



# HAWAI'I MEDICAL JOURNAL

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# Talking About Psychiatric Medications: A Parent-to-Parent Perspective (For Children and Youth) Part I

Susan Cooper JD, Michael L. Rimm MD, and Alfred M. Arensdorf MD



Susan Cooper JD



Michael L. Rimm MD



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## Abstract

*This article presents a format for parent-to-parent and parent-to-professional guidance on psychiatric medications for children and youth. It reviews progress in Hawai'i's system of care for child mental health. Between 1999 and 2006, Hawai'i had nationally and internationally renowned experts in psychiatric medication conduct CME for Hawai'i's primary care and specialist care physicians. These conferences have included consumers and non-physician mental health colleagues. The importance of involvement of consumers in the process of rational decision-making for the individual child or youth is an emphasis in the system of care in Hawai'i. The approach featured in Susan Cooper's "Meditation on Medication" presentation in the 2005 symposium breakout for parents demonstrates the genuine collaboration with consumers that may be a partial remedy for the data that shows an overall poor adherence to prescribed interventions.*

## Introduction

Providing psychiatric medication for children and youth stirs powerful emotions. Parent-to-parent and parent-to-professional guidance on talking about psychiatric medications for children and youth is presented in an understandable and family-friendly format in this article.

## Background

The Surgeon General's 2000 Report,<sup>1</sup> Roberts,<sup>2</sup> and Costello<sup>3</sup> note that 10% of children and youth have treatable mental health disorders. Less than 1 in 5 of these children and youth of these emotionally and behaviorally challenged youth who might benefit from psychiatric medications actually are assessed and offered treatment including medication.<sup>4,5,6</sup> Children and youth assessed in need of medication and receiving a prescription experience problems with adherence for a variety of reasons: less than 50% adhere to a "trial" beyond the first prescription. Parents are exposed to popular media distortions and misinformation. The availability of information on the internet is extensive. Its reliability is generally poor with much misinformation and an abundance of inappropriate recommendations without empirical support. Direct-to-consumer advertising by the pharmaceutical industry adds to parental, youth,

and community confusion and perplexity. The available Hawai'i data follows the national data pattern.

Families, caregivers and loved-ones are able to be the most consistent, reliable resources for our children and adolescents throughout their entire lives. Children and adolescents with emotional and behavioral challenges live and interact with their families/caregivers on a daily basis and spend more time with family than with health providers and educators. It is therefore of great importance to such children and adolescents to have their families directly involved in their treatment in ways that are specific to the needs of the child and to the strengths of the family and the community.

In 1984 the United States Congress appropriated funds for the development of core principles that would serve as the foundation for the development of public mental health systems that emphasized the key elements of family centered, culturally competent, strength based mental health services. These Child and Adolescent Service System Program (CASSP)<sup>7</sup> principles state that mental health services for children and adolescents will be "child and family centered and culturally sensitive... with the needs of the child and family determining the services provided." These principles also state that family strengthening and preservation, "...shall be the primary focus of the system of care, and that families or surrogate families will be full participants in all aspects... of the delivery of services."

Further emphasis for family centered mental health services were again highlighted in 2003 with the release of the President's New Freedom Commission Report on Mental Health.<sup>8</sup> This landmark document calls for a "transformation" in mental health services and challenges our state and local governments to provide child and adolescent mental health services that focus on the child/adolescent *and* key family members as the core focus of treatment interventions. Interventions are to be family-focused and not exclusively provider- or program-driven as is common within the "medical model."

The state of Hawai'i has made tremendous progress in developing mental health services that value and utilize the family and caregivers as essential participants in the services. Working in partnership, the State of Hawai'i

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Departments of Health and Education, with close collaboration with other state agencies, has developed a "System of Care" for eligible children and adolescents with behavioral and mental health challenges.<sup>9,10,11,12</sup> Guided by CASSP Principles, evidence-based treatments, and system accountability, the system of care model organizes a variety of mental health services and resources that are set up in a "service continuum" in terms of service intensity. Service intensity is primarily defined by the level of containment of a treatment setting and the amount of professional mental health services that may be provided, e.g., community-based crisis intervention service, acute psychiatric hospital service, hospital-based crisis stabilization service, hospital-based residential program, community residential program, intensive in-home service, supportive in-home services, foster homes with therapeutic services, multidimensional therapeutic foster care, multisystemic treatment service, and office-based services. Service intensity is also determined by the number and qualifications of mental health staff needed to provide the necessary intensity (staff to client ratio). Specialist child and adolescent psychiatric consultative and direct service are also available throughout the levels of the continuum of services.

As the Hawai'i system evolves, developing and adjusting to the needs of our youth and families, the Hawai'i mental health system continues to receive national attention for the development of child and adolescent services and the provision of services with demonstrably improved outcomes. Hawai'i system leaders have received national recognition and awards, have delivered keynote addresses at prestigious conferences, conducted workshops, and served as visiting faculty for other states and universities. Hawai'i mental health professionals routinely present at prestigious conferences, publish in leading scientific journals, and appear in local and national media. Hawai'i has hosted major conferences attracting internationally recognized leaders in the fields of child and adolescent psychopharmacology, family-therapy, various evidence-based treatment modalities, and child and adolescent mental health intensive case management. The American Academy of Child & Adolescent Psychiatry held its 48th Annual Meeting in Hawai'i in 2001 and will return in 2009 for its 56th Annual Meeting.

Navigating through the many components of any system of care can be stressful and at times overwhelming. Hawai'i is fortunate to have an organization such as Hawai'i Families as Allies (HFAA). HFAA is a statewide parent-run family network organization, recognized in Hawai'i and nationally as a voice on behalf of families of children and adolescents with emotional and/or behavioral challenges. HFAA is the Hawai'i state chapter of the Federation of Families for Children's Mental Health, a national organization that has been at the forefront in effectively advocating for service system change so that families are valued and treated as true partners.

HFAA works closely with the Hawai'i Department of Health's Child & Adolescent Mental Health Division (CAMHD). It is the mission of HFAA to assure that the family members are well supported and informed as youth and families are offered the services available in the service continuum. HFAA is present on each island in Hawai'i and is readily available to work alongside families who are in need of mental health treatment for their children.

The numbers and details of the many effective mental health interventions may at first appear overwhelming to many of our children and families. The evidence-based information available

and the frequent media-fed misinformation concerning many psychiatric medications further add to the confusion and perplexity of parents.

The parental guidance in addendum A by Susan Cooper JD, Executive Director of Hawai'i Families as Allies, offers pragmatic and rational guidance for families making decisions when psychiatric medications are recommended for children. The importance of collaboration and partnership between families, providers, payers, and the community is evident. There will always be incidents of misunderstanding and disagreement among the members of treatment teams.

## Conclusion

This article, with the background on the evolving Hawai'i mental health system of care for children and youth and with its pragmatic approach to the common issues facing families concerning psychiatric medications for children, provides prescribing physicians (whether primary care or specialists) with information and tools that may assist in the management of children and youth with challenging conditions that may be improved with judicious prescription and management of medication.

## Summary

Susan Cooper's guidance resonates well with the parental concerns and offers wise and practical counsel to parents as they participate and consent (or withhold consent) to the use of psychiatric medications in the treatment decision-making process. This open and family-involved approach may assist in assuring that the physician's patients are receiving and accepting (and thus adhering to) prescribed interventions.

## Addendum A

### Guidance for Talking with Parents

**Parent-to-Parent (and Parent-to-Professional):** There are four areas of concern that frequently arise with regard to medication. The **first** is what to say when it seems as though the entire world is encouraging you to put your child on meds but you do not believe it is in the best interest of your child to do so. The **second** topic is what to say when you want to put your child on meds with your doctor's recommendation, but grandparents, other family and friends feel it is a bad idea. The **third** situation, and by far the most difficult, is what to do when your child refuses to take medication. The **fourth** issue is how the professional can assist families in this decision-making process.

**First**, the school cannot force you to medicate your child. This is a protection provided under IDEA. If the school does give you a hard time, you might ask to talk to someone in an administratively higher position than the person you are speaking with. Do not simply tell people "I just don't want to put my kid on meds." It is better to have an arsenal of concise and short responses.

Depending on your situation, you may want to be a little more forthcoming with family and friends. You might try, "I've read (talked to my child's doctor) about the pros and cons of medication and don't want to medicate my child at this time. Perhaps if his/her behavior changes for the worse, I'll reconsider." Alternatively, "After looking at the pros and cons of medication, we're going to

try alternative approaches first. I feel it's healthier." On the other hand, "My child has had bad side effects when on meds, so we're trying other things." Or, "My child refuses to take medication and trying to force him/her to, only increases both our frustration levels, and his/her behavior. So for now we're going to try something else besides meds." You might try ending the discussion with a sincere "But thank you for your concern" and walk away, or change the subject.

**The second topic**, what if you and the child's doctor want to medicate your child, but family and friends do not understand your child's disability or how it affects the child, family, school and the community? As any of you parents know all too well, it is difficult to explain this to others who have not walked in our shoes.

My family had this situation. Both my husband and my parents were leery about putting our son on meds. It helped when I suggested to my husband that we try the meds as a trial, for a limited period, just to see if it improved our son's behavior and learning. Fortunately, my husband finally agreed, and as my parents are on the mainland, they were not too vocal. Unfortunately, we had trouble getting our son to take his meds and eventually he stopped altogether.

The "we're giving it a try" approach helps to diffuse others' criticism. You might tell others that you are going to monitor your child closely and if any negative effects occur, you will discuss the appropriateness of the meds with his doctor. If nothing else works, you again might try, "Thank you for your concern but I am going to follow our doctor's recommendation, at least for now." In these scenarios a firm but tactful approach is probably best.

