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Letter to the Editor

As we become busier, we would like to ask that we all work together to insure we use email in an appropriate manner. We need to recognize that e-mail has a limited purpose in communication and is only effective for basic exchange of information. We cannot read someone’s tone of voice or see their facial expressions in e-mail. Often what we read in each other’s message can be totally different that what is intended by the sender! We also tend to type out e-mails reflexly and send before allowing time to think or to cool down.

A few basic rules of e-mail etiquette are as follows:

Recognize when e-mail string goes on too long as this is a symptom of the two parties not really communicating. Hold to a basic rule of thumb, such as after the third message you write back, “let’s discuss this further, call me please at XXX-XXXX.” It’s safe to do this and both of you will appreciate it more in the end. This is an essential rule to implement immediately when the tone of the message turns nasty. No one wins by being the “more nasty” and having the last word. Everyone looks bad and the demoralizing effect is all consuming and crippling to the work environment. We need to be able to say “we need to discuss this matter further, call me or let’s meet to talk.” That discussion will be good and will have a better chance for both parties to hear and listen to what their message really is.

NEVER TYPE IN ALL CAPS as this is the same as shouting in the online chat world.

It is not effective to make your point by sending a “cc” of your message to the person’s boss, and their boss, and their boss and the rest of the universe. That usually signals a complete breakdown in willingness to communicate and can undermine effective leadership. Pick up the phone or set up a meeting.

When you respond to a mass e-mail, such as one asking for convenient meeting times, do not respond to all. The initiator should receive all the responses and summarize and communicate the results as needed.

Do not forward sensitive, inappropriate or confidential emails. Remember to “praise in public and criticize in private”… e-mail is public.

We should practice good e-mail etiquette and the start of that comes from each message we send or respond to. It’s up to us to not fall into the e-mail pitfalls, and for us to keep e-mail effective and valuable for all.

Rod G. Bjordahl DO, CMD
Chief Medical Officer
Maui Memorial Medical Center

HMA ANNUAL MEETING
& OLA PONO IKE 2007
New Dates & Locations:

September 14-16, 2007

Ola Pono Ike: Saturday, September 15 at Sheraton Waikiki
House of Delegates & General Membership Meetings:
Friday, September 14 and Sunday, September 16 at HMA Offices

HMA’s 2007 meeting features a new format: CME sessions and vendor exhibits will no longer be part of the annual meetings. They will be replaced with the new series of HMA forums held throughout the year.

For more information, contact HMA:
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april_troutman@hma-assn.org     www.hmaonline.net
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Initial Assessment of a Culturally Tailored Substance Abuse Prevention Program and Applicability of the Risk and Protective Model for Adolescents of Hawai‘i

Richard Kim PhD, Kelley Withy MD, PhD, David Jackson MA, and Leah Sekaguchi MEd

Abstract
Background: Cultural interventions to decrease substance abuse must be introduced and evaluated.
Methods: Change in risk and protective factor ratings from a brief cultural school-based program were measured.
Results: Students demonstrated significant improvements in school commitment, self esteem, and perceived harm of drugs. These changes correlated with decreased report of drug use.
Discussion: The Pono curriculum demonstrated effectiveness using the risk and protective factor model.

Introduction
Substance use is one of the most dangerous challenges facing adolescents today. It is associated with suicide, risk of violence, child abuse, unemployment, school truancy, and many medical conditions such as addiction, heart disease, and stroke. When surveyed about illegal drug usage, 51.1% of 12th graders in the United States admit to having used in their lifetime and 4% of students nationwide admit to having used crystal methamphetamine or “ice”. In Hawai‘i, the overall data are similar with 46.9% of 12th graders having used drugs in their lifetimes and 4.2% having used crystal methamphetamine. However, 60% of Native Hawaiian 12th grade students in Hawai‘i report having used an illicit drug and 5.6% have used crystal methamphetamine. This article describes a culturally tailored substance abuse prevention program targeting Native Hawaiian youth and assessment of program effectiveness using the risk and protective factor model.

The Pono Curriculum
In 2001, a group of concerned citizens, recovering substance users, health care workers, and community leaders, headed by Mr. Wayde Lee, on the rural Island of Moloka‘i, developed a culturally tailored and interactive curriculum based on 21 Native Hawaiian spiritual and cultural values that includes communication, cooperation, conflict resolution, honesty, purity, patience, encouragement, generosity, and retribution as represented in Figure 1.
The Pono curriculum stresses living the 21 program principles to increase self confidence, sense of pride about cultural heritage, and understanding of Hawaiian spiritual and cultural principles; teaching communication and conflict resolution skills to improve family and community relationships; and learning the risks of substance use. Using the Hawaiian canoe as a metaphor, the roles and responsibilities of the paddlers were compared to the youth and their relationships in the home, with friends, in school, and with the community in which they live. The ocean symbolizes the vast and dynamic environment with the waves representing emotions that peak and recede as they journey through life. The developer of this curriculum, Mr. Lee, teaches the youth about doing the right thing (being Pono), which means taking care of your family, your friends, your community, your environment, and yourself, as these are all interrelated. For example, poisoning your body with things that are harmful to you (drugs, alcohol, and cigarettes) affects not only the individual but also his or her family, friends, community, and the environment.

The implementation of the Pono Curriculum on the island of Hawai‘i and the evaluation research effort was funded by the U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), under a larger island-wide substance abuse prevention effort called the Pulama Project. The current study examines changes in risk and protective factors that are associated with decreased use of Alcohol, Tobacco, and Other Drugs.
(ATOD), as well as self report of future intent of using ATOD. This serves a dual purpose of (1) assessing the applicability of the risk and protective model in understanding substance abuse among youth of Hawai‘i and (2) assessing overall effectiveness of the Pono curriculum program in preventing youth substance abuse.

**Methods**

**Hypothesis**

The research hypothesis was that participants would significantly improve their self rating of the following factors after the intervention (from pretest to posttest):

1. School commitment
2. Family relations
3. Self-esteem
4. Problem solving skills
5. Cultural pride
6. Decision making skills
7. Negative attitudes toward drug use

The research design involved a single group, pre-post within-subjects comparison. The program group was tested at baseline and again 8 weeks later after completion of the curriculum to determine percent change. The program achieved a posttest completion rate of 86.6%.

**Survey tools**

Seven survey tools totaling 72 questions, plus demographic information was collected. Most of the measures were selected from SAMHSA’s recommended standardized core measures and the Government Performance and Results Act (GPRA).

**Instruments**

**Demographic Information** was collected to assess socio-demographic characteristics including gender, age, grade, ethnicity, and household composition and stability.

**Student Survey of Risk and Protective Factors/Little Commitment to School (School Commitment)** measures school bonding and commitment as it requests the responders to assess their perception of meaningfulness, interest, and importance as related to their school. Three items ask respondents how many days they missed school due to illness, skipping, or other reasons, and were summed into a Total Number of Days Missed scale for the current analysis. Developed by Arthur, Hawkins, Catalano, and Pollard, the overall scale has shown a reliability estimate of 0.76. The School Commitment scale was analyzed using 6 items with scores ranging from 1 to 5, which demonstrated a Cronbach’s alpha score for this sample of 0.76 also.

**Family Relations/Cohesion Scale** assesses youth perception of family closeness and time spent together. It is a 6-item measure (four-point likert-type scale) developed by Gorman-Smith that has shown a reliability estimate of 0.80 for use with children. Cronbach’s alpha for this sample of youth was 0.75.

**Self Esteem Scale** is a 10-item scale developed by Rosenberg (1965) that taps respondent’s global feelings of self-worth or self-acceptance. Scores range from 1 to 4 with higher scores indicating greater self-esteem. In previous studies, Cronbach’s Alpha Reliability estimate ranged between .77 and .88, while this sample had Cronbach’s alpha of 0.81.

**Problem Solving** is an 11-item scale developed by Nolan Zane (Four Winds Research Corporation) that assesses the participant’s ability to effectively solve problems and address problem situations. Scores range from 1 to 4 with higher scores indicating greater problem solving ability. In previous studies, Cronbach’s Alpha Reliability estimate ranged between .69 to .82, while this sample had Cronbach’s alpha of 0.68.

**Cultural Pride** is a 10-item scale also developed by Nolan Zane that assesses the youth’s general feelings and acceptance about his/her culture. Scores range from 1 to 4 with higher scores indicating greater cultural pride. This is one of few existing measures that was normed on a high-risk Asian sample with an internal reliability alpha coefficient of .86. With this sample, this scale had Cronbach’s Alpha Reliability estimate of 0.83.

**Decision Making (Resistance to Negative Peer Pressure)** is a 10-item Resistance to Negative Peer Pressure Scale (Nolan Zane, Four Winds Research Corporation) that was also normed on high-risk API sample with a .86 internal reliability alpha coefficient. Each item provides youth with a brief description of a social situation and asks them to rate the likelihood that they would respond to the situation with this particular way. The four-point likert-type response set is utilized for this measure. With this sample, this scale had Cronbach’s Alpha Reliability estimate of 0.92.

