDCs 2008 Behavioral Risk Factor Surveillance System data, a low percentage of Native Hawaiians were diagnosed with coronary heart disease (3.1%) and diabetes (8.2%) whereas a high percentage of Hawai'i's population engaged in regular exercise (80.4%) and identified themselves as non-smokers (84.6%).[2] Despite these health indicators, Asian and Pacific Islanders (API), comprising the majority of Hawai'i's population (51%), were more at risk for developing and dying from cancer, heart disease, and diabetes than the general US population. A recent sample of adult members of a health plan in Hawai'i (n=119,563) found Asians were more likely to rate their health as poor compared to Caucasians, Samoans, and Native Hawaiians.[3] The latter group also had the highest rates of obesity.

Significance of the Center

COSMCI provides the venue for research via the ability, experience and success in recruiting and retention of ethnic minority subjects in research protocols. Figure 1 presents prevalent chronic conditions by ethnicity. These patterns point to important differences among the API subgroups and exemplify the importance of determining which chronic illness health disparities impact which ethnic populations.

The COSMCI addresses the NIH Roadmap, by supporting interdisciplinary research that integrates the biological sciences with the behavioral or social sciences, and the two overarching goals of Healthy People 2010 to increase quality and years of healthy life and eliminate health disparities.[4] In conducting research on appropriate self-management interventions for diverse populations with chronic illnesses, the conceptual model presented in Figure 2 and a collaborative, interdisciplinary approach that typifies Hawai'i's cultural values, guide the Center's efforts.

Methods

Infrastructure Development

Within the SONDH and the Manoa campus, the COSMCI functions as the focal point for self-management research by expanding the breadth and depth of available resources. The infrastructure development to increase the quantity and quality of research projects aimed at improving self-management in diverse populations with chronic illness is supported by the Dean and the Vice-Chancellor for Research and Graduate Education.

COSMCI focuses on increasing understanding of the application of established self-management interventions to API populations. Studies employ comparable measures to create a Center database available for sharing with investigators in self-management research.

The initial projects use social learning theory as the framework to address self-management in HIV infection, T2D, and COPD which are prevalent in Hawai'i. Figure 2 outlines the concepts and methods.

The goals of the COSMCI program mesh well with the vision of the SONDH Research Strategic Plan, to "focus on research that advances the health of diverse populations in our region," and core commitments, "specific research emphasis on family health promotion and disease prevention throughout the life cycle, health disparities/inequities, community health including disaster preparedness, chronic illness, health professions education and healthcare policy." The emphasis of the Center on self-management provides faculty and graduate students interested in health promotion and chronic disease management with access to archived methods and tools. Further, the activities of the Center strengthen existing relationships with the community health centers and schools within UH.

Center Organization and Specific Aims

Activities of the group are implemented through the Administrative Core comprised of the project leaders and funded staff. Within this core are sub-cores for research and evaluation respectively. Figure 3 illustrates the operational structure of COSMCI.

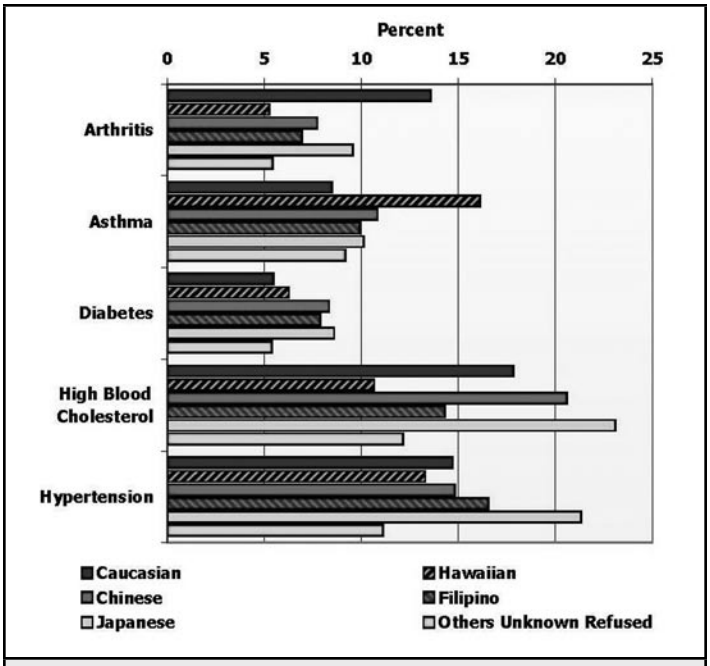

Figure 1. Chronic Health Condition Prevalence by Ethnicity, Hawai'i Health Survey, 2008[1]

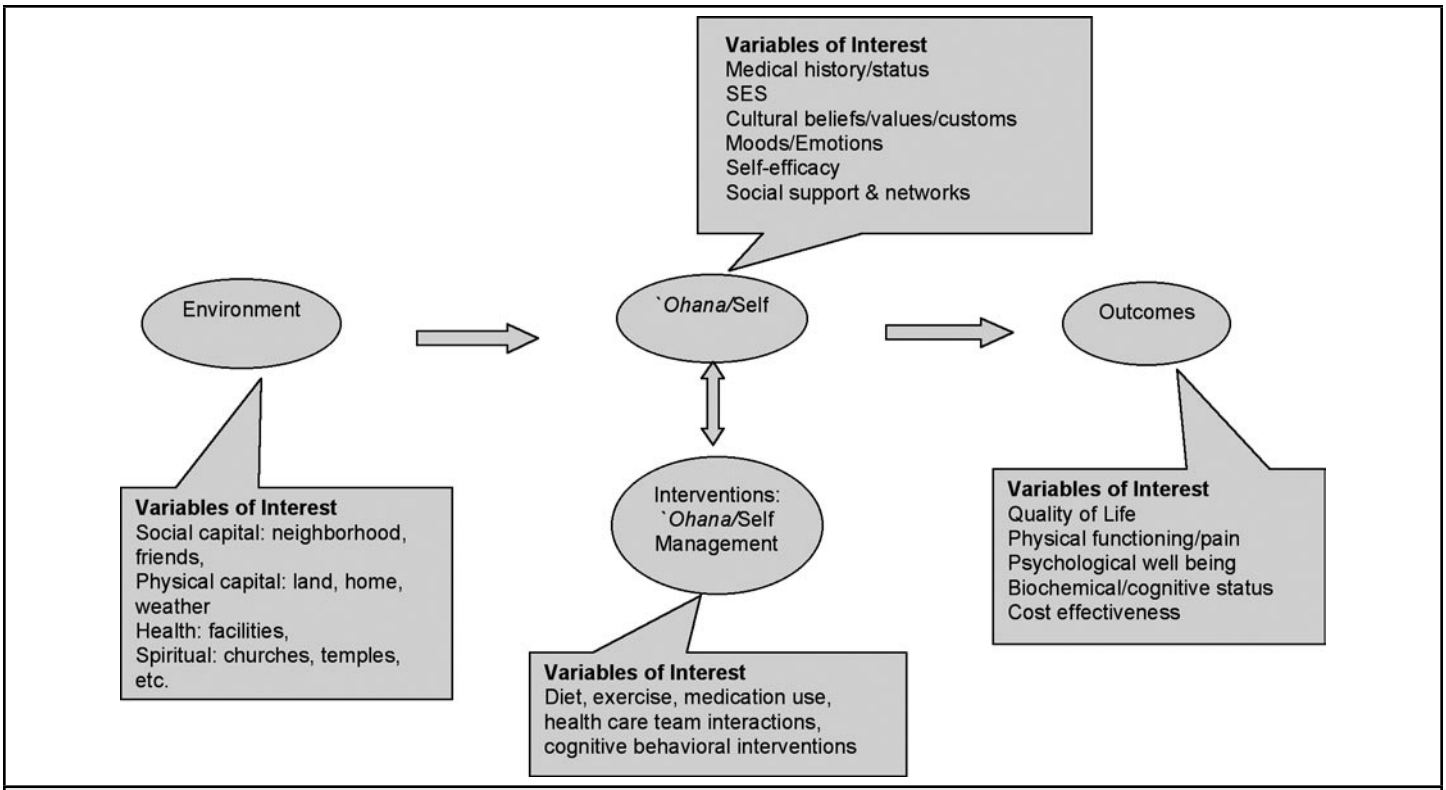

Figure 2. COSMCI Conceptual Framework

External Advisory Committee

The External Advisory Committee (EAC) provides overall guidance to the COSMCI. Committee members were selected based on expertise in self-management research, their role in the community and their strong history of collaboration. The EAC consists of renowned national scientists with expertise and experience relevant to the COSMCI's scientific program and several scientific members of the Hawai'i community involved in self-management research. They include two physicians, a nurse-physiologist, a nurse-certified diabetes educator, and two psychologists. The Committee meets in person annually with conference calls as necessary. The committee: 1) provides guidance and counsel to the Executive Committee; 2)

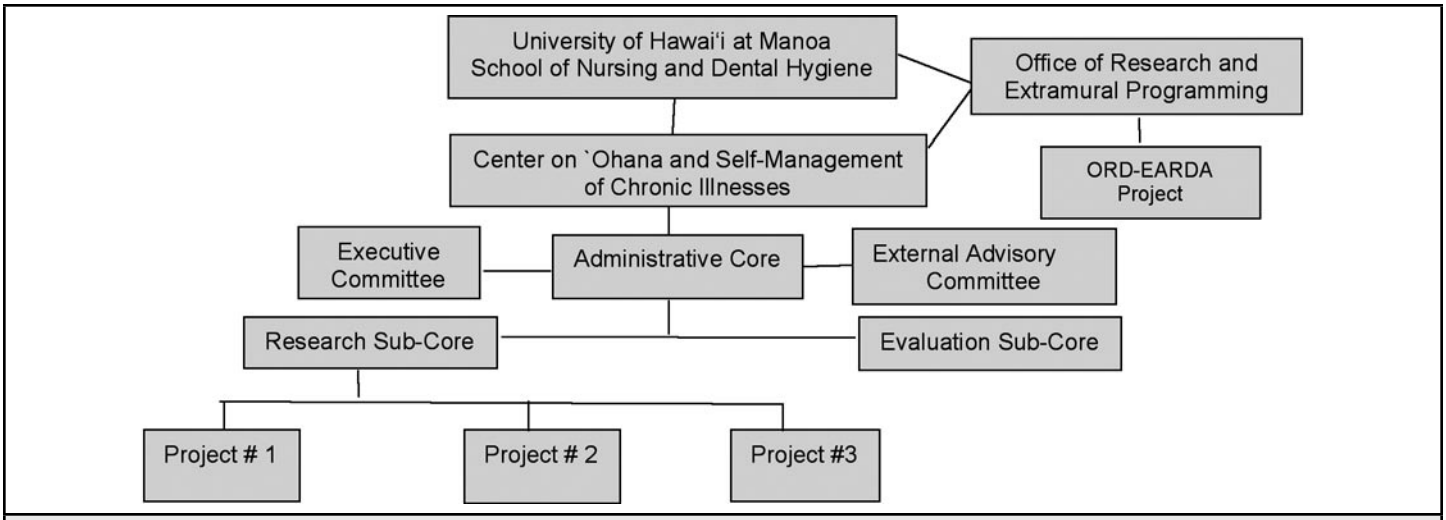

Figure 3. COSMCI Operational Structure

reviews the Center annual report and recommends strategic direction and/or course correction; 3) collaborates with the executive committee to develop an equitable and fair process for project funding; and 4) participates actively in the Center evaluation process.