**With the third issue**, there is the youth who refuses to take meds. Perhaps the meds make him "feel funny", perhaps he is "anti-drug", or perhaps he simply refuses. There is no magic solution to this problem, and it is probably a much bigger issue in families than any of us know. What I will do is give some suggestions that have worked for parents our agency has helped in the past.

- A reward program: Generally, this seems to work best for younger children. The problem I had with my son in about sixth or seventh grade was that he did not care about rewards and "nothing we tried to interest him in worked."
- For younger kids: You might try disguising the meds in food, meanwhile talking about the benefits and feelings associated with meds. Then set up a calendar with, for example, stickers, and begin a reward system so the child has a positive reaction to medication.
- Letting the child make the decision. This probably works best for older teens. One of our HFPA parents has a 17-year-old son who was severely depressed. He refused to take the medication. However, his depression and behavior were not improving, so finally Mom said we have done it your way and it has not worked. Now you will do it my way and take your meds. Although still reluctant, the youth has now agreed to take medication.

At age 11, a child with ADHD was prescribed a stimulant medication. The child did not want to take the medication. Mom said to give it six weeks and if there is no improvement, you do not need to take it. Son agreed but reported after six weeks that he did not feel any better. Furthermore, reports from the school did not show any improvement. Mom told son he no longer had to take meds. (Maybe a better solution would be to report to the physician and try a different medication). In his late teens, the boy now does take medication.

There is not a "fix all" solution to this issue. Each child is different and requires his or her own individual medication issue addressed. Perhaps you have had some success with getting your child or a patient to take meds. If so, please share it with others.

**As to the fourth topic**, how can you, as professionals, assist families in medication decisions?

- First, recognize that families are experts on their kids. Treat them as partners working together for the benefit of the child. Include the families in decision-making, openly allowing families to make the final decision on medicating or not medicating their child.
- Second, to do this, you need to provide families with all available information on the medication. Be up front with both the pros and the cons. Answer parents' questions. In addition, be sure to ask the appropriate questions of parents...the "why" questions..."why isn't your child taking the prescribed medication?" What can I do to assist you with giving medication to your child? Do not stop with writing the prescription...parents do not always know what questions to ask.
- Third, explain which and why certain medications take weeks to take effect. Be a support to the parent whose child's teacher reports that the child is "zombied out" during first and second period.
- Fourth, recognize that when a parent doesn't give the child his/her medication that it's usually not because the parent is lazy or doesn't care, but rather because of something else going on...the child refusing to take the meds...a battle every morning before school that wears down on the parent and exacerbates behavior problems...even to the extent that the child refuses to go to school.
- Fifth, refer parents to agencies such as Hawai'i Families as Allies, where we have many parents who have gone through most of the challenges that your patients are having with regard to giving/not giving medication. Parents who have had similar experiences can be an invaluable tool in assisting parents with medication decisions.

*Continues on next page*

Table 1.— CAMHD Conferences 2001 to 2006

Conference	Theme	Date	Chair(s)	Distinguished Guest Faculty
Best Practice Conference	“Choosing Effective Strategies for Serving and Supporting Children and Families”	1/10/01	Dr. Arensdorf	Dr. Barbara Burns Dr. Larry Greenhill Dr. Mario Hernandez Dr. Ann Vander Stoep Dr. John Weisz B.J. Wise Dr. Timothy Knoster Dr. John Burchard Dr. Scott Hennggeler
Best Practice Conference	“Supporting Best Practice Approaches for Youth with Emotional Disturbances”	10/23/01	Dr. Arensdorf	Dr. Robert Friedman Dr. Kimberly Hoagwood Dr. Peter Jensen Dr. Hill Walker Dr. Patricia Chamberlain Dr. Kay Hodges
Evidence-Based Pediatric Psychopharmacology 2004	“ADHD, Mood Disorders, and Aggression”	1/30/04	Dr. Arensdorf	Dr. Peter Jensen Dr. James McCracken
Family Intervention	“Building on Strengths, Supporting Change”	12/15/04	Dr. Rimm Dr. Slavin	Dr. Peter Sprengelmeyer Dr. John Sargent
Evidence-Based Pediatric Psychopharmacology 2005	“Lessons from the SSRI Experience in 2004”	4/14/05	Dr. Arensdorf	Dr. John Walkup
Intensive Case Management	“Emerging Best Practice in Intensive Case Management”	5/24/05	Dr. Arensdorf	Dr. Mary Evans Dr. Mary McKay Karl Dennis Dr. Sue Smith
Evidence-Based Pediatric Psychopharmacology 2006	“Does Everyone Have Bipolar Disorder?”	5/17/06	Dr. Viesselman	Dr. Gabrielle Carlson

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# Broken Heart Syndrome – A critical review of transient left ventricular apical ballooning

Stephen G. Chun MSIII, Grant L. Harada MS, Dawn K. Kuriyama MSIII, Timothy M. Nywening MSI, and Ralph V. Shohet MD



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## Abstract

*Transient left ventricular apical ballooning (TLVAB) is a recently proposed clinical entity that mimics an acute coronary syndrome in its clinical presentation. Retrospective studies suggest that it may account for 1% of myocardial infarction diagnoses. We provide a review of TLVAB including its clinical presentation, diagnostic studies, etiology, pathogenesis, criticism, complications, and management.*

## Introduction

Transient left ventricular apical ballooning (TLVAB) is a poorly understood clinical entity that mimics an acute coronary syndrome in its presenting symptoms and findings. It is characterized by transient left ventricular apical dilatation that is provoked by stressful stimuli. Recent retrospective studies suggest that it may account for as many as 1% of myocardial infarctions.<sup>1</sup> Since TLVAB has often been observed in post-menopausal women to be precipitated by emotionally stressful events such as news of the sudden death of a relative, it has also been called “Broken Heart Syndrome”.<sup>2-3</sup> Patients with TLVAB typically present with left sided chest pain, dyspnea, EKG changes, and elevation of cardiac serum markers.<sup>4</sup> However, angiographic workup reveals no evidence of acute plaque rupture or significant coronary stenosis. Echocardiography and ventriculography reveal left ventricular apical dilatation and dyskinesis, basal hyperkinesis, and a severely diminished ejection fraction.<sup>5-6</sup> The shape of the left ventricle in TLVAB seen in ventriculography and echocardiography has been likened to a *takotsubo* (a traditional Japanese octopus pot) which inspired the Japanese name for TLVAB of “takotsubo cardiomyopathy” (see Figure 1). Despite its worrisome acute manifestations, TLVAB is a relatively benign clinical entity that resolves spontaneously in the majority of cases with excellent clinical outcomes.<sup>2</sup>

Until reports of this syndrome in Caucasian patients in 2003,<sup>7</sup> this syndrome had been described exclusively in the Japanese population for over a decade.<sup>8</sup> With recent reports of TLVAB in multiple ethnic groups,<sup>2,9-10</sup> it has become apparent that TLVAB has no ethnic or geographic limits. As TLVAB has been documented in Hawai'i,<sup>9,11</sup> it is important for primary care physicians

in Hawai'i to understand the clinical manifestations and treatment options for TLVAB.

## Clinical Presentation and Diagnostic Studies

Post-menopausal women represent 82-100% of patients in studies of TLVAB with a typical age of onset of 62-75 years.<sup>6</sup> Patients with TLVAB usually present with left sided chest pain, dyspnea, signs of acute cardiac failure, and EKG changes suggestive of an acute anteroapical myocardial infarction.<sup>6</sup> Serum cardiac enzymes are typically found to be mildly elevated with studies indicating that troponin I peaks at <20 ng/mL, and CK-MB fraction peaks at <115 ng/mL.<sup>4</sup> Very high elevations of cardiac serum enzymes are inconsistent with the diagnosis of TLVAB.

Angiographic evaluation shows patent coronary arteries with no evidence of significant stenosis, acute plaque rupture, coronary vasospasm, or other abnormality. Echocardiography and ventriculography shows left ventricular apical dilatation, reduced ventricular systolic function, and an area of dyskinesis/akinesis that encompasses the entire left ventricular apex (see Figure 2). Ejection fractions range from 20-50%.<sup>4</sup> Subsequent imaging studies exhibit a reversal of ventricular dilatation and a return to normal ventricular systolic function in days to weeks.<sup>2</sup> It should be emphasized that even in cases where TLVAB is suspected, angiographic evaluation is necessary to exclude coronary occlusion, since their clinical manifestations are similar.

