# HAWAII MEDICAL JOURNAL

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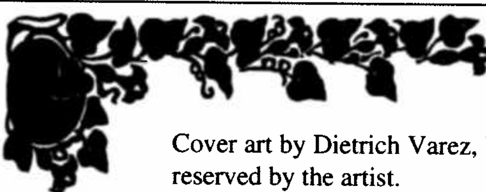

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***Manu***

Manu means "bird" in Hawaiian. Many Hawaiian birds have the long curved beak with which to extract nectar and pollen from flowers.

# Editorial

**Norman Goldstein MD**
**Editor, Hawaii Medical Journal**

## Report to the House of Delegates at the 143rd Hawaii Medical Association Annual Meeting – Big Island, Hawaii October 29,1999

### Another Good Year for the Journal

This has been another good year for our Journal. January 2000 will mark the 60th year of continuous publication of the Hawaii Medical Journal, first published in September 1941.

As further testimony to the continued interest in the broad base of medical subjects that we publish, requests are increasing for HMJ reprints from other medical journals, both statewide and nationally.

Many thanks to News Editor Henry Yokoyama MD, whose column has been a favorite for the last 36 years, as well as to Russell T. Stodd MD, author of "The Weathervane." Both editors remind us of the importance of humor in keeping our balance. Many thanks also to our small but very efficient Editorial Staff, Becky Kendro, Drake Chinen, and our master salesman, Michael Roth. The volume of advertising pages has quadrupled in the last three years, allowing us to increase the number of editorial manuscripts.

A special mahalo to Dr. Ann Catts and Dr. Drake Will for their help in editing our manuscripts. We owe a debt of gratitude to our Peer Review Panel of more than 200 members and nonmembers of the HMA.

### End of the Year Manuscripts

As we turn the calendar from December 1999 to 2000, we still have many outstanding manuscripts awaiting publication. In this issue, Theresa Danao-Camara MD and Kiwi Camara surveyed patients with chronic inflammatory polyarthritis asking about alternative therapies. This is a small but very significant study. As we see more patients presenting with copper bracelets, "special" diets, and magnets on all parts of their bodies, we would like to review results from controlled studies using some of these unconventional therapies.

Thirty years ago, I took a medical hypnosis course. The hypnotist, a former circus side show performer, made an impressive presentation. I recall one of his best lines, "Docs, you don't have to hypnotize your patients, just get their minds off what the hell you're going to do to them." Doctors Simon and James review the subject of hypnosis in this manuscript, suggesting that we should consider trained medical hypnotherapists for some of our patients undergoing surgery, smoking cessation, and weight loss.

Our Hawaii State Hospital at Kaneohe has been in the news recently and, thanks to the effort of the Health Department and Hospital staff, Kaneohe has again been certified for continued treatment of mentally disturbed patients. Patrick and Associates studied substance abuse in the 1980's and 1990's, and present good information for our interest.

### Christmas Ballet

I stopped the car for Susan to shop
At the autoteller...and out she hopped.
I glanced away while she worked the machine
To study the mountains, covered in green.

My eyes returned to the front of the bank
Where she took her cash and murmured a "thank"
For modern technology which never sleeps
And gives back on holidays, the money it keeps.

She smiled as she turned to approach the car,
But such as the winds here at Christmas are -
They lifted her hat with its embroidered sash
and she lunged for it using the hand with the cash!

Those winds who targeted first her hat,
Seized on that handful of bills stacked so fat.
They swirled in the air as high as the roof
Reminiscent of movements in a ***Keystone Cops*** spoof!

She looked like a puppy snapping at flies,
Grasping for "twenties" espied by her eyes.
Leaping and jumping in a comic ballet
A scene I'll remember 'til I'm old and gray.

Pirouettes, and toe stands, arabesques, swan dives
Fouettes and entrechats, unusual for wives.
Then all of a sudden the wind stilled its force,
But the "twenties" recovered were deficient, of course!

A lone one was missing: I joined in the search,
Scouring the shrubs and the trees for a "perch"
At last we found. But I really must say...
I'd surely have paid it... for that Christmas Ballet.

*Robert S. Flowers*
*August 25, 1990*

---

### Hanukkah

Lord of Hosts, this Feast of Lights
Grows one candle every night
For Hanukkah, reDedication
of Jerus'lem's restoration.

With this act that seems so simple
We remember your great temple.
How the oil kept burning bright
When fuel was there for just one night.

But let your lamp inside my heart
Burn forever...as a start!
Amen.

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# Medical School Hotline

## The Role of Telemedicine in Medical Education

**Stanley M. Saiki, Jr. MD**
**Assistant Professor, Department of Medicine**
**Director, UH Telemedicine Project**
**University of Hawaii,**
**John A. Burns School of Medicine**

### The New Age:

We live in historic times. Not since the industrial revolution has the advent of new technologies so affected our lives. In fact, one is hard pressed to think of any activity of living today that remains unaffected by the new technology. We internalize one new development after another, without stopping to pause and reflect on how profoundly our lives are touched by technological developments. When we do step back and consider the "rate of change" of our electronic revolution, we find its pace both exhilarating and terrifying. Like it or not, this pace is accelerating.

Telecommunications, but one of the arts of the electronic age, is undergoing a transformation of heroic proportions. The attainment of a "global dial-tone," phone service that brings direct connection to phones all over the globe, an immense accomplishment, is already an accomplishment overlooked, accepted as pedestrian. Wireless communication, global cellular service, mobile email, fax and data transfer capability, infrared computer links and data transfers through the human contact of a handshake, are the exotic technologies that now catch the eye.

### Telemedicine: Not a Discipline

*"Telemedicine –the use of advanced telecommunications technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers."* Jim Reid [1] provides one of the many definitions for the term. All such definitions are broad, inclusive, vague and require additional comment.

Telecommunications technologies, the electronic transfer of information, includes a number of modalities. Telephone, radio, other voice modalities, picture phones, fax, computer real time data/ images, video teleconferencing (VTC), computer store and forward (enhanced email) data/images, broadcast video, world wide web pages and virtual reality are examples.

Telemedicine information, another inclusive term, includes clinical information from and about patients as well as medical education information and curricula. Computerized clinical information systems, electronic medical records organize huge amounts of clinical information into user friendly formats.

Telemedicine is not a discipline, it is a tool used in the delivery of health care. Telemedicine is a tool forged from the convergence of technologies. Advances in telecommunications, computer science, informatics, basic and clinical science and educational science have matured to allow innovations in health care delivery whose coordinated scientific application can be termed "Telemedicine" or "Telehealth".

### Telehealth Hawaii:

Internationally, a renewed interest in telemedicine is powered by new technologies, lowered communications costs and increased demand for health care services. In the U.S, additional momentum has been added by changes in the structure of health care delivery systems such as managed care and capitated payment systems.

Hawaii has long been investing in telecommunications and telehealth technologies. State leaders have had the vision to anticipate the digital revolution and championed the development of the infrastructure necessary to meet our telecommunications needs. State and federal institutions in Hawaii have built networks with the bandwidth (carrying capacity) to meet anticipated needs. The private sector has been aggressive, correctly anticipating the development of telecommunications technology. The cable networks are particularly advanced in relation to the remainder of the nation.

Telemedicine and Telehealth operations have grown in Hawaii as in the rest of the US. The Department of Defense through the Tripler Army Medical Center and the AKAMAI Project have been pioneers and leaders of telemedicine, nationally and internationally. Teleradiology in Hawaii is a mature application with proven utility. All the major community hospitals and health systems have been investigating and investing in telemedicine capabilities. The Hawaii Health Systems Corporation (HHSC) an association of State Hospitals regularly utilize telemedicine technologies. HHSC and community health centers have been recipients of grants from the Weinberg Foundation for telemedicine equipment. University of Hawaii units, such as the Schools of Nursing at Manoa and the community colleges have been using telemedicine technologies for medical education and patient care. Pilot studies using low bandwidth video phones are currently underway. Other health organizations such as third party payers, capitated health plans and medical service organizations are looking to telemedicine to improve their level of functioning.

### U.H. John A. Burns School of Medicine (JABSOM):

In medical education, telemedicine is integrated into the JABSOM curriculum. Undergraduate, graduate, post graduate and continuing medical educational programs currently do, or will soon, utilize multiple modalities of telemedicine including store and forward systems as well as real time, full motion, multipoint video teleconferencing.

JABSOM faces unique challenges related to our geographic location, commitment to community based medical education and our problem based learning curriculum. These factors require small group teaching rather than the more traditional lecture hall approach. Small group teaching formats while quite advantageous for the learner, pose a greater challenge to the distance telemedicine educator. The single big group can use a single large monitor or digital projector in specially equipped rooms to allow 2 way video teleconferencing (VTC). One large group, one instructor, one telemedicine video unit, one communication charge; break that one group into 6 or 7 small group sessions and technologic as well as instructional requirements are significantly magnified. These challenges are a small hurdle to overcome when the advantages of small group learning and teaching are considered.

Telemedicine technologies at JABSOM include support for Internet based educational programs. World Wide Web based curricular

programs, store and forward (email) systems and library access are basic requirements for all students. The JABSOM M.D. program curriculum emphasizes Informatics and Evidence Based Medicine in the curriculum making access to computer networks and searchable databases essential.

Ke Ola O Hawai'i[3] is an academic community partnership organization of which the JABSOM is a founding partner. Ke Ola is collaborating with the JABSOM Telemedicine Project to develop a system to support training of multiprofessional teams of health professions students, including medical students, in community health centers and on neighbor islands.

Ke Ola O Hawai'i has developed the Ke Ola HealthNet, which connected community-based learning centers at Waianae Coast Community Health Center, Kalihi-Palama Health Center, Queen Emma Clinics, and Kokua Kalihi Valley, as well as the Biomedical Building of the University of Hawai'i at Manoa, to the state fiberoptic network (SONET). Multiprofessional teams of students and faculty utilize the high speed connection for email communication, research, and utilization of web-based resources. Interactive video workstations provided to community health centers through the JABSOM Telemedicine Project and Weinberg Foundation will expand the resource to include distance learning through interactive video.

Additional resources are in development with support of the federal Area Health Education Center (AHEC) grant to JABSOM, which is administered through the Ke Ola partnership. These include interactive video workstations in Hilo and Maui, which will allow third year medical students in an innovative six month clerkship to remain in neighbor island training sites at Hilo and Maui without returning to the Manoa campus for weekly seminars. Facilities are also being developed at Kauai Community College to support health professions training activities for students from high school, community college, and UH Manoa, including third year medical clerkships.

The Department of Psychiatry, routinely uses point to point live VTC for administrative and educational purposes. The Departments of Medicine and Family Practice use store and forward telemedicine in support of students on rotation in the south pacific and other rural locations. All departments are keenly interested in using technology to leverage educational resources.

## U.H JABSOM Telemedicine Project

The UH Telemedicine Project is a task group based in the Dean's office of the School of Medicine. The goals of the project are several. To develop a bank of telemedicine experience and intellectual assets to serve the School of Medicine, The University of Hawaii and the State of Hawaii. The project uses a collaborative approach, fostering cooperative works with other UH schools and campus organizations, community hospitals, health care organizations and state institutions.

The Project is currently setting up a clinical telemedicine network[2] to allow our University students, residents, faculty and community attendings and sub-specialists and other health care providers to learn to use the technologies and techniques of telemedicine both in medical education and in actual patient care. The project invites community collaboration to leverage resources.

Network connections, bandwidth, hardware, software and technical skills needed are being integrated with the generous aid and cooperation from the UH/ Information and Technology Service (ITS) and the UH Telecommunication Information and Policy Group (TIP-G). UH/ITS provides connections that will allow high speed data transfer for VTC as well as store and forward access, to the University of Hawaii system, Community College sites, as well as Waianae Coast Comprehensive Health Center, The Queen Emma Clinics, and the Kalihi Palama Community Health Center. TIP-G has developed and administers the State of Hawaii Telehealth Access Network (STAN) that allows similar connections to HHSC, the VA Regional Medical Clinic, private health care organizations and via satellite, facilities in the Pacific islands.

These broad bandwidth network connections will allow us access to a number of teaching sites for real time VTC with multipoint conferences as well as store and forward modalities. Medical education programs for individuals at all levels of training and in a multitude of different University programs will become readily available. The opportunity is now available for our graduates and faculty associated community health care providers to incorporate the use of telemedicine into their practice of medicine.

## Conclusion:

An ever growing choice of developing technologies, begs the question; just because we can do a thing, does that mean we should do a thing? New technologies often emphasize style over substance, offering an elegant, stylish or ostentatious method to a simple task. Technophiles and gadgeteers are often "touched by the monkeys paw", seduced by the dark side of technology. Careful consideration and study of the true benefits from the use of these technologies remains lacking. There are some clear, obvious and undeniable benefits to the use of new technologies. Conversely, there are more subtle advantages and disadvantages that need to be carefully considered. We have the opportunity to study these technologies, to scientifically and rationally assess the utility of these technical advances.