Executive Committee

The Executive Committee (EC) is responsible for the operations of the COSMCI, including resource allocation, research strategies, evaluation, and dissemination. They maintain oversight of the solicitation, review, and selection of all research projects. Membership includes the Administrative Core/Center Director (PI), the Center Co-Director, sub-core leaders, and SONDH Director of Operations (business official). These key personnel represent nursing, public health, and the Cancer Research Center of Hawai'i, to bring complementary expertise to the Center. Collectively, they have a history of collaborating with each other on grants. Each individual brings skills including NIH program background, management in a large health care system, and administrative access in the university system. The commitment to creating a sustainable center guided the effort to develop the conceptual framework, proposal narrative, budget, and strategy for the administrative core.

Administrative Core

The Administrative Core (AC) develops, coordinates and assures seamless integration of the Center efforts to achieve the mission and specific aims. The AC developed the COSMCI's infrastructure, coordinates activities of the academic and community partners, and assures external evaluation of the Center. The AC experience and expertise in research, education, and grant administration within the University of Hawai'i provides the management of the Center.

The aims of the AC are to: 1) develop and coordinate the Center's long and short-term activities; 2) optimize utilization of shared resources of the Center; 3) promote networking and collaboration with the larger research community; 4) establish and maintain communication with EC, EAC, research projects, and other entities; 5) publicize and disseminate activities and study results by publicizing the Center's activities through the web page, electronic newsletter, and other means; 6) in conjunction with the evaluation core, assist with the evaluation plan; and 7) plan for sustainability of the Center once support is completed, including development of collaborations and seeking NIH and other support.

Research Sub-Core

The goal of this sub-core is to guide the research capacity development within the Center, university, and community partners. The research sub-core facilitates research activity through mentoring and coaching of researchers, refining the conceptual framework for self-management, and management of interdisciplinary research training. The aims of the research sub-core are to: 1) maintain oversight of the solicitation, review, selection, and support of all projects; 2) collaborate with the evaluation sub-core to review the COSMCI's research activities and adherence to the aims and objectives; 3) support research and training activities related to self-management; and 4) serve as the resource center on research related to 'ohana and self-management.

Evaluation Sub-Core

The Center project evaluation uses the evidence collected for the first three center aims. The evaluation sub-core: 1) monitors the quantity of 'ohana and self-management research conducted in the state; 2) monitors and documents the development of sustainable research capacity relevant to 'ohana and self-management of chronic illnesses; and 3) monitors the dissemination and translation of knowledge obtained from project studies. The Center components and project specific studies are monitored through periodic progress reports. These progress reports are based on the components included in the logic model for each center component and for each project specific study. In addition, this sub-core developed and monitors the Center evaluation plan including an ongoing assessment of early outcomes.

Center Research Projects

The three funded research projects utilize the COSMCI theoretical framework but focus on different 'ohana or self-management areas and illness categories. The specific illnesses include HIV infection, T2D, and COPD. Standardized tools are used for each study including the SF-36 and the Self-Efficacy for Managing Chronic Disease (S-EMCD). This approach contributes to the larger COSMCI aims

by increasing the pool of data for multiple chronic illnesses across ethnic groups. This is a unique collaboration, which highlights the communication among the research project directors and the COSMCI to fulfill the larger objectives. Partnering with senior faculty from other disciplines addresses NIH's Roadmap initiative of interdisciplinary and mentored science.

Self-Efficacy and Self-Management of Symptomatic HIV/AIDS A Pilot Study. The objectives of this pilot study are to: 1) deliver to a sample of symptomatic HIV-seropositive clients residing in Hawai'i, a group educational program for chronic disease self-management entitled, Positive Self-Management Program For HIV [PSMP]; 2) test the feasibility and efficacy of the PSMP within an ethnically diverse HIV seropositive population; and 3) measure the effects of the PSMP on a variety of physical, psychological and behavioral indicators.

Kalusagan ay Kayamanan (Health is Wealth)
The three objectives for this project are to: 1) develop an innovative culturally tailored lifestyle intervention for Filipino-Americans to reduce the risk of developing T2D; 2) test the feasibility of this lifestyle intervention which incorporates flexible scheduling of the curriculum on weekends to accommodate working adults; 3) assess the efficacy of this lifestyle intervention by gathering preliminary data to inform a fully powered study.

COPD Self-Management: A Breathing Pattern Retraining Intervention with an Interactive Telecommunication System among People with COPD
The aims of the study are to: 1) explore the feasibility of an interactive telecommunication system to reinforce the self-management intervention; 2) compare a structured pursed-lips breathing self-management intervention for dyspnea reduction, increased physical activity, and improved health-related quality of life (HQOL) to a wait-list control group; 3) examine if self-efficacy predicts changes in dyspnea, physical activity, and HQOL.

Center Synergy
The individual proposals included within COSMCI are logically related on several levels and the represented chronic diseases provide breadth to the research. The interventions are delivered through varying modes with the ultimate outcome of sustainability and dissemination in mind (see Table 1). One project implements a peer/lay led education model where the information is disseminated to the participants through peers or lay leaders; one utilizes a tested model for self-management in a different population; and one project involves technology as the main mode (i.e., web technology) of intervention. Each project includes the general multicultural population from Hawai'i or a specific minority group (e.g., Filipino). Primary care providers play a key role in the recruitment of participants from their patient population for one of the studies. Other studies include community participants with no linkage to their primary care providers. All projects are feasibility studies, and preliminary data collection indicated no clinical issues for health care providers. In the event of any untoward findings, the participants will be referred to their care providers. Other impacts on providers are not anticipated as the cost and time impact on the primary care provider is negligible.

Additionally, all intervention approaches utilize the social cognitive model that facilitates measurement of the same concepts across interventions (e.g., self-efficacy). In terms of outcomes, all projects are addressing feasibility issues allowing lessons learned to be shared among the approaches taken, and all projects will assess their interventions' impact on quality of life.

Table 1. Summary of Research Projects

Chronic Disease	Modes of Delivery	Population	Common Outcome Measures
T2D	Peer/Lay led	Filipino	SF-36, S-EMCD*
COPD	Computer	Mixed	SF-36, S-EMCD
HIV/AIDS	Peer/Lay led	Mixed	SF-36, S-EMCD

*Self-Efficacy for Managing Chronic Disease 6-Item Scale

Results and Discussion

Successes to date include development of learning opportunities coordinated by COSMCI and offered to interdisciplinary faculty, students, community agencies, and collaborating organizations. Within UH, COSMCI is one of a few funded health sciences research venues where faculty and students in at least four disciplines interact, collaborate, and learn together. The community-focused research may increase patients' participation in their own care. As pilot studies recruited or will recruit primarily from churches, self-help groups, and non-profit organizations, the impact on the workload of primary care physicians are not excessive. To apprise them of their patient's participation, one study has pre- and post-intervention biometric measures written in one of the workbooks so participants can share results with their health care providers.

The learning opportunities for those in academia include journal clubs, training sessions, research colloquia, and symposiums open to all faculties in the university. A writing group facilitates dissemination of activities, which includes input from a Native Hawaiian organization representative. COSMCI efforts led to a diversity supplement to enrich and expand one of the pilot research projects. The greatest impact is the interdisciplinary nature of the projects and core faculties and associates, which have added richness to the center. In concert with these efforts, the Center members submitted a joint research grant on a topic central to self-management (obesity) and are awaiting the funding decision. Thus, the Center is building UH capacity for health sciences research that crosses the boundaries of schools and disciplines.

Plans for the Future
The stakeholders and Center's experience will inform the sustainability of COSMCI. Components of a sustainability plan include, but are not limited to: a) institutional commitment; b) Center membership and maintenance of structures; c) growing the individual faculty research programs started from the P20 projects; d) increasing dissemination; e) diversifying support; and f) progression to a larger funded center of excellence.

The nature of the interdisciplinary efforts has increased the potential for success in these efforts. For example, physicians can refer patients to the projects. Findings will inform the structure and operation of the medical homes of the future including referring patients with chronic illness to community-based self-management programs. If larger studies develop from these pilot investigations, physicians and other health care workers could be involved with recruitment for the community study sites where their practices are located.

Summary

This paper describes the first two years of UH experience in developing an interdisciplinary research center focused on self-management of chronic conditions. This first phase focused on building organizational capacity and establishing community relationships. While each research project addresses a distinct chronic condition, the use of social cognitive theory as the conceptual framework and common data measures supports the self-management focus. Future reports will describe the results of the projects, experience with research capacity building, and sustainability.