TLVAB is a diagnosis of exclusion with no universally accepted diagnostic criteria. The Mayo Clinic has recently proposed these criteria for diagnosis: 1) transient akinesis or dyskinesis of the left ventricular apical and mid-ventricular segments with regional wall-motion abnormalities, 2) absence of obstructive coronary disease or angiographic evidence of acute plaque rupture, 3) EKG changes – ST-segment elevation or T-wave inversion, and 4) absence of recent significant head trauma, intracranial bleeding, pheochromocytoma, obstructive epicardial coronary artery disease, myocarditis, hypertrophic cardiomyopathy, or any other obvious cause of left ventricular dilation.<sup>5</sup>

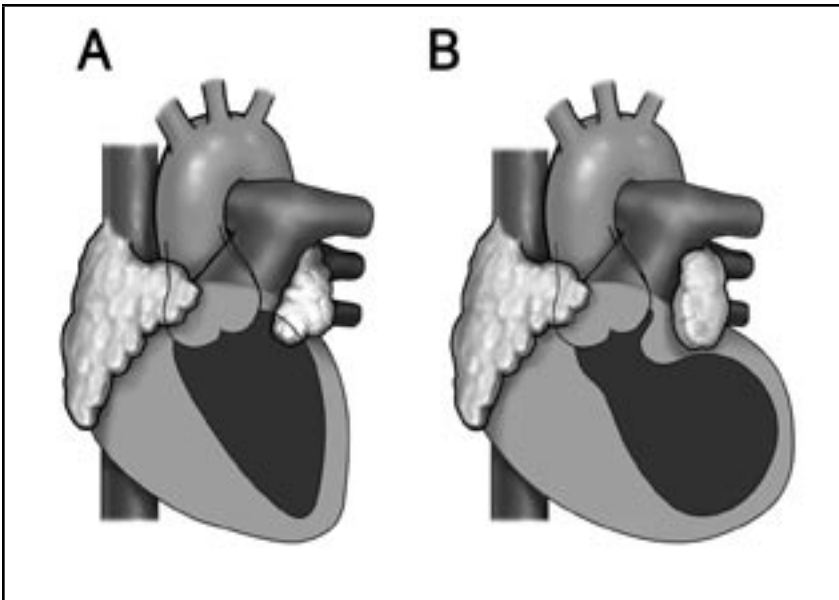


Figure 1.—A, diagram of a normal LV ventriculogram in end diastole. B, diagram of LV ventriculogram findings typical of takotsubo cardiomyopathy in end diastole. Transient apical dilation of the left ventricle causes acute left sided heart failure from a severely diminished ejection fraction. The dilation of the left ventricle seen in ventriculography and echocardiography resembles the shape of a takotsubo (a traditional Japanese octopus pot).

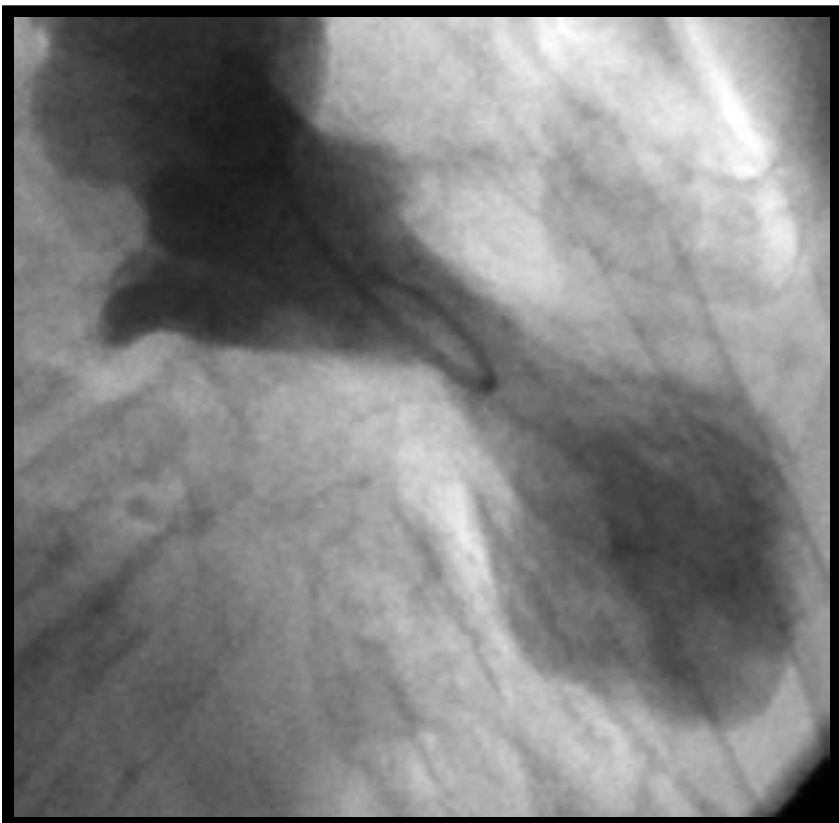


Figure 2.— Cardiac ventriculography findings suggestive of TLVAB. Systolic image shows transient left ventricular anteroapical and inferoapical dilation.

Although TLVAB has been used to describe transient myocardial stunning in the past, the current literature reserves the diagnosis of TLVAB for transient left ventricular dilatation that occurs in the absence of any other obvious anatomic, physiologic, or myopathic etiology.<sup>2,6</sup>

### Etiologies and Pathogenesis

TLVAB has been reported to be associated with a diverse array of physiologic and psychological stressors. In addition to the sudden death of a relative, reports attribute TLVAB to earthquakes,<sup>14</sup> pacemaker implantation,<sup>15,10</sup> cocaine use,<sup>16</sup> alcohol withdrawal,<sup>17</sup> and general anesthesia.<sup>18</sup> All stressors are thought to elevate serum catecholamines which are the major suspect in the pathogenesis of TLVAB. Elevated serum catecholamines have been frequently found in patients with TLVAB.<sup>2</sup> It has been proposed that elevated serum catecholamines may cause TLVAB through coronary microvascular vasospasm or through direct damage to the myocardium.<sup>2</sup> Dobutamine infusion has also been documented to precipitate TLVAB, lending credibility to the hypothesis that TLVAB is a catecholamine mediated process.<sup>19</sup> Although catecholamines are thought to play a major role in the pathogenesis of TLVAB, the predominance of this syndrome in post-menopausal women suggests that hormonal influences may also play a role in its pathogenesis. Recent attempts to elucidate the role of estrogen in TLVAB indicate that estrogen may reduce the sympathetic outflow and stress induced cardiovascular responses in ovariectomized rats that mimic the post-menopausal state.<sup>20</sup>

In summary, though excess serum catecholamines and sex hormones are implicated in the pathogenesis of TLVAB, their precise roles in the pathogenesis are unclear.

### Criticism

Though TLVAB has gained popularity in the medical literature and the popular media, it is not universally accepted that TLVAB is truly a novel clinical entity. Some suggest that TLVAB is merely a rare manifestation of an aborted acute myocardial infarction that underwent rapid endogenous thrombolysis.<sup>12</sup> Although elevated serum catecholamines have been documented in TLVAB,<sup>2</sup> it is possible that pro-thrombotic catecholamines<sup>13</sup> cause TLVAB by promotion of a transient thrombus rather than by a direct cardiotoxic effect. It has also been suggested that the large area of transient myocardial stunning observed in TLVAB may reflect a transient thrombus in a long left anterior descending artery that wraps around the left ventricular apex.<sup>12</sup> If TLVAB is actually a manifestation of transient thrombotic occlusion, than this syndrome could be an opportunity to study the process of rapid endogenous thrombolysis. Another possibility is that coronary spasm, lasting long enough to produce stunning, is the

culprit. Consideration of spasm, perhaps with provocative measures, should be considered as part of the angiographic evaluation.

## Complications

The most important role of the primary care provider in treatment of TLVAB is in the management of its complications, since there is no evidence that intervention will alter its clinical course. Though TLVAB resolves spontaneously with excellent clinical outcomes in over 95% of cases,<sup>6</sup> complications of TLVAB can include acute left sided heart failure with pulmonary edema, cardiogenic shock, mitral regurgitation, ventricular arrhythmia, and left ventricular mural thrombus formation.<sup>6</sup> Fatal complications of TLVAB reported in the literature include left ventricular free wall rupture<sup>21</sup> and multi-system organ failure from cardiogenic shock.<sup>7</sup> Although a few instances of recurrent TLVAB have been documented,<sup>22</sup> the role of preventative measures in TLVAB is unclear.

## Management

At present, there is no clear evidence-based approach to the management of TLVAB. Since TLVAB has a good prognosis, most of the literature advocates supportive care as a mainstay of treatment. Diuresis and ventilatory support are commonly used to manage pulmonary edema associated with acute left sided heart failure. Thrombolytics are contraindicated because there is no evidence of acute plaque rupture or thrombosis of the coronary arteries.  $\beta$ -blockers are thought to be particularly helpful as they reduce the effect of catecholamines on the myocardium and reduce ventricular wall stress. Administration of short-term anti-coagulation has also been suggested to prevent endocardial thrombus formation and cardiogenic thromboembolism from ventricular akinesis.<sup>6</sup> For patients with a past medical history of TLVAB, prophylactic sedation prior to stressful procedures and long-term  $\beta$ -blocker therapy have been proposed as strategies to prevent recurrence.<sup>23</sup> An antithrombotic level of chronic aspirin therapy would also appear to be worthwhile if there is no contraindication to its use. Although there is little guidance in the literature, it would seem that avoiding adrenergic cardiotoxic agents would be prudent if feasible.

## Discussion

TLVAB is a recently described clinical entity that should be considered as a part of the differential diagnosis for patients presenting with signs and symptoms of an acute coronary syndrome or acute heart failure. The existence of TLVAB as a clinical entity distinct from an unusual presentation of coronary thrombosis with rapid endogenous thrombolysis or from an unusual presentation of coronary spasm is not established. However, the large number of recent reports of TLVAB in the literature suggests that it is becoming more widely accepted. TLVAB is a diagnosis of exclusion for which the Mayo Clinic diagnostic criteria<sup>6</sup> may be helpful, although there is not yet a standardized definition. It is useful for clinicians to distinguish transient left ventricular apical ballooning syndrome from an acute coronary syndrome because their treatment and prognoses are distinct. Currently, there are no evidence-based guidelines for treatment though the administration of  $\beta$ -blockers and short-term anticoagulation have been recently proposed as strategies to prevent serious complications of this syndrome.