**GPRA instrument** contains items assessing Past 30 Day Alcohol, Tobacco, and Other Drug (ATOD) Use (19 items), lifetime alcohol use (single item), age of first ATOD use (4 items), Intent to Use ATOD (reversed and renamed Intent to Nor Use ATOD; 4 items), Perceived Harm of ATOD Use (5 items), and Positive Attitudes Toward ATOD Use (reversed and renamed Negative Attitudes Toward ATOD Use; 4 items). Cronbach’s Alpha Reliability estimate for the Past 30 Day ATOD Use scale was 0.87; the Intent to Use ATOD scale was 0.63; the Perceived Harm of ATOD Use was 0.89; and the Negative Attitudes Toward ATOD Use Scale was 0.82.

**Subjects**

The target population for the project included troubled and at-risk adolescent youth on the island of Hawai‘i. Youth meeting at least 3 of the following inclusionary criteria were screened by program staff as potential participants: (1) family income at or below poverty level, (2) multiple children residing in single headed household, (3) history of family or peer substance or alcohol abuse, (4) one or more parent unemployed, (5) family members have past or current legal involvement, (6) lack of supervised positive alternative activities for the youth, (7) poor family housing condition, including crowded living space, or (8) youth who have begun experimenting using substances and are at risk of becoming active or chronic substance
abusers. Exclusionary factors were: (1) the presence of a severe developmental delay, (2) youth with chronic physical illness, (3) youth with diagnosed mental disorder or pervasive developmental disorders, or 4) youth who have active or chronic substance abuse problem. Appropriate referrals were made for students meeting these criteria. Excluded participants were still invited to take part in the prevention education, but were not surveyed for research purposes.

Of the youth who completed the baseline version of the survey, there were 120 (55.3%) boys and 96 (44.2%) girls; one participant did not respond about their gender. Ages ranged from 10 to 15 years old, with an average age of 12.16. Grade levels ranged from 6th to 9th, with the largest percentage (43.3%) being in the 7th grade. Most of the participants (84.3%) were born in the United States. In terms of race/ethnicity, 57.6% of the youth considered themselves mixed/part/all Native Hawaiian. Many youth are multiethnic and were allowed to choose more than one category. Other races/ethnicities included 27.6% White, 24.9% Filipino, 24.0% Portuguese, 21.2% Chinese, 19.8% Japanese, 7.8% Indian/Alaskan Native, 7.4% Samoan, 5.1% Korean, 3.7% Hispanic, 2.3% Black, 2.3% Okinawan, 1.4% Other Asian, 6.9% Other Pacific Islander, and 14.7% ‘Other.’ About 30% said that a language other than English (primarily Hawaiian and Filipino dialects) is spoken in their home most of the time. When asked how many times they moved in the last 12 months, 65.9% reported never moving. Others reported moving once (17.5%), twice (6.0%), three times (2.8%), four times (1.4%), six times (1.4%), seven times (0.5%), and nine times (0.5%), while 4.1% of the participants did not respond. When asked how many people live in their home, 51.6% reported one to five people, 39.2% reported six to ten people, 5.1% reported 11 to 15 people, and 2.8% reported more than 16 people. Over three-fourths (78.3%) of the youth reported living with their mothers and 65.9% with their fathers, while 71.0% reported living with brothers and/or sisters, 23.0% with their grandparents, 15.7% with other adult relatives or guardian, 0.5% each live alone, with roommates, or with a spouse/significant other, and 7.8% reported ‘Other.’

Informed consent

Consent was obtained in writing from the parents of all participants, and verbally and in writing from the students involved in the study. All informed consent procedures were conducted in English or in their native language at the time of the initial registration into the project by a trained staff and/or research assistant.

Procedures

All research and project staff had extensive knowledge and experience in working with youth of Hawai‘i and their cultures and were trained regarding: (1) legal and ethical data collection procedures and guidelines, (2) using care and sensitivity when collecting data from youth subjects, (3) providing proper and consistent instruction to subjects, (4) minimizing missing data, (5) assuring confidentiality and anonymity to each subject so that their response would be as honest and accurate as possible, and (6) using culturally appropriate communication and approaches in data collection for the target population. The research team worked closely with the project staff to streamline the data collection, data entry, and data storage process.

The data entry system was developed by the evaluation team that includes a detailed codebook and data entry computer file utilizing the Statistical Package for Social Sciences (SPSS) software package version 11.5 software. All Pono surveys were administered in a scannable version format. An administrative assistant trained in the scanning software program, and not involved in direct data collection, reviewed the data file and randomly checked for accuracy against the hard copies of the questionnaires. Additional reviews of the quality of data entry included examining frequency statistics on all variables to ensure that the codes entered were consistent with the codebook and as instructed as well as to examine any extreme outliers.

Analysis

Multiple analysis of variance for repeated measures procedures were performed on the pre and post surveys from the 155 youth who provided complete data for all items at both pretest and posttest. A 0.05 level of significance was used with multivariate (Hotelling’s T) and univariate (F-ratios) significance testing. Similar analyses were also used to explore gender differences across variables. Correlation analyses were conducted to examine the relationships between the variables in the risk and protective factor model for this target population. Statistical analyses were completed using the SPSS.

Results

Statistically significant increases were found in the total sample after intervention in the areas of: Self-Esteem (p < 0.042), Perceived Harm of ATOD Use (p < 0.040) and School Commitment (p < 0.007). An unexpected statistically significant increase was also revealed for Total Number of (School) Days Missed (p < 0.003). Problem Solving, Cultural Pride, Decision Making, Family Bonding, Intention to Not Use in the Future, and Negative Attitudes Toward ATOD Use demonstrated trends toward improvement, although they did not reach significance. Furthermore, while not statistically significant, the mean scores for Past 30-Day ATOD Use remained low: on a scale of 1 to 7, the mean score at pretest was 1.06 and the mean score at posttest was 1.05. Likewise, the mean scores for Illicit Drug Use showed a non-significant decrease from 0.25 to 0.14.

Analyses of gender differences revealed that girls had increased Self-Esteem (p < 0.015) and Problem Solving (p < 0.044), and decreased Intention to Not Use ATOD (p < 0.049) after the intervention. Boys only showed a significant increase in School Commitment (p < 0.045). However, both gender groups reported unexpected significant increases in Total Number of (School) Days Missed (for girls: p < 0.033; for boys: p < 0.050).

Results of correlational analyses found significant relationships between ATOD use and almost all of the risk and protective factors assessed in this study. Past 30 Day ATOD Use was significantly negatively correlated with School Commitment (r = -0.247, p < 0.001), Family Relations (r = -0.433, p < 0.000), Self-Esteem (r = -0.254, p < 0.000), Cultural Pride (r = -0.187, p < 0.011), Problem Solving (r = -0.189, p < 0.009), Decision Making (r = -0.343, p < 0.000), Intention to Not Use ATOD (r = -0.485, p < 0.000), and Negative Attitudes Toward ATOD Use (r = -0.385, p < 0.000). A significant positive correlation was shown between Total Number of Days Missed and 30 Day ATOD Use (r = 0.311, p < 0.000). Numerous other statistically significant relationships among the risk and protective factors are also shown in Table 2.
Table 1.— Total Sample Pre-Post Results

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pretest</th>
<th>Posttest</th>
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<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>School Domain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Commitment (0-3)</td>
<td>2.82</td>
<td>0.68</td>
</tr>
<tr>
<td>Number of Days Missed (0-18)</td>
<td>2.21</td>
<td>2.80</td>
</tr>
<tr>
<td>Family Domain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Bonding (1-4)</td>
<td>3.33</td>
<td>0.47</td>
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<tr>
<td>Individual Domain</td>
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<tr>
<td>Self Esteem (1-4)</td>
<td>2.96</td>
<td>0.53</td>
</tr>
<tr>
<td>Problem Solving (1-4)</td>
<td>2.96</td>
<td>0.40</td>
</tr>
<tr>
<td>Cultural Pride (1-4)</td>
<td>3.31</td>
<td>0.48</td>
</tr>
<tr>
<td>Decision Making (1-4)</td>
<td>3.30</td>
<td>0.65</td>
</tr>
<tr>
<td>ATOD Domain</td>
<td></td>
<td></td>
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<tr>
<td>Perceived Harm of ATOD Use (0-3)</td>
<td>2.18</td>
<td>0.76</td>
</tr>
<tr>
<td>Negative Attitudes Toward ATOD (0-3)</td>
<td>2.57</td>
<td>0.62</td>
</tr>
<tr>
<td>Intention to Not Use in the Future (0-2)</td>
<td>1.72</td>
<td>0.42</td>
</tr>
<tr>
<td>Illicit Drug Use (0-14)</td>
<td>0.25</td>
<td>1.31</td>
</tr>
<tr>
<td>Past 30-Day ATOD Use (1-7)</td>
<td>1.06</td>
<td>0.24</td>
</tr>
</tbody>
</table>

Discussion

In a sample of 155 students, the 8-week Pono curriculum for substance abuse prevention was found to be effective at significantly increasing protective factors of school commitment, self esteem, and perceived harm of ATOD use. In girls, it also increased self report of problem solving ability and intention to not use ATOD. Youth who reported less ATOD use were more likely to also report greater school commitment, family relations, self-esteem, cultural pride, problem solving skills, decision making skills, intent to not use ATOD, and negative attitudes toward ATOD, as well as fewer school absences. In addition, most of these risk and protective variables showed significant correlations with each other. These results are consistent with findings from previous research efforts exploring risk and protective factors and substance use. Because the results of correlational analyses revealed expected relationships between risk and protective factors and ATOD use, the authors infer decreased rates of drug use in the future in this group of students. Furthermore, the fact that overall ATOD and illicit drug use were low at pretest and remained at a low level at posttest, suggest a positive preventive effect of the program.