Acknowledgments

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Authors' Affiliations:

- University of Hawai'i at Manoa School of Nursing & Dental Hygiene,Honolulu, HI, 96822 (J.I., M.G.B., K.S., A.L., D.M.)
- Department of Public Health Sciences, John A. Burns School of Medicine, University of Hawai'i at Manoa, Honolulu, HI, 96813 (C.R.N.)
- Cancer Research Center of Hawai'i, Honolulu, HI, 96813 (C.L.A.)

Correspondence to:

Jillian Inouye PhD, APRN
University of Hawai'i at Manoa School of Nursing & Dental Hygiene
2528 McCarthy Mall, Webster Hall 402, Honolulu, HI, 96822
Ph: (808) 956-8522; Fax: (808) 956-3257; Email: jinouye@hawaii.edu

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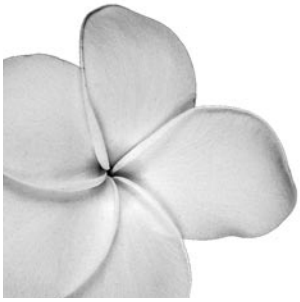

Responding to the Needs of Culturally Diverse Women Who Experience Intimate Partner Violence

Lois Magnussen EdD, APRN; Jan Shoultz DrPH, APRN; Karol Richardson PhD, APRN; Mary Frances Oneha PhD, APRN; Jacquelyn C. Campbell PhD, RN, FAAN; Doris Segal Matsunaga MPH; Selynda Mori Selifis; Merina Sapolu; Mariama Samifua BA; Helena Manzano MSW; Cindy Spencer BA; and Cristina Arias BA

Abstract

This paper presents the findings from a community based participatory research (CBPR) study that investigated the interface between culture and intimate partner violence (IPV) for women in selected cultural groups in Hawaii: Native Hawaiian, Filipino, Samoan, and Chuukese. The research question was, "What are the cultural perceptions, responses, and needs regarding IPV of selected individuals and groups served through a variety of programs that are affiliated with the three participating Community Health Centers (CHCs)?" This cross sectional, descriptive study collected both qualitative and quantitative data. Individual interviews were conducted with women who had experienced IPV. Focus groups were also conducted with other women from the same culture. Five common themes were identified across the four cultural groups: Living within a Collective; Cultural Protective Factors; Cultural Barriers to Helpseeking; Gender Specific Roles; and Belonging to a Place. The outcome from this study is increased knowledge that will be used to develop culturally appropriate interventions. Specific findings from each cultural group have been published.[1-4] The purpose of this paper is to present common perceptions and responses to IPV from the four groups and suggest interventions based on the findings. Implications for practice are presented.

Introduction

Intimate partner violence (IPV) is a complex health and social issue affecting women around the world.[5,6] Annually in the United States, IPV is responsible for forty to fifty per cent of all murders of women, approximately 1,300 deaths.[7] Approximately 25% of women and 7.6% of men reported being assaulted either sexually or physically, or both, during their lifetime.[8] Approximately 5-6% of women are abused during pregnancy.[9] An estimated $5.6 billion was spent on medical care for the more than 2.5 million injuries due to interpersonal and self-directed violence.[10] Women in the United States lose nearly 8 million days of paid work each year because of IPV. In 2000 alone, the total costs associated with nonfatal injuries and deaths due to IPV were more than $70 billion. Most of this cost ($64.4 billion or 92%) was due to lost productivity. If household chores are included, it results in a total of 13.6 million days of lost productivity. Clearly, IPV places a significant burden on society.[7]

IPV has a significant negative impact on the well-being of women and their children. The effects may last well into adulthood and may include chronic pain,[11] depression and physical symptoms[12] including autoimmune diseases in adults.[13]

Impact of Culture

The population of women who are victims is not homogenous;[14] differences in cultural perspectives may lead to barriers that prevent women from receiving effective care.[15] Services are geared to women in general and do not account for the unique perspectives of different cultures. Intervention strategies have traditionally been based on Western notions of family and family life. Clinical interventions for abused women should be based on principles that include cultural competence and empowerment.[16]

Reported rates of IPV have a wide range of variation from one cultural group to another.[1,8] There is a growing body of literature regarding the incidence and prevalence of IPV in women who are of a variety of cultural groups.[2-4,17,18] Women who are categorized as Asian and Pacific Islander (API) report a lower rate of IPV than other cultural groups.[8] Researchers have estimated that the prevalence is as great in API populations and call for more research to ascertain the extent to which this phenomenon can be explained by the level of willingness of these groups to disclose abuse. IPV may be hidden in the context of other civil and criminal complaints such as assault or in the skewed proportion of emergency room visits by API Americans (18% of all visits) versus European American (12% of all visits).[17]

IPV in Hawai'i

In Hawai'i's diverse population,[18] twenty per cent of women age 19-64 have been victims of IPV in their lifetimes. In 2006, 22,000 adults reported IPV, 2.4% of the adult population, and 10% of high school students reported being physically hurt by partners.[19] Hawai'i frequently tops the annual national average for IPV murders per capita. Between 2000 and 2010 there were 63 murders of women resulting from IPV.[20] Only a small percentage of abuse situations are reported to police and by the time an arrest is made, the violence has continued for a number of years.[21]

In a 2003 retrospective review of records in four primary care settings,[1] 16% of IPV occurred in Filipino women (the specific dialect spoken was not indicated in the chart review) although Filipinos make up only 14% of the total population of the state. In that same study 32.3% of the total reports of IPV were Native Hawaiian women, contrasted with Hawaiians comprising approximately 20% of the population. Other Pacific Islanders comprised 16.1% of the total IPV reports; however, Pacific Islanders are only 4.5% of the population. These data provide an indication that the scope of this problem in these cultural groups is significant.

Methods

Critical social theory (CST) provided the theoretical framework for this research. The intent of this theory is to "challenge conventional assumptions and social arrangements."[22] Community based participatory research (CBPR) is consistent with the perspective of CST. An expected outcome of CBPR is the attainment of new knowledge that guides actions, increases the relevancy of studies and leads to a deeper understanding.[23,24]

In this study the concern about IPV led to the development of a CBPR team, comprised of personnel from three community health

centers (CHC's) and two nurse scientists from the University of Hawai'i.[24] The participating CHCs identified the specific cultural groups to be included based on their questions about meeting the unique needs of the people they serve. The CHC prioritized Native Hawaiian, Filipino, Samoan, and Chuukese because there was documentation of high rates of IPV in these populations, and little was known regarding their perceptions of IPV.

Research Design

This cross sectional, descriptive study collected both qualitative and quantitative data. Individual interviews were conducted with women who had experienced IPV. Focus groups were also conducted with other women from the same culture who might or might not have experienced IPV. Inclusion criteria included: women, 18 years and older, served through a variety of programs that were affiliated with the agency. Purposive sampling was used and phased so that women who had experienced IPV and participated in the individual interviews were not recruited to participate in the focus groups. The study was approved by the institutional review boards of the University of Hawaii and the Waianae Coast Comprehensive Health Center. Safety of the participants, researchers, and staff guided every aspect of this research. World Health Organization guidelines,[25] a confidentiality agreement, and an NIH Certificate of Confidentiality were instituted at the sites, and safety plans were developed.

Population and Setting

A total of 53 women ranging in age from 21–64 years participated. Demographic information is included in Table 1.

Table 1. Demographic Information of Participants

	Chuukese	Filipino	Native Hawaiian	Samoan	Total*
# Participants	22	10	10	11	53
Married/ Partner	14	5	5	8	32
Single/ Widowed	5	2	4	3	10
Sep/Divorced	3	3	1	0	6
# Children					
0 – 3	10	3	5	4	22
4 – 7	8	2	4	6	20
10	1	0	0	1	2
Education					
Elementary	4	1	0	0	5
< High School Grad.	0	2	0	2	4
(HS) Graduate	2	0	2	5	9
Greater than HS	4	2	8	4	18
Primary Language					
English	0	0	10	4	14
Chuukese	22	0	0	0	22
Filipino Dialect	0	10	0	0	10
Samoan	0	0	0	7	7
Years of Residence in Hawai'i					
< 20 years	22	3	0	9	34
> 20 years	0	2	9	1	12

* Differences in numbers reflect omitted data on demographic forms.

Table 2

Individual Interview Guide
Perceptions of the Acceptability of Violence

Please estimate between 0 to 9 the number that best fits each question.
Partner refers to the person you are in (or have had) an intimate relationship with.

Questions	Low				Medium			High		
a. The American culture as a whole seems to think that it's understandable and sometimes OK for partners to hit each other in certain situations. Within your cultural group, on a scale of 0 to 9, how ok is it for partners to hit each other in certain situations?	0	1	2	3	4	5	6	7	8	9
b. On a scale of 0 to 9, when you were brought up, how ok was it to believe that partners could hit each other?	0	1	2	3	4	5	6	7	8	9
c. On a scale of 0 to 9, how ok do you think it is for partners to hit each other in certain situations?	0	1	2	3	4	5	6	7	8	9
The next three questions ask about your partner:										
d. On a scale of 0 to 9, how much of _____ (your partner's cultural group – identify cultural group), think it's OK for partners to hit each other?	0	1	2	3	4	5	6	7	8	9
e. On a scale of 0 to 9, how ok does your partner's family think it is for partners to hit each other in certain situations?	0	1	2	3	4	5	6	7	8	9
f. On a scale of 0 to 9, how ok does your partner think it is for partners to hit each other in certain situations?	0	1	2	3	4	5	6	7	8	9

These questions were adapted from a study reported by Torres, S., Campbell, J., Campbell, D., Ryan, C., Price, P., Stallings, R., Fuchs, S., & Laude, M. (2000). Abuse before and during pregnancy: Prevalence and Cultural Correlates. Violence & Victims. 15(3), 303-321.

Instrumentation

A demographic form allowed cultural disaggregation. Three tools used during the study included two semi-structured interview guides (one for the individual interviews and one for the focus groups) as well as a quantitative tool, Perceptions of the Acceptability of Violence (PAV).[4] See Tables 2-4.

