Special Issue on Healthcare Legislation

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Hale Kilolani
Hale Kilolani means, “Observatory” in Hawaiian. Hawaii’s high mountains provide an ideal setting for such scientific observations.
Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Special Issue on Healthcare Legislation

This is a very special issue. It is not the Hawaii Law Journal, but our legal and legislative associates have been major contributors to these two laws - with the help of HMA’s new President-Elect, Phil Hellreich, our legislative committees, Heidi Y. Singh, HMA Director of Legislative and Government Affairs who summarized and extracted the laws, Becky Kendro, Drake Chinen and our HMA staff.

These laws, the Uniform Healthcare Decisions Act, and the Patient Bill of Rights and Responsibilities Act, may well impact on every physician and every patient. As President-Elect Phil suggests, “Keep this edition of the Journal as a reference for future use.”

A special “Thank You” to Jim Pietsch, J.D., for his “FAQ” (for those of you not on the Web, That’s Frequently Asked Questions) about these important laws. Jim and I spent two years on the Governor’s Blue Ribbon Panel on Living and Dying with Dignity, and he’s the author of the Elder Law Handbook published by the University of Hawaii Press.

Guest Editor

Philip Hellreich MD

Every legislative session bills that directly impact the way you practice medicine are debated at the Capitol. HMA devotes considerable time to drafting or amending bills that affect the way we care for patients and run our practices. Passage of the prompt payment bill is direct evidence of the importance of legislative advocacy. We also expend a lot of effort to defeat legislation that is harmful to patient care (e.g.: prescriptive authority for mid-level practitioners). Throughout the legislative session we try to keep you updated on what is occurring at the Capitol through “blast fax” weekly legislative updates, the newsletter and the comprehensive summary of bills sent to members at the end of the session. However, there are certain laws which have a greater impact on our profession and therefore require a more in-depth analysis for your reference. Two such laws are the Uniform Health Care Decisions Act, (signed into law on July 1, 1999), and the Patient Bill of Rights and Responsibilities Act (the original was signed into law in 1998 and a second bill was signed into law on June 25, 1999). This edition of the journal contains detailed summaries of these laws.

The Uniform Health Care Decisions Act repeals current law on Medical Treatment Decisions (“Living Will”) and Power of Attorney for Health Care Decisions and combines them into one statute. It also creates a sample, optional advance directive/living will form for individuals to use or modify to their needs. This sample is provided for you to share with your patients.

The two Patient Bill of Rights and Responsibilities laws provide for significant protections for patients enrolled in all health plans. In particular, all health plans in the state must be accredited by a nationally recognized accrediting body. Plans must demonstrate to the insurance commissioner, upon request, that they make benefits available and accessible to each enrollee, provide access to sufficient numbers and types of providers and provide emergency health care services 24 hours a day and 7 days a week. The law also calls for the federal “prudent layperson” standard for emergency services and prohibits gag clauses or practices from being imposed upon physicians for discussing treatment options or services not covered by the plan. Moreover, plans must establish and maintain an internal complaint and appeal procedure. Upon exhausting a plan’s internal appeals structure, a patient, or the patient’s physician or designee, is allowed to appeal to an external review body set up by the insurance commissioner.

I hope you will take the time to review these laws and to keep this edition of the journal as a reference for future use. It is important that as patient advocates we be knowledgeable about living wills and protections for patients under managed care.

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A woman at a riverbank sees somebody caught in the current. She jumps into the water, rescues the nearly drowned victim, and brings her to safety. As soon as she is back at the riverbank, she sees somebody else in the water. She rescues that person, too. Again, as soon as she is back, she sees another person drowning—then yet another. Finally, she decides that it is a better use of her time to go upstream to figure out who is pushing these people into the water.1 This classic parable illustrates the relationship between medicine and public health. While clinical medicine can be of benefit in relieving suffering, without an understanding of what is at the root of suffering, we cannot make any headway into preventing it, and we will always be faced with drowning victims. With this viewpoint in mind, we examine the role of public health in medical education.

Recent changes in medicine itself encourage a more population approach to medicine for all practitioners. Evidence-based medicine is a means for applying the results of data collected on populations of patients to the clinical setting of the individual patient. Managed care applies population data to rationalize medical care, contain costs, and increase profits. Given, however, that the goal of proprietary organizations is to externalize costs, they cannot fulfill the role of meeting the needs of society as a whole, particularly the needs of the most disadvantaged. Thus, despite the growth of managed care, the public sector will be the ultimate ensure of the public’s health. The need for physicians to be able to practice effectively in the present and future health care environment has prompted the American Association of Medical Colleges to call for enhancement in the teaching of populational issues in U.S. medical education.2

The four perspectives that comprise the foundations of the curriculum at the University of Hawaii3 John A. Burns School of Medicine (JABSOM) are (1) population, (2) behavioral, (3) biological, and (4) clinical.3 Among JABSOM faculty, there is agreement that the populational and behavioral perspectives are insufficiently emphasized and integrated into the curriculum. Thus far, past academic year, some public health issues have been introduced into the first-year health care problems that students encounter as part of their Problem-Based Learning (PBL) curriculum. For example, the diarrhea case was rewritten so that it is now that of an infant from the Marshall Islands, so that students examine public health aspects of diarrheal disease in developing countries, the number one cause of childhood mortality worldwide. During the mid-trimester evaluation and feedback session, a student asked whether such public health concepts would be covered on the final examination. In this question there was a plea. Students were saying, we are already laboring under the weight of basic science and clinical information overload. We cannot learn public health in addition to medicine. During the feedback session, the faculty replied that, as they were in medical school, that the focus of the exam would be medical. Indeed, the examination largely tested biological and clinical concepts. Perhaps, however, an appropriate response to the student query would have been the parable above.

Indeed, its unrealistic to expect that medical students will learn the material that students of public health must master. In some ways, the situation is analogous to that of our medical school colleagues in the basic sciences. They cannot expect medical students to learn the material that they expect their graduate students to master. The difficulty is deciding to what depth medical students need to know the material and presenting the material in such a way that makes it relevant and useful to the work of medical practitioners. The key is to keep in mind the principles of PBL: keep the material relevant to the case, i.e., integrate the material into the health care problems.

How, then, can the teaching of public health concepts at the medical school be improved? Firstly, the PBL curriculum needs to be re-examined to see if the cases cover the diseases that cause the greatest morbidity and mortality. The health care problems, initially adapted from the curriculum of McMaster University in Ontario, Canada, follows an organ-based se

4. The general guide actually lists three perspectives: populational, behavioral, and biological.
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The California Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. CMA has designated this continuing medical education activity for up to 16 credit hours, which may be applied toward the CMA Certification in Continuing Medical Education and the AMA Physician's Recognition Award. At the conclusion of this conference, participants will understand physicians' changing roles, demonstrate leadership skills, understand current issues related to managed care, and be able to articulate other key health care delivery issues in today's medical practice environment.

*The Physician Leadership Program, sponsored by the Health Care Leadership Institute, is an intensive 3-day seminar designed to assess and refine physicians' leadership skills. For information, contact Laura Johnson Monisch at (415) 394-9121.
Legislative Briefing: Patient Rights and Responsibilities Laws

Background
In 1998, the Governor signed into law ACT 178 which establishes the Hawaii Patient Bill of Rights and Responsibilities Act. This law is the first step toward insuring that patients are afforded rights and protections in the evolving health care industry. ACT 178 created a task force chaired by the Insurance Commissioner to monitor implementation of the law and to draft additional legislation to strengthen the original bill. HMA is a member of the task force along with individuals representing consumers, hospitals, health plans, and government. This past legislative session, a second bill was drafted by the task force to build upon the original Patient Bill of Rights and Responsibilities Act. The bill passed and was signed into law (ACT 137) on June 25, 1999.

The purpose of this document is to provide you with a summary of the provisions of the two patients’ rights and responsibilities laws. This document is intended as an informational guide only and not as legal advice. For a complete copy of the law or for additional information, please contact Heidi Singh, Director of Legislative/Gov’t Affairs, at 536-7702, ext. 2241 or hysingh@juno.com.