Positive trends in mean scores were also revealed for other scales, although they were not statistically significant. These include problem solving, cultural pride, decision making, and negative attitudes toward ATOD use. A factor to consider, however, is that most of the scales demonstrated relatively high mean scores at pretest, making it difficult to achieve further improvements. The significant increase in reported school absences was an unexpected finding. School officials and project staff have indicated that increase in absences as the school year progresses is a common phenomenon in these schools.

Table 2.— Correlations Between Self Rating Variables

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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</thead>
<tbody>
<tr>
<td>1) School Commitment</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2) Family Relations</td>
<td>0.441***</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>3) Self Esteem</td>
<td>0.267***</td>
<td>0.430***</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4) Cultural Pride</td>
<td>0.419***</td>
<td>0.485***</td>
<td>0.268***</td>
<td>1.000</td>
<td></td>
<td></td>
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<tr>
<td>5) Problem Solving</td>
<td>0.391***</td>
<td>0.479***</td>
<td>0.428***</td>
<td>0.367***</td>
<td>1.000</td>
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<tr>
<td>6) Decision Making</td>
<td>0.444***</td>
<td>0.278***</td>
<td>0.282***</td>
<td>0.219**</td>
<td>0.315***</td>
<td>1.000</td>
<td></td>
<td></td>
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<tr>
<td>7) Intention to Not Use ATOD</td>
<td>0.382***</td>
<td>0.309***</td>
<td>0.284***</td>
<td>0.138</td>
<td>0.211**</td>
<td>0.530***</td>
<td>1.000</td>
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<tr>
<td>8) Perceived Harm of ATOD</td>
<td>0.115</td>
<td>-0.005</td>
<td>0.168*</td>
<td>0.082</td>
<td>0.050</td>
<td>0.238**</td>
<td>0.289***</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) Neg. Attitudes Toward ATOD</td>
<td>0.419***</td>
<td>0.354***</td>
<td>0.219**</td>
<td>0.198**</td>
<td>0.300***</td>
<td>0.512***</td>
<td>0.557***</td>
<td>0.126</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>10) Tot. Number of Days Missed</td>
<td>-0.200**</td>
<td>-0.296***</td>
<td>-0.255***</td>
<td>-0.013</td>
<td>-0.150*</td>
<td>-0.187*</td>
<td>-0.395***</td>
<td>-0.096</td>
<td>-0.312***</td>
<td>1.000</td>
</tr>
<tr>
<td>11) 30 Day ATOD Use</td>
<td>-0.247**</td>
<td>-0.433***</td>
<td>-0.254***</td>
<td>-0.187*</td>
<td>-0.189**</td>
<td>-0.343***</td>
<td>-0.485***</td>
<td>-0.060</td>
<td>-0.385***</td>
<td>0.311***</td>
</tr>
</tbody>
</table>

*p < 0.05, **p < 0.01, ***p < 0.001
Study limitations include the lack of a comparison or control group, and thus the researchers could not rule out other potential causes of changes. Second, larger program effects may not have been detected, since posttests were administered after only 8 weeks. A longer period of study, including follow-up assessments, would be required to adequately assess changes in these youth on a longer-term basis. Third, while gender appeared to be a factor in outcomes, larger sample sizes would be needed to determine the program’s differential effect on boys and girls. Fourth, although the expected correlations among risk and protective factors and ATOD use were found, it is not clear whether changes in risk and protective factors are causally linked to ATOD use in these students. Further research must be conducted to substantiate the findings presented in this study.

In summary, while many considerations must be taken into account when interpreting these results, they offer an initial step toward assessing substance abuse prevention programs for youth of Hawai‘i. The findings suggest that the risk and protective model, along with the measures used in this study, may be usefully applied in prevention research and practice with this population. Furthermore, this data suggests that the Pono Curriculum is a potentially efficacious culturally-based program for youth of Hawai‘i and merits further study.

References
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Centipede Bites in Hawai‘i: A Brief Case Report and Review of the Literature

Anthony P.S. Guerrero MD

Editor’s Note:
Bite and sting have been used interchangeably in this article. To clarify, the head of a centipede has a pair of antennae which have evolved from the first set of legs, have become hollow, and transmit the venom to the intended target when the centipede uses them as claws. Thus, the “sting” is actually from the front, and not the back end, of a centipede.

Abstract
In this article, a local case of a centipede bite, with fairly typical symptoms and an uncomplicated course, is presented. The literature is reviewed, indicating that serious complications, while rare, are possible. The author recommends that clinicians structure assessments of centipede bites around knowledge of serious potential complications and provide counseling on prevention of future attacks.

Case Report
The victim (myself, a 35-year-old Filipino otherwise healthy man who had been bitten by centipedes in the past) awoke from his sleep on December 16, 2006, at around 4:30 AM, with severe localized burning pain on the right forearm. Within the first several minutes, 2 small bite marks were noted in the middle of a 2.5 x 1.5 cm wheal, which was in turn surrounded by a 5.5 x 3.5 cm area of erythema (Figure 1). A relatively small centipede (Figure 2) was discovered in the bed sheets and killed with several hits from a slipper. The wound was washed with soap and hot water, with some relief of pain. Over-the-counter polymyxin, bacitracin, neomycin, and pramoxine ointment was applied topically, and 50 mg of diphenhydramine po was ingested. Significant erythema and itching, along with edema and pain, continued through the next few days, as shown in Figure 3, which is a photograph taken approximately 48 hours after the initial bite. Over the next several days, the erythema, itching, and pain subsequently declined without any further complications, other than mild anticipatory anxiety when sleeping in the same bed.

Introduction
While bites from snakes and rabid animals do not occur, centipede bites are relatively common in Hawai‘i, with its warm tropical climate. Centipedes are referred to in local song, such as “La‘ahina,” by Loggins & Messina, and are unpleasantly remembered by visitors to Hawai‘i who experience evenomation while vacationing in the islands. Given the common nature and potential seriousness of centipede bites, this article was written as a practical guide to managing and preventing centipede bites in Hawai‘i.

Review of the literature and discussion
The species of medical importance in Hawai‘i is Scolopendra subspinipes, which has been described as “one of the largest and most aggressive tropical centipedes.” Like in the case described above, attacks frequently occur indoors and at night, and often affect the extremities. The most common effects of centipede bites are local pain, edema, erythema, and pruritus, as was experienced in the above case report. Pain and pruritus may persist for up to a few weeks after the attack. Functional impairment may occur, depending on the degree of edema. Local necrosis and a general ill feeling have also been described. Other potentially serious side effects are possible, including anaphylaxis with systemic urticaria and dyspnea, local infection, Well’s syndrome or eosinophilic cellulitis, compartment syndrome, proteinuria, and rhabdomyolysis with renal failure. Acute myocardial ischemia and infarction, presumably secondary to vasospasm and myocardial toxic effects of the venom, have also been described as complications of centipede stings. Pediatric patients may be at higher risk for serious side effects. Although a 28-day-old newborn recovered completely from a centipede bite after a period of uncontrollable crying, poor feeding, and hypersomnolence, a 7-year-old girl in the Philippines died from a centipede bite on her head.

Probably because of the unlikelihood of convincing subjects to consent to a randomized, controlled study of experimentally inflicted centipede bites, there is relatively little written about evidence-based management approaches. The majority of the literature on centipede bites consists of case reports and case series. Based on the available literature and the known common effects and complications, it is recommended that, when initially confronted (either via telephone or in person) with a case of a likely centipede bite, the clinician should carefully assess and consider:

- The age and size of the patient;
- Whether or not the offending pest was
captured, as centipede bites may be sometimes be confused with other bites for which more specific management may be indicated;\textsuperscript{18}

- The size of the offending centipede – although, as the case described illustrates, even relatively small centipedes can produce significant pain and swelling;
- History of allergies and current symptoms suggestive of systemic allergic reaction;
- Immunization history, including adequacy of tetanus immunization;
- Presence of other chronic medical conditions (including coronary artery disease) that may possibly render a patient more likely to experience side effects;
- Non-dermatological symptoms (such as chest pain or shortness of breath); and
- The local appearance of the wound (which classically contains 2 puncture wounds), the anatomical location of the wound, and the presence or absence of significant swelling or functional impairment.