Procedure for Individual Interviews and Focus Groups

Women were enrolled after receiving study information and signing the informed consent. The interviews and focus groups were conducted in a private place by researchers who were members of the culture and spoke the appropriate language. They were certified in the Protection of Human Subjects, had advanced knowledge of IPV, and had conducted interviews and focus groups previously.

In total, 20 of the women who screened positive for IPV were invited to participate in the individual interviews (5 from each cultural group). An initial and a validation member-checking focus group were conducted with each cultural group for a total of eight meetings. Each focus group included up to 10 women from the 4 specific cultural groups.

Table 3

Individual Interview Guide
Intimate Partner Violence: Cultural Perceptions

The Interviewer will make a brief statement clarifying that the focus of the discussion is IPV and does not include other forms of domestic violence such as elder abuse or child abuse.

1. Perceptions: How do you understand IPV as an individual? Where did this understanding come from?

The following questions will be asked to elicit discussion about this category:

1a. Tell me about IPV? How do you understand this? [Cues to be covered: When does abuse become abuse? Physical injury, isolation, intimidation (when he looks at you and you're absolutely terrified)].

1b. What about your partner? How do you think your partner understands IPV?

1c. What does your family think about IPV?

2. Responses: How have you responded to IPV? How has your family responded?

The following questions will be asked to elicit discussion about this category:

2a. How did you deal with IPV? Did you talk with anyone?

2b. How about your family – what did they say or do?

3. Needs, Satisfaction, and Access: What did you need from the health provider/community? Did you get it?

3a. Was there support (outside of your family)that you needed?

3b. What was it? Was it helpful to you? [Cues to be covered: What health/social services did you need? Were they available? What services have you used? Did they work for you?]

4. Reasons women may or may not have disclosed: Did you talk with your doctor or nurse about IPV? If not, how come? If yes, why did you decide to talk about this?

4a. Did he/she ask you questions about IPV or did you just tell them? What was this like for you? [Cues to be covered: Tell me all your thoughts and feelings of what it's been like for you and how you've reacted when you were in a situation where you could have reported the IPV.]

5. Influence of specific elements of culture regarding IPV.

5a. Tell me about…(the following topics will be individually introduced: cultural protective systems, spiritual and religious practices, family rituals, gender roles, art and music, and the roles of individuals and groups related to IPV).

These questions were adapted from a study conducted in Seattle, reported by Senturia,K., Sullivan, M., Ciske, S., & Shiu-Thornton, S. (2000). Cultural Issues Affecting Domestic Violence Service Utilization in Ethnic and Hard to Reach Populations. http://www.metrokc.gov/health/dvreport.htm.

Table 4

Interview Guide for Focus Groups
Intimate Partner Violence: Cultural Perceptions

The Group Leader will make a brief statement clarifying that the focus of the discussion is IPV and does not include other forms of domestic violence such as elder abuse or child abuse. The Group Leader will also explain that women who participate in this group may or may not have any experience with domestic violence. Women are not being asked to say anything about their own personal experience. It will be made clear that the questions pertain to women of this cultural group within this particular community.

1. Perceptions and awareness: What is the perception/awareness women have about IPV? What is the perception/awareness women think the community has about IPV?

The following questions will be asked to elicit discussion about this category:

1a. What do people think about IPV? Do they know what it is? [Cues to be covered: What are examples of abuse? When does abuse become abuse? Does it include physical injury, isolation and intimidation?]

1b. How much do people talk about IPV? What kinds of things do they say?

1c. When IPV occurs, how would you know about it? Who would you most likely talk to about it? Who wouldn't be told about it? What are the reasons? [Cues to be covered: Who most likely talks about IPV?]

1d. How do you teach your children/grandchildren about IPV? When would you do this? [Cues to be covered: How is information passed from one generation to another?]

1e. Tell me about: cultural protective factors, spiritual and religious practices, family rituals, gender roles, art and music, and the roles of individuals and groups related to IPV.

1 f. How ok is it for partners to hit each other in certain situations?

2. Responses: What are the responses of the women participants to IPV?

The following questions will be asked to elicit discussion about this category:

2a. How do women cope with IPV?

2b. Do you think there is a difference between how you understand/experience IPV and how your larger community understands/experiences IPV? If yes, what do you do about it?

2c. How come people don't want to talk about IPV?

3. Actions: The following questions will be asked to elicit discussion about this category:

3a. What are the actions women participants would like the health center to take? What do you think should be done about IPV in the health center? What is the best way to help women experiencing IPV? [Cues to be covered: Awareness of available services and perception of those services; other services needed and how to go about implementing them].

3b. What are the cultural systems that can help when there is IPV?

3c. What are the roles of individuals or groups in dealing with IPV?

These questions were adapted from a study conducted in Seattle, reported by Senturia, K., Sullivan, M., Ciske, S., & Shiu-Thornton, S. (2000). Cultural Issues Affecting Domestic Violence Service Utilization in Ethnic and Hard to Reach Populations. http://www.metrokc.gov/health/dvreport.htm.

Data Management and Analysis

Quantitative data included the demographics and the results from the PAV. All quantitative data was analyzed using descriptive methods. All qualitative data were audiotaped and subsequently transcribed and analyzed by the research team using content analysis, with line-by–line coding.[26] Qualitative analysis was initially undertaken for each cultural group by each researcher, followed by research team analysis with attention paid to the cultural and community context. This ensured trustworthiness[27] that is widely used to evaluate qualitative research. The translation of the instruments and discourse contributed to the credibility by providing accurate data. Additional techniques that were used to establish credibility were the researchers' prolonged engagement with the topic, and persistent observation of the participants to give greater depth and understanding of culturally diverse women's experience. The goal was to summarize what was said, determine recurrent themes, and validate with the participants. The research team maintained comprehensive field notes that were integrated together with the other data.

Results

The findings point to the clear importance of the perceptions, responses and needs of participants from the 4 cultural groups as a basis for intervention and policy development. Women from all 4 cultural groups who completed the PAV tool during the individual interviews believed that violence was not acceptable to them individually; however, they indicated their spouse or partners perceived

Table 5. Description of Themes Across Cultures

Common Themes	Chuukese	Filipino	Native Hawaiian	Samoan
Living Within a Collective	In Chuuk the head of the clan can provide advice and assistance when IPV occurs. More so in Hawai'i, the church pastor assumes a role in providing support for the family.	The women believed it is important to defend the collective Filipino culture. In the case of IPV, reporting not only brings shame to the family but it reflects on the broader Filipino community group.	Intimate partner violence is understood to be a "family matter," dealt with in the family or by one's self. *"…family business is family business and don't shame the family."*	Samoan response to violence begins at the family level with the couple's parents advising them. If the abuse continues, the Chief (or pastor) becomes involved. If IPV continues, the perpetrator is asked to leave the village or is dismissed from the village council.
Cultural Protective Factors	In Chuuk, if families are involved in the selection of a spouse it gives them permission to intervene when IPV occurs. There is a protocol for seeking forgiveness where the spouse's family seeks to make amends to the woman's family. This procedure ensures that the husband and his family are accountable on all behaviors directed towards the wife.	Joint decision making is the norm, yet the culture is matriarchal in the household with women dominating in decisions about household budgets and men dominating in decisions of family finances and investments.	Participants recalled that during their parent's/ grandparent's generation, it was the woman's obligation and responsibility to keep the family together. The woman may have had her partner arrested and sent to jail, but still accepted him back because of the need to keep the family together.	In Hawai'i the protection that was available "back home" in Samoa because of open housing, allowing intervention by others, is lost. In Samoa it is common for newlyweds to reside with the husband's families.
Cultural Barriers to Helpseeking	Women's responsibility in a relationship is to "keep the peace". There is shame associated with IPV becoming known. Even with injuries, women may choose to stay in an abusive relationship out of duty and to preserve family honor. Women do have the choice to stay, take a break or to leave; but women are expected to be strong and resilient in family and marital life.	Women petitioned to enter the United States by a spouse or family members, have a "debt of gratitude" that never ends. They may be threatened with deportation. They can't return to the Philippines because this would bring "shame". Pressure from family in the Philippines who rely on the woman for financial support is a deterrent.	Participants described their families reaching a point of "enough is enough." Families stop helping because the woman continues to go back to the violent relationship or the relationship is interfering with the functioning of the family.	Samoan women are ashamed of being abused and think that people might blame them. Another factor might be that women do not want people to know that they are controlled by their husbands.
Gender Specific Roles	Chuukese women believe IPV is closely linked with marital infidelity but Christians "honor vows", and all "honor saving face". Women are expected to endure suffering; a mark of character is when a woman does not cry out during childbirth. Most of the time, when a Chuukese man is finished with an affair, he will come back to his wife.	The participants believed that it was their responsibility to keep the family intact at all costs, particularly if they have children, regardless of IPV being present. They perceived that their faith would sustain them and most relied on prayer and their ability to endure suffering to get them through the abuse.	As above, it was the woman's obligation to keep the family together. Leaving a legacy was important and therefore, women ensured that children knew how to respond appropriately to situations, and the appropriate roles of males and females.	Women believed that violence was often associated with men's alcohol or drug use. They also related that jealousy, a "sickness that affects men", could be associated with IPV. They believed that the need for power and control prompted some men to be violent. Fathers and brothers are expected to seek reprisal against the spouse.
Belonging to a Place	Communal living in Chuuk offers protection which is lost with the move to Hawai'i. Land is the number one asset in Chuuk and land is given up with the move to Hawai'i.	Immigrant women who participated in the study discussed difficulty in making the transition from Filipino culture and expectations to the changed environment in Hawai'i. They described their resulting problems with their own expectations and identity.	*"I'm part Hawaiian, who needs to reconnect with self. I know how to do it, and that is to get back to where I came from, which is to the land."* Feeling "at home" was conveyed in the need to establish or re-establish relationships with their community or the place they came from.	During the process of acculturation to a new environment the roles held as a cultural norm might need to be completely reversed in order to support ones' family. Immigrants may find themselves in situations that deviate from long held cultural norms.

violence as acceptable within a relationship. Many unique cultural aspects emerged; however, there were some points of similarity among groups (Table 5). This paper focuses on the five common themes identified across the four cultural groups: Living within a Collective; Cultural Protective Factors; Cultural Barriers to Helpseeking; Gender Specific Roles; and Belonging to a Place.