### References:


1. A Telemedicine Primer: Understanding the Issues, Jim Reid PA-C 1996ISBN 0-9653045-0-7
2. DoD Cooperative Agreement No. DAMD17-99-2-9003
3. Ke Ola O Hawaii information provided courtesy of Dr. Carol Murry, Director



Perceptions of Stroke's Effects

American Heart Association

79% of people surveyed associate stroke with paralysis or weakening.
A stroke is a brain attack.
Common effects are:
- *paralysis or weakening*
- *neglect of the recovering side*
- *trouble understanding speech*
- *difficulty talking or communicating*
- *memory lapses*
- *problems performing tasks*

SOURCE: American Heart Association 1995

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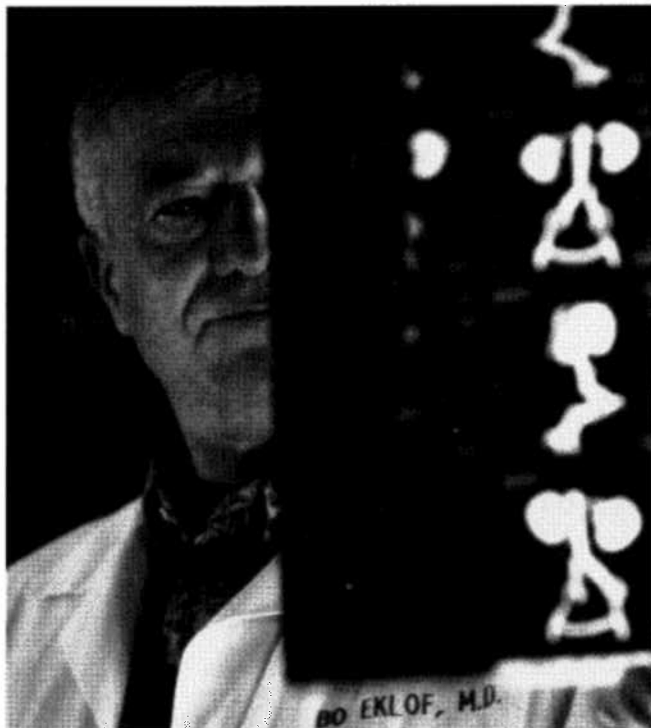


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– Friday Noon Conference –
Luncheon

**Diabetes Care in the 1990's**

*Mehmood A. Khan, MD*

December 3, 1999, 12:30 – 1:30 p.m.

Doctors Dining Room

**Learning Objectives**

**At the conclusion, participants should be able to:**

- Interpret diagnosis of type II diabetes.
- Describe treatment options for type II diabetes.
- Manage obesity and diabetes care.

We would like to acknowledge the Educational Grant from Hoechst Marion Roussel.

– Friday Tumor Board Conference –
Luncheon

**Assisted Suicide: A Case for Pain Management**

*Louis Saeger, MD*

December 6, 1999, 12:30 – 1:30 p.m.

Doctors Dining Room

**Learning Objectives**

**At the conclusion, participants should be able to:**

- Summarize the controversial issues and motivations surrounding patients requests for assisted suicide.
- Recognize the specific and controllable aspects of pain management in these patient types, which identify the case for improved pain management.
- Manage patients pain syndromes effectively by utilizing existing standards and assessment tools.
- Describe existing legislation and arguments regarding assisted suicide (national update and impacts).

We would like to acknowledge the Educational Grant from Purdue Pharma L.P.

– Friday Noon Conference –

**End-of-Life Care, Part 1: a) Advance Care Planning; b) Common Physical Symptoms; c) Anxiety, Delirium, and Depression**

*David C. Des Jarlais, MD & Kenneth K.H. Kau, MD*

December 10, 1999, 12:30 – 1:30 p.m.

Doctors Dining Room

**Learning Objectives**

**At the conclusion, participants should be able to:**

- Define advance care planning and update on 1999 Hawaii legislation.
- Understand management of common physical problems in end-of-life care.
- Identify and treat depression, anxiety, and delirium in end-of-life care.

– Friday Noon Conference –

**End-of-Life Care, Part 2: a) Communicating Bad News; b) Pain Management; c) Withholding, Withdrawing Therapy; d) Last Hours of Living**

*Randal Liu, MD & R. Gary Johnson, MD*

December 17, 1999, 12:30 – 1:30 p.m.

Doctors Dining Room

**Learning Objectives**

**At the conclusion, participants should be able to:**

- Learn an approach to communication of bad news.
- Understand approach to pain management in end-of-life care.
- Describe the principles of withholding or withdrawing therapy.
- Assess and manage the pathophysiologic changes of dying.

**Please call Fran Smith at 522-4471 for more information.**

# Awareness of, Use and Perception of Efficacy of Alternative Therapies by Patients with Inflammatory Arthropathies

Kiwi Camara and Theresa Danao-Camara MD, FACP, FACR

## Abstract

*Fifty one patients with chronic inflammatory polyarthritis were surveyed on unconventional treatments they used to self-treat their condition. Awareness of the availability of alternative therapies (ATs) was universal. Sixtysix percent (66%) of patients had tried one or more ATs. The most popular ATs were dietary manipulation (no red meat, dosing with vinegar and honey), the wearing of magnets and copper bracelets, and acupuncture. The best predictors of AT use were male sex, Caucasian race and formal education beyond high school. Numbers were too small to make definitive statements about perceptions of efficacy, but the users of magnets and fish oils tended to be dissatisfied with these ATs, while those who had tried bee stings, herbs and hormones claimed effectiveness.*

## Introduction

Alternative treatments (ATs) are widely used by patients with arthritis.[1] In the 48 contiguous states, utilization patterns favor educated, middle class persons between the ages of 25 to 49.[2] In a rural North Carolina study,[3] African-American adults with arthritis were found to make greater use of ATs compared to European-Americans.

Hawaii is a multiracial community with no one ethnic group constituting a numerical majority. According to the 1990 Census, Caucasians comprise 33.4% of the population, Japanese 22.3 %, Filipinos 15.2 %, Hawaiians and part-Hawaiians 12.5%; the remaining 16.6% include the Chinese, Portuguese, Koreans and a smattering of other races. The authors embarked upon this study with the hypothesis that non-Caucasians closer to the Asian medical traditions would use ATs more frequently.

Correspondence to:
Theresa Danao-Camara MD
Palma 5/Rheumatology
Straub Clinic and Hospital
888 South King Street
Honolulu, HI 96813

## Methods

Fifty one consecutive adult patients with inflammatory arthropathies from the islands of Kauai and Oahu were administered an in-office survey about their awareness of, use and impressions of efficacy of 23 ATs. The list was gleaned from a patient-information brochure published by the Arthritis Foundation on unproven remedies, and supplemented by the clinical experience of one of the authors (TDC). The ATs were: acupuncture, alfalfa, bee stings, black walnuts, chiropractic, copper bracelets, fasting, fish oils, herbs, homoeopathy, hormones, the "immune power diet", magnets, "metabolic therapy", elimination of red meat from the diet, elimination of pork, avoidance of nightshade vegetables, the use of plant oils, reflexology, tai chi, vaccines, and drinking vinegar and honey. The survey was explained by the attending physician, and the patients were asked to complete the survey privately. Completed surveys were sealed, collected and collated in a manner that preserved the patient's anonymity.

## Results

The 51 patients completing the survey had a mean age of 51 years (range 26 to 81) and a mean disease duration of 9 years (range 1-42). The male-to-female ratio was 10:41, in accord with the known predominance of inflammatory arthropathies in females. The average number of years of formal education did represent graduation from high school (mean 13 years; range 2 to 24). Self-reported racial classification results were as follows: Caucasian 13, Japanese 13, Filipinos 5, Chinese 3, Pacific Islander 5, African American 1, mixed race 11.

Awareness of ATs was universal. Every single patient reported having heard of the utility of at least one of the ATs in the list for his/her condition (Table 1). Over two-thirds (69%) of the group had tried at least one AT. The most popular ATs were dietary manipulation, magnets, copper bracelets and acupuncture.

The following demographic subgroups admitted to the most AT use: males, Caucasian race, and formal education beyond high school (Table 2).

User subgroup numbers were too small to make definitive statements about perceptions of efficacy, but users of magnets, fish oils and acupuncture tended to report dissatisfaction with the results they had obtained. (Table 3).

Table 1. Awareness of Alternative Therapies per Demographic Group*

| | Total who have heard of it | Disease Duration | Disease Duration | Age | Age | Yrs of Formal Education | Yrs of Formal Education | Sex | Sex | Race | Race |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Item | | ≤ 5 yrs | > 5 yrs | ≤ 40 yrs | > 40 yrs | ≤ 12 yrs | > 12 yrs | Male | Female | Caucasian | Asian |
| Acupuncture | 43<br>84 | 23<br>88 | 20<br>80 | 14<br>100 | 29<br>78 | 22<br>78 | 21<br>91 | 9<br>90 | 34<br>83 | 11<br>85 | 19<br>90 |
| Alfalfa | 21<br>41 | 10<br>38 | 11<br>44 | 6<br>43 | 15<br>40 | 10<br>36 | 11<br>48 | 5<br>50 | 16<br>39 | 7<br>54 | 8<br>38 |
| Bee Stings | 25<br>49 | 12<br>46 | 13<br>52 | 7<br>50 | 18<br>49 | 12<br>43 | 13<br>56 | 5<br>50 | 20<br>49 | 7<br>54 | 11<br>52 |
| Black Walnuts | 5<br>10 | 2<br>8 | 3<br>12 | 1<br>7 | 4<br>11 | 3<br>11 | 2<br>9 | 1<br>10 | 4<br>10 | 1<br>8 | 2<br>9 |
| Chiropractor | 27<br>53 | 13<br>50 | 14<br>56 | 9<br>64 | 18<br>48 | 13<br>46 | 14<br>60 | 4<br>40 | 23<br>56 | 9<br>69 | 9<br>43 |
| Copper Bracelet | 38<br>75 | 21<br>81 | 17<br>68 | 11<br>78 | 27<br>73 | 17**<br>61 | 21**<br>91 | 7<br>70 | 31<br>76 | 11<br>84 | 17<br>81 |
| Fasting | 16<br>31 | 10<br>38 | 5<br>20 | 6<br>43 | 10<br>27 | 7<br>25 | 9<br>39 | 3<br>30 | 13<br>32 | 4<br>30 | 5<br>24 |
| Fish Oils | 26<br>51 | 13<br>50 | 13<br>52 | 8<br>57 | 18<br>48 | 11<br>39 | 15<br>65 | 8**<br>80 | 18**<br>44 | 8<br>61 | 12<br>57 |
| Herbs | 29<br>57 | 15<br>58 | 14<br>56 | 11<br>78 | 18<br>49 | 16<br>57 | 13<br>56 | 5<br>50 | 24<br>58 | 7<br>54 | 12<br>57 |
| Homeopathy | 14<br>27 | 6<br>23 | 8<br>32 | 7**<br>50 | 7**<br>19 | 5<br>17 | 9<br>41 | 3<br>30 | 11<br>37 | 7**<br>54 | 3**<br>14 |
| Hormones | 12<br>24 | 6<br>23 | 6<br>24 | 4<br>28 | 8<br>22 | 5<br>17 | 7<br>30 | 1<br>10 | 11<br>27 | 4<br>30 | 5<br>24 |
| "Immune Power Diet" | 6<br>12 | 0**<br>0 | 6**<br>24 | 2<br>14 | 4<br>11 | 2<br>7 | 4<br>17 | 0<br>0 | 6<br>15 | 3**<br>23 | 1**<br>4 |
| Magnets | 27<br>53 | 17<br>65 | 10<br>40 | 8<br>57 | 19<br>51 | 15<br>53 | 12<br>52 | 4<br>40 | 23<br>56 | 5<br>38 | 14<br>67 |
| Metabolic Therapy | 2<br>4 | 0<br>0 | 2<br>8 | 1<br>7 | 1<br>3 | 1<br>3 | 1<br>4 | 0<br>0 | 2<br>5 | 1<br>8 | 1<br>4 |
| No Meat | 19<br>37 | 10<br>38 | 9<br>36 | 6<br>43 | 13<br>35 | 11<br>39 | 8<br>35 | 4<br>40 | 15<br>36 | 6<br>46 | 6<br>28 |
| No Nightshades | 14<br>27 | 5<br>19 | 9<br>36 | 4<br>28 | 10<br>27 | 7<br>25 | 7<br>30 | 3<br>30 | 11<br>27 | 4<br>30 | 6<br>28 |
| No pork | 14<br>27 | 9<br>35 | 5<br>20 | 1**<br>7 | 13**<br>35 | 9<br>32 | 5<br>22 | 4<br>40 | 10<br>24 | 3<br>23 | 6<br>28 |
| No Red Meat | 20<br>39 | 10<br>38 | 10<br>40 | 4<br>28 | 16<br>43 | 12<br>42 | 8<br>35 | 5<br>50 | 15<br>36 | 6<br>46 | 9<br>43 |
| Plant Oils | 9<br>18 | 5<br>19 | 4<br>16 | 4<br>28 | 5<br>13 | 5<br>18 | 4<br>17 | 3<br>30 | 6<br>15 | 1<br>8 | 4<br>19 |
| Reflexology | 12<br>24 | 8<br>31 | 4<br>16 | 5<br>32 | 7<br>19 | 2**<br>7 | 10**<br>43 | 2<br>20 | 10<br>24 | 6<br>46 | 4<br>19 |
| Tai Chi | 22<br>23 | 13<br>50 | 9<br>36 | 9<br>64 | 13<br>35 | 9<br>32 | 13<br>56 | 6<br>60 | 16<br>39 | 5<br>38 | 8<br>38 |
| Vaccines | 8<br>16 | 2<br>8 | 6<br>24 | 1<br>7 | 7<br>19 | 5<br>18 | 3<br>13 | 2<br>20 | 6<br>15 | 3<br>23 | 4<br>19 |
| Vinegar & Honey | 25<br>49 | 10<br>38 | 15<br>60 | 7<br>50 | 18<br>35 | 12<br>43 | 13<br>56 | 5<br>50 | 20<br>48 | 6<br>46 | 4<br>19 |
| Total in subgroup | 51 | 26 | 25 | 14 | 31 | 28 | 23 | 10 | 41 | 13 | 21 |