[A NOTE: The definition of managed care plan in the laws is drafted to apply to all health plans. The term "commissioner" refers to the insurance commissioner]

Access to services
A managed care plan shall demonstrate to the commissioner upon request that its plan:

1) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner which promotes continuity in the provision of health care services;

2) Provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without reasonable delay;

3) When medically necessary, provides health care services 24-hours a day/7-days a week; (NOTE: The task force has recently been directed by the Legislature to develop a definition of "medically necessary")

4) Provides a reasonable choice of qualified providers of women’s health services such as gynecologists, obstetricians, certified nurse-midwives, and advanced practice nurses to provide preventive and routine women’s health care services;

5) Provides payment or reimbursement for adequately documented emergency services

6) Allows standing referrals to specialists capable of providing and coordinating primary and specialty care for an enrollee’s life-threatening, chronic, degenerative, or disabling disease or condition.

Emergency care
A health plan shall reimburse an emergency provider and an emergency department for any items or services not necessary to stabilize the patient under at least one of the following:

1) The items or services are determined to be medically necessary to treat the illness that led the patient to believe that he had an emergency medical condition, and that a reasonable patient would expect to receive such items or services from a physician at the time of presentation; or

2) The items or services are determined to be medically necessary by the emergency provider, if the emergency department:

   (A) After a documented good faith effort, is unable to reach the enrollee’s health plan:
       (i) Within thirty minutes from the initial examination of the enrollee; or
       (ii) If the enrollee needs to be stabilized, within thirty minutes of stabilization;

   (B) Has successfully contacted the plan as required in subparagraph (A), and has not received a denial from the plan within thirty minutes of the initial contact, unless the plan is able to document that it has made an unsuccessful good faith effort to reach the ER department within 30 minutes after receiving the request for authorization; or

   (C) Has successfully contacted the plan and has received a denial from a person other than a participating physician and:
       (i) A participating physician authorized by the plan to review denials reverses the denial; or
       (ii) A participating physician authorized by the plan to review denials fails to communicate a determination affirming the denial, (unless the treating physician waives the requirement for such determination), within 30 minutes after the initial denial is communicated by the plan.
A health plan shall immediately arrange for an alternate plan of treatment for the member if a non-participating emergency provider and the plan are unable to reach agreement on services necessary beyond those immediately needed to stabilize the member, under which:

(A) A participating physician with privileges at the hospital arrives at the emergency department of the hospital promptly and assumes responsibility for the treatment of the member; or

(B) With the agreement of the treating physician or another health professional in the emergency department:
   (i) Arrangement is made for transfer of the member to another facility using medical resources consistent with the condition of the enrollee;
   (ii) An appointment is made with a participating physician or provider for treatment needed by the enrollee; or
   (iii) Another arrangement is made for treatment of the enrollee.

Enrollee participation in treatment decisions
An enrollee shall have the right to be informed fully prior to making any decisions about treatment, benefit, or non-treatment. In order to inform enrollees fully, the provider shall:

1) Discuss all treatment options with an enrollee and include the option of no treatment at all;

2) Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan; and

3) Discuss all risks, benefits, and consequences to treatment and non-treatment; and

4) Discuss with the enrollee and the enrollee’s immediate family both living wills and durable powers of attorney in relation to medical treatment.

[NOTE: The HMA has concerns with the vague nature of this section and is working through the legislative process to have the informed consent law clarified.]

Ban on Physician “Gag Orders:”
A plan is prohibited from imposing any type of prohibition, disincentive, penalty, or other negative treatment upon a provider for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not provided by the plan.

Complaints and appeals procedure for enrollees
Plan’s Internal Appeals Procedures
1) All plans shall establish and maintain a procedure to provide for the resolution of enrollees’ complaints and appeals. The procedures shall be reasonably understandable to the average layperson and shall be provided in languages other than English upon request.

2) A plan shall send notice of its final internal determination to the enrollee, the enrollee’s appointed representative, if applicable, and the commissioner.

External Appeals Procedures
After exhausting a plan’s internal complaint and appeal process, an enrollee, or the enrollee’s treating provider or appointed representative, may appeal an adverse decision of a plan to a three-member review panel appointed by the commissioner. The panel is to be composed of a representative from a health plan not involved in the complaint, a provider licensed to practice and practicing medicine Hawaii not involved in the complaint, and the commissioner or the commissioner’s designee.

1) The enrollee shall submit a request for review to the commissioner within 30 days from the date of the final determination by the plan;

2) Upon receipt of the request and upon a showing of good cause, the commissioner shall appoint the members of the panel. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel;

3) The review hearing shall be conducted as soon as practicable, taking into consideration the medical exigencies of the cases, provided that the hearing shall be held no later than sixty days from the date of the request for the hearing;

4) The commissioner may retain an independent medical expert trained in the field of medicine most appropriately related to the matter under review;

5) After considering the enrollee’s complaint, the plan’s response, and any affidavits filed by the parties, the commissioner may dismiss the appeal if it is determined that the appeal is frivolous or without merit;

6) The review panel shall review every adverse determination to determine whether or not the plan involved acted reasonably and with sound medical judgment. The review panel shall consider the clinical standards of the plan, the information provided, the attending physician’s recommendation, and generally accepted practice guidelines;

7) The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying or reversing the decision within thirty days of the hearing;

8) Members of the review panel shall be granted immunity from liability and damages relating to their duties on the panel.

Information to enrollees
A managed care plan shall provide to its enrollees upon enrollment and thereafter upon request the following information:
1) A list of participating providers which shall be updated on a regular basis indicating, at a minimum, their specialty and whether the provider is accepting new patients;

2) A complete description of benefits, services, and copayments;

3) A statement on an enrollee’s rights, responsibilities, and obligations;

4) An explanation of the referral process, if any;

5) Where services or benefits may be obtained;

6) Information on the plan’s complaints and appeals procedures;

Every managed care plan shall provide to the commissioner and its enrollees notice of any material change in participating provider agreements, services or benefits, if the change affects the organization or operation of the managed care plan and the enrollee’s services or benefits. The plan shall provide notice to enrollees not more than sixty days after the change in a form that makes the notice clear and conspicuous so that it is readily noticeable by the enrollee. A plan shall provide generic participating provider contracts to enrollees, upon request.

Utilization review

Every plan shall establish procedures for continuous review of quality of care, performance of providers, utilization of health services, facilities, and costs.

Managed care plan performance measurement and data reporting standards

All managed care plans shall adopt and comply with nationally developed and promulgated standards for measuring quality, outcomes, access, satisfaction, and utilization of services. Every contract between a managed care plan and a participating provider shall require the provider to comply with the plan’s requests for any information necessary for the plan to comply with the data reporting requirements of the law.

Accreditation of managed care plans

Beginning January 1, 1999, the commissioner shall contract with one or more certified vendors of the consumer assessment health plan survey to conduct a survey of all plans actively offering managed care plans in the state. The purpose of the survey is to provide plans with an opportunity to learn whether any deficiencies exist or any improvements are required; provided that the information collected shall be kept confidential in the first year, and thereafter shall be available to the public.

All plans in the state must either be accredited by January 1, 2000 or they must submit a plan to the commissioner to achieve national accreditation status within five years.
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Physicians' Responsibilities Under Hawaii's New Uniform Health Care Decision Law

On July 1, 1999 Governor Cayetano signed into law ACT 169 which creates a comprehensive, modified uniform health care decisions act. ACT 169 repeals current laws on Medical Treatment Decisions ("Living Will") and Power of Attorney for Health Care Decisions and consolidates them into a single statute. The following information describes physicians' responsibilities under the new law. This document is intended as an informational guide only and not as legal advice. For a complete copy of the law, please contact Heidi Singh, Director of Legislative/Gov't Affairs, at 536-7702, ext. 2241 or hysingh@juno.com.

Definitions

Advance Health Care Directive ("Living Will"): an individual instruction or a power of attorney for health care.

Agent: an individual designated in a power of attorney for health care to make a health care decision for the individual granting the power.

Guardian: a judicially appointed guardian or conservator having authority to make a health care decision for an individual.