If there do not appear to be any complications or significant risks of complications, the clinician could recommend treatment modalities summarized in Table 1. These modalities were considered in the case described above, ultimately treated with hot water, wound care, a topical analgesic, and an oral antihistamine.

The clinician should counsel the patient to call or seek emergency care for any symptoms of bacterial infection, unusual or persisting dermatological lesions, or non-dermatologc symptoms (such as chest pain or changes in the appearance of urine). Overall, most studies do not suggest that laboratory studies are uniformly indicated for uncomplicated centipede bites, although it is suggested that a urinalysis to look for proteinuria and myoglobinuria may be reasonable, particularly if there appears to be significant extremity swelling and pain, which could suggest rhabdomyolysis.\textsuperscript{12}

For the benefit of the patient (and the patient’s housemates, especially young children), it is reasonable to provide counseling on pest control and prevention of future centipede bites. Because centipedes seek warm, dark, and humid areas, they tend to reside in shoes and clothing, under bedding, in cracks and crevices, and in bathrooms, damp closets, and basements. Potential portals of entry into households should be identified and sealed off. This author has witnessed live centipedes dropping from lighting fixtures in the ceiling. Suitable habitats, such as those found under rocks and in leaf litter, compost, and abandoned automobile tires, should be eliminated.\textsuperscript{4} Gardeners should wear heavy gloves and should exercise caution when collecting leaves, turning soil, or picking up rocks.\textsuperscript{12} There are pesticides that may be efficacious for centipede infestations, although it is possible that pesticides applied outside the home may encourage centipedes to enter the home. Because centipedes may prey on cockroaches and other arthropods, control of these other pests may also reduce the centipede population.\textsuperscript{21}

Based on experience, this author also recommends that people who have seen (or been bitten by) centipedes in their household should consider having grasping instruments (such as pliers or hemostats), slippers, and scissors readily available, as centipedes are not as easily killed as other insects and may sting if approached.
Figure 3.— Photograph of the centipede bite, 48 hours after the initial attack.

Table 1.— Recommendations for management of uncomplicated centipede bites

<table>
<thead>
<tr>
<th>Modality</th>
<th>Reference</th>
</tr>
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<tbody>
<tr>
<td>Ice</td>
<td>6</td>
</tr>
<tr>
<td>Hot water and local heat (which may de-activate venom components)</td>
<td>1, 6</td>
</tr>
<tr>
<td>Analgesics</td>
<td>1, 6</td>
</tr>
<tr>
<td>Wound care and tetanus immunization</td>
<td>1</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>1, 7</td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>7, 19, 20</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>1</td>
</tr>
</tbody>
</table>

with bare hands or bare feet. While it is true that certain animals common in Hawai‘i, such as toads and mongooses, prey on centipedes and theoretically could control the population, it is not recommended that human victims try to control the population by doing the same, as humans may experience systemic side effects from live centipede ingestion.22

References
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Intimate Partner Violence: Systematic Review of Literature Focused on the Cultures of Hawai‘i

Lois Magnussen EdD, APRN, Janice Shoultz DrPH, APRN, Mary Frances Oneha APRN, PhD, Mya Moe Hla PhD, and Zavi Brees-Saunders MPH

Abstract
Although research on intimate partner violence (IPV) categorizes populations broadly; there is great diversity within the broad categories of Asian and Pacific Islanders. This paper reviewed the literature published between 1996 and 2005 focused on the intersection of IPV and culture within specific cultures in the State of Hawai‘i. The current research literature related to IPV against women and these specific populations is summarized.

Introduction
Much of the research on intimate partner violence (IPV) categorizes populations broadly even though there is cultural diversity within broad categories. It is important for providers to understand the values and life ways that influence perceptions and behavior in order to intervene in culturally appropriate ways. Krane, Oxman-Martinez, and Ducey note several authors have argued that broad categorizations related to ethnoracial groups lead to judgments that are made according to pre-defined standards and fail to account for the unique cultural traditions of specific groups.

Purpose of the review
The purpose of this paper is to review the literature published between 1996 and 2005 focused on the intersection of IPV and culture within the specific cultures widely represented in the State of Hawai‘i: Asian (Chinese, Filipino, Japanese, Korean, Vietnamese); and Pacific Islander (Micronesian, Native Hawaiian, and Samoan). The paper summarizes the current literature regarding the state of practice and research related to IPV in these specific populations. A table with a complete description of each citation is available from the authors.

Background and rationale
Intimate partner violence is a significant problem affecting 25% of women in this country. Annually, in the United States 5.3 million IPV events occur among women 18 years and older. The rate of assaults from IPV exceeds the number of injuries sustained from motor vehicle crashes, muggings, and rapes combined. Although IPV is found in all cultural and socioeconomic classes it is reported more commonly in minorities and women of lower socio-economic status. Reported rates of IPV have a wide range of variation from one cultural group to another. There is little data available regarding the incidence and prevalence of IPV in women who are of a variety of cultural populations. One of the reasons for this situation may be that differences between cultural perspectives related to IPV may lead to barriers that prevent women from reporting abuse and receiving effective care. Campbell and Campbell suggest that clinical screening and intervention should be based on principles, which include cultural competence and empowerment.

Definitions
For this systematic review IPV is defined as:

Abusive behaviors perpetrated by someone who is, was, or wishes to be involved in an intimate relationship, and are aimed at establishing control by one partner over the other.

Culture can be defined as “the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, life ways, and all other products of human work and thought characteristics of a population of people that guide their world view and decision making.”

IPV in Hawai‘i
This review was undertaken by a Community Based Participatory Research (CBPR) team that provides services to diverse populations in Hawai‘i through four Community Health Centers on the island of Oahu. The review reports literature of different cultural perceptions of IPV in Asian or Pacific Islander groups. Culture is a complex phenomenon, particularly important for Hawai‘i. While people in Hawai‘i are influenced by their cultural heritage, their perspectives are often moderated within a multi-cultural context. Caucasians – known as Haole, Asians, Native Hawaiians, Pacific Islanders and others live together and inter-marry; thus influencing each other’s values and behavior.
Estimates are that 20% of women in Hawai‘i aged 18 to 64 have been victims of IPV. Unpublished data from a clinical survey at a rural Oahu clinic found that 18% of women (N=60) indicated that they had been “slapped, punched, kicked, or otherwise physically hurt by an intimate partner” at least once. Between 1985 and 1993, nearly 30% of homicides in Hawai‘i resulted from IPV. Findings from previous studies confirm that only a small percentage of abuse is reported to police, and by the time an arrest is made, the violence has occurred for a number of years.

In Hawai‘i, it is difficult to obtain accurate statistics regarding IPV. Consistently IPV is under-reported by victims. Despite these limitations, in 2001 there were 2,368 arrests for violation of temporary restraining orders (TROs) statewide. This represents a growth of 87% of IPV related arrests between 1999 and 2001. This figure may under-report the actual prevalence of IPV. In a 1999 report of TROs issued during the last six months of 1996, ethnicity data were not available for those requesting the TROs but were available for defendants who were arrested. Ross & Kanuha report that the majority of incidences were associated with Hawaiians/Part-Hawaiians (25%), Caucasians (23%), and Samoan (16%).

Magnussen et al. report that disclosure of IPV was documented in 9% of records from a retrospective chart review conducted at 4 community health centers on Oahu. The sample included Native Hawaiian, Caucasian, Black, Filipino, Japanese, Chinese, Vietnamese, Laotian, Korean, Samoan, Tongan, and Chuukese women.

The population of women who are victims of IPV is not homogenous, yet intervention strategies for responding to IPV do not take into account the unique perspectives of different cultures. Campbell and Campbell suggested that clinical interventions for abused women should be based on principles which include cultural competence and empowerment. Campbell, et al. called for research that considers the role of cultural factors, but does not necessarily assume that an individual identifies with the minority culture of their race or surname.

Methods
A systematic review of the literature focused on the intersection of IPV and culture within the specific cultures widely represented in the State of Hawai‘i: Asian (Chinese, Filipino, Japanese, Korean, Vietnamese); and Pacific Islander (Micronesian, Native Hawaiian, and Samoan) was conducted covering ten years (1996 through 2005).

Findings (1996 - 1999)
Only 11 articles published between 1996 and 1999 met the criteria. Fishbach and Herbert, in 1997, note that gender-based violence is emerging as a global issue for women across diverse cultures. Culture and power within the cultural context were discussed by Malik and Lindahl. In Woelz-Stirling, Kinaher, & Manderson’s qualitative study of violence in Filipino-Australian marriages a recurrent theme was the under-reporting of violence. The authors posited that under-reporting was linked to unequal relationships of power within the marriage; shame and fear of the women; and stereotyping and social disapproval of culturally mixed marriages.