* Data expressed as N % of Total

** Chi square statistic significant at 5%

Table 2. Alt Use Per Demographic Group*

| | | Disease Duration | Disease Duration | Age | Age | Yrs of Formal Education | Yrs of Formal Education | Sex | Sex | Race | Race |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total who have Used it | ≤ 5 yrs | > 5 yrs | ≤ 40 yrs | > 40 yrs | ≤ 12 yrs | > 12 yrs | Male | Female | Caucasian | Asian |
| Acupuncture | 9 | 5<br>19 | 4<br>16 | 3<br>21 | 6<br>16 | 3<br>11 | 6<br>26 | 1<br>10 | 8<br>19 | 4<br>31 | 4<br>19 |
| Alfalfa | 3 | 0<br>0 | 3<br>12 | 1<br>7 | 2<br>5 | 1<br>4 | 2<br>9 | 2<br>20 | 1<br>2 | 1<br>8 | 2<br>10 |
| Bee Stings | 2 | 0<br>0 | 2<br>8 | 0<br>0 | 2<br>5 | 2<br>7 | 0<br>0 | 0<br>0 | 2<br>5 | 0<br>0 | 2<br>10 |
| Black Walnuts | 0 | 0<br>0 | 0<br>0 | 0<br>0 | 0<br>0 | 0<br>0 | 0<br>0 | 0<br>0 | 0<br>0 | 0<br>0 | 0<br>0 |
| Chiropractor | 7 | 5**<br>19 | 2**<br>8 | 3<br>21 | 4<br>8 | 3<br>11 | 4<br>17 | 2<br>20 | 5<br>12 | 0<br>0 | 2<br>10 |
| Copper Bracelet | 11 | 8<br>31 | 3<br>12 | 3<br>21 | 8<br>21 | 7<br>25 | 4<br>17 | 1<br>10 | 10<br>24 | 1<br>8 | 5<br>24 |
| Fasting | 3 | 2<br>8 | 1<br>4 | 1<br>7 | 2<br>5 | 2<br>7 | 1<br>4 | 2<br>20 | 1<br>2 | 2<br>26 | 1<br>5 |
| Fish Oils | 12 | 4<br>15 | 8<br>32 | 4<br>28 | 8<br>21 | 6<br>21 | 6<br>26 | 3<br>30 | 9<br>22 | 5<br>38 | 4<br>19 |
| Herbs | 4 | 3<br>12 | 1<br>4 | 2<br>14 | 2<br>5 | 2<br>7 | 2<br>9 | 3**<br>30 | 1**<br>2 | 1<br>8 | 1<br>5 |
| Homeopathy | 3 | 1<br>4 | 2<br>8 | 1<br>7 | 2<br>5 | 2<br>7 | 1<br>4 | 0<br>0 | 3<br>7 | 1<br>8 | 1<br>5 |
| Hormones | 2 | 1<br>4 | 1<br>4 | 1<br>7 | 1<br>2 | 1<br>4 | 1<br>4 | 0<br>0 | 2<br>5 | 2<br>26 | 0<br>0 |
| "Immune Power Diet" | 1 | 0<br>0 | 1<br>4 | 1<br>7 | 0<br>0 | 0<br>0 | 1<br>4 | 0<br>0 | 1<br>2 | 1<br>8 | 0<br>0 |
| Magnets | 9 | 6<br>23 | 3<br>12 | 4<br>28 | 5<br>14 | 4<br>14 | 5<br>22 | 1<br>10 | 8<br>19 | 2<br>26 | 4<br>19 |
| Metabolic Therapy | 1 | 0<br>0 | 1<br>4 | 0<br>0 | 1<br>2 | 1<br>4 | 0<br>0 | 0<br>0 | 1<br>2 | 0<br>0 | 0<br>0 |
| No Meat | 8 | 3<br>12 | 5<br>20 | 4<br>28 | 4<br>8 | 3<br>11 | 5<br>22 | 1<br>10 | 7<br>17 | 5<br>38 | 2<br>10 |
| No Nightshades | 7 | 2<br>8 | 5<br>20 | 2<br>14 | 5<br>14 | 3<br>11 | 4<br>17 | 2<br>20 | 5<br>12 | 3<br>23 | 1<br>5 |
| No pork | 7 | 4<br>15 | 3<br>12 | 0<br>0 | 7<br>19 | 4<br>14 | 3<br>13 | 2<br>20 | 5<br>12 | 2<br>23 | 2<br>10 |
| No Red Meat | 11 | 4<br>15 | 7<br>28 | 3<br>21 | 8<br>21 | 7<br>25 | 4<br>17 | 4<br>40 | 7<br>17 | 5<br>38 | 3<br>14 |
| Plant Oils | 2 | 1<br>4 | 1<br>4 | 2**<br>14 | 0**<br>0 | 1<br>4 | 1<br>4 | 1<br>10 | 1<br>2 | 1<br>8 | 0<br>0 |
| Reflexology | 4 | 2<br>8 | 2<br>8 | 2<br>14 | 2<br>5 | 0**<br>0 | 4**<br>17 | 0<br>0 | 4<br>9 | 1<br>8 | 1<br>5 |
| Tai Chi | 1 | 1<br>4 | 0<br>0 | 1<br>7 | 0<br>0 | 1<br>4 | 0<br>0 | 0<br>0 | 1<br>17 | 0<br>0 | 0<br>0 |
| Vaccines | 1 | 1<br>4 | 0<br>0 | 0<br>0 | 1<br>2 | 1<br>4 | 0<br>0 | 1<br>10 | 0<br>0 | 0<br>0 | 0<br>0 |
| Vinegar & Honey | 11 | 4<br>15 | 7<br>28 | 4<br>28 | 7<br>19 | 5<br>18 | 6<br>26 | 2<br>20 | 9<br>22 | 1<br>8 | 4<br>19 |
| Ave # Items used | 2.30 | 2.19 | 2.48 | 2.00 | 2.08 | 2.11 | 2.61 | 2.80 | 2.22 | 2.90 | 1.62 |

* Data expressed as N % of Total

** Chi square statistic significant at 5%

*** T Statistic not significant between demographic subgroups

Table 3. Perception of Efficacy

| Alternative Treatment | Number Using | # who think it is effective (%) | # who think it is ineffective (%) |
|---|---|---|---|
| Acupuncture | 9 | 3 (33) | 6 (67) |
| Alfalfa | 3 | 2 (67) | 1 (33) |
| Bee Stings | 2 | 2 (100) | 0 (0) |
| Black Walnuts | 0 | 0 | 0 |
| Chiropractor | 7 | 4 (57) | 3 (43) |
| Copper Bracelet | 11 | 4 (36) | 7 (64) |
| Fasting | 3 | 2 (67) | 1 (33) |
| Fish Oils | 12 | 4 (33) | 8 (67) |
| Herbs | 4 | 4 (100) | 0 (0) |
| Homeopathy | 3 | 2 (67) | 1 (33) |
| Hormones | 2 | 2 (100) | 0 (0) |
| "Immune Power Diet" | 1 | 1 (100) | 0 (0) |
| Magnets | 9 | 1 (11) | 8 (89) |
| Metabolic Therapy | 1 | 1 (100) | 0 (0) |
| No Meat | 8 | 4 (50) | 4 (50) |
| No Nightshades | 7 | 4 (57) | 3 (43) |
| No pork | 7 | 4 (57) | 3 (43) |
| No Red Meat | 11 | 6 (55) | 5 (45) |
| Plant Oils | 2 | 1 (50) | 1 (50) |
| Reflexology | 4 | 2 (50) | 2 (50) |
| Tai Chi | 1 | 1 (100) | 0 (0) |
| Vaccines | 1 | 1 (100) | 0 (0) |
| Vinegar & Honey | 11 | 4 (36) | 7 (64) |

## Discussion

The interest in and use of unproven remedies is widespread in the United States and cuts across race, gender and age groups. In this study, educated male Caucasians still appear to be the highest users of ATs, confirming the trend reported by Eisenberg et al (2). This is true even in Hawaii, where multiple Asian cultures and their medical systems and practitioners exist side-by-side with conventional allopathic medicine. This is information that is important to the providers and payers of health care, suggesting that insurers marketing to the employed, educated Caucasian male may gain a marketing advantage by paying attention to ATs.

Two possible design features may have resulted in the underreporting of AT use by Asians. First, many Asians still consider the patient-physician relationship as patriarchal, and patients may have hesitated (despite reassurances of anonymity) to admit using modalities that their physician did not prescribe or could object to. Second, the list of ATs may not have adequately included treatments routinely used by Asian cultures, having been generated from a patient information brochure designed for the average American on the mainland.

The impressions of efficacy reported by the surveyed patients are difficult to interpret. No methodologic standardization could be undertaken given the study design. Only superficial descriptions of satisfaction were obtainable, subjectively and retrospectively. Nonetheless, these broad strokes point to those areas that may lend themselves most easily to prospective, controlled trials.

Since this survey was conducted, many other ATs have entered the Hawaii market, mostly in the form of herbal encapsulations and supplements. These preparations get to patients via retail stores, direct mail, multi level marketers and alternative practitioners. Further study of patterns of spending, use and perceived effectiveness, as well as prospective controlled trials of usefulness, tolerability and side effects need to be pursued.

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**"This engine is so good,**

it makes us want to hold a little seminar for the V-6 engineers at Audi, General Motors and Honda (well, every car company, really) so they can learn how it should be done."

***—Automobile Magazine, July 1999, in an article about the 2000 Maxima***

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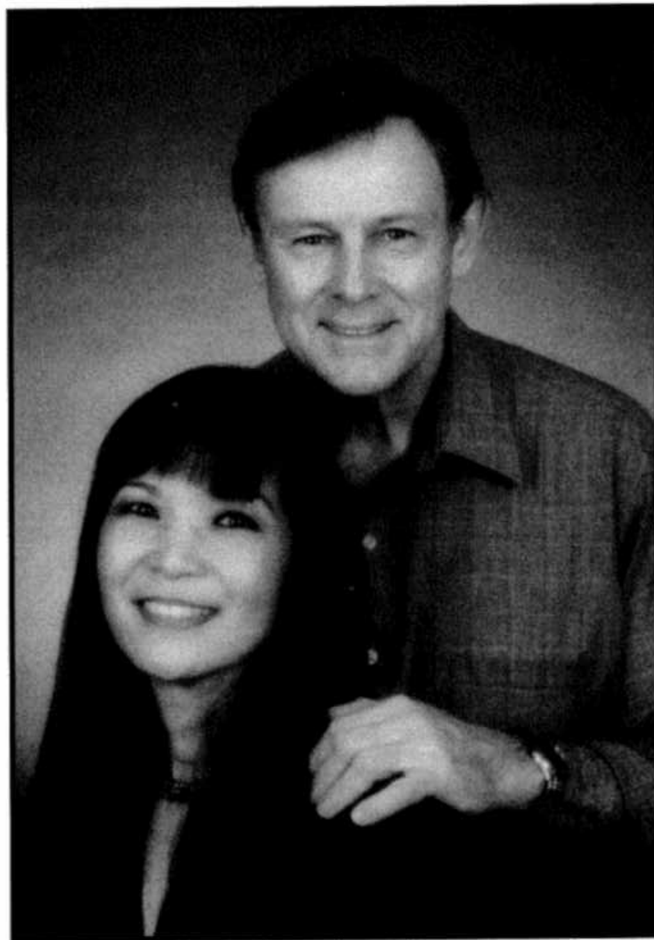

## Best Wishes to Fred and Diane!

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# Trends Across Two Time Periods in the Diagnosis of Substance Abuse Comorbidity at the Hawaii State Hospital

Vijayalakshmy Patrick MD, Earl S. Hishinuma PhD and Joseph Pehm MSW, LSW

**Abstract**

*This study investigates the changes from the late 1980s to early 1990s of comorbidity (mental illness plus substance abuse) at the Hawaii State Hospital. For the 1990s, a prevalence rate ranging from 14.2% to 30% was estimated, with the latter figure based on a closer review of the records. A higher proportion of comorbid clients were single, and compared to the non-abusers (i.e., patients diagnosed with only schizophrenia or affective disorder), a higher percentage were male and had an educational level less than high school. There was an increase in the percent of non-abusers and substance abusers, but a decrease in the dual diagnosed. The implications of these findings are discussed.*

## Introduction

Dual diagnosis of mental illness and substance abuse has been clinically well-recognized and there is a substantial literature on prevalence, diagnosis, and treatment. For individuals with substance abuse comorbidity, varying rates of prevalence have been reported in different client groups. In the general population among those with mental disorders, 28% had an addictive illness.[1] Individuals with drug disorders had a 53% rate of dual diagnosis, and alcoholics had a 37% rate of comorbidity. In the psychiatric population, prevalences have ranged from 30-80%[2-5] with an even higher rate of 94% being reported in a prison population.[6] A trend towards increased admissions of comorbid patients has been seen among veterans from 23% in 1976 to 44% in 1988.[7] The characteristics of the dual diagnosed have been as follows: young, male, homeless, tendency to use emergency services frequently, and higher hospitalization and incarceration rates.[8-14] However, no differences have been found on educational level and marital status.[11]

These and other previous studies have provided a wealth of important findings. However, more research is needed on at least two fronts: more investigations are necessary that examine population changes across time, and the effects of institutional and societal changes that may affect admission rates need to be researched more closely.