Living Within a Collective

Women described the importance that the collective (family, clan and community) plays in individual decision making. The women viewed themselves as an extension of the clan, in contrast to the more individualized perspective of the American culture. The extended family is the basic unit in all of the cultural groups. This meant that women believed they carried an obligation to preserve family and community relationships. As an example, in the Filipino culture (although the interviews and focus groups were conducted in the Tagalog language, the official language of the Philippines, several of the participants in the focus groups or individual interviews were Ilocano and also spoke Tagalog. Even though there may be major cultural differences between individuals who speak these dialects, their responses regarding IPV were similar across the board, reflecting a shared perspective which is documented in this paper) there is a strong sense of interdependence that leads to the Filipino concept of reciprocity and balance, or *utang ng loob*. Parents take care of children, and later in life the children care for their parents. Women disclosed that they must consider not only themselves and their nuclear family, but also their extended family in decisions.

Women described their role in "Defending the Collective." They did not believe they should share their problems with others. They were very concerned about what people might think about their family and the cultural group and believed they would carry an additional burden of shame if their situation became known. They were aware that if one discloses IPV there is a risk that the information could get back to the extended family and other community members. If that occurred, the family's good name would be compromised and they would be judged. The women valued defending the collective.

Cultural Protective Factors

When the abuse became obvious, members of the family could be an important source of support. Families offered a place for the women to "take a break" from the perpetrator, provided a safe place for the children, and allowed the women time and freedom to be away from the abusive situation.

In two of the groups, Chuukese and Samoan, historically there have been protective factors in place whereby families, clans and those responsible for the community's wellbeing had processes to maintain a stable environment. One protective factor was a mechanism for mediating disputes in ways that were acceptable and perpetuated fair treatment of women. When a woman experienced violence the matter came under the protective scrutiny of the family and community structure. Efforts were taken to resolve the situation. If abused women moved back to their family homes to avoid further injury and violence, the perpetrator and his family were expected to make amends. This included providing gifts to the victim's family and asking for forgiveness, pledging their protection for the woman who had been abused.

For these two cultures, the social organizational structure in the country of origin the Chief serves as the community leader. Protective measures at the Chief's level include conflict resolution between the partners and the two families. If these measures are unsuccessful, the Chief can banish the perpetrator from the community. After migration to the United States, the church pastor may take on the role of community leader and provide guidance when IPV occurs.

Cultural Barriers to Helpseeking

Family values, attitudes, and needs created significant barriers for some of the women. In two of the cultural groups (Chuukese & Samoan), fathers and brothers of the abused women were honor bound to seek revenge with further violence against the perpetrators. Women sometimes avoided telling their fathers and brothers about their abuse because they wished to avoid such a confrontation that could lead to arrest or injury of their own family. If a father or brother advised a woman to leave an abusive situation she was honor bound to abide by that mandate.

Samoan women disclosed that mothers might discourage women from leaving an abusive partner because "you made your choice, now you must live with it." Immigrant Filipina women disclosed that their families often expected them to remain in an abusive situation particularly if the family was benefitting financially or hoping to migrate to the United States. Some violent partners have threatened violence against the woman's family in the Philippines to keep them from leaving the abusive relationship**.**

Religious views also served as barriers. Some women believed that it was their responsibility to keep the family intact at all costs, particularly if they had children, regardless of IPV being present. They perceived that their faith would sustain them in the face of this difficulty and most relied on prayer and their ability to endure suffering to get them through the abuse. Separation and divorce is frowned upon for moral and religious reasons and not considered a viable alternative. Chuukese women noted changes that are occurring within their cultural group. Although, they won't readily seek divorce, Chuukese women may "take a break" from a relationship.

Gender Specific Roles

Women as Peace Makers: Women from three of the cultural groups described a cultural norm that placed the blame for IPV on women who are expected to maintain peace in the family. Women's role is centered on the idea that women are "kinder and gentler" than men and it is up to them to maintain a peaceful environment. If they are abused by their partners, the women are expected to tolerate the abuse in silence.

Women's Concerns for Children: Even though the women believed that it was their responsibility to keep the family intact at all costs, they worried about their children's safety and had concerns about their future. Many of the women had been exposed to violence as children and had been raised in such a way that they had not regarded abuse as "out of the ordinary" until they became involved with an external agency regarding their situation. Even with this misconception that violence was the norm, they discussed the suffering they had experienced as children and realized that it affected their lives.

Men as Head of Household: Fathers and brothers assumed a protective role for their daughters and sisters. If they became aware that the woman was in an abusive relationship it was their responsibility to provide protection and retribution. Consequently, women will speak to their mothers and sisters but will not disclose abuse to their fathers or brothers.

In the Samoan culture obedience to the family head is the primary responsibility of all members. Punishment for disobedience is corporal and commonly administered to children and adolescents. If wives do not "obey" they, too, may be punished in this way.

Men as Providers: Males have traditionally been expected to provide economic support and serve as the family decision maker. With changes in society or a move to a new environment these gender roles once held as a cultural norm might need to be completely reversed. Men's traditional role as provider has been eroded in recent years. This has occurred as a result of immigration, but may also be true for Native Hawaiian men as the traditional means of support (fishing, hunting and farming) are replaced. Available work may be more suited for women; therefore, men may find themselves unable to provide for their families.

Belonging to a Place

All groups referred to the importance of the land and their country of origin. As the indigenous peoples of this State, the land has symbolic meaning for Native Hawaiians. Natural elements of the land, mountain, ocean, rain, wind, and stars provided a source of "serenity," an avenue to release "pilikia" (troubles), a sense of

belonging, relaxation or calm, and removed them from the violent experiences. Participants described seeing the ocean and mountains as landmarks, which signified home. Native Hawaiians were identified in this study solely from self-report. Readers should use the findings cautiously, not only with respect to individual Native Hawaiians, but also across communities of Native Hawaiians. These findings present a picture within a context by community and ethnic group, and of course, by those who were willing to speak about it. For the immigrant participants, the sense of belonging felt in their homeland was disrupted by the move away from land they had occupied for generations to a new and foreign environment. This disruption impacts on the cultural protective factors no longer in place.

Discussion

Responses to meet the needs of women

These five themes provide an introduction for meeting the needs of women from these cultural groups. Women wanted the abuse to stop. Understanding why women from these cultural groups choose to stay or leave required an appreciation of the cultural context in which they and their family function. Women wanted alternatives that would allow safety and prevent injuries beyond having to move to a shelter. They sought help that was consistent with their cultural roles and priorities. One culturally specific strategy is for women to seek refuge in the homes of relatives or friends temporarily to heal physically and mentally with space to mitigate the conflict.

Response of Health Center

The issues related to IPV do not have easy answers. The challenge for the CHCs is to recognize that change may be needed in their own system and the systems that support CHCs. Services are currently based on the traditional Western model of screening and treatment. For CHCs serving diverse populations there is a need to base services on the cultural perceptions of the women. Identification and assessment of IPV may be more difficult if culturally sensitive screening instruments are not available. Planning of interventions should be culturally appropriate, and proceed at the women's pace. It is important to avoid stereotyping and to develop an awareness of variation within cultural groups in the context of a specific community. For example young women who are immigrants may not have the same attitudes and beliefs as their parents. The women who participated in this research recommended that members of the same cultural group who are also CHC staff were best suited to respond to their needs. Culturally appropriate care is far deeper than just being sensitive; however, there is a need to exercise caution as hiring within a small group or a specific neighborhood can present barriers to disclosure related to confidentiality.

There are system issues to be considered when planning IPV policies. It takes time for health care providers to develop a trusting relationship that encourages disclosure of IPV and to find the resources that the woman may need. It is important that providers care for themselves and seek reinforcement and assistance when they are working with families where IPV may be occurring. Conventional methods of providing care may not work with culturally specific groups. Training needs to include attention to somatic and behavioral cues.

CHCs are in a position to offer a variety of resources including preventive measures, gender separate counseling, and interventions in the home. Interpretation and translation do not necessarily assure cultural competency or competence in providing IPV services.

Community Response

Beyond typical legal and professional services, individuals, families, and communities should be encouraged to develop their own prevention and intervention strategies. While most participants learned about IPV through their family experiences, they also recognized that prevention begins with the family. Participants expressed the importance of people looking out for each other. They recalled that this was prominent when they were growing up and identified this as a valued resource for families.

CHCs can work with community members and groups to build capacity in order to develop solutions for their cultural group. Strategies to address this include: 1) Identifying gaps in services; 2) Identifying natural helpers who are open to addressing this issue and respected as sources of knowledge or support within their cultural group; 3) Presenting information within a cultural context that is safe and does not judge nor isolate the woman experiencing violence; and 4) Supporting and advocating for community involvement in prevention strategies from a public policy perspective.

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Authors' Affiliations:
- University of Hawai'i at Manoa School of Nursing & Dental Hygiene, Honolulu, HI, 96822 (L.M., J.S., K.R.)
- Waianae Coast Comprehensive Health Center, Waianae, HI 96792 (M.F.O.)
- Johns Hopkins University School of Nursing, Baltimore, MD 21205 (C.L.A.)
- Kokua Kalihi Valley Health Center, Honolulu, HI 96819 (D.S.M., S.M.S., M.S.)
- Domestic Violence Action Center, Pilipina Rural Project, Honolulu, HI 96801 (H.M., C.S., C.A.)

Correspondence to:
Lois Magnussen EdD
2528 McCarthy Mall, Webster Hall 433
Honolulu, HI 96822
Ph: (808) 956-4917; Fax: (808) 956-3257

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An Unusual Cause of Vertigo and Syncope: A Case Report

Ravi Reddy MD

Abstract

A 72-year-old woman with recurrent bouts of vertigo and syncope was found to have a glomus tympanicum tumor. Surgical removal of this tumor resulted in complete symptom resolution. This report summarizes the presentation, workup, treatment, and clinical significance of this case when dealing with these presenting symptoms.