Huisman discussed wife battering in Asian American communities and identified the service needs of an overlooked population. Cultural beliefs based on a patriarchal ideology may inhibit reporting and affect help-seeking behavior among Asians. Gabler, Stern, & Miserandino’s research compared attitudes about spouse abuse, retaliatory behaviors, and the legal implications of those behaviors in students from Latin America, the United States, and Asia (Japan and Korea). A key finding was that, contrary to the other groups, the Asian subjects indicated a man could be justified in hitting his wife/partner. Subjects from Asia indicated greater acceptance for a man to mutilate a woman who had abused him.

In the United States, Davidhizar, Dowd, and Giger recognized abuse as a major problem. They noted that providers know little about abuse among ethnically diverse persons. The authors described a model of transcultural assessment as a tool for providing culturally competent care. Campbell and Campbell explained the concept of cultural competence, adding advocacy as a component of appropriate responses for clinical intervention.

In a study conducted by Bauer, Rodriguez, Quiroga, and Flores-Ortiz, Asian and Latina women identified a variety of social, political, and cultural barriers to help-seeking. A variety of Asian women (Chinese, Korean, Japanese, S.E. Asian, Filipino, and Pacific Islanders) were clustered into focus groups. These women identified specific barriers that included language, discrimination, and fears of deportation, dedication to the children and family unity, shame related to the abuse, and the cultural stigma of divorce.

Two studies examined the role of researchers or practitioners related to IPV. Fontes examined ethical issues related to IPV research across cultures and pointed out that research reinforces the power imbalances of society. Researchers often study people who are less powerful than themselves. Chung, Wong, and Yiu studied attitudes and beliefs of emergency room nurses in Hong Kong. They found that nurses were not well prepared to care for victims of IPV and traditional cultural beliefs led to biases.

Within Hawai‘i 3 studies were conducted during this period. Two of the studies focused on the population as a whole. Kuban, et al., found that IPV was associated with posttraumatic stress disorder (PTSD).
The severity of the PTSD was associated with depression, lowered self-esteem, and diminished quality of life. They urged that IPV screening should be conducted routinely in medical settings. Goebert presented relevant IPV data, demonstrating that IPV is a significant challenge and an overlooked public health problem. Wilcox and Armstrong focused specifically on the Native Hawaiian population and developed a community prototype for identifying IPV incorporating Native Hawaiian values and practices. Both individual and collective aspects of the impact of IPV are recognized and addressed.

Results (2000 – 2005)

Asian cultures

Chinese

In China women reported IPV in a range of 34–46%. Eleven to 12% reported assaults that occurred during pregnancy. In the United States the number of assaults reported for Chinese-American women was lower (14%). Reasons given for violence against Chinese women included the rigid cultural view of gender roles and the patriarchal nature of society. Legalistic perceptions held by providers may undermine their effectiveness. The Chinese values, ren (endurance) as a coping mechanism and yuan (predestination) as an explanation for failure of a relationship, were seen in women’s response to battering. A randomized controlled trial of empowerment training for Chinese abused pregnant women revealed that an empowerment intervention was an effective strategy for reducing IPV.

Filipino

The prevalence of IPV reported in 2 studies of the Filipino population (conducted in the Philippines) was 13% and 21.2% (for lifetime experience). Patriarchal values were associated with IPV, and patterns of decision making emerged as a predictor of violence. When either gender dominated the decision making pattern, violence was likely to occur. In both China and the Philippines education emerged as a protective factor. Filipino men were shown to be receptive to interventions aimed at reducing IPV, particularly when they do not lead to “loss of face.” In a retrospective chart review conducted in a Cebu City medical center, Acobes-Escobal, Nerida, and Chez described the highest incidence of physical abuse as occurring in the home against women 26–35 years old, and perpetuated by husbands and live-in partners. Two studies that included Filipino women were conducted in the United States. In both studies women suffered IPV. In the Hawai’i, multi-cultural section.

Japanese

In Japan 67% (118 of 177 subjects) reported IPV. While IPV is considered very shameful, a study of women’s methods of coping comparing United States and Japan born Japanese-American women revealed that U.S.-born women were much less likely to minimize the IPV and much more likely to confront their partner about the violence. Yoshihama’s qualitative study of IPV in Japan found that the patriarchal system and the ideology of male superiority fostered reinforcement of the effects of violence. Yoshihama and Horrocks investigated the effects of trauma and found that it led to emotional numbing and arousal. These findings contrast with the current DSM-IV diagnostic criteria that list emotional numbing and avoidance as an effect of trauma. The same research team also investigated the relationship between IPV and PTSD. They found no evidence that the effect of IPV (on the development of PTSD) decreases over time. The relationship in general between IPV and PTSD was strong and highly significant.

Korean

Findings from studies of Korean women revealed that gender roles, patriarchal values, and education/income (called socio-structural power) of the women were key variables in both the incidence of IPV and the women’s response to the violence. Social stigma attached to reporting incidents of abuse, as well as face-saving concerns, influenced Korean-American women to avoid seeking help until the problem became severe.

Vietnamese

A study of IPV in Vietnam reported an incidence range of 5–20%. Gender and role expectations were factors in the abuse. Confucianism holds that women should be more concerned than men about peace and harmony in the family. The Vietnamese-American population immigration law and race relations were seen as barriers to receiving help. The 1986 Immigration Marriage Fraud Amendments and 1996 Illegal Immigration Reform and Responsibility Act lead to the worry and threat of deportation if violence is reported.

The study conducted by Shiu-Thornton, Sentura, and Sullivan found that there was an awareness of marital conflict in the Vietnamese community, but violence was regarded as a personal, private family matter. The concept of domestic violence (DV) as a health concern was only understood as a result of migration to the United States and the acculturation process.

Pacific Island Cultures

Micronesian

In Micronesia IPV was generally viewed as a misunderstanding between husband and wife. Many Micronesians regarded IPV as the behavior of an enraged, jealous husband, and others viewed it as a natural expression when men were not happy with the way their wives served them. The use of alcohol was consistently blamed for violence. In the past, people lived in close proximity and male relatives of women made sure that they were well protected. With current immigration patterns, the living circumstances do not provide the same level of protection for women. Since most Micronesian families considered IPV to be a family problem to be resolved by themselves or their family members, they were generally reluctant to seek help outside of the family.

Samoan

Crichton-Hill discussed the views of Samoan women regarding IPV. She criticized health care providers for trying to provide solutions for problems rather than allowing the women to make choices for themselves. She proposed that services should be provided by Samoan women who are culturally competent and have knowledge
and skills in DV.

Hawai`i, multicultural
Only two studies of the multi-cultural population in Hawai`i met the criteria for this analysis. In a retrospective chart review conducted in community health centers during 2002, 9% of the sample had documented disclosure of IPV. The level of IPV reported varied tremendously between cultural groups: Native Hawaiian 32.3%; Filipino 16.6%; Japanese 3.3%; Pacific Islander 16.1% and Caucasian 9.7%. In a qualitative study of preferred situations for disclosing IPV to a health care provider, the Native Hawaiian women stated their preference to talk to someone who knew their family or friends and who was well-known, trusted, and shared their values.47

Discussion
There is a need for caregivers to be aware of differences between Western notions of independence and individualism and the ideals of interdependence and group harmony held by specific cultural groups. Understanding the perspectives of these groups requires researchers and providers be prepared for findings that challenge their traditional knowledge base and interventions. Although in most Asian countries the governments have declared that women should enjoy equal rights with men, there continues to be a discrepancy between policy and practice. Cultural beliefs perpetrating this discrepancy include: husbands have a right to punish their wives; women are required to obey fathers, husbands, and sons; women hold an inferior position because they are not able to continue their father’s lineage; and women are responsible for the peace and harmony in the family. Developing interventions based upon these values is one of the greatest challenges in working with abused women from these specific populations. Ethnocentric behavior of women survivors of IPV and providers can lead to barriers to disclosure and intervention.

Liang, Goodman, Tummala-Narra, and Weintraub 58 suggest a conceptual framework for understanding the process of help-seeking, a multilayered experience that varies depending on many factors. The 3 stages include: (1) Defining the problem; (2) Deciding to seek help; and (3) Selecting a source of support. Analysis of this framework highlights various implications for IPV research and practice. Fontes 59 recommends that continued reflection on ethical issues will help shape investigations that simultaneously attend to the participants’ well being. Yoshioka and Choi60 question standard IPV policy by recommending interventions that involve staying in the relationship and eliminating the violence. The need to use culturally responsive and valid interventions calls into question the recommendation of Klevine and Bangdiwala 61 regarding using a standardized protocol for IPV research. Although rates can be compared with this approach the tools and protocols need to be adapted to be culturally appropriate so they are valid for the population being assessed.