The circumstances associated with the Hawaii State Hospital (HSH) provided the opportunity to study these areas. First, admission and discharge records at the HSH are intact such that a study could be conducted examining admission rates across time. Second, four events occurred between 1990-92: (a) The HSH went through an organizational transition where direct admissions from emergency rooms ceased. Prior to that time, the HSH accepted referrals from emergency rooms and the Hawaii Correctional System, resulting in patients being admitted who were homeless, chronically mentally ill, or forensic in nature. Subsequent to 1990, however, only patients referred by the correctional system were admitted. The purpose of this change was to decrease the patient-to-staff ratio and limit over-crowding. Subsequently, the bed occupancy decreased by approximately 30% (b) Another related change was that the HSH went under a U.S. Department of Justice mandate requiring improvement of services. This facilitated the reduction of the patient-to-staff ratio. The decreased patient loads enabled staff to complete more extensive assessments and to provide more effective treatments (c) The HSH became a university-based institution and a training site for medical students and psychiatric residents. As a result, a more systematic approach to diagnosis was implemented (e.g., standardized screening methods). And (d) external to the HSH, throughout the past decade, there has been a trend of increased substance abuse in Hawaii especially with highly addictive substances (e.g., crystal methamphetamine, crack cocaine).[15-16]

The specific purposes of the present investigation were as follows: (a) To examine admission rates at the HSH and compare these figures for Period 1 (1984-89; prior to changes in the institution) vs. Period 2 (1990-94). It is hypothesized that Period 1 will have a significantly higher rate of admissions than Period 2 due mainly to the institutional policies at that time.

(b) To investigate the relative rates between periods for patients with the following diagnoses: non-substance abuse (i.e., schizophrenic and/or affective disorder), substance abuse (only), dual diagnosis (mental disorder plus substance abuse), and other. It is hypothesized that there will be a significant increase in the percent of admissions for substance abusers and for the dual diagnosed from Period 1 to Period 2 due mainly to the exclusive forensic referrals, more systematic assessments, and increased substance use in Hawaii for Period 2.

(c) To determine whether there are any age-based trends for the comorbid group across periods. It is hypothesized that there will be no significant trends in age across periods and that the majority of subjects will be in the younger age ranges.

(d) To investigate, on an exploratory level, the relationship

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between groups without substance abuse and those dual diagnosed as a function of gender, marital status, and educational attainment across periods. Based on prior research findings, there should be a higher ratio of males, but no other differences should be found.

(e) To study the substances abused, Axis I disorders, and Axis II disorders of the dual diagnosed across periods. It is hypothesized that one of the highest rates of mental disorders comorbid with substance abuse will be antisocial personality disorder, as reported in the literature.[17-19]

## Methods

### *Participants*

Subjects consisted of patients admitted to the HSH from 1984-94. The HSH is the only state psychiatric facility in the Hawaiian Islands, and thus, serves a multicultural population reflective of Asian-Pacific Islanders. Although ethnicity data were not coded for each subject for this study, the approximate breakdown of the patient population at the HSH is as follows: 32% Caucasian, 3% Chinese, 13% Filipino, 21% Hawaiian/Part-Hawaiian, 17% Japanese, and 14% mixed or other.

### *Procedures*

Medical records were examined and admission frequencies were obtained for each year from 1984-94. The data were coded to represent two different time periods: (a) Period 1 = 1984-89, and (b) Period 2 = 1990-94. It should be noted that during the 1990s, a more systematic approach was used to assess patients. For example, the use of reliable and valid instruments became standard.

Patients who were admitted, discharged, and then readmitted all within the same calendar year were represented in the data only once. Participants who were admitted in one year and discharged, and then readmitted in a following calendar year were represented as many times as readmissions occurred in different calendar years. This set of circumstances occurred due to the manner in which the HSH's records were organized. However, the percentage of such patients was only 9-12%, thus unlikely to affect the major conclusions of this study.

For discharged patients, diagnoses were based on the discharge summaries. For inpatients not yet discharged, their diagnoses were based on current psychiatric assessments. Axis I diagnoses were categorized into four groups: (a) non-abusers (i.e., schizophrenia and/or affective disorders only), (b) substance abusers only, (c) dual diagnosis (i.e., mental illness plus substance abuse), and (d) "other" for those not falling into any of the previous categories. For all dual-diagnosed patients, basic demographics of age range and year of admission were recorded. Five age ranges were utilized: 19-30, 31-40, 41-50, 51-60, and 61-70.

A subgroup of subjects were randomly selected from the larger pool of dual-diagnosed and non-abusing clients. However, in reviewing the records for the non-abusers, substance abuse was mentioned in the assessment and progress notes, but was not reflected in the final diagnosis. These subjects were not included in the random sample (37% from Period 1; 31% from Period 2). For the remaining subjects, the following were recorded: gender, marital status, and educational attainment. For the dual-diagnosed subgroup, additional data were gathered: substance that was abused, Axis I comorbid diagnosis, and Axis II comorbidity.

## Results

For each year from 1984-94, the following numbers of patients were admitted: Period 1 = 612, 591, 675, 642, 766, & 841; Period 2 = 460, 339, 452, 357, & 223. Significantly more admissions occurred per year during Period 1 (1984-89) with an average (mean) of 687.8 patients than Period 2 (1990-94) with an average of only 366.2 clients ($t[9] = 5.48, p < .001$).

Table 1 includes the number and percent of types of patients by period. A test of significance revealed that the diagnostic percentages were different across the two periods ($\chi^2[3] = 169.9, p < .001$). Subsequent analyses indicated that there was a statistically lower percentage of patients with schizophrenia and/or affective disorder in Period 1 (34.0%) as compared to Period 2 (47.8%), and for clients who were substance abusers in Period 1 (5.8%) as opposed to Period 2 (9.8%). However, this trend was reversed for dual-diagnosed patients where a larger percentage was obtained in Period 1 (23.0%) as opposed to Period 2 (14.2%). The proportion of "other" diagnoses was also higher for Period 1 (37.2%) than Period 2 (28.2%).

Table 2 presents the number of dual-diagnosed participants by age range and period. There was a significant difference in the age proportions across the two periods ($\chi^2[4] = 44.8, p < .001$). Subsequent analyses revealed that of the dual diagnosed falling in the 19-30 age range, a significantly greater proportion was admitted in Period 1 (55.1%) as compared to Period 2 (33.8%). However, the converse was found for the 31-40 and 41-50 age ranges whereby significantly higher percentages were found in Period 2 (40.8% and 18.8%, respectively) than in Period 1 (27.0% and 10.0%, respectively). No significant differences were found between periods for the 51-60 and >60 age ranges.

In examining the random sample of non-abusers vs. dual diagnosed (see Table 3), the ratio of males to females was larger for the dual diagnosed than for the non-abusers in Period 2 and for both periods combined. Although there were no significant differences in the marital-status proportions across the two time periods, there was a significant difference in the marital-status ratios when examining the dual-diagnosed only, with a higher ratio for those who were single (i.e., 5 married, 22 separated or divorced, and 70 single; $\chi^2[2] = 70.4, p < .001$). In addition, the ratio of those who graduated from high school (or above) to those who did not was larger for non-abusers than for patients with dual diagnosis. This finding was statistically significant for each period examined alone, and for both periods combined. Overall, the high school graduation rate for the dual diagnosed was only 43% in comparison to the 79% rate for non-abusers.

Table 4 presents the frequency, percent, and confidence interval of substances abused for the dual-diagnosed subgroup. Polysubstance, alcohol, and marijuana abuse occurred most frequently. There was a significant increase in *self-reported* use of alcohol (44.4% for Period 1 vs. 67.4% for Period 2) and for marijuana (20.4% for Period 1 vs. 46.5% for Period 2).

The frequencies and percents of Axis I comorbidity are presented in Table 5 for the dual-diagnosed subgroup. Schizophrenia was the most frequent diagnosis followed by affective disorder. No significant difference was found between periods for all comorbid diagnoses. Table 6 displays the data on Axis II comorbidity. Period 2 (25.6%) had a greater percent of patients with anti-social personality

disorder as compared to Period 1 (9.3%). No other significant difference was found.

## Discussion

A dramatic decrease in overall admissions was confirmed by the results. This was not surprising given the changes that occurred across the two time periods. To limit over-crowding and to increase the quality of services provided by the HSH, direct admissions from emergency rooms ceased and only patients referred by the correctional system were admitted.

Table 1. — Frequency, Percent, and Confidence Interval by Diagnosis and Period

| Psychiatric Diagnosis | Period 1 (1984-89) Freq. | % | Confidence Interval (95%) | Period 2 (1990-94) Freq. | % | Confidence Interval (95%) | $\chi^2$ ($df$ = 1) | $p$ value if <.05 |
|---|---|---|---|---|---|---|---|---|
| Schizophrenia &/or affective disorder | 1404 | 34.0% | 32.6-35.5% | 875 | 47.8% | 45.5-50.1% | 101.8 | < .001 |
| Substance abuse | 240 | 5.8% | 5.1-6.6% | 180 | 9.8% | 8.5-11.3% | 31.2 | < .001 |
| Dual diagnosis | 948 | 23.0% | 21.7-24.3% | 260 | 14.2% | 12.7-15.9% | 60.4 | < .001 |
| Other | 1535 | 37.2% | 35.7-38.7% | 516 | 28.2% | 26.2-30.3% | 45.6 | < .001 |
| Total | 4127 | 100% | | 1831 | 100% | | | |

Table 2. — Frequency, Percent, and Confidence Interval of Dual-Diagnosed Patients by Age Range and Period

| Age Range | Period 1 (1984-89) $N$ | % | Confidence Interval (95%) | Period 2 (1990-94) $N$ | % | Confidence Interval (95%) | $\chi^2$ ($df$ = 1) | $p$ value if <.05 |
|---|---|---|---|---|---|---|---|---|
| 19-30 | 522 | 55.1% | 51.9-58.2% | 88 | 33.8% | 28.4-39.8% | 36.7 | < .001 |
| 31-40 | 256 | 27.0% | 24.3-29.9% | 106 | 40.8% | 35.0-46.8% | 18.4 | < .001 |
| 41-50 | 95 | 10.0% | 8.3-12.1% | 49 | 18.8% | 14.6-24.0% | 15.1 | < .001 |
| 51-60 | 48 | 5.1% | 3.8-6.6% | 11 | 4.2% | 2.4-7.4% | 0.3 | |
| >60 | 27 | 2.8% | 2.0-4.1% | 6 | 2.3% | 1.1-4.9% | 0.2 | |
| Total | 948 | 100% | | 260 | 100% | | | |

Table 3. — Frequency of Randomly Selected Non-Abusing and Dual-Diagnosed Patients by Period Based on Sex, Marital Status, and High School Education

| Variable | Period 1 Non-Abusers ($N$ = 42) | Period 1 Dual-Diagnosed ($N$ = 54) | Period 2 Non-Abusers ($N$ = 36) | Period 2 Dual-Diagnosed ($N$ = 43) | Periods Combined Non-Abusers ($N$ = 78) | Periods Combined Dual-Diagnosed ($N$ = 97) |
|---|---|---|---|---|---|---|
| Gender | | | | | | |
| Male | 25 | 38 | 24 | 37 | 49 | 75 |
| Female | 17 | 16 | 12 | 6 | 29 | 22 |
| ($df$ = 1) | ($\chi^2$ = 1.2; $p$ >.05) | | ($\chi^2$ = 4.2; $p$ <.05) | | ($\chi^2$ = 4.4; $p$ <.05) | |
| Marital status | | | | | | |
| Married | 4 | 3 | 3 | 2 | 7 | 5 |
| Separated, divorced | 6 | 13 | 10 | 9 | 16 | 22 |
| Single | 32 | 38 | 23 | 32 | 55 | 70 |
| ($df$ = 2) | ($\chi^2$ =1.7; $p$ >.05) | | ($\chi^2$ = 1.0; $p$ >.05) | | ($\chi^2$ = 1.0; $p$ >.05) | |
| Education | | | | | | |
| Less than high school graduate | 10 | 35 | 6 | 20 | 16 | 55 |
| High school graduate or greater | 32 | 19 | 30 | 23 | 62 | 42 |
| ($df$ = 1) | ($\chi^2$ = 16.0; $p$ <.001) | | ($\chi^2$ = 7.9; $p$ <.01) | | ($\chi^2$ = 23.5; $p$ <.001) | |

Table 4. — Frequency, Percent, and Confidence Interval of Substance Abused by Period for the Randomly Selected, Dual-Diagnosed Patients

| | Period 1 (1984-89) | | | Period 2 (1990-94) | | | | |
|---|---|---|---|---|---|---|---|---|
| Substance Abused | *N* | % | Confidence Interval (95%) | *N* | % | Confidence Interval (95%) | $\chi^2$ (*df* = 1) | *p* value if <.05 |
| Polysubstance | 28 | 51.9% | 38.9-64.6% | 19 | 44.2% | 30.4-58.9% | 0.6 | |
| Alcohol | 24 | 44.4% | 32.0-57.6% | 29 | 67.4% | 52.5-79.5% | 5.1 | < .05 |
| Marijuana | 11 | 20.4% | 11.8-32.9% | 20 | 46.5% | 32.5-61.1% | 7.5 | < .01 |
| Methamphetamine | 10 | 18.5% | 10.4-30.8% | 6 | 14.0% | 6.6-27.3% | 0.4 | |
| Cocaine | 9 | 16.7% | 9.0-28.7% | 12 | 27.9% | 16.7-42.7% | 1.8 | |
| Phencyclidine (PCP) | 1 | 1.9% | 0.3-9.8% | 3 | 7.0% | 2.4-18.6% | | |
| Heroin | 1 | 1.9% | 0.3-9.8% | 3 | 7.0% | 2.4-18.6% | | |
| Barbiturates | 1 | 1.9% | 0.3-9.8% | 3 | 7.0% | 2.4-18.6% | | |
| Lysergic Acid Diethylamide (LSD) | 1 | 1.9% | 0.3-9.8% | 3 | 7.0% | 2.4-18.6% | | |
| Anticholinergics | 0 | 0.0% | 0.0-6.6% | 1 | 2.3% | 0.4-12.1% | | |
| Total | 54* | | | 43* | | | | |

[Note: *Sums of columns do not add up to the total indicated because patients could be categorized with more than one substance abuse. Rows with a percent equal to or greater than 10% were tested with chi square.]