Primary Physician: a physician designated by an individual or the individual’s agent, guardian, or surrogate, to have primary responsibility for the individual’s health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

Supervising Health Care Provider: the primary physician or the physician’s designee, or the health care provider or the provider’s designee who has undertaken primary responsibility for an individual’s health care.

Surrogate: an individual, other than a patient’s agent or guardian, authorized by this act to make a health care decision for an individual.

Physician Responsibilities

A determination that an individual lacks the capacity, or has another condition that affects an individual instruction or the authority of an agent, shall be made by the primary physician, unless otherwise specified in a written advance health care directive. A health care provider or institution may not require or prohibit the execution of an advance directive as a condition of providing care.

Revocation of advance health-care directive:

a) An individual may revoke the designation of an agent only by a signed written statement or by personally informing the supervising health-care provider.

b) An individual may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

c) A health care provider, agent, guardian, or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health care provider and to any health care institution at which the patient is receiving care.

d) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care.

e) An advance health care directive that conflicts with an earlier advance health care directive revokes the earlier directive to the extent of the conflict.

Surrogate Health Care Decisions:

a) A patient may designate or disqualify any individual to act as a surrogate by personally informing the supervising health care provider. In the absence of such designation, or if the designee is not reasonably available, a surrogate may be appointed to make a health care decision for the patient.

b) A surrogate may make a health care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available. Upon a determination that a patient lacks decisional capacity to provide informed consent to or refusal of medical treatment, the primary physician or the physician’s designee shall make reasonable efforts to notify the patient of the patient’s lack of capacity. The primary physician or the physician’s designee must make reasonable efforts to locate as many interested persons as practicable, and the primary physician may rely on such individuals to notify other family members or interested persons.

c) Upon locating interested persons, the primary physician, or the
provide a written declaration under the penalty of false swearing stating facts and circumstances reasonably sufficient to establish the claimed authority.

**Decisions by a Guardian:**

a) A guardian shall comply with the ward’s individual instructions and shall not revoke the ward’s pre-incapacity advance health care directive unless expressly authorized by a court.
b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.
c) A health care decision made by a guardian for the ward is effective without judicial approval.

**Obligations of Health Care Provider:**

a) Before implementing a health care decision made for a patient, a supervising health care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.
b) A supervising health care provider who knows of the existence of an advance health care directive, a revocation of an advance health care directive, or a designation or disqualification of a surrogate, shall promptly record its existence in the patient’s health care record, and if it is in writing, shall request a copy. If one is furnished, the provider shall arrange for its maintenance in the health care record.
c) A supervising health care provider who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian or surrogate, shall promptly record the determination in the patient’s health care record and communicate the determination to the patient, if possible, and to any person then authorized to make health-care decisions for the patient.
d) Except as provided in subsections (e) and (f), a health care provider or institution providing care to a patient shall:

1) Comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health decisions for the patient.
2) Comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.
e) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience. A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.
f) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medi-
cally ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

g) A health care provider or institution that declines to comply with an individual instruction or health care decision shall:

1) Promptly inform the patient, if possible, and any person then authorized to make health care decisions for the patient;
2) Provide continuing care to the patient until a transfer can be effected; and
3) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

h) A health care provider or institution may not require or prohibit the execution or revocation of an advance health care directive as a condition for providing health care.

Health Care Information

Unless otherwise specified in an advance health care directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

Immunities

a) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution shall not be subject to civil or criminal liability or to discipline for unprofessional conduct for:

1) Complying with a health care decision of a person apparently having authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;
2) Declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or
3) Complying with an advance health care directive and assuming that the directive was valid when made and has not been revoked or terminated.

Statutory Damages

a) A health care provider or institution that intentionally violates this chapter shall be subject to liability to the individual or the individual's estate for damages of $500 or actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees.

b) Anyone who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health care directive, shall be subject to liability to that individual for damages of $2,500 or actual damages resulting from this action, whichever is greater, plus reasonable attorney's fees.

Other

This chapter shall not:

a) authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of the state.

b) authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or institution.

c) shall not authorize an agent or surrogate to consent to the admission of an individual to a psychiatric facility as defined in chapter 334, unless the individual's written advance health care directive expressly so provides.

d) shall not affect other statutes of the state governing treatment for mental illness of an individual involuntarily committed to a psychiatric facility.

e) shall not apply to a patient diagnosed as pregnant by the attending physician.
Effective Management of Inflammatory Skin Disease

Locoid Lipocream therapy features a patented, scientific base consisting of nearly 70% oil dispersed in 30% water, effective in dry, chronic conditions.

This vehicle provides the occlusive properties of an ointment, yet maintains the cosmetic appeal of a cream.

Locoid Lipocream demonstrated efficacy in over 20 clinical studies worldwide involving over 1,600 patients.*

The Locoid Lipocream vehicle is also available as the OTC formulation SBR-Lipocream.

Distributed by: FERNDALE PHARMA,
A Division of FERNDALE LABORATORIES, INC.
Ferndale, Michigan 48220 USA
**Locoid Lipocream® Cream (hydrocortisone butyrate 0.1%)**

*For Dermatological Use Only*

**DESCRIPTION**

Locoid Lipocream® Cream contains the topical corticosteroid hydrocortisone butyrate, a hydrocortisone ester. It has the chemical name: (11β,17,21-trihydroxy-16α-methylpregna-1,4,6-triene-3,20-dione; the molecular formula: C₂₄H₃₁O₄; the molecular weight: 342.54; and the CAS registry number: 1369-67-1. The structural formula is:

```
           O
          /\       \          
         /     \     \         
        C-O-C   C-O-C     C-O-C  
        |       |       |         
        |       |       |         
        C-H-C   C-H-C     C-H-C  
        |       |       |         
        CH₃     CH₂     CH₂OH   
```

Each gram of LOCIOID Lipocream® Cream contains 1 mg of hydrocortisone butyrate in a hydrophilic base consisting of cetostearyl alcohol, octyl-20, menthol, white petrolatum, citric acid, sodium citrate, propyl paraben and butyl paraben (preservatives) and purified water.

**CLINICAL PHARMACOLOGY**

Topical corticosteroids share anti-inflammatory, anti-pruritic and vasoconstrictive actions. The mechanism of anti-inflammatory activity of topical corticosteroids is unclear. Various laboratory methods, including vasomotor assays, are used to compare and predict corticosteroids and/or clinical efficacies of topical corticosteroids. There is some evidence to suggest that a recognizable correlation exists between vasoconstrictor potency and therapeutic efficacy in man.

**PHARMACOKINETICS**

The extent of percutaneous absorption of topical corticosteroids is determined by many factors including the vehicle, the integrity of the epidermal barrier, and the use of occlusive dressings.

Topical corticosteroids can be absorbed from normal intact skin. Inflammation and/or other disease processes in the skin increase percutaneous absorption. Occlusive dressings or widespread application may increase the possibility of systemic corticosteroid absorption and systemic toxicity. The vasoconstrictor assay showed that LOCIOID Lipocream® Cream had a more pronounced skin blanching effect than LOCIOID Cream, suggesting greater percutaneous absorption from the former. At the present time, no adequate HPA axis suppression studies have been conducted for LOCIOID Lipocream® Cream. Once absorbed through the skin, topical corticosteroids are handled through pharmacokinetic pathways similar to systemically administered corticosteroids. Corticosteroids are bound to plasma proteins in varying degrees.

Corticosteroids are metabolized primarily in the liver and are then excreted by the kidney. Some of the topical corticosteroids and their metabolites are also excreted into the bile.

**INDICATIONS AND USAGE**

LOCIOID Lipocream® Cream (hydrocortisone butyrate 0.1%) is indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

**CONTRAINDICATIONS**

Topical corticosteroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

**PRECAUTIONS**

General

Systemic absorption of topical corticosteroids has produced reversible HPA axis suppression, manifestations of Cushings syndrome, hyperglycemia, and glucosuria in some patients. Conditions which increase the risk of systemic toxicity include the application of more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity. (See PRECAUTIONS — PEDIATRIC USE.) If irritation develops, topical corticosteroids should be discontinued and appropriate therapy instituted. In the presence of dermatological infections, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

**Information for the Patient**

Patients using topical corticosteroids should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only.
2. Avoid contact with the eyes.
3. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
4. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occlusive.
5. Patients should report any signs of local adverse reactions.
6. Patients of pediatric age should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.