An ecological model for understanding responses to IPV has been synthesized from a review of the literature and is illustrated in Figure 1. The model includes individual and group perspectives and factors that influence the behavior of both women and men. The factors include cultural norms and expectations; socio-economic forces; and relationship factors. These factors interface with individual behavior and determine perpetration of and responses to IPV. This model shows the complexity of understanding IPV within the context of the individual, culture, and community. Screening and interventions derive from this model and must be developed with an awareness of all of these factors, based upon input from the specific cultural groups.

Recommendations for future research
There is no doubt that more research/publication is necessary to fully understand IPV in this growing and extremely diverse population of Asian and Pacific Islanders. Further support for the importance of adopting an ecological model comes from Kasturirangan et al.,62 who concluded that cross cultural comparison studies should acknowledge varying contextual influences such as racism, immigration status, and ethnocentrism. An understanding of these forces can lead to a fuller understanding of factors that influence IPV in specific cultures. Almgren63 hypothesizes studies focused on individual and collective efficacy may identify significant protective factors against IPV.

Liang, Goodman, Tummala-Narra, and Weintraub’s 58 recommendation of qualitative research and client-centered interventions to address women’s experiences, and Kasturirangan et al.’s 62 recommendations that CBPR be used to study the impact of culture present sound approaches for future studies. Finally, individual views within provider groups should be explored to reach a better understanding of factors influencing screening and interventions.

References
Figure 1.—Ecological Model of Intimate Partner Violence

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The Role of Pharmacology in Medical Teaching

Abby C. Collier PhD, Assistant Professor of Pharmacology
Department of Tropical Medicine, Medical Microbiology and Pharmacology
John A. Burns School of Medicine, University of Hawai‘i

The role of pharmacology in medical education appears to be straight-forward: doctors need to understand the actions and uses of drugs to prescribe medications effectively and give quality medical care to patients. However, there are several other key issues to the role of pharmacology in medical education: (1) teaching clinical pharmacology is distinct from teaching the pharmacological basis of therapeutics and is, in fact, a specialist teaching discipline; (2) increasingly, professors who are best able to teach clinical pharmacology are leaving academia; and (3) how to integrate pharmacological instruction with problem based curricula (medical teaching based on case presentations and small group discussion) while ensuring that basic principles are also imparted.

Teaching Clinical Pharmacology
Pharmacology is perhaps the most integrative of all biomedical sciences. Its study requires understanding of anatomy, physiology, biochemistry, and cellular and molecular biology as well as the fundamentals of medical practice. All of this is in addition to learning the nomenclature and conventions of pharmacology as a discrete medical science. Graduate students have remarked that the core requirements of a pharmacology degree are difficult to achieve in the face of other, more focused courses such as neuroscience. In addition, in the last several years graduate programs have moved away from subject-specific emphasis into larger umbrella programs such as Graduate Programs in Biomedical Sciences. Such an umbrella program is offered at the University of Hawai‘i and University of California, San Francisco medical Schools, to name two examples. This is diluting the pharmacology degree. For example, 40% of PhD programs in the United States granting a pharmacology major require no formal course work in pharmacokinetics. Such statistics were the catalyst for a joint meeting between the Association of US Pharmacology Chairs and Industry Leaders in 2006. This panel cited the following as a central concern “…The impending lack of remaining “generalist” pharmacology professors who can teach medical pharmacology at the organ system and whole body level and medical schools are increasingly losing outstanding educators to private practice and industry.

In the United States, increased focus on sub-disciplines of pharmacology is largely a consequence of the highly compartmentalized research that has been required to be competitive for funding. Thus far, specialization has had little impact on graduate education because graduate students themselves go on to ever-more specialized careers. In contrast, specialization has strongly impacted medical education. For example, professors who sub-specialize into areas such as G-protein coupled receptors and cell signaling may become less willing or able to impart knowledge at the organ system or whole body level that is medically relevant and up-to-date. In addition, there is a lack of remaining “generalist” pharmacology professors who study the action and disposition of drugs at organ systems and/or whole body levels.

Physicians with additional post-graduate pharmacology training, usually through an MD/PhD or a post-graduate training program, are the other essential contributors to clinical pharmacology teaching. Clinical pharmacologists are being trained in ever decreasing numbers. The most recent data (1996) indicated that only 39 medical schools in the United States and Canada offered clinical pharmacology training programs. Furthermore, 113 fellows (84 physicians and 29 non-physicians) were enrolled in these programs but only 20 successfully complete training each year. For those that graduate, only two thirds follow academic careers.

Faculty Training, Recruitment and Retention
In addition to recognizing that basic and clinical pharmacology are separate sub-disciplines, there is concern surrounding the lack of clinical pharmacologists entering training and, once they have trained; the loss of pharmacology professors from academia. While all biomedical sciences in the United States are currently experiencing a period of uncertainty in relation to funding levels, pharmacology is experiencing additional problems. The pharmacology community believes that in vitro models and cell biology have become the driving force for funding research, training scientists, and for drug discovery and development. Pharmacologists do not dispute the importance of investigation at cellular and subcellular levels but, as a whole, they believe that the decline in investigations at organ-system, whole-animal, and human levels has become a serious threat to advancing medicine. This is impacting medical pharmacology teaching in 2 important and inter-related ways, namely: sub-specialization is reducing the number of professors who can teach medical pharmacology at the organ system and whole body level and medical schools are increasingly losing outstanding educators to private practice and industry.

In addition, more than
half of those enrolled in clinical pharmacology fellowships were primarily supported by competitive research dollars. Since these data were presented, anecdotal evidence suggests that things have not improved with declining enrolments and reduced availability of research dollars. The net result is a lack of professors with the appropriate background to teach full clinical pharmacology curriculum.

A way of addressing these issues has been advanced by a partnership between Sweden and pharmaceutical company Merck. Since 1990, Merck has created fellowships for physicians to specialize in clinical pharmacology at Swedish medical schools. The most recent data shows that Sweden alone (population 9 million) is training almost as many clinical pharmacologists as the United States and Canada combined (population 330 million). This demonstrates the immense value in dedicating resources to areas of the medical curriculum that are essential but difficult to fund through research-intensive paths. Another successful avenue for training clinical pharmacologists is the Hospital Pharmacology Program at State University of New York Upstate. This program funds academic physician-clinical pharmacologists and training in clinical pharmacology and has significantly boosted the number of clinical pharmacologists being trained.

Of further concern, pharmacology and pharmacy faculty are disappearing after post-graduate during post-doctoral training and junior faculty years. This is particularly relevant for women, who comprise 25% of the pharmacology and toxicology professoriate but are 6 times more likely to resign their academic appointments.

Finally, there is a feeling among many pharmacology professors that their research is criticized for not being disease-specific enough. Until the recent advent of the National Institutes of Health (NIH) “Roadmap” emphasizing translational research, disease specificity was a hallmark of NIH prioritization for funding. This is compounded when researchers from medical schools approach more basic agencies such as National Science Foundation and are commonly referred immediately back to the NIH as a primary source of dollars. In addition, when academic departments wish to increase their fundability to hire faculty based on dollar decisions which may increase the specialization within departments. Added to the ever-increasing stringency of animal and human ethical review boards (not necessarily negative), this means that pharmacologists face greater difficulties in setting up and running a research program. Because success as a professor relies upon research, service, and teaching, if one of these is truncated the remaining two cannot form the necessary support for academic career. One response to this is to leave academia for the pharmaceutical and biotechnology industries or for other careers including medical writing, regulatory affairs, or patent law.

**Integrating Pharmacology Instruction into Changing Medical Curricula**

In addition to training new faculty, it is important to address the role of pharmacology in the changing face of the medical curriculum. For many years the discipline has recognized a need for integration in medical teaching as evidenced by the split in designation between basic and clinical pharmacology. Being an integrative discipline, pharmacology departments were some of the first to comfortably incorporate Problem Based Learning (PBL). Pharmacological PBL may be described as teaching drug prescribing, use, and surveillance through small group discussion of clinical case studies consisting of presentation, medical diagnosis, and laboratory findings. While most professors would agree that pharmacology is well suited to the PBL environment, there are certain aspects of training, such as dosing and pharmacokinetics, independent of case-based learning that need to be taught in a lecture format. Balancing this can be challenging for professors, deans, clinicians, and educators who are all vying for time in an increasingly busy curriculum. An example of how to balance these competing interests can be taken from the Hawai‘i experience at the John A. Burns School of Medicine. In the past, integration of medical sciences was taken to its practical extreme by implementing a pure PBL curriculum. This was subsequently re-assessed and the medical curriculum, while still strongly PBL-based, is now supplemented with didactic lectures. Several recent studies have shown that didactic clinical pharmacology courses significantly improve the clinical practice of physicians. Other basic sciences at the John A. Burns School of Medicine are reporting similar improvements.