Table 5. — Frequency, Percent, and Confidence Interval of Axis I Comorbidity by Period for the Radnomly Selected, Dual-Diagnosed Patients

| | Period 1 (1984-89) | | | Period 2 (1990-94) | | | | |
|---|---|---|---|---|---|---|---|---|
| Psychiatric Diagnosis | *N* | % | Confidence Interval (95%) | *N* | % | Confidence Interval (95%) | $\chi^2$ (*df* = 1) | *p* value if <.05 |
| Schizophrenia | 22 | 40.7% | 28.7-54.0% | 23 | 53.5% | 38.9-67.5% | 1.6 | |
| Affective disorder | 15 | 27.8% | 17.6-40.9% | 10 | 23.3% | 13.2-37.7% | 0.3 | |
| Organic brain disorder | 6 | 11.1% | 5.2-22.2% | 2 | 4.7% | 1.3-15.5% | 1.3 | |
| Schizo-affective | 6 | 11.1% | 5.2-22.2% | 2 | 4.7% | 1.3-15.5% | 1.3 | |
| Mental retardation | 4 | 7.4% | 2.9-17.6% | 4 | 9.3% | 3.7-21.6% | | |
| Dysthymic disorder | 1 | 1.9% | 0.3-9.8% | 0 | 0.0% | 0.0-8.2% | | |
| Anxiety disorder | 1 | 1.9% | 0.3-9.8% | 0 | 0.0% | 0.0-8.2% | | |
| Schizophreniform disorder | 1 | 1.9% | 0.3-9.8% | 1 | 2.3% | 0.4-12.1% | | |
| Adjustment disorder | 0 | 0.0% | 0.0-6.6% | 3 | 7.0% | 2.4-18.6% | | |
| Total | 54* | | | 43* | | | | |

[Note: *Sums of columns do not add up to the total indicated because patients could be categorized with more than one psychiatric disorder. Rows with a percent equal to or greater than 10% were tested with chi square.]

Table 6. — Frequency, Percent, and Confidence Interval of Axis II Comorbidity by Period for the Randomly Selected, Dual-Diagnosed Patients

| Psychiatric Diagnosis | Period 1 (1984-89) *N* | % | Confidence Interval (95%) | Period 2 (1990-94) *N* | % | Confidence Interval (95%) | $\chi^2$ ($df$ = 1) | *p* value if <.05 |
|---|---|---|---|---|---|---|---|---|
| Antisocial | 5 | 9.3% | 4.0-19.9% | 11 | 25.6% | 14.9-40.2% | 4.6 | < .05 |
| Mixed | 3 | 5.6% | 1.9-15.1% | 0 | 0.0% | 0.0-8.2% | | |
| Histrionic | 2 | 3.7% | 1.0-12.5% | 1 | 2.3% | 0.4-12.1% | | |
| Schizotypal | 2 | 3.7% | 1.0-12.5% | 0 | 0.0% | 0.0-8.2% | | |
| Passive aggressive | 2 | 3.7% | 1.0-12.5% | 1 | 2.3% | 0.4-12.1% | | |
| Borderline | 2 | 3.7% | 1.0-12.5% | 0 | 0.0% | 0.0-8.2% | | |
| Dependent | 1 | 1.9% | 0.3-9.8% | 0 | 0.0% | 0.0-8.2% | | |
| Narcissistic | 0 | 0.0% | 0.0-6.6% | 3 | 7.0% | 2.4-18.6% | | |
| Schizoid | 0 | 0.0% | 0.0-6.6% | 1 | 2.3% | 0.4-12.1% | | |
| Total | 54* | | | 43* | | | | |

[Note: *Sums of columns do not add up to the total indicated because patients could be categorized with more than one psychiatric disorder. Rows with a percent equal to or greater than 10% were tested with chi square.]

The hypothesis that there would be an increase in substance abuse and dual diagnosis was only partially supported. A greater percent of patients was admitted with substance abuse in Period 2 as compared to Period 1, but the converse was found for dual diagnoses. It is difficult to determine the exact reasons for these findings given the factors that may have affected the admission rates and diagnoses. Assuming that these findings are valid, they indicate that in the 1990s, the courts referred a larger proportion of patients to the HSH who were either schizophrenic, had an affective disorder, *or* had a substance abuse problem, and that these diagnoses may be more representative of the prison population.

However, for both periods, the figures on substance abusers and the dual diagnosed may be under-estimates because the data were based on patient self-reports.[20-22] The exclusive forensic population of Period 2 would be expected to have provided even greater under-estimates. Galletly et al.[21] found considerable discrepancies between patients' self-report of recent drug intake and the results of urine drug screening. As possible causes, Drake, Alterman, and Rosenberg[23] discussed minimization and distortion due to cognitive impairment or psychosis. The less systematic assessment approach in Period 1 may have resulted in under-estimates of substance abuse. Further, substance-induced delusional, hallucinatory, and mood disorders could have been misdiagnosed as schizophrenia or affective disorder. Several investigators have alluded to the difficulty in making an accurate diagnosis.[13,24]

Another factor to consider in Period 2 is that because the HSH ceased to admit directly from emergency rooms, there was the possibility that many patients were "criminalized" in order to gain access to the HSH. This would explain the increase in admissions for non-abusers in Period 2. Consequently, this increase in non-abusers would have indirectly decreased the percent of dual-diagnosed patients.

A final mechanism for under-estimations involves the finding that approximately one-third of the randomly selected non-abusers had some indication of substance abuse (e.g., these patients were provided treatments consistent with substance abuse). Although this under-estimation was expected to have been greater for Period 1 than Period 2, approximately the same percent was found for both periods. Drake, Alterman, and Rosenberg[23] included lack of awareness, inattention to substance abuse as a problem, and unfamiliarity with standard modes of assessment by mental health clinicians as factors contributing to the failure to report substance abuse in psychiatric populations. In the case of the HSH, because of its university collaboration and in spite of better assessment by university psychiatrists, it is more likely that under-diagnosis was due simply to failure to include substance abuse as a diagnosis in the patients' discharge summaries.

It is suggested that the effects of 9-12% of the patients who were counted more than once within a period was negligible with regard to the relative prevalence rates. In other words, if the distribution of the 9-12% was similar to the overall rates for each of the four categories of patients, then the rates for each type of patient would remain approximately the same. Even if the distribution was dissimilar between the 9-12% and the overall population, the rates of the four categories should not change considerably (i.e., only by 1-2%).

With these factors in mind, the 14.2% prevalence rate for substance abuse comorbidity for the more recent Period 2 is probably an

under-estimation. Perhaps a figure closer to 30% would be more accurate for this culturally diverse population at the HSH.

With regard to age effects, there was a relative increase of the dual-diagnosed admitted in the 31-40 and 41-50 age ranges in Period 2 indicating that an older group was abusing drugs and being referred and admitted to the HSH. This finding was contrary to that found in the literature.

The present study found that the dual diagnosed were primarily single males who did not complete high school. In comparison to non-abusers, a higher ratio of males-to-females and noncompletion-of-high-school to completion was found for patients who had substance abuse comorbidity.

Polysubstance, alcohol, and marijuana were the most frequently abused drug categories. In examining across periods, an increase in both alcohol and marijuana use was found. However, this may have been a result of the more systematic approach to assessment in Period 2. In particular, every patient was assessed about his or her use of drugs.

Schizophrenia was the most commonly diagnosed category in both periods among the dually diagnosed population, but no differences were found across periods for all of the Axis I diagnostic categories. Axis II antisocial personality disorder was the most commonly diagnosed personality disorder which was consistent with findings of other researchers. A significant increase in the percentage of patients with antisocial personality disorder was found across periods perhaps due to the exclusive referrals from the correctional system in Period 2.

## Conclusion

There are several implications of the results of this study for clinicians. Prevalence rates of comorbid diagnoses must be made cautiously in light of various factors that may cause either an under- or over-estimation. Taking into account such variables, the present investigation suggests a prevalence rate of dual diagnosis at approximately 30% of this culturally diverse, forensic population at the HSH. This means that about one-third of the entire patient population may have both a mental disorder and substance abuse. This has serious implications for program development, implementation, and evaluation.

Additional factors that may have important ramifications regarding intervention programs include the relatively higher proportion of the dual diagnosed having an educational level less than high school. The type of treatment and rehabilitation may have to be altered given the educational achievement level, and there may be a need for greater emphasis on academic and vocational retraining for this comorbid group. The older age, diagnosis of schizophrenia, increased use of alcohol and marijuana, and increased comorbid prevalence of antisocial personality disorder may also be possible factors to consider in programming.

When an institution like a state psychiatric hospital exclusively admits only forensic patients, further research is needed on such effects including the possibility of "criminalizing" the mentally ill. What are the effects on the clients when they are "criminalized?" If there are adverse effects, how can the system be changed? Longitudinal studies may be necessary in this regard.

A final implication is related to substance-abuse diagnosis. Mental health clinicians should be more meticulous in their record keeping of formal diagnoses such as substance abuse. In addition, structured diagnostic interviews rather than retrospective review of medical records should allow one to make more definitive statements. In conjunction with self-reports and standardized screening instruments, it may be prudent to include laboratory evidence for substance use in diagnostic assessments. Given that there could be a time lag between arrest and admission to the hospital, laboratory assessments may need to be conducted at different points in time: at the time of the arrest, upon admission, and when psychotic symptoms stabilize.

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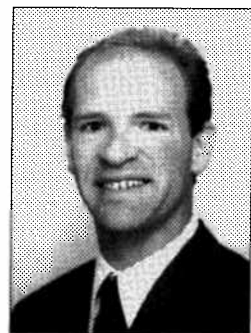

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# Clinical Applications of Hypnotherapy In A Medical Setting

Eric P. Simon PhD, ABPP and Larry C. James PhD, ABPP

**Abstract**
*Since 1958, hypnosis has been recognized by the American Medical Association as a legitimate form of medical treatment when administered by an appropriately trained practitioner. With the prevalence of certification societies and international organizations, the specialty has increased its level of professionalism and clinical applications. However, in spite of increased exposure and utilization of this unique clinical application, its use within medical settings varies considerably. The purpose of this article is to provide an understanding of clinical hypnosis and offer clinical applications, with the goal of increasing its exposure and utilization within medical settings.*

The Western medical approach has traditionally been oriented towards differential diagnosis, leading to surgical procedures and/or pharmacological curative agents. In the new Mind-Body paradigm, we now understand that "alternative" treatments can bring about symptomatic relief that is often equivalent, if not superior to drug outcomes. One such approach is hypnosis. With hypnosis, one can evoke physiologic changes that were once thought beyond voluntary control. For example, subjects have shown "voluntary control" over sympathetic tone, vasoconstriction/vasodilation, heart rate, muscle tension, and so forth. Hypnosis is similar to biofeedback, in that physiologic change is brought under a patient's voluntary control. In biofeedback, however, a patient is taught how to do this using external feedback of their physiologic systems, whereas in hypnosis, control over these physiologic processes are evoked from within the person.