**Laboratory Tests**

The following tests may be helpful in evaluating the HPA axis suppression:

- Urinary free cortisol test
- ACTH stimulation test

**Carcinogenesis, Mutagenesis, and Impairment of Fertility**

Long-term animal studies have not been performed to evaluate the carcinogenic potential or the effect on fertility of topical corticosteroids.

Studies to determine mutagenicity in Salmonella typhimurium strains TA98, TA100, and TA102 with phenylethanol and hydrocortisone have revealed negative results.

**Pregnancy: Teratogenic Effects:**

**Pregnancy Category C:**

Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Some corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. In teratogenicity studies, topical administration of 1% or 10% hydrocortisone butyrate in an ointment to pregnant Wistar rats (gestational days 6-15) or New Zealand white rabbits (gestational days 9-18) resulted in no teratogenic findings. However, a dose-dependent increase in fetal resorptions was reported in rabbits, and fetal resorptions were observed in rats treated with 10% hydrocortisone butyrate.

The doses given to rats are approximately 4 to 80 times the human topical dose based on a body surface area comparison (assuming 100% absorption). For rabbits, the doses given were approximately 0.2 and 2 times the human topical dose. Increased resorptions were also noted in Wistar rats given subcutaneous administrations of hydrocortisone butyrate (0.5mg/kg/day; 3 times the human topical dose) on gestational days 9 through 15. If most recent subcutaneous administrations of 0.5mg/kg/day (0.2 times the human topical dose), an increased number of cervical ribs and exenceplasia with clubbed legs was reported. There are no adequate and well-controlled studies in pregnant women on teratogenic effects from topically applied corticosteroids. Therefore, topical corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. LOCIOID Lipocream® (hydrocortisone butyrate 0.1%) Cream should not be used extensively on pregnant patients in large amounts, or for longer than two weeks.

**Nursing Mothers**

It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in breast milk.

Systemically administered corticosteroids are secreted into breast milk in quantities not likely to have a deleterious effect on the infant. Nevertheless, caution should be exercised when topical corticosteroids are administered to a nursing woman.

**Pediatric Use**

Safely and effectiveness in pediatric patients have not been established.

Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced HPA axis suppression and Cushings syndrome than mature patients because of a larger skin surface area to body weight ratio.

**OVERDOSAGE**

Topically applied corticosteroids can be absorbed in sufficient amounts to produce systemic effects. (See PRECAUTIONS.)

**DOSEAGE AND ADMINISTRATION**

LOCIOID Lipocream® (hydrocortisone butyrate 0.1%) Cream should be applied to the affected areas as a thin film two or three times daily (depending on the severity of the condition) and for no longer than two weeks. If an infection develops, appropriate antimicrobial therapy should be instituted.

**HOW SUPPLIED**

LOCIOID Lipocream® (hydrocortisone butyrate 0.1%) Cream is supplied in tubes containing:

- 15 g NDC 0496-0821-15
- 45 g NDC 0496-0821-45

**STORAGE**

Store at controlled temperature between 59° and 77°F (15° and 25°C).

**Distributed by:**

FERMIA LABORATORIES INC.
Ferndale, Michigan 48220 USA

Protected under U.S. Patent

** Manufactured by:**

Yamanouchi Europe B.V.
Leiderdorp/The Netherlands

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02950031-C
Durable Power of Attorney/Advance Health Care Directive Sample, Optional Forms

On July 1, 1999 Governor Cayetano signed into law ACT 169 which creates a comprehensive, modified uniform health care decisions act. ACT 169 repeals current laws on Medical Treatment Decision ("Living Will") and Power of Attorney for Health Care Decisions and consolidates them into a single statute. The law includes sample, optional forms to create a durable power of attorney and an advance health care directive. These forms are attached and may be modified in accordance with your wishes.

PART I: DURABLE POWER OF ATTORNEY
Part I of the sample form is a durable power of attorney in which you may designate another individual (an “agent”) to make health care decisions for you should you become incapable of doing so or would like someone else to make those decisions for you now even though you are still capable of doing so.

PART II: ADVANCE HEALTH CARE DIRECTIVE
Part II of the sample form may be used to create an advance health care directive. An advance health care directive allows you to give specific instructions about your care (e.g., whether or not you want treatment to be withheld or withdrawn, provision of pain relief, artificial nutrition and hydration).

PART III: DONATION OF ORGANS AT DEATH
Part III of the sample form allows you to specify whether or not you want to donate your organs upon your death.

PART IV: PRIMARY PHYSICIAN
Part IV of the sample form allows you to designate a physician to have primary responsibility for your health care.

SIGNING/WITNESSING THE FORM:
Once you complete the form, you must sign and date it in the presence of witnesses by one of two alternatives: 1) Before two adult witnesses neither of whom may be a health care provider, an employee of a health care provider or facility, or the agent. At least one of the witnesses cannot be someone who is related to you by blood, marriage, or adoption, nor entitled to any portion of your estate upon your death under any will or codicil existing at the time of execution of the power of attorney for health care or; 2) Before a notary public.

WHO TO GIVE A COPY OF THE FORM TO:
You should give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should also talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to have the responsibility of your care.
§ -16 Optional form. The following sample form may be used to create an advance health-care directive. This form may be duplicated. This form may be modified to suit the needs of the person, or a completely different form may be used that contains the substance of the following form.

"ADVANCE HEALTH-CARE DIRECTIVE"
Explanation
You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care. Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) Select or discharge health care providers and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you donate your organs upon your death if you so desire.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care. After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.
PART 1
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(name of individual you choose as agent)

(address) (city) (state) (zip code) (home phone) (work phone)

OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address) (city) (state) (zip code) (home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address) (city) (state) (zip code) (home phone) (work phone)

(2) AGENT’S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed)

(3) WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent’s authority to make health care decisions for me takes effect immediately.

(4) AGENT’S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.
PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Check only one box).

☐ (a) Choice Not To Prolong Life
I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

☐ (b) Choice To Prolong Life
I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box ☐, artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: If I mark this box ☐, I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

____________________________________________________________________________________
____________________________________________________________________________________

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

(10) Upon my death: (mark applicable box)

☐ (a) I give any needed organs, tissues, or parts, OR

☐ (b) I give the following organs, tissues, or parts only:

____________________________________________________________________________________
____________________________________________________________________________________

☐ (c) My gift is for the following purposes (strike any of the following you do not want)

(i) Transplant, (ii) Therapy, (iii) Research, (iv) Education
(11) I designate the following physician as my primary physician:

________________________________________________________________________
(name of physician)

________________________________________________________________________
(address) (city) (state) (zip code)

________________________________________________________________________
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

________________________________________________________________________
(name of physician)

________________________________________________________________________
(address) (city) (state) (zip code)

________________________________________________________________________
(phone)

(12) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(13) **SIGNATURES:** Sign and date the form here:

________________________________________________________________________
(date)

________________________________________________________________________
(sign your name)

________________________________________________________________________
(address)

________________________________________________________________________
(print your name)

________________________________________________________________________
(city) (state)

(14) **WITNESS:** This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.
ALTERNATIVE NO. 1

Witness
I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(date) (signature of witness)

(address) (print name of witness)

(city) (state)

Witness
I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

(date) (signature of witness)

(address) (print name of witness)

(city) (state)

ALTERNATIVE NO. 2

State of Hawaii

County of ____________________________

On this ______ day of ________, in the year _______, before me,

______________________________ (insert name of notary public) appeared

______________________________, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

________________________________ (Signature of Notary Public)
Abstract:
The Hawaii Uniform Health Care Decisions Act (Modified) became law, effective July 1, 1999. The Act makes major changes to the law pertaining to Advance Directives and surrogate decision-making. While some of the changes seem to be confusing, most practitioners should find the new law helpful in attempting to assure that the rights of their patients to self-determination and autonomy are preserved and their wishes are followed. Using a question and answer format, this article will provide a basic guide to the new law. The "frequently asked questions" and the answers follow a brief overview of the Uniform Health Care Decisions Act. For busy practitioners, a conclusion summarizes key points.