TLVAB is poorly understood and warrants further studies on its incidence, risk factors, clinical management, pathogenesis, rate of recurrence, and possible preventive measures. The current flurry of reports of this syndrome in the literature may reflect an increasing incidence of this syndrome due to an aging population, since TLVAB almost exclusively afflicts post-menopausal women. It may also reflect increased detection due to the widespread access to coronary angiography. Further studies should attempt to determine whether TLVAB represents a special abnormality of adrenergic sensitivity in the myocardium, or simply a rare presentation of a better known cardiac pathophysiology.

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# Intimate Partner Violence: Perceptions of Chuukese Women

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## Abstract

*Purpose:* This qualitative study examined Chuukese women's views about Intimate Partner Violence (IPV). *Methods:* Focus groups were conducted in Chuukese. *Themes emerged from content analysis. Results:* Migration may disrupt protective cultural practices. Cultural norms place the responsibility for family peace on the women who perceive that IPV is closely linked with marital infidelity. *Implications:* Understanding cultural practices is important in addressing IPV.

## Introduction and Review of the Literature

This paper reports a qualitative pilot study that examined cultural perceptions, awareness, responses, and actions recommended about Intimate Partner Violence (IPV) by Chuukese (Micronesian) women served by a community clinic on O'ahu. Violence against women by an intimate partner is a common experience worldwide.<sup>1</sup> Annually in the United States, IPV is responsible for 40 to 50 percent of all murders of women, approximately 1,300 deaths.<sup>2</sup> Estimates are that annually 5.3 million IPV victimizations occur among women 18 years and older. As high as these figures are, it is consistently accepted that IPV rates are underestimated.<sup>3</sup> Nearly 2 million injuries result from this violence with 550,000 of them requiring medical attention. In 2003, 1 in 3 women injured during a physical assault or rape required medical care.<sup>1</sup> Intimate partner violence is associated with significant health and other related consequences including acute and long-term psychological, physical, social, and economic effects.<sup>4</sup> Reported rates of IPV have a wide range of variation from one cultural or ethnic group to another.<sup>5,6</sup> There is little data available regarding the incidence and prevalence of IPV in women who are of specific cultural traditions.<sup>7,8,9</sup> Differences between cultural perspectives related to IPV may lead to barriers that prevent women from receiving effective care.<sup>10</sup> Campbell and Campbell<sup>11</sup> suggest that clinical interventions for abused women should be based on principles that include cultural competence and empowerment.

Estimates are that 20% of women in Hawai'i aged 18 to 64 have been victims of IPV.<sup>12</sup> Between 1995 and 2004 in Hawai'i there were 57 murders of women from IPV.<sup>13</sup> On O'ahu, the research team conducted a retrospective review of randomly selected medical

records of women seen between 1997 and 2002 at 4 community health centers (CHCs). In 9% of the 337 records there was documentation of disclosure of IPV. The sample included Native Hawaiian, Caucasian, Black, Filipino, Japanese, Chinese, Vietnamese, Laotian, Korean, Samoan, Tongan, and Chuukese women.<sup>5</sup>

The research group that conducted the retrospective chart review in 2003 was comprised of clinical staff from 3 CHCs and 2 faculty members from the Department of Nursing from the University of Hawai'i. This research group made a commitment to continue working together on this challenging issue by becoming a community based participatory research group. The group has adopted a common mission and agreed to approach research with an emphasis on mutual respect, shared decision making, and inclusion of all participants in analysis and dissemination.

As this research group continued to respond to the challenges faced in addressing IPV within the context of the CHCs, each center identified their priority population. One of the CHCs was seeing an increased number of women from Chuuk. This increase is related to the historical relationship between the Pacific Island Nations of Micronesia and the United States under the Compacts of Free Association that allows migration without visa or time limits. The relationship has led to an increased number of Micronesians now living in Hawai'i.<sup>14</sup> Limited economic resources and struggling health care systems in Micronesia motivate many to migrate. People from the islands of Chuuk, which is the most populous group in the Federated States of Micronesia are the fastest growing Micronesian group in Hawai'i. Cultural traditions of the Chuukese include the importance of sibling relationships, the centrality of the church and political clans, and land as the basis of wealth. These factors contribute to the challenges and transition from Chuuk to Hawai'i.<sup>15</sup>

The new immigrants are seeking services from the CHCs resulting in the need for additional information regarding the health and social needs of this population. The CHCs intentionally recruit staff from the populations they serve. At one of the CHCs health care providers who care for women from Chuuk were concerned about disclosures of IPV to Chuukese staff and the lack of information on the cultural views of Chuukese women

regarding this topic. These Chuukese staff members became a part of the CBPR group.

The CBPR group reviewed the literature to seek additional information. Only one study was found. Samuel<sup>8</sup> reported that many Micronesians regard IPV as the behavior of an enraged, jealous husband, or a natural expression when men are not happy with the way their wives serve them. In that study the use of alcohol was consistently blamed for violence. Samuel also noted that in the past, people within extended families lived in close proximity for survival and protection and male relatives of women made sure that the women were well protected. When families move away from Micronesia, the nuclear family system does not provide the same level of protection for women as the extended family did. The report concluded that most Micronesian families consider IPV to be a family problem, to be resolved by themselves or their family members, and they are generally reluctant to seek help outside of the family.

There were no additional research studies regarding Chuukese women's perception of IPV and services that would be helpful for them when the traditional system of protection is disrupted by migration to Hawai'i. Recognition of the need to further investigate IPV in this population led the CBPR group to develop this qualitative pilot study. Members of the CBPR group were granted a small amount of seed grant funds to conduct this pilot study in Chuukese and to fund the translation and transcription expenses. The amount of this funding limited the number of focus groups that could be conducted. The study examined cultural perceptions, awareness, responses, and actions recommended about IPV by Chuukese (Micronesian) women served by a clinic on O'ahu. The current study builds on previous studies of IPV conducted individually and collectively by members of this research team. It is part of a series of studies leading to the development and testing of culturally appropriate IPV screening questions and interventions in Hawai'i. The terms IPV and domestic violence have been used synonymously. This study investigated only IPV, not other inter-familial abuse. For this study IPV is defined as: a pattern of assaultive and coercive behaviors that may include physical injury, psychological abuse, sexual assault, progressive isolations, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.<sup>16</sup>

## Methods

The study is a part of a series of exploratory CBPR studies based on critical social theory,<sup>17</sup> a theoretical foundation oriented towards improvement of the human condition. This descriptive study used a qualitative approach by conducting 2 focus groups with 7 Chuukese women. Focus groups ideally are comprised of between

7 and 10 participants.<sup>18</sup> The CBPR group selected focus groups as the method of data collection for two primary reasons. First Chuukese women regularly met in groups to discuss health topics at the CHC. In addition, focus groups can be used effectively to understand the experiences, perceptions and preferences of different people by convening homogenous groups that increase the participants' comfort in talking with similar others about complex and difficult issues.<sup>18</sup> In preparation for this study, the CBPR group including the Chuukese research team members participated in 12 hours of training conducted by expert consultants on 3 topics: conducting focus groups; protection of human subjects; and IPV.

Chuukese women served by an O'ahu community clinic who were 18 years and older, and might or might not have experienced IPV, were recruited to participate in the focus group. Younger women were excluded. Demographic data were also collected. Women participating in the focus groups were asked about cultural perceptions and awareness of their cultural group regarding IPV; cultural responses of women to IPV; and to identify the actions that they believed would address the problem of IPV in their cultural group. The instruments were translated from English to Chuukese and back translated into English.

The focus group proceedings were audio taped and transcribed in Chuukese and then back translated into English. Individually each member of the research team including the bilingual Chuukese facilitators reviewed the transcripts using content analysis to identify themes that emerged from data.<sup>19</sup> Subsequently the entire research team met to discuss their analysis which led to an agreed upon document that was organized according to the identified themes. The same 7 participants were then invited to a second session (validation group) to provide them with an opportunity to review the findings, assure the accuracy of the findings, and add any additional thoughts. Demographic data were analyzed using descriptive methods.

## Results

Seven Chuukese women between 28-58 years old participated in the focus groups. Six of the women were married and 1 was single. The women had from 1 to 6 children, 6 were unemployed and 1 was employed. Six of the spouses were unemployed and 1 was employed and the annual income was less than \$10,000 for all the participants. The educational level of the participants ranged from 3 who completed elementary education to 2 who had some high school education and 2 who finished high school. The primary language of the participants was Chuukese and they had lived in Hawai'i between 1 and 5 years. Safety considerations dictated that information on direct experience of IPV was not solicited in the demographic information or from the questions posed during the focus group.

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The women participating in the focus groups described a cultural norm that placed the responsibility of maintaining family peace on women. They stated that women are expected to tolerate the abuse in silence. Women were aware that IPV occurred in their cultural group and they noted that physical signs (such as bruises), hearing loud fighting, and separation of the couple were all indicators of IPV.

The Chuukese women perceived that IPV is closely linked with marital infidelity. The women stated “This is one of the major problems Chuukese women have to go through.” The women related that there are times when a man wants another woman and has an affair but it is hard for him to admit it. He will, however, start to make life very difficult and hard for the wife. He does not want his wife to ask questions and will get upset if she mentions her fears. From there “problems” will arise. He won’t want to talk to her and will create problems just so he can go back to the other woman. The women recounted that the wife is expected to hide all her problems and her hurts because it is shameful. She should not tell anybody. She will not want people to know. “When people do find out that a couple is having problems, they automatically blame the wife and assume that it is probably because she does not want to sleep (have intercourse) with the husband.”

The women acknowledged that abused Chuukese women may respond to their husbands in different ways. They noted that there are some women who do everything their husbands tell them to do. However, there are times when women do not want to listen to their husbands, and the men will not be happy and will respond with more violence. So there are women who feel the pain but try to be accepting, and others don’t bother themselves with the pain. In other words, some women carry on and try to suppress their feelings.