### *Hypnotherapy Defined*

According to the American Psychological Association Division of Psychological Hypnosis, hypnosis can be seen as a procedure during which changes in sensations, perceptions, thoughts, feelings, or behavior are suggested.[1,2] Kihlstrom[3] offered a much more specific understanding of hypnosis, asserting that hypnosis is a set of procedures in which a person designated as the hypnotist suggests that another person (the patient or subject) experience various changes in sensation, perception, cognition, or control over motor behavior. It has an induction phase and an application phase. Others have taken issue with the concept of a "trance state" and simply describe hypnosis as a heightened state of relaxation or a state of focused attention.[4] Finally, investigators from the "Stanford hypnosis research lab" have elucidated the commonalties of hypnosis with dissociation, a mental separation of components of experience that would ordinarily be processed together.[5,6]

A trance is associated with many physiologic changes to include: flattening of facial muscles, decrease in orienting movements, immobility, changes in blinking and swallowing, catalepsy in a limb, autonomous motor behavior, altered breathing and pulse, fixed gaze, faraway look, changed voice quality, time lag in response, literalism, perseveration in response, dissociation, relaxed muscles, amnesia, and time distortion.

During a hypnotic session, the patient is encouraged to focus on the hypnotherapist's voice, pleasant images and to fix his or her gaze in some particular manner. During this induction phase, the patient begins to enter a hypnotic trance, at which time the conscious mind becomes less and less vigilant to the immediate surroundings. When this conscious-unconscious mind dichotomy becomes more salient to the patient, the unconscious mind becomes more amenable to suggestions (which are congruent with the patient's belief system) for new possibilities from the hypnotherapist. The hypnotherapist serves as a guide, helping transport a patient from the normal awake state of consciousness to a state of hypnotic trance. Patients often describe trance as a pleasant, relaxed altered state of consciousness, and/or a type of reverie. This ability can be taught to the patient so that he or she can enter trance on his or her own and control distressing psycho-physiological symptoms.

Medical hypnosis, or hypnotherapy, is the clinical application of hypnosis to medical disorders/procedures. In 1955 the British Medial Association declared hypnosis as a legitimate form of medical treatment when applied by an appropriately trained practitioner, and in1958 the American Medical Association gave their formal endorsement as well. Health care professionals from a variety of disciplines can be trained to administer hypnosis. Information about training opportunities can be obtained by contacting the American Society of Clinical Hypnosis (www.asch.net), the Milton H. Erickson Foundation (www.erickson-foundation.org), the Society for Clinical and Experimental Hypnosis (www.sunsite.utk.edu), or Division 30 (Psychological Hypnosis) of the American Psychological Association (www.apa.org/divisions/div30). Hypnotic treatment will commonly involve 1-4 treatments, at a typical cost of approximately $125/session. The following discussion outlines some of the many possible clinical applications for medical hypnosis within a medical setting.

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### *Chronic Pain Applications*

Chronic pain disorders (e.g., Complex Regional Pain Syndrome, Myofascial Pain Syndrome, Fibromyalgia, Chronic Pelvic Pain, Orchalgia, Failed Back Syndrome, etc.) have been shown to be very responsive to hypnotherapeutic treatment.[7,8] One component of the treatment mechanism is that in a hypnotic state, patients are often induced into a deep state of physiologic relaxation. This acts to decrease Sympathetic Nervous System arousal in the same manner as sympathiolytic medications (e.g., alpha-2 blockers) which are commonly prescribed for chronic pain symptoms. In spite of the data indicating the efficacy of hypnosis over and above relaxation strategies and simple placebo effects, some critics of hypnosis have mistakenly argued that a hypnotic trance is nothing more than a deeply relaxed state. While deep relaxation is a common component of hypnosis, hypnotic trance is not defined by limited to such a state. Research conducted at Stanford University[9] has revealed that patients can remain in a trance state even during Sympathetic hyper-arousal (for example, when patients are pedaling on stationary exercise machines). Further, it is well established that patients often respond to direct suggestions for pain control[2] independent of sympathetic or parasympathetic arousal.

Hypnotic anesthesia and analgesia are typically central aspects of hypnotherapy for pain control. Using hypnosis, patients can be given suggestions to reduce and often eliminate particular sensory experiences, to include pain, by helping patients reinterpret their sensory experience. This can be demonstrated with both acute pain (e.g., placing a subject's hand in a bucket of ice and water), chronic pain that is related mostly to psychological factors, and chronic pain secondary to a medical condition.

### *Applications For Hyperemesis Gravidarum & Nausea Associated With Chemotherapy*

Hypnotherapy is an effective treatment to control hyperemesis and nausea during pregnancy[10,11] as well as nausea associated with chemotherapy.[11] Patients can be provided with suggestions to relax their stomach and throat muscles causing their nausea, gagging, and vomiting to subside.

### *Applications In The Treatment of Motion Sickness*

Hypnotherapy has been demonstrated as a successful treatment for motion sickness in an operational environment (in aircraft and submarines).[12] These authors highlighted the clinical utility of hypnotherapy in a military medical setting. In a military medical center the authors have successfully treated several patients suffering from exercise-induced nausea and vomiting with hypnotic suggestions designed to decrease muscle tension and nausea. In a similar manner, Jones and his colleagues[13] yielded positive findings with Air Force pilots suffering from airsickness.

### *Psychosomatic/Stress Disorders*

Hypnosis can be a powerful mechanism in teaching patients to gain control of psychophysiologic functions, in particular, by decreasing hyper-sympathetic arousal. As such, hypnosis is effective in the treatment of migraines[14], tension headaches[15], irritable bowel syndrome[16], seasonal allergies[17], asthma[18], and a whole host of other stress-related disorders.

### *Dental Applications*

A virtually ubiquitous problem treated both by dentists and chronic pain physicians is Temporomandibular disorder (TMD). Despite the typical treatment involving occlusional splint therapy, many patients brux through dental splints worn at night, as they clench and grind their teeth during sleep.

With this in mind, the first author has developed a group hypnotherapy TMD program at Tripler Army Medical Center. After an initial dental evaluation, patients referred for this treatment are given post hypnotic suggestions so that the tensing of the muscles around the Temporomandibular joint and any feelings of pain or discomfort in that area become cues for these muscles to immediately relax. This process of cued relaxation can occur at both a conscious and unconscious level. Thus far, the results have been very promising, with the average patient reporting 80% reduction in symptoms, without of course, side effects so common with most medications.[19]

The effectiveness of hypnotherapy in the treatment of temporomandibular disorders has been empirically demonstrated.[20] Further, Kent[21] has provided an in depth overview of clinical applications in a variety of dental disorders. More specifically, Scott[22] and Bills[23] offered data and information to suggest that hypnotherapy is effective with dental phobias.

### *Smoking Cessation*

Our Behavioral Medicine Clinic commonly receives referrals for patients who would like to quit smoking cigarettes, but for various reasons, are seeking a treatment other than that offered by our formal cognitive-behavioral smoking cessation program, which entails using the nicotine patch or Buproprion combined with cognitive-behavioral strategies. The first author works with patients who, for example, seek hypnotherapeutic treatment to quit smoking, as they are well into pregnancy, and thus do not want to use a medication agent. These patients are given post-hypnotic suggestions for urge control, and for the induction of nausea immediately upon taking a puff, which immediately subsides at the moment of extinguishing the cigarette.

Many researchers, for example, Johnson and Karkut[24] have demonstrated the efficacy of hypnosis for smoking cessation. However, it has been suggested that hypnosis is effective for weight loss and smoking cessation in only approximately 25% of the cases, but for that 25% of people, a single-session treatment can produce complete long-term abstinence.[25] This low effectiveness is likely due to the challenges of any treatment for habit control.

### *Hypnotherapy For Weight Loss*

As part of the LE$^3$AN program (an inpatient plus outpatient healthy lifestyle service to assist patients with weight loss), we offer a segment on hypnosis to help patients gain control over their habitual eating responses to stress. James, Folen, Garland, et al.[26] have employed bi-weekly hypnosis sessions to help patients manage stress as it relates to maladaptive eating behaviors. Rigorous meta-analytic studies have indicated a significant effect of adding hypnosis to cognitive-behavioral treatments for weight reduction.[27]

### *The Treatment of Phobias*

Phobic individuals are typically more responsive to hypnotic treatment than less hypnotizable individuals.[28] These patients' phobic symptoms respond very well to hypnotic suggestions for symptom relief.[29] The first author successfully treated both a patient with a 50-year history of needle phobia, and a patient with a 30-year history of Gecko phobia by combining hypnosis with systematic desensitization and flooding techniques, respectively. Finally, Simon has recently documented the efficacy of novel hypnotic techniques for patients phobic of MRI equipment [30] and lumbar puncture procedures.[31]

### *Hypnotherapy for Uncomfortable Medical Procedures*

Many patients, in particular pediatric patients, experience great distress from various medical procedures. Clinicians can work with parents, teaching them how to use hypnotic distraction techniques in helping their children through uncomfortable medical procedures such as lumbar punctures and bone marrow aspirations.[32] These children typically report a great decrease in anxiety, accompanied by a greater internal sense of control over the experience.

### *Labor & Delivery*

Hypnosis is naturally amenable to applications for pain control with labor and delivery. Pregnant women are taught how to use eye fixation, dissociation, trance deepening strategies, and relaxation, and are given post-hypnotic suggestions for anesthesia and analgesia (to include hypnotic reframing of the pain signals and the labor and delivery process) for the labor and birth process. Women trained in the use of hypnosis report significantly lower ratings of both pain and anxiety.[33]

### *Coping With Trauma*

Many professionals have used hypnosis for assisting patients to cope with a variety of traumas such as post traumatic stress disorder,[34] childhood trauma,[35] childhood sexual abuse,[36] rape,[37] and burns[38]. It should be underscored here that cases involving psychological trauma are best handled with a consult to a psychologist or psychiatrist.

### *Applications For Surgery*

Surgery can be seen as a very traumatic event for many patients. For this reason, hypnotherapy is often employed. A recent well controlled study demonstrated that as compared with surgical patients taught basic stress reducing strategies, surgical patients who were hypnotized reported significantly lower ratings of peri- and post-operative anxiety and pain, a significant reduction in intraoperative requirements for sedating agents, a significant reduction in nausea and vomiting, better surgical conditions, less signs of patient discomfort and pain, significantly more stable vital signs, a greater sense of intraoperative control, and higher satisfaction scores.[39]

### *Limitations of Hypnosis*

One of the major problems in the hypnosis/hypnotherapy community is that there is a discrete chasm between the clinicians and the more academically-oriented researchers.[40] Much of the research done by academicians is often not very clinically relevant, and much of the research conducted by clinicians is presented in the form of case studies, thus lacking the scientific rigor of well-controlled designs. There has been a call for greater integration between the two groups to produce well-constructed, clinically relevant research.[41]

Table 1. Clinical Applications of Medical Hypnosis (Hypnotherapy)

| Application | Recent Empirical Study Demonstrating Treatment Efficacy |
|---|---|
| Asthma | Kohen & Wynne (1997) |
| Burns | Patterson et al. (1996) |
| Dental Disorders | Dworkin (1997) |
| Hyperemesis from Chemotherapy | Genuis (1995) |
| Hyperemesis Gravidarum | Torem (1994); Simon & Schwartz (1999) |
| Irritable Bowel Syndrome | Houghton et al. (1996) |
| Labor and Delivery | Mairs (1995) |
| Migraines | Nolan et al. (1995) |
| Motion Sickness | James & Harasym (1993) |
| MRI examinations | Simon (1999) |
| Pain Management | Barber (1996) |
| Phobias | Somerville & Jupp (1992) |
| Post Traumatic Stress Disorder | Spiegel (1996) |
| Seasonal Allergies | Madrid et al. (1995) |
| Smoking Cessation | Johnson & Karkut (1994) |
| Surgical Procedures | Faymonville et al. (1997) |
| Tension Headaches | Zitman et al. (1992) |
| Uncomfortable Medical Procedures | Simon & Cannonito (in press) Rape & Bush (1994) |
| Weight Management | Kirsch (1996) |

While generalizations cannot be made from any single case study, the trend from the many case studies conducted over the past few decades suggest that hypnosis is an effective form of treatment for a variety of medical disorders. Further, meta-analytic studies provide more rigorous evidence of the efficacy of hypnotherapeutic treatment.[42] Hypnotherapy, by no means, should be thought of as a panacea. While there has been supportive evidence for its effectiveness in treating many of the disorders discussed in this article, the efficacy of hypnotherapy has not been convincingly demonstrated for a variety of other disorders, for example, ADHD[43] and alcohol/substance abuse.[44]

There is also some research that would suggest that a patient's level of hypnotizability plays an important role in determining outcome of therapeutic success,[45] although other studies indicate that this is often not the case.[46] This issue is of critical clinical importance, and future research should seek greater clarification. Another issue of significant clinical importance is that many patients fear undergoing hypnotic treatment because of the frightful distortions and fallacies they have witness on television, in the movies, or with stage hypnosis. It is our experience that hypnotherapy will fail if the myths and misconceptions of hypnosis are not discussed and dispelled prior to initiating treatment.

## Discussion

The applications of hypnosis are varied and it would seem that hypnotherapy is a valuable adjunctive treatment option for many physicians to consider. The authors have worked collaboratively with physician providers over the past five years and have had considerable success using hypnotherapy interventions. Once their anxieties about hypnosis are alleviated, patients typically welcome a procedure that does not involve medication, is non-invasive, reduces physical pain (rather than causes more pain), and offers a mechanism to autonomously control pain or discomfort. Thus, it is the hope of the authors that the examples and information provided in this paper spark interest to expand the applications of medical hypnosis in medical settings.