In conclusion, while the discipline of pharmacology as a whole faces challenges, its role in medical education continues to be strong. As a discipline, it is recognized that teaching pharmacology to medical students surpasses the pharmacological basis of therapeutics and needs a strong clinical emphasis to ensure effective and high-quality medical training. This approach is particularly well suited to bridging didactic and PBL curricula. Issues regarding the training and retention of pharmacology professors are still evolving and are being addressed at multiple levels on the international (pharmaceutical company sponsorship of training), national (NIH, national societies) and local (hospital-based training programs) stage.

**References**

Tobacco Smoking Increases Risk of Colorectal Cancer

Margreet Lüchtenborg PhD and Loïc Le Marchand MD, PhD
Epidemiology Program, Cancer Research Center of Hawai'i

Tobacco smoke is a major contributor to morbidity and mortality. In the United States, about 1 in 3 cancer deaths is due to exposure to tobacco smoke. Of the 185,000 smoking-related cancer deaths annually, 75% are due to lung cancer. Besides lung cancer, an increased risk of cancers of the urinary tract, head and neck, esophagus, pancreas, stomach, and cervix, as well as leukemia, has been shown to be associated with tobacco smoking. The evidence for an association between tobacco smoking and colorectal cancer on the other hand, has been less convincing. Because of the inconsistencies in the findings of past studies and because of the lack of adequate control for possible confounding factors, both latest United States Surgeon General1 and International Agency for Research on Cancer (IARC)2 reports concluded that there was insufficient evidence for including colorectal cancer among tobacco-related malignancies.

Cigarette smoking, however, has been consistently associated with colorectal adenomas, which are generally accepted as being precursor lesions for colorectal cancer. Thus, exposure to tobacco constituents may be an initiating factor for colorectal carcinogenesis. It has been hypothesized that the association between tobacco smoking and risk of colorectal carcinoma has been more difficult to establish than the association with adenoma because of a substantial time lag (of as long as 35 years) that may be required between smoking initiation and colorectal cancer development, which could reflect the time involved in the formation of a cancerous lesion.

A plausible biologic mechanism relating tobacco smoking to the occurrence of colorectal cancer includes the production of numerous genotoxic compounds in the combustion of tobacco. These tobacco carcinogens may cause irreversible damage to the colorectal mucosa via the circulation after bronchoalveolar absorption into the bloodstream or by direct contact after ingestion of contaminated saliva.

We recently had the opportunity to comprehensively investigate the relationship between tobacco smoking and colorectal cancer by pooling data from 2 large, successive population-based case-control studies that were conducted in Hawai‘i.3,4 These 2 consecutive case-control studies were conducted on Oahu between January 1987 and December 1991, and January 1994 and August 1997. A group of 1,959 patients with a first, histologically confirmed, primary adenocarcinoma of the colon or rectum and under 85 years of age agreed to participate and were interviewed within 1 year of diagnosis. Control subjects for both studies were selected randomly from a list of Oahu residents and matched to each case on sex, ethnicity, and age (±2.5 years). In-person interviews were conducted at the subjects’ homes by trained interviewers. The questionnaire included detailed information on country of birth, number of years spent in the United States, and ethnicity of each grandparent; a quantitative food frequency questionnaire; a lifetime history of tobacco use, including type of tobacco ever smoked, and if smoked, dose smoked for each tobacco product type (non-filtered cigarettes, filtered cigarettes, cigars, and pipes), age when started smoking, and if subjects stopped smoking, when and for which period; a lifetime history of consumption of alcohol and other beverages; a lifetime occupational history and history of recreational sport activities since age 18; a personal history of various relevant medical conditions, including constipation and laxative use; a family history of colorectal cancer; information on height and weight at different ages; and, for women, a history of reproductive events and hormone use.

Risk estimates (odds ratios and 95% confidence intervals) were computed for quartiles of pack-years of tobacco products (“pack-years” are defined as the number of tobacco products smoked per day divided by 20, times the number of years smoked), using never-smokers as the reference group and adjusted for other colorectal cancer risk factors in these studies (family history of colorectal cancer, body mass index 5 years ago, lifetime hours in recreational sport activities, and consumption of egg, calcium from foods and supplements, non-starch polysaccharides from vegetables, and alcohol). In addition, we estimated the risk associated with smoking over different time periods [i.e., 10-year increments in pack-years of smoking cumulative up to defined periods (0.5, 10, 20, 30, 40 and 50 years prior to diagnosis for cases or interview for controls)]

We found that, compared to never-smokers, both men and women who smoked were at a significant ~25% increased risk of colorectal cancer [odds ratio (95% confidence interval): 1.23 (0.99-1.52) and 1.27 (1.01-1.59) for men and women, respectively]. We did not find any evidence for a time-lag between smoking initiation and diagnosis that would suggest a long induction period for the effect of smoking on colorectal cancer. Increasing quartiles of pack-years of all tobacco products combined showed a clear dose-dependent association in men, but a dose-response trend was less clear in women. Interestingly, these associations appeared to be mostly due to the effect of smoking non-filtered cigarettes. Men in the highest quartile of pack-years of non-filtered cigarettes (>24 pack-years) were at a 1.73-fold increased risk (95% confidence interval: 1.27-2.34). The corresponding increase in risk was 2.23 (95% confidence interval: 1.25-3.98) for women who smoked more than 11 pack-years of non-filtered cigarettes. Smoking of cigars also increased risk of colorectal cancer in men.

The association between non-filtered cigarettes and colorectal cancer was observed or suggested consistently for each sex and ethnic group (Japanese, Caucasians, and Native Hawaiians). Increasing pack-years of smoking filtered cigarettes were significantly associated with rectal cancer, but not colon cancer. If confirmed, a more pronounced risk of developing colon or rectal cancer with non-filtered cigarettes, compared to filtered cigarettes, may be attributed to the greater likelihood to ingest tobacco smoke condensates from non-filtered cigarettes. Furthermore, higher exposure to carcinogenic polycyclic aromatic hydrocarbons may occur with...
Questions in Medical Malpractice XI
S.Y. Tan MD, JD, Professor of Medicine and Adjunct Professor of Law, University of Hawai‘i

Question: In spotting patients who may be suit-prone, which of the following are true?

A. Patients who are critical of others
B. Poor patients on welfare
C. Educated patients who surf the internet
D. Doctor-shoppers
E. Angry patients

Answer: A, C, D, E are correct. The vast majority of patients do not sue their healthcare providers even though there may have been a negligent act leading to injuries. Demanding and well-educated patients are more likely to sue, as are those who are already familiar with the legal system and with lawsuits. Watch for the hyper-critical patient. Financial gain is not the usual reason for a malpractice suit. Poor and uneducated patients are less likely to sue as they do not have the medical sophistication to recognize substandard treatment and they lack the know-how to seek legal redress.

Factors that Prompt Litigation

Anger

Question: What do you call an angry patient? Answer: A plaintiff. This is a familiar refrain of malpractice attorneys and should serve as a warning to doctors. Anger lies at the root of all malpractice claims, either from the adverse result itself or maltreatment of patient or family, e.g., a negative, indifferent, or arrogant attitude of the healthcare provider. Unjustified delays, stonewalling, not returning calls, and refusing to meet with the aggrieved, are all warning signals. These attitudes betray a lack of caring, which angers the injured patient who may then seek legal redress. And angry jurors who may have had similar bad experiences are the ones most likely to return a runaway verdict.

Plaintiff attorneys remind us that the majority of calls from would-be litigants are prompted by poor communication. The patients may not have a serious injury or a meritorious claim, but they are so angry about their physician’s inability or refusal to communicate that they contact an attorney to vent their anger. In one study of 263 patients and families who had successfully sued a physician, more than half said that they wanted to sue him even before the alleged malpractice incident took place.

Poor Service

Experts remind us that at Disney theme parks, everyone is a guest. There is a plan for guest comfort, and customer service is everyone’s job. Only people with a smile on their face are hired. Hospitals on the other hand may hire unskilled personnel who may receive little or no training before being put on the job. Overworked workers may treat patients as burdens, and oftentimes no one is present who is empowered to promptly address customer complaints.

We are urged to think of Nordstrom department store whenever we think of service. This retailer is a legend when it comes to putting the customer first. The story is told of the man who asked for a “refund” on a car tire that had obviously been in use for some time. Instead of arguing over whether the tire failed to meet the customer’s satisfaction, or whether it was defective, the sales clerk promptly and smilingly “refunded” the full cost. Nordstrom gained a happy customer, even though it does not sell tires.