When in this situation, Chuukese women seek support from their mothers or sisters, but generally avoid discussion with their brothers or fathers unless they are willing to be told to end the relationship with their partner. Women also described the importance of their relationships with the partner’s larger family as an influence in decision-making regarding continuation of the relationship. They said as long as they know that the husband’s family loves, supports and accepts the wife as the “one and only one” for the husband then it does not matter what he does. The women agreed that most of the time, when a Chuukese man is finished with the affair, he will come back to his wife. The husband may tell the wife not to worry because even though he goes out with other women, she is, and will always be, his “number one,” and he will always come back to her. The women concluded that “there are those that can go crazy. There are those that don’t worry as long as they have family support from the husband’s side. And then there are those that say, ‘It’s okay if he goes somewhere else, for he will always come back to me.’”

The women noted changes that are occurring within their cultural group regarding respect for the sanctity of marriage. One woman recounted a traditional Chuukese saying that “there is a meaning to this word marriage, ‘Punuwei is Pununuwei’ – until my head falls off my head that will be the time I will let go of my wife/husband.” This is her interpretation of a Chuukese saying although it is not an exact definition. They also noted a current Chuukese saying about marriage today, “Married life today for the young is as easy as getting dressed and then getting undressed. Last month I had her/him,

this month I have her/him, but long ago marriage was forever.” The women stated that there are also “habits” today that make one go crazy and lose all respect for family and cultural life. They identified the use of alcohol and drugs (ice) as habits that are related to IPV. The women identified cultural ways to confront the problem of IPV. Their suggestions included using specific Chuukese “magic” to make women more appealing to their husbands. They also identified others beyond their family such as church leaders and the head of the clan who could provide advice and assistance. They mentioned, and would use shelters for a break from their husbands; however, they stated they would not call the police.

In response to the question of how IPV was described across generations, they responded that girls would be instructed when they were considering marriage, or at the time of their marriage. The instruction would include information about family life so they could avoid marital problems. For example, they suggested that women should always be cautious of the words they use when talking to their husbands to avoid creating any problems. “We tell our daughters to obey their husbands.” They also advised that women needed to be prepared for their husbands in bed to help reduce any problems. All this would make it much easier for the women to get back together with their husbands/partners. Voicing an alternative perspective the women also acknowledged that, “sometimes people will tell you not to go back to him if he is having an affair.”

In response to the question of how the agency could help with this problem the women said that there should be counseling to help increase understanding between the couple. For example they said, “When a woman is having problems someone should be there to help counsel her and to tell her ‘everything is going to be okay.’” They believed that women should be urged to be patient and not be troubled.

## Discussion

Chuukese women who participated in this study were recent immigrants to Hawai‘i and had multiple socio-economic challenges such as unemployment, very low incomes, limited education, and families that included multiple children. In Hawai‘i these factors may contribute to a lack of ability to consider alternatives when responding to health and social concerns. In addition to these challenges, the cultural expectations of these women may place them at additional risk when experiencing IPV. For example, when women are abused, their cultural role as the peacemaker of the family may be a barrier to disclosure and action. If an abused woman seeks help, she may feel like a failure and perceive that she is stigmatized. These cultural norms may reinforce the women’s silence and isolation and increase their risk of mental health conditions.

Cultural strengths may be used to design screening tools and interventions that may be more readily accepted than the Western protocols commonly implemented. For example, Chuukese women may confide in other women and have relationships with their partners’ family that could be supportive as they struggle with abuse and its impact on their individual and family situation. Although in Hawai‘i the change from extended family dwellings to living within a nuclear family structure may place women at increased risk when they are abused, the close community ties still provide some degree of protection. The tradition, of discussing the implications of marriage with young women, might be used to raise the level of



awareness of the potential for violence with the marriage relationship. However, it should be noted that young Chuukese women may view their roles and relationships differently as they continue to be exposed to other traditions and perspectives. The mention of the link between IPV and the use of alcohol and drugs requires further exploration.

The women recognized that the clinic could be a resource for them. This connection with the agency offers promise of assistance for Chuukese women who are facing the multiple risks associated with IPV. There is a need for providers to be aware of differences between cultural groups. While Western interventions rely on providing safety through separation when there is violence, other traditions may prevent the ready acceptance of this approach. Standard IPV protocol needs to be questioned<sup>20</sup> leaving open the consideration of 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 & Bangdiwala<sup>21</sup> regarding using a standardized protocol for IPV. Their assumption that rates can be compared by using a standardized protocol is based on the belief that the protocol is valid in any cultural context. Our study leads us to question the use of standardized protocols if they have not been culturally tailored.

Results from the Chuukese study reinforce the need for an ecological model for understanding cultural influences that may effect screening for IPV.<sup>22</sup> The model proposed by Magnussen et al. 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. Further support for the importance of adopting an ecological model comes from Kasturirangan et al.<sup>23</sup> 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 recognition of factors that influence IPV in specific cultures.

This exploratory descriptive qualitative study was designed to examine cultural perceptions, awareness, responses, and actions recommended about IPV by Chuukese women. The findings from this pilot study reflect views of a small number of Chuukese women served by only one clinic in Hawai'i. Although these results are an important first step, they are not intended to be generalized beyond that group. There is no doubt that more research is necessary to further understand IPV within the historical and currently changing traditions of the Chuukese population. Additional research data is needed regarding both the collective cultural view and individual perceptions pertaining to IPV. Almgren<sup>24</sup> hypothesizes that studies focused on individual and collective efficacy may identify significant protective factors against IPV. Future studies should consider recommendations by Liang et al.<sup>25</sup> on the use of qualitative research and client-centered interventions to address women's experiences and by Kasturirangan et al.<sup>23</sup> on the use of CBPR to study the impact of culture. Finally, individual views within provider groups should

be explored to reach a better understanding of factors influencing screening and interventions.

## Acknowledgement

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## Student Profile, Class of 2011

### John A. Burns School of Medicine (JABSOM), University of Hawai'i

**Satoru Izutsu PhD, Senior Associate Dean and Chair, Admissions Committee  
John A. Burns School of Medicine, University of Hawai'i**

On July 20, 2007, 37 women and 25 men matriculated as first year medical students at the John A. Burns School of Medicine by receiving their first white coat and stethoscope. This event was the "White Coat Ceremony" held before more than 400 family members, guests, faculty and staff. This traditional event is held each year for the in-coming class to welcome them into the profession. Sponsors were the Class of 1982 who celebrated their twenty-fifth anniversary since their graduation from JABSOM. The keynote speaker was Dr. Robert J. Bidwell. He opened his remarks with, "I welcome you because I believe absolutely that your presence will enrich our JABSOM *ohana*, each of you coming with your own life experiences and challenges, with your talents, passions, and dreams. And if we, as JABSOM faculty, take the time to listen, we will learn as much from you over the next 4 years, as you from us."

Who are these students?\* For 62 positions, 1901 candidates applied. Of this number, 240 were granted interviews. Finally, 62 were selected; 55 are residents and 7 are from out-of-state. Forty-five were new applicants and 17 re-applicants. There were no "Early Decisions" or "Delayed Matriculants". The ages ranged from 20-39, with an average of 23.

JABSOM is a very diverse school. This fact is illustrated again this year by: 16 Japanese/Japanese-White; 11 Mixed Asian; 10 White/Chinese-White; 6 Native Hawaiian; 4 White; 2 Guamanian or Chamorro; 2 Korean/Korean-White; 2 Vietnamese; 1 Chinese-American Indian; 1 Asian Indian; 1 Chinese-Japanese-Palauan; 1 Japanese-Okinawan-White; 8 declined to respond.

Twenty percent graduated from public high schools; 11% from mainland high schools; 3% from Pacific Basin high schools; 61% from private high schools; and, 5% from foreign schools. Forty-four graduated from colleges on the mainland; 15 from Hawai'i colleges; 2 from foreign colleges; and, one from the University of Guam. Of the total, 9 attended graduate colleges; Georgetown University, Pennsylvania State University, Santa Clara University, Tufts University, University of California-Irvine, University of Hawai'i at Manoa, University of Michigan-Ann Arbor, University of North Texas, and University of Toronto. All students have Baccalaureate Degrees; in addition, seven have Master Degrees; and two have earned doctorates.

The academic credentials for the entire, entering class were: Median Cumulative Grade Point Average (GPA), 3.65; and, median Science GPA, 3.60. Medical College Admissions Test (MCAT) median scores were: Verbal Reasoning- 9; Physical Sciences-10; Writing Sample-P; and, Biological Sciences-11. Median Total Score was: 31.

The process of entering the John A. Burns School of Medicine is similar to that used by 126 US medical schools accredited by the American Association of Medical Colleges. All applicants must sit for the Medical College Admissions Test and apply through the American Medical College Admissions Service. This Service compiles transcripts, academic data, and personal histories to send to the schools designated by the applicant. Applicants who pass an academic screen are assigned two interviewers. All applicants meet the Senior Associate Dean, who is also Chair of the Admissions Committee, at the end. The interviewers (70 faculty, regular and clinical, and fourth year medical students) are interested in learning about the applicant as a person. Therefore, MCAT and GPA scores are not transmitted to the interviewers. Interviewers receive all essays, the personal history from AMCAS and two from JABSOM that: 1) "Describe succinctly the important experience(s) in your life which began the process that motivated you to enter the career of medicine" and 2) "Please explain why you are applying to the University of Hawai'i John A. Burns School of Medicine". The interviewers are interested in assessing an applicant's leadership skills, interpersonal skills, quality of compassion to help people, and stamina and motivation to pursue at least eight years of training and education. The meeting with the Committee Chair ensures that all questions and issues related to admissions are answered in a timely, accurate manner.