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# News and Notes Henry N. Yokoyama MD

## POTPOURRI I

Mrs. B came for her first visit at term, in labor, with a well-buried cerclage. We managed a healthy girl and she told us this story.

She'd flown to Vancouver with a history of recurrent 2nd trimester abortions.

Her GP Dr. Brown had referred her to Dr. Jones, a gynecologist. Dr. Jones, after a physical and history told her "You have an incompetent os."

"Dr. Jones, she interrupted, "I found Dr. Brown to be very professional and quite competent. And he was kind enough to refer me to you, so why are you calling him names?"

*Oruvie Uptigrave MD*

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## CLOSE CALL...

A patient I'd previously delivered was pregnant again and saw her family doctor who ordered an ultrasound and sent me a copy of the report...

The baby was fine and the bladder normal, but the kidneys weren't properly visualized. So I noted at the bottom of the report, "Suggest you repeat the ultrasound in 2 weeks (for CYA reasons)

His secretary called to inquire what CYA meant. With great difficulty, she pried "Cover Your Ass" out of my secretary...Twenty minutes later, the patient called and wanted to know the meaning of CYA.

I was too embarrassed to speak to the patient, so I asked my secretary to tell her not to worry—that it was too early for the ultrasound and it would be repeated in one or two weeks...

The patient was not satisfied and the exasperated secretary put her on hold and begged me to handle the situation.

The lights came on in my head...My secretary repeated my explanation viz "The ultrasound Cannot Yet Assess the kidneys" The patient was satisfied and hung up.

*Michael Silver MD*

## CONFERENCE NOTES:

**"New Data in the Management of Diabetic Peripheral Neuropathy and Post herpetic Neuralgia" VP Elyse Winger, MD, Assoc. Prof. Neurology, UCLA School of Medicine. Fri. Oct. 10 QMC Kam Auditorium...**

A. Neuropathic pain: Post herpetic and diabetic neuropathy...

Description: 1/2 to 1% of adult population have neuropathic pain described as "burning", electric shock, shooting, like ant crawling, paresthesias, paroxysmal etc...Puzzling with minimal physical evidence e.g. trigeminal neuralgia, phantom limb pain etc. EMG may be normal

Two types of pain viz nociceptic vs. neuropathic (e.g. post herpetic; diabetic neuropathy; reflex sympathetic dystrophy; radicular pain without skin lesions esp. in chemotherapy patients...

Neuroanatomy of Pain Pathways:
a) A Delta and C Fibers
b) Spinothalamic tracts
c) Spino-radicular tract: "Pain is 'Ying' and 'Yang' kind of thing."

Neurotransmitters:
a) Serotonin
b) GABA
c) Glutamate
d) Substance P
e) Opioid Peptides

***Drugs as treatment beefs up existing pathways...
—Mechanism of neuropathic Pain:
↓firing = $Cl^-$; ↑firing = $Na^+$, $K^+$

B. Tricyclic Therapy: a. Amitriptyline: ↓serotonin uptake;↓norepinephrine reuptake – *Analgesic effect are independent of anti-depressant properties...

C. Anticonvulsants: ↓ pain and ↓ epilepsy; $Ca^{++}$, $Na^+$, $K^+$ ions flow in; $Cl^-$ flow out...

a. Phenytoin: Not a powerful analgesic; less $Na^+$ ingress; used in trigeminal neuralgia
b. Valprate: Used in migraine and ties; blocks Na channel; ↑GABA activity
c. Lomotrigine: Na channel; GABA mediates
d. Topriamate:
e. GABAPENTIN: Used in diabetic neuropathy; postherpetic neuropathy; Bipolar disorder trial: ↑ GABA; ↓ $Na^+$

GABAPENTIN Trial (8 wks) Dose 2400 mg/d to 3600 mg/d for diabetic neuropathy & post herpetic neuralgia

Prior epilepsy: 1800 mg/d; start 300 mg/d → tid → qid

Study results: ↓ pain within 2 weeks

Side effects: Dizziness, Peripheral edema, Infection, Ataxia, Pain, convulsions

Research Studies for intractable Pain:

a. Capsacin (Hot Pepper)
Used long enough: ↓substance p; ↓ glutamate
b. Localized pain & arthralgia: Use lidocaine gel for 3d...

## POTPOURRI II

A government worker found an old brass lamp in a filing cabinet. When he dusted it off, a genie appeared and granted him 3 wishes. "I'd love an ice cold beer right now!" he told the genie. Poof! A beer appeared.

Next the man said, "I wish to be on an island surrounded by beautiful and willing women." Poof! He was on an island with gorgeous women fawning all over him.

"Oh man, this is the life, the guy thought, "I wish I never had to work again." and poof! He was back at his desk in his government office.

- - - - - - - - - -

The doctor tells his patient, "I have some good news and some bad news."

"What's the good news, Doc?"

The doctor says, "They're going to name a disease after you."

- - - - - - - - - -

Three psychiatrists were taking a walk... "People are always coming to us with their guilts and fears," one says, "but we have no one to go to with our own problems."

"Since we are all professionals," another suggest "why don't we hear each other out right now?" They agree that is a good idea.

The first psychiatrist confessed, "I'm a compulsive shopper and deeply in debt. So I over bill our patients as often as I can."

The second admits, "I have a drug problem that's out of control and I frequently pressure my patients into buying illegal drugs for me."

The third psychiatrist says, "I know it's wrong, but no matter how hard I try, I can't keep a secret."

*Reader's Digest Oct 99*

## CONFERENCE NOTES:

**"Allergy for the Primary Care Physician" VP Theodore Chu, MD, Clinical Assistant Professor of Medicine, Stanford...QMC Fri AM Conference, Nov 5, 99**

A. Clinical Management of Anaphylaxis:

Sequence – Fatal Anaphylaxis: 10": Itchy mouth, tight throat; 90": Abdominal pain; 120": enuresis; 125": wheezing SOB; 130": respiratory arrest; 135": resuscitated by CRP; 165": electroconvulsive Rx; 180": declared dead

**Epinephrine must be given within 3" of a food induced anocphylaxis...

Steroids do not reverse

B. Dx of Anaphylaxis: a. Acute hypotension, b. Cardiovascular collapse, c. Bronchial obstruction, d. Allergic Sy's, e. Recent exposure to agents, f. ↑mast cell tryptase

C. Rx Anaphylaxis: Epinephrine (drug of choice) subcutaneously (0.3-0.5 ml of 1:1000 dilution q10-20 min) Watch for biphasic anaphylaxis.
Caution: avoid bolus of epinephrine
For upper respiratory obstruction, besides epinephrine, give $O_2$; extend neck, give antihis tamines and insert oropharngeal airway.

D. Prevention of Anaphylaxis: a. Immunize against stinging insect venom in persons allergic; b. persons with hx of allergy, asthma, cardiac disease or on beta blockers are more likely to have anaphylaxis from IV radiocontrast media and should be premedicated with diphenhydramine 50 mg IM one hour before procedure, prednisone 50 mg orally 13, 7, and 1 hour before the procedure, c. Patients at risk for anaphylaxis should be prescribed adrenalin for self administration (Epi-Pen or ANA-kid)

## Pharmacologic Treatment of Systemic Anaphylaxis in Adults.*

| Agents | Indications | Dosages | Goals | Complications |
|---|---|---|---|---|
| Initial Therapy | | | | |
| Epinephrine[9] | Bronchospasm, laryngeal edema, urticaria, angioedema | 0.3-0.5 ml of 1:1000 dilution (0.3-0.5 mg) subcutan. fluid q 10-20 min | Maintain airway patency, reduce extravagation and pruritus | Arrhythmias,[10] hypertension, tremor |
| Oxygen | Hypoxemia | 40-100% | Maintain $pO_2 \geq 60$ mm Hg | None |
| Albuterol | Bronchospasm | 0.5 ml of .5% soln in 2.5 ml saline | Maintain airway patency | Same as for epinephrine |
| Secondary therapy | | | | |
| Aminophylline | Bronchospasm | Loading dose: (6 mg/kg IV over 30 min; then maintain 0.3-0.9 mg/kg/hr IV | Maintain airway patency | Arrhythmias, nausea, vomiting, seizures |
| Corticosteroids | Antiallergic | 250 mg hydrocortisone or 50 mg methylprednisolone IV q6h for 2-4 doses | Block or reduce prolonged or late-phase reactions | Hyperglycemia, fluid retention |
| Antihistamines ($H_2$ blocker use controversial) | Urticaria | 25-50 mg hydroxyzine or diphenhydramine IM or PO q 6-8 h prn | Reduce pruritus, antogonize $H_1$ effects of histamine | Drowsiness, use dry mouth, urinary retention |
| | | 300 mg of cimetidine slowly IV or po q6h | Antagonize $H_2$ effects of histamine | |
| Cardiovascular reactions | | | | |
| Initial therapy | | | | |
| Trendelenburg position | Hypotension | -- | Maintain sys. BP ≥80-100 mm Hg | None |
| Intravenous fluids (saline, colloid e.g. 5% albumin) | Hypotension | 1 liter q 20-30 min prn, titrate | Maintain sys. BP ≥80-100 mm Hg | Congestive heart failure, pulmonary edema |
| Epinephrine | Hypotension | 1 ml of 1:1000 dilution in | Maintain sys. BP ≥80-100 mm Hg | Arrhythmias, hypertension |
| 500 ml of D5W | | nervousness IV at 2 μg (1 ml) /min; titrate | | tremor |
| Secondary therapy | | | | |
| Norepinephrine | Hypotension | 4 mg in 1 liter of D5W IV at 8 μg (2 ml)/min | Maintain sys. BP ≥80-100 mm Hg | Same as for epinephrine |
| Antihistamines ($H_2$ blocker use controversial) | Hypotension | same as above | Antagonize $H_1$ and $H_2$ effects of histamine on myocardium and periph. vasc. | Drowsiness, dry mouth, urinary retention |
| Atropine | Refractory hypotension, tachycardia | 0.3-0.5 mg IV q5-10 min up to 2mg | Antagonize cholinergic effects | Drowsiness, dry mouth, urinary retention |
| Glucagon (use controversial) | Refractory hypotension esp. in persons on ß-blockers | 1 mg in 1 L D%W IV 5-15μg (5-15 ml)/min | Increase heart rate and cardiac output | Nausea |

*Adapted from Bochner and Sim refs. Dosages, choice of agents, efficacy and safety must be individualized. Lower doses of aminophylline for older patients, those taking meds that reduce metabolism, those with hepatic dysfunction and congestive heart failure.

## POTPOURRI III

A young Chinese couple, having made love one evening were lying in comfortable relaxation and the young man said, "What I would like now is some sixty nine"...

Whereupon the young wife said, "Are you crazy? Do you want me to get out of bed, get dressed and make you broccoli and rice?"

*Asimov*

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Mr. Ginsberg, age 83, went to the doctor for a complete physical. About halfway through, the doctor was called to the phone.

He said, "Mr. Ginsberg, this will take no more than a few minutes. Here's a jar. Go to the bathroom and place a semen sample in it for examination.

A minute later, the doctor, returned and there stood Mr. G with an empty jar.

"Doctor," said Mr. G "I did my best. I tried with my right hand, I tried with my left hand, I even tried with both hands, but nothing happened."

The doctor said soothingly, "Now Mr. G...don't be embarrassed...It is quite common to be impotent."

Whereupon Mr. G with towering indignation, "What do you mean impotent? I couldn't open the jar."

*Asimov Laughs Again*

----------

A few months ago, a large man about 40 came to my office. The symptoms that finally drove him there was an intolerable thirst. Additional questioning revealed that for several months he'd experienced polyuria and had lost 40 of his 300 lbs. A few days later when the blood sugar was controlled and he was launched on an educational program, I told him I was puzzled why he did not seek medical help sooner. "Well, Doctor, I figured that with all that peeing, I must have prostate trouble. I knew what you guys do to check for that."

*Jane Parnay, Calgary*
*Stitches...*

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I prescribed some medication to a sweet, sometimes confused elderly patient and reviewed the instructions: "Take two pills every six hours."

"Are there any side effects?" she asked.

"Drowsiness, but that occurs at higher doses."

Next day, she called me in a panic. "Doctor, I ran out of pills.

"How can that be? The prescription was for seven days. Did you take them as I told you?"

"Oh, yes, Doctor. Exactly like you said, 'Six pills every two hours!"

"No," I explained,, "I said, 'two pills every 6 hours' How are you feeling?"

"Actually very good, Doctor. Last night I had my best sleep in years. I think you cured my insomnia."

*David Thow MD, Toronto*

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**Not Exactly**

One of my patients, quite a boisterous and colorful character had chest discomfort and SOB. Since he was a heavy smoker, I sent him for pulmonary tests and EKG.

He was at the Outpatient Dept. for his pulmonary function test. He returned a few days later for an EKG.

While sitting in the waiting area, he saw the female tech who'd done his pulmonary function test – He sang out, "How are ya today?"

The lady was surprised and asked him where they had met before. He responded loudly: "You must remember me – You gave me one of those blow jobbie things a few days ago."

The entire waiting room exploded in hysteria.