Presenting Symptoms

Mrs M. is a pleasant 72-year-old woman who presented with vertigo and syncope. She had prior mild episodes of vertigo every three years, which subsided spontaneously, or with an oral antihistamine. She now presented with more severe episodes, resulting in syncope.

Chart Notes

Mrs M. is a 72-year-old woman who presents today with a bruised right eye. She suffers from vertigo. Four days ago she had a vertigo episode, fell, passed out and hit the right side of her face/eye and her left knee on a concrete floor. The fall was unwitnessed. The patient was getting orange juice from refrigerator at the time, turned, felt dizzy, and passed out. She is taking "motion sickness pills." Vertigo attacks occur once every three years. This is the first time that she has actually passed out. There was no antecedent headache, palpitations, or chest pain. The patient has been asymptomatic since event; no headache, no visual changes, no weakness, no numbness, no paresthesias. She has been ambulating well, without dizziness since then.

Initial Workup

Physical exam - negative
24 hour Holter monitor – negative

Referral and Subsequent Evaluation

Referred to otolaryngology.
CT of posterior fossa revealed a mass in the right tympanic (middle ear) canal.
Surgical pathology revealed a glomus tumor.
Patient's symptoms completely resolved after surgical removal of the tumor.

Glomus Tumor Overview

Glomus tumors are generally benign, vascular tumors arising from glomus bodies, which arise from chemoreceptor cells in paraganglionic bodies, and assist with temperature, pressure, and chemical regulatory functions in the body.[1]

The most common location is in the distal extremities, most commonly subungual, where it may be seen as a bluish discoloration under the fingernail.[2]

Glomus tumors may also be found in the head and neck, with the most common sites being the jugular foramen, middle ear cavity, carotid body bifurcation, and vagal nerve. Glomus tumors represent 0.6% of neoplasms of the head and neck and 0.03% of all neoplasms. Glomus jugulare tumors are the most common head and neck glomus tumor; the rarest are glomus tympanicum tumors. Glomus tumors are the most common tumors of the inner ear. Tumors in the middle ear may appear as a small red spot visualized behind the tympanic membrane on otoscopy.[3]

Most glomus tumors are asymptomatic. However, they may cause pain (especially in the subungual location), hearing loss (ear), pulsatile tinnitus, dizziness, or cranial nerve palsies (ear or cranial nerves). If the paraganglioma cells of the glomus tumor are functional, which is rare, catecholamine secretion may cause systemic symptoms.[4]

The peak age incidence of glomus tumors of the head and neck occurs between 50 and 60 years, with a slight female predominance.

Imaging is usually accomplished by contrast CT or MRI; because of the high vascularity in these tumors, contrast material is helpful in their visualization and distinction from adjacent structures, particularly lymph nodes.[5]

Treatment of glomus tumors involves local excision, when possible. Other modalities include radiation treatment (though these tumors are generally not very radiosensitive), particularly with intracranial tumors or in elderly patients. Selective arterial embolization is another treatment modality, which is also often used prior to surgery, to reduce intraoperative bleeding in these vascular tumors.

Excision may be particularly difficult if the tumor is growing on a nerve, as excision might result in nerve damage. Removal is also difficult when the tumor is intracranial, such as in the jugular foramen, and may involve multiple subspecialist skills during surgery, i.e, neuroradiologist, otolaryngologist, neurosurgeon.

Successful tumor removal generally results in symptom resolution.[6]

Case Relevance

This case highlights the need to consider glomus tumor of the ear when considering the differential diagnosis of a patient with dizziness and syncope, particularly when the patient complains of hearing loss or pulsatile tinnitus. Many patients with dizziness and syncope present with vague and varied complaints, so evaluation is often difficult. In patients with dizziness, the differential diagnosis is vast, and peripheral (i.e, labrynthitis, Meniere's disease, benign paraxysmal positional vertigo) causes must be differentiated from central (i.e, brain tumor or stroke) causes. Patients with syncope, particularly the elderly, often require a cardiac workup, to rule out dysrhythmia (i.e, heart block, rapid atrial fibrillation) or valvular dysfunction (i.e, aortic stenosis) as potential causes. Those with associated focal neurological signs or symptoms may benefit from intracranial and carotid artery imaging.[7] This case also revealed the lack of sensitivity of general head CT scan in making this particular diagnosis; only the CT with attention to the posterior fossa, as ordered by the otolaryngologist, was able to successfully reveal the tumor. Because the tumor, in this case, was limited to the tympanic canal without extension into the mastoid or jugular foramen, the otolaryngologist was able to resect the tumor via excision of the tympanic membrane.

The patient returned for follow up symptom-free, and was delighted with her successful outcome.

Disclosure: There was no grant funding for this case report.

Author's Affiliation:
- Department of Family Medicine & Community Health, University of Hawai'i, John A. Burns School of Medicine, Honolulu, HI 96813

Correspondence to:
Ravi Reddy MD
Medical Director, Physician Center at Mililani
95-390 Kuahelani Avenue, Mililani, HI 96789
Email: ravirmd@pol.net

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RMATRIX — Clinical Translational Research Award

Jerris R. Hedges MD, MS, MMM (Dean); Bruce Shiramizu MD (Professor, Department of Pediatrics); and Todd Seto MD (Associate Professor, Department of Medicine); John A. Burns School of Medicine, University of Hawai'i

The University of Hawai'i (UH) at Manoa, John A. Burns School of Medicine received a research infrastructure award in November 2010 to advance clinical and translational research in health disparities reduction in Hawai'i. Clinical and translational research refers to the translation of knowledge from the laboratory bench to the patient's bedside and then to the larger community. The grant was awarded by the National Institutes of Health's National Center for Research Resources (NIH, NCRR) on a competitive basis to provide resources to campuses to foster collaborative research. The Clinical & Translational Research Award is a Research Center in Minority Institutions (RCMI) program aimed at addressing health disparities (differences in health between subsets of the population) through the conduct of clinical and translational research.

Entitled **R**CMI **M**ultidisciplinary **A**nd **T**ranslational **R**esearch **I**nfrastructure E**X**pansion in Hawai'i or RMATRIX, this grant is a 3-year award with the opportunity to renew and/or extend the clinical and translational research activities into other national collaborations. The UH Manoa, John A. Burns School of Medicine is the backbone for this award that will complement many areas of excellent health disparities research that are already underway in our state. Given the emphasis of the 2010 federal Patient Protection and Affordable Care Act on improving health across the population and finding innovative, cost-effective best practices, building the infrastructure to pursue clinical and translational research focused on the reduction of health disparities in Hawai'i is a timely endeavor.

The grant has three primary objectives:

- Establish RMATRIX at the University of Hawai'i as the lead clinical and translational research infrastructure entity for UH system partners, national collaborators in the RCMI Translational Research Network (RTRN), and local community collaborators with the overarching goal being to reduce health disparities in our community
- Encourage clinical and translational research development through a multidisciplinary research education, training and career development program
- Establish Key Functions to support and promote multidisciplinary clinical and translational research in Hawai'i and beyond

These Key Functions, forming the core of this grant, are designed to support the development of researchers, including those based in the community, with a focus on reducing health disparities. The specific Key Functions are:

- Collaborations and Partnerships (i.e., building synergy between researchers and institutional partners)
- Community-Based Research (i.e, working with community-based partners to address health disparities)
- Participant and Clinical Resources (i.e., supporting clinical trial initiation and execution)
- Multidisciplinary Research Education, Training, and Career Development (i.e., training of junior investigators who are seeking careers in health disparities elimination, clinical & translational research, and/or community-based research)
- Biomedical Informatics (e.g., developing data storage, electronic record linkages and Internet based applications for researchers)
- Research Design & Biostatistics (e.g., assisting with research study design and data analysis)
- Research Ethics (e.g., helping researchers address community-based concerns and other research ethics mandates)
- Regulatory Knowledge & Support (i.e., guiding researchers facing research regulatory challenges)
- Evaluation Milestones (i.e., helping investigators to monitor their progress and that of the overall RMATRIX program)

In Hawai'i, substantial health disparities have been reported, particularly in Native Hawaiian, Pacific Island, and Asian communities. RMATRIX will focus on supporting research for those conditions where differences in the incidence, severity, or outcome of disease have been noted in subsets of the population of Hawai'i. The grant seeks to enhance the health of all in Hawai'i by identifying mechanisms leading to disease, the reasons that some subsets suffer disproportionately, and treatments or preventive interventions that are effective for those most at risk. To be addressed are the complex relationships between genetics, socioeconomic factors (such as life-style, occupation, stress, health psychology, and access to care), culture (such as diet and physical activity, illness recognition, sociological and psychological factors), and geography (including island remoteness). The multicultural and multiethnic nature of Hawai'i provides the perfect environment in which to confront