Overview of the New Uniform Health Care Decisions Act (Modified)
There is a new law that makes major changes to Hawaii’s laws pertaining to health care decision-making, including advance health care directives and surrogate decision-making. The 1999 Hawaii Session Laws Act 169, effective July 1, 1999, is called the Uniform Health Care Decisions Act (Modified). It repealed Hawaii Revised Statutes (HRS) Chapter 327D (Medical Treatment Decisions) in its entirety and it significantly modified the provisions under HRS Chapter 551D pertaining to the durable power of attorney for health care decisions. Hawaii’s version of the Uniform Health Care Decisions Act (UHCDA) was adapted from the Uniform Act approved by the National Conference on Uniform Laws and by the American Bar Association House of Delegates. The text of Act 169 is included in this edition of the journal.

Even with certain limitations added by the legislature, the act:
1. Acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances.
2. Is comprehensive and enables Hawaii to replace its existing legislation on the subject with a single statute.
3. Is designed to simplify and facilitate the making of advance health care directives
4. Seeks to ensure that an individual’s decisions about health care are governed by the individual’s own desires concerning the issues to be resolved.
5. Addresses compliance by health care providers and institutions.
6. Includes procedures for the appointment of a surrogate, if needed, and for resolution of disputes, specifically through initiation of guardianship proceedings.

Limitations in the law include the imposition of special rules for decisions by “non-designated” surrogates to withhold or withdraw artificial nutrition and hydration and the inapplicability of the act to a patient diagnosed as pregnant by the attending physician.2 Anecdotal evidence suggests that many health care professionals still do not have a good understanding of the new law and that several specific provisions are problematic. This article is intended to help answer some of the most frequently asked questions. Readers may submit additional questions to the author through the journal for possible inclusion in future editions of the journal.

Frequently Asked Questions
QUESTION # 1
Why was the law changed and why was the Uniform Health Care Decisions Act model used?

Answer
In 1997 the Governor established a Blue Ribbon Panel on Living and Dying With Dignity to explore the issues relating to living and dying in Hawaii. The panel found that dying has not been managed as well as it could and in 1998 submitted seven recommendations to the governor.3 One of the recommendations was that the content of Advance Directives for Healthcare including Living Wills be made more specific, their use more widespread and their provisions more binding. With respect to patient self-determination, the panel found that most people do not make Advance Directives and even when they are made, a significant percentage of Advance Directives is ignored or not followed by health care providers.4 The report went on to indicate that several factors contributed to this situation:
1) Existing statutes provide few incentives to execute advance directives;
2) They contain few sanctions to encourage compliance; and
3) There is no mechanism to determine whether the provisions of the law are being met.

Despite the fact that Advance Directives possess legal status, physicians and health care facilities continue to be influenced by their own
1999

opinions of what is in the best interest of the patient or by the demands and desires of family members or other third parties. Too often the patient’s own expressed instructions are not reflected in end of life care. Further, the panel found that another difficulty was that statutes regarding end of life care (Medical Treatment Decisions, Durable Power of Attorney for Health Care, Do Not Resuscitate necklaces and bracelets, Surrogate Decision-Makers, Brain Death) are scattered throughout state law. 

The 1997 Health Care Decisions By Legal Surrogate Act created a two-year demonstration project that the legislature felt would protect the health and safety of a person who: (1) Previously had the ability, but who no longer had the ability, to understand the significant benefits, risks, and alternatives to proposed health care, and to make and communicate health care decisions; (2) Resided in a skilled nursing or intermediate care facility; and (3) Had not executed a health care directive for health care decisions which addressed the specific health care decisions presented, at the time, by or to the facility or health care provider; or whose agent was unavailable and whose whereabouts could not be ascertained within a reasonable period of time. This act was incorporated into HRS Chapter 327D and "sunsetted" effective June 30, 1999. The enabling legislation created a task force to study the implementation of the act and to make recommendations for new legislation regarding surrogate decision-making.

The legal issues focus group of the Governor’s Blue Ribbon Panel ultimately recommended that Hawai’i consider adopting a version of the Uniform Health Care Decisions Act (UHCDA) which was adapted from the Uniform Act approved by the National Conference on Uniform Laws and by the American Bar Association House of Delegates. After many months of hearings and deliberations, the Health Care Decisions By Legal Surrogate task force which has been meeting during the same period of time, agreed that utilizing the UHCDA format was the best approach to the issue, in essence following the recommendations that came from the work of the Blue Ribbon Panel. The task force ultimately agreed, however, to recommend significant changes to the surrogate provisions of the UHCDA in order for the bill to go forward. A modified version of the Model UHCDA was submitted to the legislature in the fall of 1998 as part of the Governor’s legislative package.

QUESTION # 2
What “Advance Directives” are covered under the UHCDA, what can they include, and is there a standard form?

Answer
The term “Advance Medical Directive,” “Advance Health care Directive” or more simply “Advance Directive” (AD), in the broadest sense, applies to all directives, instructions, or even desires that a person may communicate in writing, orally or in some other fashion concerning decisions about one’s body. In a stricter sense, ADs can be defined as written documents directing the consent or non-consent, application, withdrawal or withholding of medical treatment, or the appointment of a surrogate decision maker. Hawaii law has never required written advance directives although they have been preferred. Each state or territory has different laws on the subject it is often questionable whether an AD executed in one jurisdiction will be recognized in another jurisdiction. (One version of an AD must, by federal law, be recognized by all states. The Military Advance Medical Directive, if properly executed in accordance with military legal assistance guidelines, must be recognized in every U.S. jurisdiction) There has been some movement toward creating uniformity among the states as is evidenced by enactment of the UHCDA in several jurisdictions, including Hawai’i.

Under the new UHCDA an adult or emancipated minor may make advance health care directives by giving an “individual instruction” orally or in writing and/or by executing a power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity. The term “living will” is not used in the UHCDA. Copies of a written advance health care directive have the same effect as the original. The new advance directives should be more “portable” than those executed under the old law, especially in jurisdictions that adopt the UHCDA.

Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity. An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider but an individual may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

The new law includes an optional sample form (and explanation) which may be duplicated or modified to suit the needs of the person, or a completely different form may be used that contains the substance of the sample form found in the statute. A sample form with an explanation is found in the copy of the UHCDA which is included in this edition of the journal. The sample optional form was written with the intention that consumers utilize the form without having to seek the assistance of an attorney but the University of Hawai’i Elder Law Program (UHELP) has received numerous comments from clients, physicians and attorneys. Many indicate that the new optional sample form is too long and too complicated, especially for individuals with diminished capacity or limited education. UHELP has developed its own forms for clients with diminished capacity or limited education.

The UHCDA does not include all of the types of advance directives. There are some health care decisions that were not ordinarily addressed by traditional advance directives or by surrogates. Traditional AD’s were not very useful or applicable under circumstances where a patient suffers cardiac or respiratory arrest. Of course, surrogate decision-making at the time of such a medical emergency can be difficult. In 1995 a law was passed in Hawai’i which allows a terminally ill person to state in advance that he or she does not want to be resuscitated in an emergency if he or she:

(A) Has been certified in a written “comfort care only” document by the person’s physician to be a terminally ill patient of that physician; and

(B) Has certified in the same written “comfort care only” document that the person directs emergency medical services personnel, first responder personnel, and health care providers not to administer chest compression, rescue breathing, electric shocks, or medication, or all of these, given to restart the heart if the person’s breathing or heart stops, and directs that the person is to receive care for
comfort only, including oxygen, airway suctioning, splinting of fractures, pain medicine, and other measures required for comfort; and

(C) Has been prescribed by a physician a "comfort care only—do-not-resuscitate" (CCO-DNR) identifying bracelet or necklace. The written document containing both certifications must be signed by the patient with the terminal condition, by the patient's physician, and by any one other adult person who personally knows the patient.