Disparaging Remarks or Attitudes

Some lawsuits are filed because of suspicion raised in the patient’s mind by disparaging remarks made by one practitioner about another’s diagnosis or treatment. An example: “Who did that to you?” (doctor or nurse pointing to a large abdominal surgical scar). Without having all the facts, one should avoid making critical comments about a colleague’s work. Worse yet, unthinking health care providers sometimes enter disparaging remarks into the medical records. Statements like “physician refused to respond” should be replaced by “no response yet, will try again.” Disagreements between doctor and nurse require proper channels for resolution. The medical record is not one of them. In the event a staff member makes a mistake, a physician should respond in a calm and professional manner, without actively criticizing the person in front of the patient or family.

The staff can also be the cause of the lawsuit. Staff members are typically the first people in contact with the patient and family. They must listen to the patients and make them feel important. Staff should be as well trained in customer service as in quality care. One should counsel, and if necessary, discipline those who engage in gossip.

Money Disputes

Out-of-pocket costs for medical care are skyrocketing, and patients are less tolerant if they perceive insufficient value for their money. Because of the increasing impersonality of the medical encounter and the commercialization of health care, we can expect injured patients to retaliate, especially if they feel unjustifiably overcharged.

Aggressive billing practices run the risk of further angering a patient who may have suffered an adverse outcome. Great tact and sensitivity is necessary to avoid turning this into a malpractice claim. This is not to say that only good clinical results deserve to be paid for. However, a patient angry over the bill may have an unspoken agenda or otherwise legitimate reason for feeling hostile.

Some doctors resort to a collection agency for unpaid patient bills. This usually does not amount to much, and may be counterproductive, especially if there has been a complication. The habit mostly benefits the debt-collecting agency. Consider adopting the policy of writing off all unpaid bills in the name of public service, although this may be impractical for institutions or where the sums owed are large.
non-filtered cigarettes due to a less complete combustion of tobacco in non-filtered than in filtered cigarettes.

The data from our study provide strong evidence for an association between smoking and colorectal cancer. The study was very large, allowing for a careful examination of sub-groups separately (by sex, ethnicity, and anatomical site). The strength and uniqueness of this study was in the collection of a comprehensive life history of smoking for each tobacco product type. The detailed information on other lifestyle and dietary characteristics collected allowed for a careful adjustment for potential confounders in the data analysis.

This study suggests that there may be a difference in the colorectal cancer risk associated with smoking of filtered and non-filtered cigarettes. This observation may help to understand the effect of specific tobacco carcinogens on the large bowel. More importantly, the data show a clear overall association with smoking and suggest that colorectal cancer should be added to the list of malignancies associated with tobacco smoking.

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

References
1. Some of the materials in this section (Factors that Prompt Litigation) have been excerpted or adapted from an excellent videotape entitled “Seven Secrets of Avoiding Medmal Suits.” Videotape, 1996, Frew Consulting Group, Ltd.

“Cancer Research Center Hotline,” from p. 137

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<td>6/11-6/15</td>
<td>ON, HO</td>
<td>University of Nebraska Medical Center</td>
<td>Grand Wailea Resort &amp; Spa, Maui</td>
<td>2007 Pan Pacific Lymphoma Conference</td>
<td>Tel: (877) 832-6924 Email: <a href="mailto:coted@unmc.edu">coted@unmc.edu</a></td>
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<td>OBG</td>
<td>University of California - Davis</td>
<td>Hapuna Beach Prince Hotel, Kohala Coast</td>
<td>UC Davis Women’s Health Conference</td>
<td>Tel: (916) 734-5390</td>
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<td>6/22-6/26</td>
<td>OPH, OTO, HNS</td>
<td>Pacific Coast Oto-Ophthalmological Society</td>
<td>Turtle Bay Resort, O’ahu</td>
<td>The 91st Annual Pacific Coast Oto-Ophthalmological Society Meeting</td>
<td>Tel: (510) 232-6703 Web: <a href="http://www.PCOOS.org">www.PCOOS.org</a></td>
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<td>GYN</td>
<td>University of California, San Francisco</td>
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<td>Essentials of Women’s Health: An Integrated Approach to Primary Care and Office Gynecology</td>
<td>Tel: (415) 476-5808 Web: <a href="http://www.cme.ucsf.edu">www.cme.ucsf.edu</a></td>
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<td>7/2-7/5</td>
<td>IMG</td>
<td>Methodist Healthcare</td>
<td>The Fairmont Orchid, Kona</td>
<td>Geriatrics for the Primary Care Physician</td>
<td>Tel: (801) 516-8933 Web: <a href="http://www.methodistmd.org">www.methodistmd.org</a></td>
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<td>Multi</td>
<td>The Queen’s Medical Center</td>
<td>Hilton Hawaiian Village, Honolulu</td>
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<td>Tel: (808) 547-7009 Web: <a href="http://www.quueens.org/cme/">www.quueens.org/cme/</a></td>
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<td>R</td>
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<td>ORS</td>
<td>Department of Orthopaedic Surgery, Kaiser Permanente Hawai‘i</td>
<td>Grand Wailea Resort &amp; Spa, Maui</td>
<td>15th Annual Update in Orthopaedic Surgery, Hawai‘i 2007</td>
<td>Tel: (877) 843-8500 Web: <a href="http://www.cmxtravel.com">www.cmxtravel.com</a></td>
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<td>7/30-8/2</td>
<td>IM</td>
<td>University of California - Davis</td>
<td>Mauna Lani Bay Resort, Kohala Coast</td>
<td>New Advances in Internal Medicine</td>
<td>Tel: (866) 263-4338 Web: cme.ucdavis.edu</td>
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<td>Mayo Clinic College of Medicine</td>
<td>Hapuna Beach Prince Hotel, Kohala Coast</td>
<td>Mayo Clinic Practical 21st Century Clinical Neurology Review</td>
<td>Tel: (480) 301-8323 Web: <a href="http://www.mayo.edu/cme/">www.mayo.edu/cme/</a></td>
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<td>ON</td>
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<td>Keck School of Medicine of USC</td>
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<td>Stanford University School of Medicine</td>
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<td>EM</td>
<td>University of California - Davis</td>
<td>Waikoloa Beach Resort &amp; Spa, Hawai‘i</td>
<td>Emergency Medicine Update: Hot Topics 2007</td>
<td>Tel: (866) 263-4338 Web: cme.ucdavis.edu</td>
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<td>(415) 476-5808</td>
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<td>OTO, HNS</td>
<td>Hilton Hawaiian Village, Honolulu</td>
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ALL GREAT SUCCESS IS A WORK OF ART!
Now there truly is a therapeutic tool for treating macular degeneration (AMD). At a medical meeting in Montreal in July 2005, Genentech Inc. reported the results of a big phase III study which showed that Lucentis when injected into the eye was found to halt blindness in 90% of patients with AMD and improved vision in 30%.
This is not just great; it is miraculous! However the cost is $2000 per injection and a two-year program would reach nearly $50,000. But wait! Almost simultaneously, additional off-line trials with the anti-cancer compound Avastin, the molecule Lucentis was derived from, has been used by some bold doctors. They found it to be just as effective and it costs a mere $40 per injection. For the first time, the National Institutes of Health (NIH) has received federal funds to conduct a head to head study to compare the two biotechnology drugs. Both compounds are marketed by Genentech, but (needless to say) company executives are hoping Avastin will fail. This test sounds simple enough, but pharmaceutical industry moguls are terrified. They see the study as the first step in the government comparing cost vs. effectiveness and refusing to pay for drugs that fail to make the grade. That is exactly what has happened in the United Kingdom.

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THE NURSING BOARD LACKS SEX REPEAT!
The specialty of the house at the Heart Attack Grill in Tempe, Ariz., is a Quadruple Bypass Burger piled high with 4 half-pound beef patties, cheddar cheese, lettuce, tomato, and special sauce. But the obvious gastronomic insult is not what has the Arizona State Board of Nursing upset. They are angry because the waitresses wear stethoscopes around their necks, white hats with a cross, brief little skirts, fishnet stockings, and tight cleavage-baring tops. The nursing Board even got the attorney general’s office to write a letter stating that the wait staff called themselves “nurses” and were misleading the public. The proprietor, “Dr. Jon,” has laughed it off, been very grateful for the publicity, and stated that it is a matter of free speech. He says that the waitress title of nurse is a parody and his clientele is well aware that their skills are limited to food service. Moreover, he is no more a doctor than Julius Irving (Dr. J), the retired basketball star. He offered free french fries to the Arizona State Board of Nursing.

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The issue of physician-assisted suicide was regenerated in the current session of the Hawai’i Legislature. In 2005 a similar bill was killed after intense testimony. This time the measure was wisely 86’d after one committee hearing. One difference in the current measure is that physicians would be required to provide the patient’s death wish or refer the patient to a doctor who is willing to help him/her die. Repeated polls have shown that about 60% of Americans believe that people suffering with incurable medical conditions have a right to end their own lives. Yes, that is an important social issue. However, the American Medical Association and the Hawai’i Medical Association have consistently held that physicians are in the business of preserving life not ending it, and if society decides to help people die, do not make doctors the hammer.

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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.
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