The Admissions Committee is composed of 11 members, 7 clinicians, 3 basic scientists, and 1 social scientist. There are 4 women and 7 men who represent the major ethnic groups in Hawai'i and age levels. They meet 21 times beginning in September and ending in April. The activities of the Committee are as follows: a few days prior to a meeting the dossier of the applicant to be discussed will be assigned randomly to a member of the Committee. The member will go "on line" with a designated password to examine the AMCAS folder that consists of: MCAT scores, academic transcripts, and the personal history statements. In addition, the members will review the applicant's hard copy interview reports, letters of recommendations, and essays requested by JABSOM in their folders. The respective committee member, at the meeting, will follow a pre-determined sequence in reporting the highlights of each section of the dossier. Questions will be forthcoming from the other members of the Admission Committee. When the Chair of the Admissions Committee determines that there is an understanding of the "whom" and "what" of the candidate, he will call for a secret ballot. An individual, confidential ballot is cast by rating the candidate from 1-10, not discussed, and submitted to the Registrar

See "Medical School," p. 276



## RTOG Clinical Trials for Prostate Cancer

**Paul A. DeMare MD, FACR, FACRO**

**Principal Investigator, Radiation Therapy Oncology Group, Cancer Research Center of Hawai'i  
Associate Professor, John A. Burns School of Medicine**

Clinical trials for cancer have been available for more than 50 years. It was demonstrated in the 1960s that the survival of children entered on protocols was superior to those who were not on a study. Even the patients on the control arm did better than the non-study patients. Early on, this has changed the way that pediatricians approach children with malignancies. More than half the children with cancer are currently treated on randomized clinical trials. In adults, however, clinical trials have not been embraced by the medical profession or the general public. On a national basis as well as here in Hawai'i only about 2% of the adults with cancer are enrolled on a clinical trial.

Many people feel that the reason there is such poor accrual to research studies is that there is no trial available for most of the patients with cancer. This is probably true for many types of cancer. For example, there are very few trials available for patients with lung cancer, and the ones that are available are for patients who already have Stage IV or metastatic disease. These types of trials may demonstrate some survival benefit but they are not going to improve the 5-year survival rates of lung cancer.

We need to develop trials to improve the treatment of early stage disease to improve cure rates of patients with malignancies. The Radiation Therapy Oncology Group (RTOG) has developed several different protocols that address the patients with prostate cancer along the whole continuum of disease. Therefore, almost all patients with prostate cancer have access to one or more clinical trials. By enrolling in a clinical trial, each patient can be assured that he is receiving a very complete and thorough workup as well as the most up-to-date and evidenced-based treatment available.

Low-, intermediate- and high-risk patients with prostate cancer can be characterized by the Gleason Score, prostate specific antigen (PSA) and clinical rectal examination.<sup>1</sup> The definition of low-risk most often includes those patients with a Gleason score of 6 or less, PSA of 10 ng/ml or less, and stage T2a or less disease. Intermediate-risk patients generally have a Gleason score of 7, a PSA up to 20, or palpable tumor to stage T2b, without any other high risk factor. High-risk patients generally either have a Gleason score of 8 or above, a PSA above 20, or advanced disease on digital exam beyond T2b.

There are a large number of treatment alternatives for patients with prostate cancer, and they include radical prostatectomy, radiation with external beam radiotherapy, interstitial brachytherapy with either permanent or temporary implant, hormonal therapy or some combination thereof. Watchful waiting should also be considered in some patients.

There has never been a head to head study comparing radical prostatectomy with radiation, nor is there likely to be. However, there are several studies designed to identify treatments that are

effective and offer the best quality of life (QOL) for our patients. The three studies below are Phase III studies, which are studies that are designed to compare two or more different treatment options.

For low-risk patients, **RTOG 0415** (Table 1) compares the efficiency of conventional External Beam Radiotherapy (EBRT) (which takes two months to complete) with a shorter course of treatment.<sup>2-4</sup> Complications and side effects will be evaluated. 1,067 patients will be randomized on this study, and if the results are comparable, the short and less costly arm could become the standard of care for this particular patient cohort.

For intermediate-risk patients who choose to have an interstitial permanent implant, **RTOG 0232** randomizes the addition of five weeks of EBRT in an attempt to determine if there is a benefit of treatment potential for lymph node metastasis. Overall survival and disease-specific survival will be analyzed, and QOL<sup>5-7</sup> will also be assessed in this protocol to make sure that the complication rate is not increased.

For high-risk patients (high PSA and/or high Gleason Score) **RTOG 0521** randomizes the addition of chemotherapy<sup>8</sup> with the conventional treatment of EBRT and hormone treatments. This will test the hypothesis that chemotherapy may improve the survival and local control of disease in these patients. This is a Phase III that study is being conducted on a very select population of patients and will require an enrollment of 600 patients. Should this study be positive, chemotherapy, hormones and radiation will become the standard of care for this particular group of patients.

There are also Phase II studies available which are designed to evaluate promising treatments that have been previously done in small patient populations. This will allow us to scrutinize these promising treatments in a rigorous manner and assess their value by looking at the overall results including the toxicity.

For patients with recurrent prostate carcinoma following EBRT, **RTOG 0526** is a prospective Phase II trial of brachytherapy.<sup>9-11</sup> Currently there is no standard treatment for recurrent prostate cancer. This particular study will allow us to evaluate the side effects of such treatment and evaluate the potential benefits in terms of survival and local control in a group of patients that may otherwise have been treated palliatively with hormone treatment. Surgery is not frequently used in this situation because of the high risk of complications.<sup>12</sup>

Currently, most brachytherapy is done with permanent seed implants with Iodine-125 or Palladium-103. **RTOG 0321** is a Phase II study evaluating the effectiveness of High Dose Rate (HDR) brachytherapy<sup>13,14</sup> using Iridium-192 in combination with five weeks of EBRT. Improved treatment planning has made this technique of delivering high doses of interstitial radiation to the prostate and keeps the dose of radiation to the nearby bladder and rectum to an

Table 1.		
Patient Eligibility	Protocol Number	Study Objectives
Low-Risk	RTOG 0415	Phase III randomized study of hypofractionated EBRT vs. conventional fractionation
Intermediate-Risk	RTOG 0232	Phase III comparing EBRT + brachytherapy vs. brachytherapy alone
High-Risk	RTOG 0521	Phase III androgen suppression, EBRT vs. androgen suppression, EBRT and chemotherapy
Locally recurrent prostate cancer after EBRT	RTOG 0526	Phase II prospective trial of permanent seed brachytherapy for recurrent disease
T1c-T3b, any Gleason Score, PSA <20	RTOG 0321	Phase II trial of HDR (temporary brachytherapy implant) and EBRT
Intermediate-Risk undergoing brachytherapy	RTOG 0612	Pilot study to demonstrate the feasibility of acquiring specimens to perform DNA microarrays
Stage IV with bone metastases	RTOG 0517	Phase III trial to assess the value of Sr-89 or Sm-153 to prevent or delay additional bone metastases
High-grade or locally advanced on LHRH agonists	RTOG 0518	Phase III study to evaluate the efficacy of Zometa to prevent osteoporosis and fractures

acceptable amount. Patients with PSA less than 20 are eligible to be randomized on this study.

Translational research is the use of bench research to offer aid in treatment in the clinical setting. **RTOG 0612** allows us to use biopsy specimens taken at the time of the prostate brachytherapy. Microarray technology will allow us to analyze the gene expression of the prostate cancer cells and the adjacent normal tissue. Acquiring this information may give us insight on the genetic profiles associated with a response to radiation.

For men with metastatic prostate cancer, **RTOG 0517** offers a randomized Phase III trial to evaluate radiopharmaceuticals (Sr-89 or Sm-153) and bisphosphonates (Zometa) in the palliation of osteoblastic metastases. Patients in the control arm receive zoledronic acid, 4 mg IV, monthly, plus vitamin D and calcium supplement. Patients who are randomized to the experimental arm also receive single dose of Sr-89 or Sm-153.<sup>15,16</sup> The study is designed to determine if the addition of a radionuclide (Strontium-89 or Samarium-153) to bisphosphonates for patients with asymptomatic or stable symptomatic bone metastasis will delay the time to development of malignant skeletal related events (SREs), defined as a pathological bone fracture, spinal cord compression, surgery to bone, or radiation to bone.

The RTOG studies 85-31, 86-10, and 92-02, as well as other data have shown that the use of androgen deprivation therapy (ADT) in conjunction with radiation therapy for locally advanced and/or high-grade adenocarcinoma of the prostate increases disease-free survival and in the case of 85-31, overall and disease-specific survival.<sup>17</sup> For patients with locally advanced prostate cancer receiving radiation and LHRH antagonists, **RTOG 0518** offers a randomization between vitamin D and calcium supplement and placebo vs. vitamin D, a calcium supplement and zoledronic acid (Zometa). If this study is positive, the standard of care will be changed, because currently there is not enough evidence that bisphosphonates decrease the risk of osteoporosis and associated fractures<sup>18</sup> in this setting.

Each of the eight studies described above have the potential to change the way that prostate cancer patients will be treated in the future. **RTOG 0415** will decrease the number of EBRT treatments by over 30% with a resultant 30% cost savings. EBRT added to the brachytherapy in **RTOG 232** may increase the cure of prostate cancer, and therefore, decrease the need for palliative treatment in the future. Similarly, the **RTOG 521** may demonstrate that chemotherapy improves the cure rate of high-risk patients.