The UHCDAdoes not specifically cover the decision to accept or refuse the administration of psychotropic drugs by a health care provider for a psychotic condition. A person suffering from a psychotic condition, but who is competent and in a state of remission at the time of execution may execute a written declaration directing that medical treatment, including the administration of psychotropic drugs, be provided at a time when the person has lapsed and "lacks sufficient understanding to make or communicate responsible medical treatment decisions."18

**QUESTION # 3**

Are Advance Directives executed under the old law still "valid?"

**Answer**

Yes, but the old documents may impose unnecessary limitations on the choices available to patients and may be less clear than advance directives executed under the UHCDAD. Health care providers should encourage patients to consider making new advance directives under the new law.

The old "living will" law19 provided that any competent person who had attained the age of majority could execute a declaration directing the provision, continuation, withholding, or withdrawal of life-sustaining procedures under certain conditions, such as a terminal condition or where the patient had a permanent loss of ability to communicate with others due to irreversible brain injury or coma. An attending physician who was notified of the existence of such a declaration had a duty to make a determination of whether the patient's condition corresponded to the directions in the declaration and, if so, to make a written certification of such a finding in the patient's medical record.20 Under the old law, physicians were sometimes reluctant to certify that the patient was in such a condition and had "no reasonable chance of regaining this ability."

The durable power of attorney for health care law21 had numerous limitations and was difficult for many people to execute. A competent person who had attained the age of majority could execute a durable power of attorney authorizing an agent to make any lawful health care decisions that could have been made by the principal at the time of election.22 The execution requirements for making a durable power of attorney for health care under the old law were, however, somewhat restrictive.23

The old law also included a provision which stated that "a durable power of attorney for health care decisions is presumed not to grant authority to decide that the principal's life should not be prolonged through surgery, resuscitation, life-sustaining medicine or procedures, or the provision of nutrition or hydration unless such authority is explicitly stated."24 It was not sufficient under the old law to use a phrase such as "I grant all powers relating to my health care." The new UHCDAdpermits such a broad grant of powers. The old law specifically mentioned that a durable power of attorney for health care decisions was only effective during the period of incapacity of the principal as determined by a licensed physician.25 As discussed in question # 2, this, too, is changed under the UHCDAD.

**QUESTION # 4**

How is a "surrogate" appointed and what powers do they have when a patient no longer has the ability to make health care decisions and there is no guardian or agent under a health care power of attorney?

**Answer**

Under the UHCDAd a surrogate may make a health care decision for a patient if the patient lacks capacity26 and no agent or guardian has been appointed or the agent or guardian is not available. A patient may designate or disqualify any individual to act as a surrogate by personally informing the supervising health care provider.27 How the patient is to personally inform the supervising health care provider is not spelled out in the act. It is obvious that a patient may orally inform the supervising health care professional. The designation or disqualification may be made in writing. Section 7 of the act requires a supervising health care provider who knows of the existence of an advance health care directive, revocation of an advance health care directive, reversion of an advance health care directive, or designation or disqualification of a surrogate to "promptly record its existence in a patient's health care record and, if it is in writing, (emphasis added) shall request a copy and if one is furnished shall arrange for its maintenance in the health care record. Further, Section 12 of the act provides that "a copy of a written advance health care directive, or designation or disqualification of a surrogate (emphasis added) has the same effect as the original."

In the absence of a designation by the patient of a surrogate, or if the designee is not reasonably available, a surrogate may be appointed to make a health care decision for the patient.28 Unlike the Model Act approved by the National Conference on Uniform Laws, Hawaii's version of the UHCDAdoes not provide for a common family hierarchy of decision makers for a decisionally incapacitated patient but, rather, provides for decision-making by surrogates selected from a group of "interested persons."29 Under the new law "interested persons" means the patient's spouse, unless legally separated or estranged, a reciprocal beneficiary, any adult child, either parent of the patient, an adult sibling or adult grandchild of the patient, or any adult who has exhibited special care and concern for the patient and who is familiar with the patient's personal values.30

The UHCDAd places a big burden on health care providers with respect to the selection of a surrogate. This seems to be the most difficult area for families and physicians, especially when there is family dissention. To make certain that the practitioner knows the process Section 5 of the Act is set out below:

> "...Upon a determination that a patient lacks decisional capacity to provide informed consent to or refusal of medical treatment, the primary physician or the physician's designee shall make reasonable efforts to notify the patient of the patient's lack of capacity. The primary physician, or the physician's designee, shall make reasonable efforts to locate as many interested persons as practicable, and the primary physician may rely on such individuals to notify other family members or interested persons.

(c) Upon locating interested persons, the primary physician, or the
physician’s designee, shall inform such persons of the patient’s lack of decisional capacity and that a surrogate decision-maker should be selected for the patient.

(d) Interested persons shall make reasonable efforts to reach a consensus as to who among them shall make health care decisions on behalf of the patient. The person selected to act as the patient’s surrogate should be the person who has a close relationship with the patient and who is the most likely to be currently informed of the patient’s wishes regarding health care decisions. If any of the interested persons disagrees with the selection or the decision of the surrogate, or, if after reasonable efforts the interested persons are unable to reach a consensus as to who should act as the surrogate decision-maker, then any of the interested persons may seek guardianship of the patient by initiating guardianship proceedings pursuant to chapter 551. Only interested persons involved in the discussions to choose a surrogate may initiate such proceedings with regard to the patient...

There have already been suggestions to change the UHCDA and adopt provisions recommended by the legal aspects focus group of the Governor’s Blue Ribbon Panel and originally considered by the surrogate decision committee. Since the patient can designate or disqualify a surrogate, “interested persons” can be “trumped” by an orally designated surrogate. In the same manner a patient may orally disqualify someone who otherwise would be entitled to make decisions on behalf of the patient. Under Hawai’i’s version of the UHCDA, whether the surrogate is “designated” or “non-designated” the supervising health care provider must require a surrogate to provide a written declaration under the penalty of false swearing stating facts and circumstances reasonably sufficient to establish the claimed authority.

There are restrictions on decisions by “non-designated surrogates.” Artificial nutrition and hydration may be withheld or withdrawn upon a decision by the surrogate only when the primary physician and a second independent physician certify in the patient’s medical records that the provision of artificial nutrition or hydration is merely prolonging the act of dying and that the patient is highly unlikely to have any neurological response in the future. This particular provision should encourage practitioners to emphasize the importance of personally designating an agent or surrogate.

**QUESTION # 5**

*Are there any general parameters or limitations set out under the new law?*

**Answer**

Yes. Section -13—Effect of this chapter—provides overall guidance. First of all, the UHCDA does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health care directive.

Death resulting from the withholding or withdrawal of health care in accordance with the UHCDA does not for any purpose constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary.

The UHCDA does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State.

The UHCDA does not authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or institution.

The UHCDA does not authorize an agent or surrogate to consent to the admission of an individual to a psychiatric facility as defined in chapter 334, unless the individual’s written advance health care directive expressly so provides.

The UHCDA does not affect other statutes of this State governing treatment for mental illness of an individual involuntarily committed to a psychiatric facility.

What seems to be an unfortunate placement of a provision states that the UHCDA does not apply to a patient diagnosed as pregnant by the attending physician. Such an overall inapplicability would probably be found to be unconstitutional. Pregnant women continue to have a constitutional right to make health care decisions.

**QUESTION # 6**

*Are there penalties for not following the law and are there immunities for following the directions of authorized decision-makers when there is a conflict?*

**Answer**

The UHCDA requires health care providers to follow the instructions of patients, agents and surrogates. Unless otherwise specified in an advance health care directive, the guardian, agent or surrogate has the same right as the patient to request, receive, examine, copy and consent to the disclosure of medical or any other health care information. Unless it requires medically ineffective health care or health care contrary to generally accepted health care standards, the UHCDA requires a health care provider or institution to comply with an individual instruction of a patient and with a reasonable interpretation of the instruction made by a person then authorized to make health care decisions for the patient. The same section of the law requires that a health care provider to comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity. A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience or stated policy but has certain continuing obligations to the patient.