*Wanda Whitty MD*
*From Stitches*

## Medical Tid Bits I

Heart Drugs Go Begging: A panel of 150 experts concluded that many congestive heart failure patients are not getting the best possible treatment. The experts recommend a regimen that includes digitalis and diuretics as well as two other key drugs, ACE inhibitors and beta-blockers, which are now underprescribed...

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High Fiber: A study of 89,000 women published in the NEJM in Jan has found that high fiber diet makes no difference in developing colon cancer. A similar study of men in 1997 arrived at a similar conclusion. Current evidence suggests taking a multivitamin with 400 micrograms of folic acid, don't smoke, avoid red meat more than five times a week and plenty of exercise may prevent colon cancer...

*Time Feb 1*

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Diet Pill: Effective, If Messy: Obese dieters taking Orlistat lost more weight (19 lbs) in the first year than dieters on placebo (13 lbs). Side effects include cramps and "fecal incontinence."

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Muscle Candy: Mark McGwire took both androstenedione and creatine last year and cranked out 70 home runs and Sammy Sosa took creatine and came in second. JAMA in June published a double-blind placebo controlled trial of 20 men and found that taking "andro" did nothing for testosterone levels. Instead, it boosted estrogen-like compounds and decreased levels of HDL by 12%. Moreover "andro" did not help build muscle mass at all. Creatine is not a steroid and more closely resembles a protein. It improves performance by 2% or 3% in repetitive exercises that require short bouts of explosive energy according to a panel of experts convened by the American College of Sports Medicine...

*Time Jun 14*

## Medical Tid Bits II

Standing Tall... Synthetic growth hormones help short, healthy kids achieve new heights – sometimes. The first major study to follow such youngsters through adulthood concludes that on average, 50% of patients who received the daily injections grew 2 inches taller than expected. Doctors, however, cannot predict which children will respond... Cost: up to $20,000/year...

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Posture Imperfect... Women athletes may be more vulnerable than men to knee injuries because they crouch less when playing sports like basketball and soccer... the upright posture, during landing and pivoting forces the quadriceps to exert pressure on knee ligaments...

*Time Mar 1*

Stroke Specialists...Enter an experimental drug called recominant pro-urokinase. In a clinical trial of 180 patients presented at a meeting of the American Heart Association in Feb, researchers reported that 40% of patients who received the drug within six hours of the start of their stroke made a dramatic recovery. Dr. Anthony Furlan, a stroke specialist at the Cleveland Clinic who led the study, says the recovered patients "could return to work, take care of their finances, drive a car." The drug works well because the doctors inject it via a catheter threaded directly into the site of the clot through the middle cerebral artery.

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Fight Infection and Help the Heart... A preliminary report suggests that taking certain antibiotics (Tetracycline and Ciprofloxacin) may reduce the risk of heart attack. The finding lends credence to a tantalizing new theory that infections may contribute to heart disease by causing inflammation of arterial walls...

## Medical Tidbits III

Revved Up Rx's: A new report suggests that recommended doses for many medications may be too high... among them Prozac and Lipitor. Cutting down the dose sometimes by 1/2 or more may reduce adverse reactions without sacrificing the drug's effects...

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Racial Gap: Lung Cancer kills 160,000 Americans each year, esp black men (34% black men smoke compared to 28% of white men)

Researchers at the Memorial Sloan Kettering Cancer Center and the National Cancer Institute in Bethesda Md looked at data from 10,000 white and black medicare patients with lung tumors early enough to do surgery–77% of the white patients had surgery while 64% of the blacks had. The year survival rate for black patients was 26% compared to 34% for the whites.

Currently there is no screening test for early lung cancer, but Dr. Claudia Henschke at the Weill Medical College at Cornell and her colleagues feel that low dose CAT scans can identify very small tumors. Still the experimental scan costs $300 and is so far available only in New York City; Rochester Minn and Tampa Florida...

## Medical Tid Bits IV

Block That Cold! A top cold researcher, Jack Gwaltney from Virginia School of Medicine advises:

1). Wash your hands a lot with soap and water. (Cold viruses like to linger there)

2). Don't put your fingers in your eyes or nose as they give easy access to nasal passages...

3). Take over-the-counter antihistamine like chlorpheniramine or clemestine (drowsy formulas work better against colds than the non drowsy formulas) and an anti-inflammatory like ibuprofen or naproxen.

New Treatment for Baldness? Researchers removed patches of a man's scalp (hair, roots and follicles) and transplanted them onto the forearm of an unrelated woman. The patches took root and after more than two months showed no signs of rejection...

*Time Nov 15*

When You're Older: A study of 300 women (ages 21 to 84) found that sensitivity to the bitterness of such vegetables as broccoli and spinach wanes with age. The older women preferred sour fruits such as grapefruit and lemons and bitter beverages as coffee and tea...

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Gene Blues: The Washington Post reported that half a dozen heart patients have died while undergoing gene therapy.

Gene therapy shows great promise, but anyone considering gene therapy should know it's still very experimental...

**POTPOURRI IV**
**Disorder in Court:**

Q: What is your date of birth?
A: July 15th...
Q: What year?
A: Every year...

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Q: What gear were you in at the moment of impact?
A: Gucci sweater and Reebokes.

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Q: This myasthenia gravis– does it affect your memory?
A: Yes
Q: And in what way does it affect your memory?
A: I forget
Q: You forget? Can you give me an example?

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Q: How old is your son – the one living with you?
A: 38 or 35. I can't remember which...
Q: How long has he lived with you?
A: 45 years

Q: What was the first thing your husband said to you when he woke in the morning?
A: He said, "Where am I, Cathy?"
Q: Why did that upset you?
A: My name is Susan.

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Q: Sir, what is your IQ?
A: Well, I can see pretty well, I think

*Recently reported in the Massachusetts Bar Association congress (Submitted by Sherry Hagino)*

**POTPOURRI V**

Mary was on her death bed with her husband Sam at her side. He held her cold hands with tears steaming down his face...

"Sam," she said weakly..."Hush, dear."

"Sam," she whispered, "I have something to confess."

"There's nothing to confess," Sam soothed. "It's all right. Everything is all right."

"No, no, I can't die in peace," Mary insisted. "I must die in peace,"

"I must confess Sam, that I have been unfaithful."

Sam stroked her head, "Now, Mary don't be concerned. I know all about it."

"You do?" she gasped.

"Of course dear, why else would I have poisoned you."

*Play Boy*


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*Orthopedics*

*BS – Florida State University*

*MD – University of South Alabama*

*Residency – University of Miami/Jackson Memorial Hospital*

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Compiled by Carolyn S.H. Ching and Judith A. Kearney of the Hawaii Medical Library

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# The Weathervane Russell T. Stodd MD

**One Thing Leads To Another—But Does It Have To?**
Reacting to the scare of the highly contagious Creutzfeldt-Jacobs (mad cow) disease, Britain's health boss ordered opticians to dispose of all trial contact lenses after each use. The Association of Optometrists expressed concern that the government gave no advance warning to practitioners, and the order caused considerable alarm among contact lens wearers. There is zero evidence that any mad cow disease deaths have been the result of contact lenses, and the order was characterized as simply a precautionary measure. Sounds like the stampede of the mad Health Secretary.

**Tough As It Is, When Americans Roll Up Their Sleeves, They Still Manage To Ignore This Problem.**
Whether it is prosperity, our electronic world, changes in occupational physical demands, eating habits, or simple indolence, a very serious underlying disorder with the health of too many people is excess weight, pork, obesity, fatness – the all-American accepted illness. The present White House occupant is at least 10 lbs. overweight. Unfortunately, too often the problem involves the physician as well. National data show that one-third to one-half of adults are overweight, and one-fourth are clinically obese. Accompanying diseases are high blood pressure, type 2 diabetes, sleep apnea, some cancers and cardiovascular disease. Along with these measurable conditions are social stigmatization and accompanying psychological distress with depression and plunging self-esteem. It is not just an adult problem; the American Academy of Pediatrics committee on nutrition has established that obesity is the number one problem in child health. 14% of children and 12% of adolescents are overweight with the attendant possibility for some chronic diseases later in life. Forget the counseling and ignore the diet books. The solution is hard but not complicated. It takes a dedicated change in life style to make exercise a priority, and use that most difficult of exercises, the push-away (from the table).

**If It Ain't Broke Use It Again.**
Hospitals don't want to talk about it, but the squeeze on reimbursements for medical services has caused the reuse of medical instruments. A 1999 survey of 132 hospitals revealed that almost half routinely reuse medical devices labeled for single use. Manufacturers fear liability for the misuse of their products, but also often label products single use not for safety but because they want to sell more. In January, a piece of reused catheter broke off in a woman's heart, and the doctors were unable to remove it. The hospital officials stated that the woman is in no pain or danger. A Mayo Clinic Administrator stated that the Mayo Clinic reuses special catheters to map heart problems five or six times "without any evidence of infection." The question is legal dynamite, because drug companies and hospitals are seen as deep pockets. A good plaintiff's attorney will see a big company name in a case involving a reused device, and the door is open. Juries are eager to punish what would be perceived as a cost saving mechanism with patients at increased risk.

**Don't Feed Me Any More Cheese. I Just Want Out Of The Trap.**
The Health Care Financing Administration claims that reductions in Medicare payments do not truly impact patient practices. The financial problems of so many practices around the country belies that bureaucratic assumption. The American Medical Association's Socio-economic Monitoring System (SMS) survey established some shocking statistics: (1) 31% of physicians have cut staff, salary increases and staff benefits (2) 36% have cut their own salaries and benefits (3) 61% said that Medicare cuts were a major influence on plans for early retirement (4) 69% said Medicare cuts led them to increase productivity by spending less time with patients and referring out complicated cases. Additional alterations in medical practice involved not renewing or updating office equipment, moving to a new (cheaper) location, reducing or refusing telephone consultations and counseling. Is it any wonder that organized medicine delves into previously unthinkable areas such as a medical union?

**If You Can't Find Something Everyone Agrees On, It's Wrong.**
The American Osteopathic Association House of Delegates has not followed the direction of the AMA. Delegates decided that unionization is not the answer to the problems of managed care. The AOA is supporting legislative attempts to provide an antitrust exemption so that physicians can collectively negotiate with managed care organizations. The Executive Director of the AOA stated that their House of Delegates believes they can "work together with managed care organizations to create an open and constructive dialogue to benefit patients and improve the practice environment for osteopathic physicians."

**Let's Really Save Medicare Dollars And Clean Out Those Nursing Homes.**
"Euthanasia could become the health care industry's ultimate cost-control strategy in dealing with patients thought to have little chance of survival," J.C. Pickett, MD, President, California Medical Association. Despite opposition of the bill from the CMA and representatives of the disabled and hospice organizations, the Judiciary Committee of the California state assembly has approved a proposal to legalize physician-assisted suicide, following in the steps of Oregon. At least the committee didn't approve reimbursement for death-dealing physicians as was done by their neighbor to the north. The medical association wants to alleviate end-of-life suffering by improving access to hospice care, providing counseling and pain-management services.

**Governments Are More Likely To Collapse By A Deficit Than to Perish By The Sword.**
That Medicare reform is vital should be obvious. With the birth of Medicare in 1965 there were six workers for every Medicare recipient, but today that ratio is three to one. The burgeoning size of the Medicare population is frightening, and the increased longevity coupled with sophisticated medical care is pushing program costs to constantly higher levels. President Clinton has proposed to add prescription drugs as a benefit to the existing program, a worthy thought, but Medicare does not need a new entitlement added to a poorly crafted funding system. The proposal appears modest today, but the drug benefit will surely balloon. The plan has been compared to building a swimming pool atop a rickety building. What Congress and the President should carefully consider is the Breaux-Thomas plan from the President's Bipartisan Commission on the Future of Medicare. The proposed reforms are modeled on the plan serving members of Congress and federal employees.

**The Pain In Spain Is Plainly From The Gain (numerical)**
Multiple problems exist in the health care system of the United States, including the financial crash of many management companies, the need to curb HMO abuse of patients and physicians, the squeeze on reimbursements by Medicare and other third parties, and an abiding litigious population spurred by an army of personal injury attorneys. However, consider Europe where many young trained physicians are unemployed. According to a recent JAMA article, in Spain 22% of physicians are unemployed, and many of these are highly trained professionals who passed a rigorous examination and then spent up to 5 years in residency. It's really a question of numbers with more medical schools and graduates than necessary for Spain's population, and that is where America's medical system appears headed also.

**The Young Doctor Has 20 Drugs For Each Disease; The Old Doctor Has One Drug For 20 Diseases.**
When California Attorney General Bill Lockyer told Attorney General Janet Reno and drug czar Barry McCaffrey that he has the authority to conduct marijuana research under California law, he was told he would be vulnerable to arrest and prosecution for violating federal law. Lockyer had convened a state-wide task force to study ways to implement the state's medical marijuana law, and hoped for federal support for the idea. No way is the Clinton administration going to surrender to "reefer madness" at this time. Instead, go ahead and write a prescription for an innocent drug like morphine.

**ADDENDA**

❖Literally translated, the word carnival means "flesh farewell."

❖About 50% of U.S. workers say they have had sex in the workplace. Favorite place - the boss's desk.

❖Duke Ellington once greeted Richard Nixon, and said he kissed the President four times, one for each cheek.

❖Such is the human race, it often seems a pity that Noah did not miss the boat.

Aloha and keep the faith —rts■

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