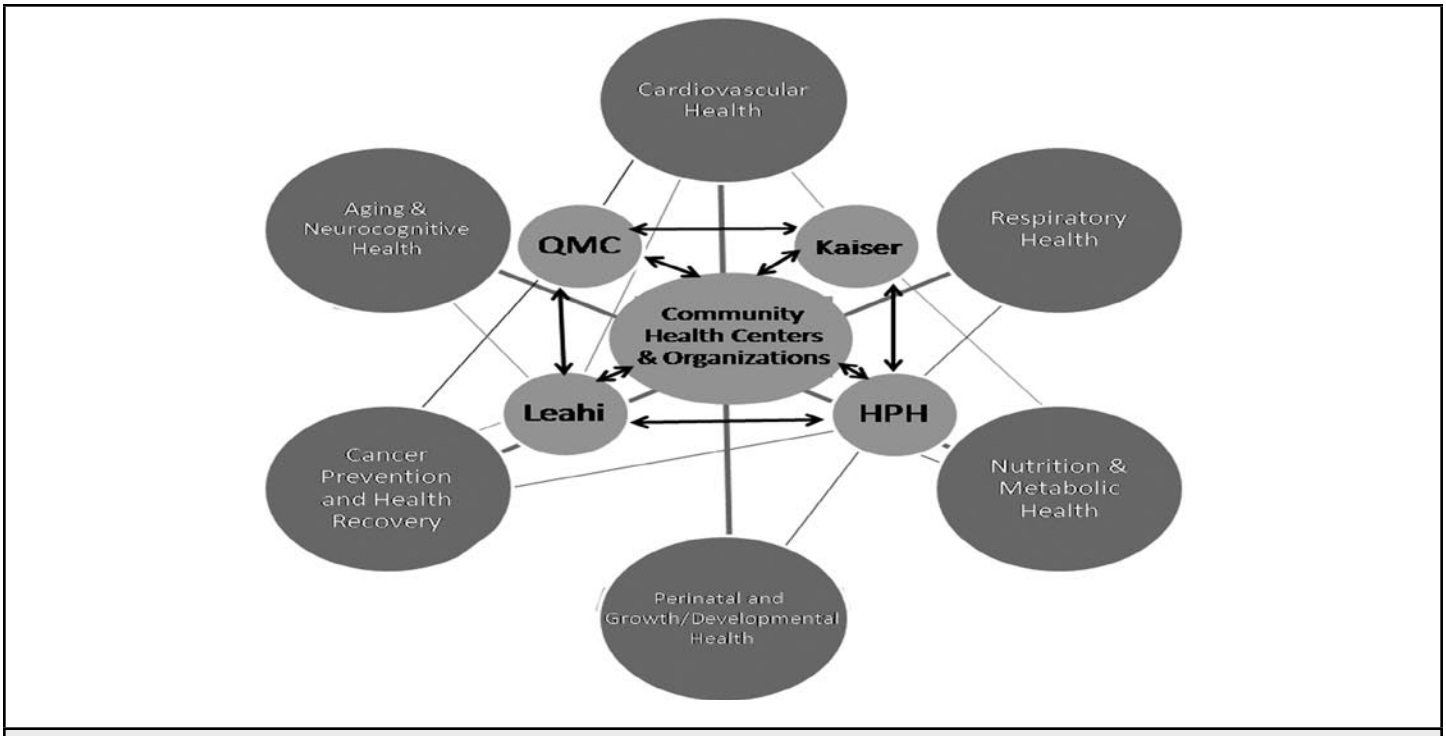

Figure 1. HEALTH Initiatives and Links to Community Research Partners. The HEALTH (**H**ealth **E**quity & **L**ifestyle **T**ransformation in **H**awai'i) Initiatives represent health disparities in Hawai'i. Queens Medical Center (QMC), Hawai'i Pacific Health (HPH) facilities, Leahi – The site of the Clint Spencer HIV-AIDS clinic, and Kaiser – Kaiser Health System represent some RMATRIX community partners. Other community organizations, federally-qualified health centers, and institutions such as Kuakini Medical Center and Tripler Army Medical Center provide other potential key contact points for community-based research.

these phenomena. Indeed, some disparities researchers believe that Hawai'i now reflects the anticipated multicultural and multiethnic nature that the US mainland may experience in 20-30 years.

The RMATRIX investigators will emphasize six **HEALTH** (Health Equity & Lifestyle Transformation in Hawai'i) Initiatives as a basis for understanding and addressing such disparities. The HEALTH Initiatives are:

- Cardiovascular Health
- Respiratory Health
- Cancer Prevention and Healthy Recovery
- Nutrition & Metabolic Health (including the issues of obesity and diabetes)
- Perinatal and Growth/Developmental Health
- Aging & Neurocognitive Health (including issues related to stroke, dementia, and substance use)

Figure 1 illustrates the ties between community-based organizations and the investigative teams. The focus of projects supported by RMATRIX Key Functions will be on the HEALTH Initiatives. The RMATRIX investigators will develop collaborations and partnerships among university-based basic science, clinical science, and translational researchers who share a focus on reducing health disparities. Partnerships between the School of Medicine, School of Nursing, and Cancer Center have already been developed. Similar collaborations with the School of Pharmacy at UH-Hilo and the College of Tropical Agriculture and Human Resources (CTAHR) at UH-Manoa are evolving. The RMATRIX investigators will link with community-based investigators and organizations such as The Queens Medical Center, Papa Ola Lokahi, Hawai'i Medical Service Association, the Waianae Coast Comprehensive Health Center, Waimanalo Health Center, and other community-based groups and health centers to reach out to the Native Hawaiian population. Similar efforts will be undertaken with organizations representing other Asian and Pacific Island ethnic groups.

The program will bring together experts and leaders from multiple disciplines throughout UH's Manoa and Hilo campuses to partner and collaborate with communities to identify the barriers and issues related to disparities in health. Recognizing that successful programs currently exist, RMATRIX will work with participants that will include neighborhood health clinics, Hawaiian civic groups, and health policy leaders. The network of professionals will begin working with leaders in communities with the greatest health disparities. The medical school will establish RMATRIX as a single administrative infrastructure for what is envisioned as a statewide effort to address health disparities. The challenges that RMATRIX hopes to tackle include bringing the university and diverse communities together for the benefit of those at a disproportionate HEALTH risk in Hawai'i with the capacity to build research in the community where ideas are self-generated and people can work with RMATRIX investigators to identify culturally-appropriate approaches to address health inequities.

Other vital components of RMATRIX are the links and collaborations with other NIH, NCRR-funded programs at the medical school and UH. Efforts will be made to coordinate and leverage resources from each of the programs to provide efficiency and avoid duplication for researchers. RMATRIX will enhance existing resources, foster collaborations, and support investigators through education, training and career development in projects that focus on the HEALTH Initiatives.

UPCOMING CME EVENTS

Date	Specialty	Sponsor	Location	Meeting Topic	Contact
February 2011					
2/11	Multi	Puʻulu Lapaʻau (Jointly Sponsored with the Hawai'i Consortium for Continuing Medical Education)	The Queen's Conference Center, Honolulu	Opioid Prescribing in 2011: A Changing Tide	Web: www.hawaiiphp.org
2/13-2/18	GS	Mayo Clinic	Wailea Beach Marriott, Maui	Mayo Clinic Interactive Surgery Symposium	Tel: (480) 301-4580
2/13-2/18	R	University of California San Francisco School of Medicine	Fairmont Orchid, Kohala Coast, Hawaiʻi	Neuro and Musculoskeletal Imaging	Web: www.cme.ucsf.edu/cme
2/16-2/20	EM	University of California San Francisco School of Medicine	Marriott Ihilani Resort & Spa, Oʻahu	High Risk Hawaiʻi 2011	Web: www.retinameeting.com
2/19-2/20	OTO	University of California San Francisco School of Medicine	Moana Surfrider Hotel, Waikiki, Oʻahu	American College of Surgeons Thyroid and Parathyroid Ultrasound Skills-Oriented Course	Web: www.osnhawaiianeye.com
2/19-2/22	OTO	University of California San Francisco School of Medicine	Moana Surfrider Hotel, Waikiki, Oʻahu	Pacific Rim Otolaryngology Head and Neck Surgery Update	Web: www.csahq.org
2/20-2/23		Hawai'i Thoracic Society and American Thoracic Society	Hyatt Regency Kaanapali	11th Annual Symposium Current Concepets in Pulmonary and Critical Care	Web: www.thoracic.org
2/20-2/25	IM	University of California San Francisco School of Medicine	Fairmont kea Lani, Maui	Infectious Diseases in Clinical Practice: Update on Inpatient and Outpatient Infectious Diseases	Web: www.csahq.org
2/25-2/26	GS	The Queen's Medical Center	Hawaiʻi Prince Hotel Waikiki, Oʻahu	The Queen's Medical Center Minimally Invasive Surgery Symposium	Tel: (808) 547-4406
March 2011					
3/2	Multi	Department of Native Hawai'i Health, John A Burns School of Medicine (Jointly Sponsored with the Hawai'i Consortium for Continuing Medical Education)	Ala Moana Hotel, Honolulu	He Huliau - A Turning Point Eliminating Health Dispartities in Native and Pacific Peoples: Building Diversity and Capacity in the Healthcare Workforce	Email: monaann@hawaii.edu
3/13/-3/18	Multi	Mayo Clinic	Mauna Lani Bay Hotel, Kohala Coast, Hawai'i	14th Mayo Clinic Endocrine Course	Web: www.mayo.edu/cme
3/20-3/23	GS	University of California San Francisco School of Medicine	Wailea Beach Marriott, Maui	Postgraduate Course in General Surgery	Web: www.cme.ucsf.edu/cme
April 2011					
4/3-4/8	IM	University of California San Francisco School of Medicine	Wailea Beach Marriott, Maui	Primary Care Medicine: Update 2011	Web: www.cme.ucsf.edu/cme
4/16	N	Hawai'i Neurological Society	MEB, John A Burns School of Medicine, University of Hawai'i, Honolulu	3rd Annual Scientific Conference of the Hawai'i Neurological Society: Trends in Neurological Medicine	Tel: (808) 537-7300
4/18-4/21	Multi	Scripps Conference Services & CME	Wailea Beach Marriott, Maui	Primary Care in Paradise: Medical Specialties from the Primary Care Perspective	Web: www.scripps.org/event/primary-care-in-paradise
May 2011					
5/14-5/19	P	American Psychiatric Association	Hawai'i Convention Center, Honolulu	164th Annual Meeting	Tel: (703) 907-7300 Web: www.psych.org
October 2011					
10/7-10/8	Multi	Department of Surgery, University of Hawai'i (Jointly Sponsored with the Hawai'i Consortium for Continuing Medical Education)	Hyatt Regency Waikiki	2nd Cross-Cultural Health Care Conference: Collaborative and Multidisciplinary Interventions	Web: www.cchc-conference.com

THE WEATHERVANE

RUSSELL T. STODD MD, CONTRIBUTING EDITOR

❖ WHILE YOU WERE SLEEPING —

Colorado and fifteen other states have passed legislation which provides policy for advanced-practice nurses to administer anesthesia without a doctor's supervision. The Colorado Society of Anesthesiologists and the Colorado Medical Society have filed a lawsuit to stop the policy change. The governor stated that the new law is necessary to provide care in rural areas where small hospitals do not have an anesthesiologist on staff. But hold on, legislators. Colorado state law states that surgeons are responsible for the actions of everyone in the operating room, and no surgeon concentrating on the operative field can control or be held accountable for the actions or mistakes which might ensue behind the sterile drape. Exceptions will have to be added to the policy change or it should be tossed in the toilet.