The UHCDA includes both civil and criminal sanctions. A health care provider or institution that intentionally violates this chapter is subject to liability to the individual or the individual’s estate for damages of $500 or actual damages resulting from the violation, whichever is greater, plus reasonable attorney’s fees. Also, patients, agent’s, guardians, surrogates and health care providers or institutions may seek judicial relief to enjoin or direct a health care decision or other equitable relief. Proceedings are governed by part 3 of article V of chapter 560 (Guardians of the Person of Incapacitated Persons).

On the positive side, the UHCDA includes certain immunities. A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution will not be subject to civil or criminal liability or to discipline for unprofessional conduct for complying with a health care decision of a person apparently having
authority to make a health care decision for a patient, including a decision to withhold or withdraw health care; declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or complying with an advance health care directive and assuming that the directive was valid when made and has not been revoked or terminated.*

**Conclusion**

The Uniform Health Care Decisions Act (Modified) has been in effect since July 1, 1999. It replaces existing legislation on medical treatment decisions, health care powers of attorney and health care decisions by legal surrogates. The UHCDCA acknowledges the right of a competent individual to decide all aspects of his or her own health care, simplifies and facilitates the making of advance health care directives, authorizes the designation of surrogate decision-makers in the event that a patient lacks decisional capacity and does not have a guardian or health care agent, addresses compliance by health care providers and institutions and provides procedures for dispute resolution.

The UHCDCA applies in all health care settings, including hospitals, nursing homes and other institutions, as well as community and outpatient settings. The new law includes safeguards to protect both patients and health care providers. The UHCDCA places new responsibilities on health care providers to follow advance directives and to obtain documentation of claimed authority of surrogates.

The UHCDCA makes it especially important for patients to consider executing written advance directives. These can include an "individual instruction" (formerly referred to as the "Living Will"), and a health care power of attorney. The new law makes it much easier to execute an advance directive. Copies of these documents should be filed in the patient's medical record.

For patients who have an "old" advance directive, they should check its currency, taking into consideration when it was executed, its clarity and whether it still reflects the patient's wishes. If a new advance directive is desired, health care providers may want to give them a copy of the sample optional form and explanation, and encourage them to individualize it.

In an emergency, in the absence of a formal document, supervising health care providers should ask patients to designate a surrogate and annotate this designation in the patient's medical record.

**References**

1. At the time this article was written, it appeared that the UHCDA (Modified) was to be designated as Chapter 327E of the Hawaii Revised Statutes.
2. Section 13 (g), Act 169, Hawaii State Legislature. Also see question # 5.
7. On February 10, 1996, President Clinton signed the "National Defense Authorization Act for Fiscal Year 1996." Section 749 of the Act recognizes advance medical directives that are prepared by attorneys who are authorized to provide legal assistance for individuals who are eligible to receive legal assistance to the same extent as an advance medical directive "prepared and executed in accordance with the laws of the state concerned." This section is codified at 10 U.S.C. § 1044c.
8. Section 3, Act 169, Hawaii State Legislature.
9. Section 2 Definitions: "Individual Instruction" means an individual's direction concerning a health care decision for the individual.
11. Section 3(g), Act 169, 1999 Hawaii State Legislature An advance health care directive shall be valid for purposes of this chapter if it complies with this chapter, or if it was executed in compliance with the laws of the state where it was executed.
12. Section 3(a), Act 169, 1999 Hawaii State Legislature.
13. Section 3(a), Act 169, 1999 Hawaii State Legislature.
15. Section 36, Act 169, 1999 Hawaii State Legislature. Several different sample forms (and Explanations) have been developed by the University of Hawaii Elder Law Program (UHELP) to address specific concerns, needs and abilities of its diverse clients. The sample form in the statute seems to be difficult for many clients, and especially clients with limited education or limited ability to read or concentrate.
16. The University of Hawaii Elder Law Program (UHELP) now housed at the Law School has been in existence for eighteen years, first at the Legal Aid Society and for the past eight years, at the University of Hawaii. As part of the Law School, provides direct legal services, advocacy, education, training, research, and even proposing legislation to better the lives of older persons in Hawaii.
18. See HAW. REV. STAT.§ HRS 327F.
19. HAW. REV. STAT.CHAP 327D Medical Treatment Decisions (First enacted in 1986, amended periodically and subsequently repealed, effective July 1, 1999)
20. See HAW. REV. STAT.§ 327D-10.  (Repealed as of June 30, 1999)
21. See HAW. REV. STAT.§ 551D-2.5(a) (Repealed as of June 30, 1999)
22. HAW. REV. STAT.§ 551D-2.5(b) (Repealed as of June 30, 1999)
23. HAW. REV. STAT.§ 551D-2.5(b) (Repealed as of June 30, 1999) The Durable Power of Attorney for Health Care:
   (1) Shall be in writing;
   (2) Shall be signed by the principal, or by another person in the principal's presence and at the principal's expressed direction;
   (3) Shall be dated;
   (4) Shall be signed in the presence of two or more witnesses who:
      (a) Are at least 18 years of age
      (b) Are not related to the principal by blood, marriage, adoption; and
      (c) Are not, at the time that the durable power of attorney is executed, attending physicians, employees of the attending physician, or employees of a health care facility in which the principal is a patient; and
   (5) Must have all signatures notarized at the same time.
24. HAW. REV. STAT.§ 551D-2.5(c) (Repealed as of June 30, 1999)
25. HAW. REV. STAT.§ 551D-2.5(d) (Repealed as of June 30, 1999)
26. Section 4(a), Act 169, 1999 Hawaii State Legislature defines "Capacity" as an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.
27. Section 5(a), Act 169, 1999 Hawaii State Legislature.
28. Section 5(b), Act 169, 1999 Hawaii State Legislature.
29. Section 5(b), Act 169, 1999 Hawaii State Legislature.
30. Section 2, Act 169, 1999 Hawaii State Legislature.
31. The original submission included the following wording:
   An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health care provider. In the absence of a designation, or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:
   (a) The spouse, unless legally separated;
   (b) An adult child;
   (c) A parent;
   (d) An adult brother or sister.
   If none of the individuals eligible to act as surrogate under subsection (b) is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available may act as surrogate.
   A surrogate shall communicate his or her assumption of authority as promptly as practicable to the members of the patient's family specified in subsection (b) who can be readily contacted.
32. Section 5(i), Act 169, 1999 Hawaii State Legislature.
33. Section 5(j), Act 169, 1999 Hawaii State Legislature.
34. Section 6, Act 169, 1999 Hawaii State Legislature-Health care information.
35. Section 7 Act 169, 1999 Hawaii State Legislature -Obligations of health care provider.
36. Section 1, Act 169 Hawaii State Legislature-Definitions. "Capacity" means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.
37. In Section 7 Act 169, 1999 Hawaii State Legislature -Obligations of health care provider. (a) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience. A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.
   (b) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.
38. A health care provider or institution that declines to comply with an individual instruction or health care decision shall:
   (1) Promptly inform the patient, if possible, and any person then authorized to make health care decisions for the patient;
   (2) Provide continuing care to the patient until a transfer can be effected; and
   (3) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.
39. A health care provider or institution may not require or prohibit the execution or revocation of advance health care directives as a condition for providing health care.
40. Section 10, Act 169, 1999 Hawaii State Legislature-Statutory damages.
41. Section 14, Act 169, 1999 Hawaii State Legislature-Administrative law.
42. Section 9, Act 169, 1999 Hawaii State Legislature-Immunities.
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Seeking Employment

Australia.– ANESTHESIOLOGIST with 3 years U. S. approved residency training, seeks full or part-time position. Contact person J Du Preez. Telephone (+61 2 66581411) Australia. After 1600hrs HWA time or e-mail kosie@compuserve.com

Wanted

Seeking.– KAUAI MEDICAL CLINIC is seeking Regular full-time and locum tenens BC/BE emergency physician for 6-person ED. 60-physician multispecialty clinic affiliated with Wilcox Health System’s 185-bed community hospital, annual ED 15,000. Excellent quality of life in a safe, family oriented community. Competitive salary, benefits and relocation package. Send/fax CV to: M. Keyes-Saiki, Kauai Medical Clinic, 3-3420 Kuhio Hwy., Suite B, Lihue, HI, 96766-1098. Fax: (808) 246-1625. E-mail: mkeyes-saiki@wilcoxhealth.org

Wanted.– PACE HAWAII AT MALUHIA, a comprehensive and innovative approach in caring for Hawaii’s elderly, is seeking a full-time physician to join its dynamic team. Experience in geriatric of internal medicine preferred. Position be filled immediately. Send C.V. or call: PACE Director, 1027 Hala Drive, Honolulu, HI 96817 (808)326-6114.