Currently there is no curative treatment option for patients who fail treatment with EBRT, but **RTOG 0526** may offer long-term local

control and improve quality of life in these patients who would have otherwise been offered only palliative treatment. Using Microarray technology as utilized in **RTOG 0612** may allow us to better individualize treatments for improved outcomes and better quality of life (QOL). It may help us to better understand the biology of prostate cancer and perhaps to know which patients might better be treated surgically, rather than with radiation. **RTOG 0517** may show that radionuclide treatments can decrease the morbidity of patients with bone metastases by preventing them from progressing and/or developing new ones, an excellent QOL benefit. We know that LHRH antagonists can improve the survival of patients with advanced prostate cancer, but the results of **RTOG 0518** may show us that we can reduce the morbidity associated with this type of treatment. By reducing morbidity, there will be an improvement in QOL together with a cost savings.

In conclusion, RTOG has been able to design clinical trials with wide eligibility criteria to include the majority of men with prostate cancer. Many of these trials could potentially result in developing new and cost effective standards of care, with both improved outcomes of survival and QOL. The challenge is for RTOG and other cooperative groups to develop similar clinical trials with broad eligibility for other cancer sites. For a true public health benefit we need to build on the current data to improve and direct treatment strategies with clinical trials for patients with early or localized lung cancer and other cancers that have high mortality rates.

For more information about the Cancer Research Center of Hawai'i, please visit its web site at [www.crch.org](http://www.crch.org).

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See "Cancer Research Center," p. 276



## Issues in Medical Malpractice XVI

S.Y. Tan MD, JD, Professor of Medicine, John A. Burns School of Medicine, University of Hawai'i

**Question: (one or more choices may be correct):** Your patient tests positive for HIV and despite your repeated advice, refuses to disclose this to his wife, who is also your patient. Assume husband and wife engage in unprotected sex.

- A. You should not disclose the diagnosis since patient has not given his consent.
- B. You have both a moral and legal duty to inform his wife.
- C. Patient may sue you if you breach confidentiality.
- D. Wife may sue you if you keep silent.
- E. You have to disclose to the health authorities as required by law.

**Answer: B, C, D, E are correct**

Only upon the basis of trust can a patient begin to form a relationship with a doctor. This means the doctor must respect a patient's confidential information, so without consent, medical information generally cannot be disclosed.

However, under some circumstances, a doctor is obligated to breach confidentiality as required by law, or because of a higher competing interest. Examples of legally required disclosures are public health hazards such as sexually transmissible diseases, which include HIV infection. The law not only permits such reporting, the law mandates it. There is therefore a legal duty to report to the authorities, and choice E is correct.

Even if there is no state regulation on point, a doctor is morally obligated to disclose sensitive information to named third parties if actual harm can be prevented through such disclosure (see *Tarasoff* case discussed below). Under the given facts, the doctor should inform patient of his intent to tell the wife of the diagnosis since patient absolutely refuses to do so himself. The fact that the wife is also your patient simply adds to the doctor's moral duty to disclose. Choice B is correct.

Of course the patient may sue the doctor for breach of confidentiality but the doctor will likely win. There is a much greater risk for a lawsuit from the wife if the doctor fails to disclose and she becomes infected. In such a lawsuit, the physician will likely lose. Both C and D are correct choices.

### Disclosure to Third Parties

Historically, patient confidentiality was part of an ethical code that all doctors abided in, the tradition dating back to Hippocrates:

*"Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all should be kept secret."<sup>1</sup>*

Notwithstanding Hippocrates (and HIPPA, its modern progeny), the professional duty of protecting the secrets of a patient is not an absolute one, and there are situations where limited disclosure is not only permissible but obligatory. An obvious exception is a state law requiring the disclosure of communicable diseases. Other examples are the mandatory reporting of suspected child abuse and gunshot wounds.

A more difficult situation arises when there is no statute on point, but the public welfare is at stake. The well-known *Tarasoff* case established that where there is threatened harm to a named third party, the practitioner is required to reveal the information to the intended victim. This has been termed the *Tarasoff* rule, after the California case of *Tarasoff v. Regents of University of California*. In *Tarasoff*, a jilted patient confided in the University psychologist his intention to kill his ex-girlfriend. The information, though shared with campus security, was not released to the intended victim, the girlfriend, whom the patient stabbed to death two months later. The Court found the psychologist and the University of California (under *respondeat superior*) liable, reasoning that the protection of public safety was more important than the sanctity of the doctor-patient confidentiality relationship:

*"We recognize the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication. Against this interest, however, we must weigh the public interest in safety from violent assault... In this risk-infested society, we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest."<sup>2</sup>*

Disclosure to third parties of sensitive patient information such as having a contagious disease may constitute defamation, which is defined as harming a person's reputation through communicating to others a verbal or written falsehood. However, there may be a qualified privilege to such disclosure where there is a public health interest. For example, in *Simonsen v. Swenson*, a physician disclosed a positive syphilis test result that turned out to be an error. In the defamation suit that followed, the court declined to impose liability on the doctor, finding that he was protected in discharging his duty to disclose.<sup>3</sup>

As a whole, health care professionals ought to be far more circumspect in observing confidentiality. Loose talk, gossip and disclosure of patient identity, in addition to the indiscriminate

*Continues on next page*



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## Medical Legal Hotline

release of a patient's medical records are all examples of confidentiality breach. Healthcare professionals commonly discuss patient problems, sometimes identifying the patient by name or room and bed number, in public places within earshot of strangers. In a 1995 study that observed 259 one-way elevator trips in 5 US hospitals, the authors overheard a total of 39 inappropriate comments which took place on 36 rides (13.9% of the trips).<sup>4</sup> Many of the comments clearly breached patient confidentiality.

This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is excerpted from the author's book, "Medical Malpractice: Understanding the Law, Managing the Risk" published in 2006 by World Scientific Publishing Co., and available at Amazon.com. You may contact the author, S.Y. Tan MD, JD, at email: [siang@hawaii.edu](mailto:siang@hawaii.edu) or call (808) 728-9784 for more information.

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## Medical School

(Marilyn Nishiki) who will average the ratings. The Chair does not vote. These ratings are ranked in April when all applicants have been evaluated. Fifty-two are notified of acceptances. The "wait list" is determined by the first natural "cut-off" of the rank order. Ten from the Imi Ho'ola Program are added, if they complete successfully the one-year Post Baccalaureate Program. Up to 10% of the class may be out-of-state candidates who are considered from a separate rank order. In an entering first-year class, there are generally 56 who are "residents" and 6-7 who are from out-of-state.

The Class of 2011 is well on its way. It is now the challenge for the student, teachers, and family to ensure that these talented and gifted young women and men are given every support and opportunity to succeed. The basic ingredients of becoming outstanding physicians to serve humankind are imbedded in each student.

\*Data compiled by Marilyn Nishiki, Registrar.

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Date	Specialty	Sponsor	Location	Meeting Topic	Contact
<b>November 2007</b>					
11/8	PD	Queen's Medical Center	Hilton Hawaiian Village, Honolulu	Pediatrics Island Style: the Hawai'i Approach to Pediatric Obesity	Tel: (808) 377-5738
11/8-11/10	Multi	Mayo Clinic College of Continuing Medical Education	Grand Hyatt Kauai Resort & Spa, Koloa, Hawai'i	Parkinson's Disease and Other Movement Disorders for the Practitioner, 2007	Tel: (480) 301-4580 Web: <a href="http://www.mayo.edu/cme/">www.mayo.edu/cme/</a>
11/9	Multi	Hawai'i Society of Addiction Medicine	Queen's Medical Center	Addiction Medicine: Perspectives and Practicalities	Tel: (808) 327-4848
11/9	Multi	Pu'ulu Lapa'au	Queen's Medical Center	The Disruptive Physician	Tel: (808) 678-1581
11/9	Multi	Telehealth Research Institute, John A. Burns School of Medicine, University of Hawai'i	JABSOM Telehealth Research Institute	Crisis Team Training	Tel: (808) 692-1093
11/10-11/13	Multi	American Medical Association	Hawai'i Convention Center, Honolulu	AMA Interim Meeting	Web: <a href="http://www.ama-assn.org/">http://www.ama-assn.org/</a>
11/12	Multi	Queen's Medical Center	Queen's Medical Center	The Queen's Medical Center Conference on Pain & Palliative Care: "Mission Impossible: Challenges in Pain & Palliative Care"	Tel: (808) 537-7009
11/12-11/19	OSM	Continuing Medical Education, Inc.	NCL Pride of Hawai'i	2007 Orthopaedics & Sports Medicine	Tel: (800) 422-6711 Web: <a href="http://www.continuingeducation.net">www.continuingeducation.net</a>
<b>December 2007</b>					
12/24-12/31	SM, PUD	Continuing Medical Education, Inc.	NCL Pride of Hawaii	2007 6th Annual Pulmonary Infectious Disease & Sleep Disorders Conference	Tel: (800) 422-6711 Web: <a href="http://www.continuingeducation.net">www.continuingeducation.net</a>
<b>January 2008</b>					
1/12	IM	American College of Physicians-Hawai'i Chapter	Koolau County Club	Updates in Internal Medicine	Tel: (808) 586-7478
1/13-1/18	R	University of California, San Francisco	The Fairmont Orchid, Kona	Breast Imaging in Paradise	Tel: (415) 476-5808 Web: <a href="http://www.cme.ucsf.edu">www.cme.ucsf.edu</a>
1/19-1/21	Multi	Pan-Pacific Surgical Association	Sheraton Waikiki, Honolulu	28th Annual Congress: Connecting Surgeons Throughout the Pacific	Tel: (808) 941-1010 Web: <a href="http://www.panpacificsurgical.org">www.panpacificsurgical.org</a>
1/20-1/25	R	University of California, San Francisco	The Fairmont Orchid, Kona	Body Imaging in Paradise	Tel: (415) 476-5808 Web: <a href="http://www.cme.ucsf.edu">www.cme.ucsf.edu</a>
1/21-1/25	AN	California Society of Anesthesiologists	Hyatt Regency Maui Resort & Spa, Ka'anapali Beach, Maui	CSA Hawaiian Seminar	Web: <a href="http://www.csahq.org">www.csahq.org</a>
<b>February 2008</b>					
2/6-2/9	Multi	Society of Laparoendoscopic Surgeons	Hilton Hawaiian Village, Honolulu	Asian-American MultiSpecialty Summit III: Laparoscopy and Minimally Invasive Surgery	Tel: (800) 872-1119
2/9-2/15	OBG	Keck School of Medicine of USC	West Maui, Maui	Perinatal Medicine 2008	Tel: (800) 872-1119
2/15-2/17	Multi	Hawai'i Academy of Family Physicians	Sheraton Waikiki, Honolulu	2008 Family Medicine Update	Tel: (808) 864-9812
2/16-2/19	OTO, HNS	Tripler Army Medical Center and the University of California, San Francisco	Hilton Hawaiian Village, Honolulu	Pacific Rim Otolaryngology - Head and Neck Surgery Update	Tel: (415) 476-5808 Web: <a href="http://www.cme.ucsf.edu">www.cme.ucsf.edu</a>