❖ AFTER ONE YEAR OF STUDY, ACTION BY THE FOOD AND DRUG ADMINISTRATION!

The latest craze for teen-age drinkers is a mixture of sugar, caffeine and 12% malt liquor. Young people don't recognize what they are doing when they chug-a-lug a can of Four Loko, Torque or a similar drink. The potency became evident when nine freshmen college kids (six girls and three boys ages 17 to 19) from Central Washington University became seriously ill at an off-campus party in Roslyn, Washington, the town where the TV show Northern Exposure was filmed. One girl nearly died with a blood alcohol concentration (BAC) of 0.335%. Many think they are drinking a beer-like product, but the alcohol content is nearly four times a can of Bud or Heineken. Washington State Liquor Control Commission voted unanimously for a state-wide ban on the sale of these drinks which are often displayed with beer and wine. They have the appearance of a benign energy soda. Michigan, Utah and Oklahoma already have similar bans in place. Phusion Projects Inc., a Chicago company that makes this poison, just announced it would remove caffeine from Four Loco right before the FDA announced alcohol and caffeine mixtures are unsafe and now illegal.

❖ TO TREAT OR NOT TO TREAT — THAT IS THE QUESTION.

A woman in Massachusetts became pregnant. Subsequently it was discovered that she had ovarian cancer and she was treated with chemotherapy during her pregnancy The baby was born prematurely and is alleged to have suffered damage. The child's attorney brought a lawsuit against the physician claiming that her injuries were due to the delayed diagnosis and treatment of the ovarian cancer. The court sustained the defendant's claim that there was no demonstration of a causal relationship between the injuries which occurred due to premature birth and her exposure to chemotherapy. The appeals court overturned that decision, and supported the plaintiff's expert who stated, "There is a genuine issue of material fact whether the plaintiff suffered adverse physiological changes which retarded intra-uterine growth and necessitated caesarian section." The suit will proceed, and obstetricians will hunker down deeper into defensive medicine.

❖ JUMPING TO CONTUSIONS CAN LEAD TO EARLY CONCLUSIONS.

In light of recent revelations about early Alzheimer's Disease and pre-senile dementia in ex-professional football players, attention is being directed to head injuries of current athletes. A research team at Virginia Tech is attempting to evaluate head trauma with Head Impact Telemetry Systems (HITS) designed and manufactured by Simbex, LLC. Sixty players, including most starters, wear helmets with six tiny sensors, called accelerometers, planted in the helmet which measure and record the direction and magnitude of each hit. Using units of gravity (G-forces) the sensors monitor each impact. A typical hit has a gravitational force (G-force) of 50 to 60, and players who suffer a concussion have usually sustained a blow of 95 Gs or more. It is not a diagnostic tool, but does alert coaches about possible concussion. The research is funded with a five year grant by the National Institutes of Health (NIH) and will contribute to the widespread discussion regarding head injuries. Cost for Simbex start-up is $65,000, including side line computer system and helmets, so the cost is too expensive for most teams. Simbex hopes to reduce helmet cost from $1,000 to that of a cell phone

❖ A MISTAKEN ID CAN BE TROUBLE UNDER ANESTHESIA.

In Maryland a man was in a car crash and med-evacuated by helicopter to a nearby hospital. When he woke up hungry the next morning, he was told by a nurse that he could not eat because he was having surgery that day. The nurse checked his ID bracelet and told him the surgery was to remove a potentially cancerous mass from his chest. He protested and told the nurse he was there for injuries suffered in a car crash. He checked his ID bracelet and found it had the name of what appeared to be a woman 13 years older than himself. Fearing for his safety, he gathered his belongings and tried to leave the hospital accompanied by his wife. The nurse refused to let him leave and called security guards. The man alleges that the guards were hostile, shoved him against the wall, knocked him down and took him to the nurse's station. Another man claimed to be the security supervisor and tried to forcefully remove the erroneous ID bracelet. A hospital administrator soon arrived on the scene and tried to convince the man to stay, which he refused to do. He signed a release form acknowledging that he was leaving against medical advice. He went to another hospital where he was found to have four broken ribs, a shoulder sprain, ruptured spleen and a concussion. A multi-million dollar suit has been filed alleging assault and battery, false imprisonment, and infliction of emotional distress among other complaints. Could the nurse really be this stupid or ill-informed?

❖ TAKE A CHILL PILL. BIG WINNERS STAY COOL.

Whether you are a professional athlete or a week-end warrior, one of the hardest parts of maintaining strength and endurance is body temperature. As core temperature rises quality and length of workout decreases. A number of personal cooling devices are on the market to bring down temperatures either during exercise or prior to it with pre-cooling, such as an ice bath. Various packs are usually filled with a cooling gel or ice water and placed in the freezer before use. A vest called Arctic Heat is available for $189, and a strap-on palm gel pack sells for $50. Neck coolers by themselves do not provide a meaningful chill and one study found neck cooling made no difference in heart rate or perceived exertion in cyclists. However, don't count on the cool tools to prevent heat stress or exhaustion. It is still necessary to drink a quart of a sports drink or water for each hour when exercising.

❖ BURNING ON URINATION? THERE'S AN APP FOR THAT.

It started as a telephone device for mobile communication. It morphed into an iPhone with global positioning system (GPS), a stereo device for musical entertainment, a camera, calculator, time clock, weather reporting, internet contact, to mention only a few of multiple functions. It should come as no surprise that now the Brits have devised a way for a person to urinate into it and find out if a he/she has a sexually transmitted disease (STD), such as chlamydia or gonorrhea, and where to go for treatment. No doubt this application (app) will soon determine if a woman is pregnant, if one has gout or even if a male has prostate cancer. So, be careful which window you touch or pee into.

❖ WHO NEEDS A VASECTOMY? JUST POUR ME ANOTHER SODA.

A study of 2500 men by a Copenhagen University team published in the American Journal of Epidemiology revealed that males who consumed a quart of soda a day produced 30% less sperm than non-soda drinkers. It was not due to caffeine since coffee drinkers showed no decrease. Disbelievers stated that the decrease was possibly due to life style because soda drinkers tend to have poorer diets, are likely to be overweight and are less likely to exercise.

❖CONFUSED ON THE CONCEPT.

Picketers in Washington, D.C. marched or camped in front of a job site protesting the use of non-union carpenters. Well, not really. Union carpenters are tired at the end of a day or work week, so instead of showing up to carry signs and banners, the Mid-Atlantic Regional Council of Carpenters hired non-union jobless and homeless people at $1 above minimum wage to carry the message to the public. It amounts to scabs being hired to protest the hiring of scabs at work sites. Critic Wayne Ranick, spokesman for the United Steelworkers of America, stated that this method is not a positive message and hardly produces any sympathy or understanding of the union position.

ADDENDA

❖ By year 2016 four million Americans could be penalized for not carrying health insurance under healthcare reform law, and could be fined 25% of income for refusal to buy. (Congressional Budget Office).
❖ Dr. Seuss' first book was rejected by 23 publishers.
❖ Never believe anything until it has been officially denied.
❖ Do not play leapfrog with a unicorn.

ALOHA AND KEEP THE FAITH — **rts**■

(Editorial comment is strictly that of the writer.)

Hawaii's Physicians CHOOSE HAPI as their Medical Malpractice Carrier

In recent years, hundreds of Hawaii's physicians have switched their coverage to HAPI, saving thousands of dollars on their medical malpractice coverage costs.

Started 32 years ago, HAPI is Hawaii's first, physician-owned medical malpractice coverage provider.

As a leading medical malpractice coverage provider, HAPI protects and defends Hawaii's most influential and respected physicians.

With a strictly local presence and NO profit motive, savings are distributed to our members.

HAPI's rates have remained stable, with several rate decreases or no change in rates in recent years.

In these tough economic times and challenging industry trends, you don't have to worry about your medical malpractice coverage costs. Let HAPI's financially sound, affordable plan protect you. Join your fellow colleagues...**contact HAPI and start saving today.**

2009 HAPI's Total Quarterly Costs (Including Fully Mature Retroactive Coverage)	
General Surgery	$4,168
Internal Medicine	$1,373
Pediatrics	$1,662

The above illustration is an example of HAPI's 2009 fully mature costs. These costs apply to physicians who need three years or more of retroactive coverage upon joining HAPI. If you do not need retroactive coverage or if you join HAPI out of a residency or fellowship, you will pay significantly less than shown above. The above specialties were selected for illustrative purposes only. Call HAPI for your specialty's costs.

If you are a D.O. or M.D. in private practice, call Jovanka Ijacic, HAPI's Membership Specialist to discuss the cost savings HAPI could offer you.

"What prompted me to search for a new malpractice insurance provider was the steep increase in premiums. I am a strong believer that you get what you pay for, but also want value. Malpractice insurance companies should provide good legal support if that fateful day arrives. In addition, I was concerned that certain companies would not have enough reserves to handle large or multiple claims. I checked with the insurance commission and researched the integrity of the attorneys and felt that HAPI has the support that I need at an affordable price. Now, that's value!"
Lance M. Kurata, M.D., Internist

"After converting my coverage to HAPI, I was pleased with the cost savings but even more impressed with their immediate attention to my concerns. It is very reassuring to know that HAPI is highly accessible if there is a concern. I've experienced excellent customer service since day one."
Art Wong, M.D., Pediatrician

"I was pleasantly surprised with the additional savings I received when signing up with HAPI. They have been extremely accommodating in providing liability coverage for my practice, and I would recommend other Osteopathic Physicians to consider HAPI as their carrier as well."
Leland Dao, D.O., Family Practitioner

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