To place a classified notice:

HMA members.– Please send a signed and type-written ad to the HMA office. As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMJ as space is available.

Nonmembers.– Please call 536-7702 for a non-member form. Rates are $1.50 a word with a minimum of 20 words or $30. Not commissionable. Payment must accompany written order.

Office Space

Pearl City Business Plaza.– Tenant Improvement Allowances for Long Leases; 680+ sqft; 24-hr security; free tenant/customer pkg; Clifford Chang 581-8853 DP, 557-9776, 531-3526.

Ala Moana Bldg.– PHYSICIANS WANTED to share space and support services. Interest in physical rehab. preferred. We have flexible rental arrangements starting at one half-day per week. Run your practice with no fixed overhead. Contact Dr. Speers, REHABILITATION ASSOCIATES, 955-7244.

Interstate Bldg.– APPROXIMATELY 1,900 FT. Office space available to share, rent or purchase. Space includes x-ray facilities. Interstate Building King & Keeaumoku – 15th Fl. 591-9339.
The HMO - Great Medical Care If You Are Not Sick!

HMOs came up with a black eye when 1063 doctors and 768 nurses of the Kaiser Foundation responded to a survey to evaluate quality. A whopping 87% of the doctors said they had patients who were denied coverage by health plans. They reported that the patients often eventually got the coverage when the doctors argued enough. However, over half of the doctors and nurses said they were obliged to exaggerate the severity of a patient’s medical condition in order to get treatment. Moreover, in a separate report HMOs last year made no progress on advising smokers to quit, on cervical cancer screening or follow-up care for mental illness. The report from the National Committee for Quality Assurance also showed that 27% of patients complained of trouble getting needed care.

Be Careful If You Are Seated On A Standing Committee.

It must be open season on editors as now the Massachusetts Medical Society (MMS) has sacked Jerome P. Kassirer, M.D. editor for eight years of the prestigious “New England Journal of Medicine” (NEJM), in disagreement over “publication policy.” The MMS wants to increase its outside income (does this sound familiar), and wants to publish specialty journals using articles rejected by the NEJM. Dr. Kassirer and the publication committee refused, claiming it would diminish the prestige of the present journal, so the MMS said it was time to go. Dr. Kassirer said he was surprised by the decision, but also stated that disagreements had become more intense in the past year. The underlying point, like the catastrophic “Sunbeam” episode with the AMA, is the conflict between commercialism and professionalism. As the old saying goes, “no matter what they are talking about, they’re talking about money.”

Americans Believe In Trial By Jury - Except When Called To Serve On One.

A star professional basketball player dropped dead at age 27 of cardiac arrhythmia during practice. A cardiologist had previously evaluated him, but stated that he had a life-threatening arrhythmia. Two weeks later the athlete dropped dead, and the widow brought a malpractice suit against the cardiologist. Testimony at trial was prolonged with multiple medical experts, and there the doctor revealed that the athlete stated he had a former cocaine user, and had ignored the doctors’ orders. A jury was expected to determine if this is physician neglect, drug abuse, patient neglect, or a combination thereof. They failed and ultimately a mistrial was declared. As Professor Jerome Bettman, M.D. has stated, “A trial is a contest of impressions and has little to do with facts.”

Success Comes In Cans; Failure In Cant’s

A study in the July Journal of Internal Medicine showed that a stamp can do more than deliver the mail. By adding a simple stamp on a patient’s chart noting smoking status - “current/former/never” caused the doctor to increase a smoking discussion from 45% to 78% with individual patients. That advice resulted in doubling the number of patients entering cessation programs from 6 to 12%. Or, to put it more simply, unless reminded, we doctors often fail to communicate. (Thanks, J.M.)

None Of The Secrets Of Success Will Work Unless You Do.

While the Hawaii Medical Association, the AMA and other state associations, are struggling to keep members, Texas Medical Association is growing with members and enthusiasm. Why, in this era of hard times? The reason is that the TMA was able to get the Texas Legislature to pass a physician collective bargaining bill. The law explicitly bans physicians strikes, boycotts, or slow-downs. The bill is a giant step toward preserving the patient-physician relationship. The law allows self-employed physicians to negotiate collectively with health plans under the supervision of the state attorney general. The Texas statute says negotiations between physicians and health plans are voluntary and non-binding, but in fact HMOs publicly concede that they would be hard pressed to turn away key physician groups. The U.S. Chamber of Commerce, the National Federation of Independent Business, the National Association of Manufacturers and the American Association of Health Plans all lobbied against the bill. The claim is that fees will go up leading to reduced affordability, access, and coverage. The TMA claims that the law could actually stabilize or even reduce costs because physicians can challenge inane and bureaucratic contract provisions that delay care. What might be the chances of such a bill for Hawaii? Probably, very slim, but what a great membership issue!

All Computer Programs Contain Errors Until Proven Otherwise - Which Is Impossible.

A 42 year old psychotherapist stopped at the drug store to refill her migraine prescription, but was refused by the pharmacist. The company that manages her benefits decided she was taking too many kinds of medicine. “I felt violated. The company made it look like I was a probable drug addict.” Now a new breed of pharmacy benefit managers maintain computerized records in order to recommend less expensive medications, to warn about wrong combination of drugs, and prevent patients from taking a drug longer than recommended. The dispute illustrates some benefits, but also the dangers of computerized medical information. Employers seek more background data, and HMOs want more information. But what about safeguarding privacy? Our befuddled Congress and the Dept. of Health and Human Services are mandated to make federal privacy rules, but so far it is a joke. The public is fed up. A national survey revealed that at least one of six patients fails to complete medical forms, or has used an alias for certain tests, or paid cash to avoid an insurance claim. In Maine a new law prohibits the release of any medical information without written permission from the patient with a fine of $50,000 for any violation. Hospitals have clammed up, even about confirming an admission, which was more than patients wanted.

It’s Not An Optical Illusion, It Just Looks Like One.

In an attempt to provide free vaccines for uninsured children in low-income families, Congress established the Children’s Health Insurance Program (CHIP). Federal money was allocated for states to expand Medicaid or create new programs. Exercising the latter option, California set up Healthy Families to provide medical insurance coverage for uninsured kids. However, free vaccines were denied when Secretary Shalala announced that the federal government in its Vaccines for Children plan would provide free vaccines only to uninsured and Medicaid-eligible children. That eliminated the children insured under California’s Healthy Families. Is anyone in charge here?

Imhoff’s Law Of The Septic Tank - The Really Big Chunks Float To The Top.

The recent prosecution of the Kapiolani Health Plan for Medicaid fraud pointed to the fact that the big cheaters are not at the corner family clinic. The whistle-blower pocketed more than $600,000 for informing the federal investigators, as the law provides, and in this case it was a nurse close to the scene who reported the sin. But meantime, the Fraud and Abuse teams are busy holding seminars to educate patients on how to read the doctor bill in hopes of catching some unfortunate physician in a billing error. Kapiolani paid the penalty, but no names were mentioned in the multi-million dollar case. No matter what excuse or rationalization the fraud people offer, the plan to turn patients into investigators drives a poisonous stake into the nature of trust and mutual respect necessary to effective medical care.

ADDENDA

* According to People for the Ethical Treatment of Animals, it takes the urine of 75,000 pregnant mares to make a year’s supply of Premarin for post-menopausal women.
* Many of those people who insist on keeping a gun at home for safety, are the same ones who never fasten a seat belt.
* After Oprah did a show on women who fake orgasms, Geraldo had a show about men who fake bowel movements. Aloha and keep the faith -rtst
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