2/17-2/22	R	University of California, San Francisco	The Fairmont Orchid, Kona	Neuro and Musculoskeletal Imaging	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
2/17-2/22	IM	University of California, San Francisco	Grand Hyatt, Kaua'i	Infectious Diseases in Clinical Practice	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
2/21-2/26	GE	Keck School of Medicine of USC	Kaua'i Marriott Resort, Kaua'i	Medical and Surgical Aspects of Esophageal and Foregut Disorders: Pathiophysiology and Treatment	Tel: (800) 872-1119
<b>March 2008</b>					
3/1	Multi	Queen's Medical Center	Hilton Hawaiian Village, Honolulu	The Queen's Medical Center Conference on Quality & Patient Safety	Tel: (808) 537-7009
3/1-3/8	D	Skin Disease Education Foundation	Hilton Waikoloa Village, Waikoloa	32nd Hawaii Dermatology Seminar	Web: www.sdefderm.com
3/17-3/21	R	Stanford Radiology Department, Stanford University School of Medicine	Grand Hyatt Kauai Resort and Spa, Poipu Beach, Kaua'i	16th Annual Diagnostic Imaging Update in Kaua'i	Web: radiologycme.stanford.edu/2008kauai/
3/30-4/4	IM	University of California, San Francisco	Wailea Beach Marriott Resort & Spa, Wailea, Maui	Primary Care Medicine: Update 2008	Tel: (415) 476-5808 Web: www.cme.ucsf.edu



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Russell T. Stodd MD

## ❖ MYSTICISM IS A RELIGIOUS DISEASE.

In Atlanta, Georgia, ophthalmologists expressed extreme concern when it was found that an estimated fifty followers of Hira Ratan Manek were following his instructions and staring directly at the sun. He defended this practice by stating that he preaches staring only 10 seconds at first and gradually building up to 45 minutes! He claimed his advocates should stare while the sun is close to the horizon. A similar cultist was loose on Maui about 15 years ago and brought about macular burns in her true believers before being reported to authorities.

## ❖ THE REALITY CHECK BOUNCED.

Surgical teams in both the United States and Europe have announced to the media that they have the ability to transplant a new face on patients who have survived with severe scarring from burns, extensive oral or facial cancer surgery, or tissue destruction from IEDs (improvised explosive devices). Often the patient is so deformed that he/she fears being seen in public and feels unable to maintain a meaningful life. The prospect of a new face sounds great, but the consequences of facial transplant are nearly insurmountable. The patient must be maintained on life-long expensive immunosuppressant drugs with the potential for kidney failure or cancer, and to discontinue the medication often results in death. Moreover, the psychological factors of wearing someone else's face (from a cadaver), and lacking expression due to inadequate muscle and nerve control, is another ethical problem to overcome. The factors of drug cost, concomitant complications of immunosuppressant therapy, and psychological burdens, means that such patients must be carefully selected. It's yet another case of doctors leaping ahead into the field of "Okay, we can do it, but should we?" Of course, it does sound wonderful on the six o'clock news.

## ❖ IF AT FIRST YOU DON'T RECEDE, COME GET INJECTED.

In the ever-so-popular field of exploiting fat Americans, a number of medical cosmetic spas are now promoting Lipodissolve, touted as a non-surgical alternative to lipo-suction. They are offering *Botox* for your brow spasm, *Restylane* for your facial creases and now PCDC for your porky bottom. Fatty areas of the buttocks or abdomen are injected with a series of tiny shots meant to melt fat. There are no fat-lysing injectables approved by the FDA, so practitioners use a custom mix from a local pharmacy or one made in a doctor's office. A concoction used by many is called PCDC, a combination of phosphatidylcholine and sodium deoxycholate. A retrospective study published in the *Aesthetic Surgery Journal* collected data from 75 physicians in 17 countries on 17,376 patients, and found that 12% were unhappy with the result, and some had complications of hyper-pigmentation, pain and allergic reactions. The pathetic truth is that an increasing number of doctors are concentrating on lucrative cosmetic procedures, and reducing standard areas of care.

## ❖ SHIFT THE RESPONSIBILITY, THE TRIAL LAWYER'S SHELLGAME.

In Sacramento, California, a 51-year-old truck driver went to his doctor for a routine physical exam. Laboratory tests were done, including CBC and urinalysis which revealed some abnormalities. The patient was scheduled to return in two weeks for a colonoscopy, but he failed to keep that appointment and did not see the doctor again. Two years later, after passing blood from his rectum, he saw a different physician who found that the patient had colon cancer. The patient brought a law suit against the original physician for failing to follow up when he did not return. The facts were not in dispute, but the patient (and his trial attorney) claimed the doctor should have contacted the patient when he missed his second appointment. Fortunately, the physician was supported in this case, but the question remains, who is responsible for not keeping an appointment, the patient or the doctor? Are we accountable for our own actions or inactions?

## ❖ FOR A GIFT ONE IS ALWAYS BEHOLDEN.

The *New England Journal of Medicine* recently published results of a study of gifts to physicians from pharmaceutical manufacturers. Collecting data from 1,662 physicians in 2003 and 2004, it was found that 94% acknowledged that they had accepted some form of gifts or money from drug companies or medical-device manufacturers. Specifically, 83% reported being treated to meals; 78% took free drug samples and 35% accepted reimbursements for the cost of attending educational conferences hosted by drug companies. Almost 7% admitted they were treated to food, lodging, travel, plus cultural and sporting events. Moreover, 28% were paid for speaking engagements and enrolling patients in clinical trials. "We all know that gifts and gratuities create a subconscious sense of indebtedness," according to lead investigator Professor David Blumenthal, MD, of Harvard Medical School. The American Medical Association strongly urges doctors to accept no gifts worth more than \$100. Some physicians challenge the broad conclusions coming from such surveys, and ask "Does having pizza with a drug rep compel me to prescribe his company's latest compound?"

## ❖ SHE RARELY HAS A HEADACHE!

According to Reuters the Orient Industry Co. of Tokyo, Japan, turns out 80 finely designed and anatomically correct "love dolls" each month which sell for \$850 to \$5500. The more elaborate models are made of silicon, are remarkably life-like, and have up to 35 movable parts. They are purchased by men who prefer synthetic girls to flesh and blood. Says one satisfied buyer who has two dozen dolls which all have names, "I prefer live women, but dating is such a bother."

## ❖ OUR SAFETY NET HAS SOME LARGE DEFECTS.

The Institute of Medicine (IOM) wants us to know that the nation's emergency-care system is breaking down. The IOM found that in some cities emergency teams save half of victims of cardiac arrest, but in other places they save only 5%. The crisis is already apparent in day-to-day emergencies which means that in any bus or plane crash or other catastrophic event, the emergency system would be unable to provide equipment, beds and personnel. The IOM report recommends that state agencies, health organizations, and hospitals set up regionally coordinated emergency systems to direct ambulances and patient flow. Considering the unique geography of Hawai'i, the potential for breakdown is even more serious. This is a challenge the DOH and Civil Defense must undertake.

## ❖ TO BE OR NOT TO BE... "HEY, WHATEVER"

In Great Britain, educators have endorsed rewriting the works of Shakespeare as comic books using simpler language for "bored" students. The examples given were from *Henry V*, "Stiffen the sinews, summon up the blood. Disguise fair nature with hard-favour'd rage; then lend the eye a terrible aspect." Comic book version, "Get a fierce look in your eyes."

## ADDENDA

- ❖ According to Price Waterhouse Coopers 10% of every dollar spent on health care is attributable to medical liability and defensive medicine.
- ❖ Officials in Saudi Arabia announced that the country is 80 beheadings ahead of last year's pace, and is on track to break the record of 191 set in 2005.
- ❖ In Belgium, the newly elected prime minister, Yves Leterme, was asked to lead in singing the national anthem on National Day, so he stepped to the microphone and sang the *Marseillaise*.
- ❖ A Finnish man won the International Mobile Phone Throwing contest with a toss of 89.62 meters.
- ❖ Headline in the *El Paso Times*, "Man stabbed outside Hiney's seeks help at Hooters."

## ALOHA AND KEEP THE FAITH — rts■

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



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