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**"Damien"**

Father Damien, a Belgian priest, lived with the Leprosy patients at their isolated colony at Kalaupapa on the island of Molokai. His mission was to mend their sores as well as their souls. Inevitably he died of Leprosy and has since been beatified. He is now a candidate for canonization.

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**Hawaii Medical Journal Forms Foundation**  
The Hawaii Medical Foundation Fund. HMA Community Research Bureau 501 (c) (3), has been established to support the Hawaii Medical Journal. All contributions are tax deductible. If you would like to support the Hawaii Medical Journal, please send contributions to the Hawaii Medical Association, 1360 S. Beretania Street, Second Floor, Honolulu, HI 96814. Please make your check payable to the Hawaii Medical Journal. Thank you for your continued support.
If the cover of this issue looks familiar, it should. We used it for the December '96 Special Issue on Death and Dying. No we're not running out of art by talented Big Island artist Dietrich Varez. (He has already supplied us with original Hawaiian prints for use on the 1997 Journal covers.) We're reusing his artwork "Damien" for a second time, because the response to our December Special Issue continues to be overwhelming. So, we're advancing the discussion in this month's Journal, Death and Dying, Part II.

Many terms are associated with the controversial topic of Physician-Aid-Dying: Euthanasia, Assisted-Suicide, Right-to-Die. The debate has been raging for aeons. Perhaps the most appropriate acronym for today is D.A.D.D.-Doctor-Assisted Death with Dignity. Physicians have learned that relatively few individuals actually take their own lives, even among the suffering terminally ill. The real issue for debate is how to provide solace to these patients with assurance that they will not be forced to die alone while experiencing excruciating pain. Though there are physicians who voice opposing views, often making reference to the "slippery slope" concept, respondents to our December Issue were preponderantly in favor of advocating D.A.D.D. as a compassionate course of ethical action.

The Journal continues to welcome Letter to the Editor—pro or con, long or short, even anonymously if you wish, on this subject of the century, Doctor-Assisted Death with Dignity.

I. Personal Experiences and Opinions

I am, as you know, an MD specializing in conditions of the skin, but one equally concerned with the welfare of the whole person. I suppose that this overarching level of concern has given my patients the confidence to ask about medical problems unrelated to my postdoctoral specialization. Over the years, an increasing number of elderly patients continue to inquire about any available medications to ease their painful, final phase of life. What's a doctor to do?

When my 86-year-old father moved to Hawaii to live in our home, I had the opportunity to talk with him and care for him every morning, evening and weekend. It was wonderful getting to know him again. Having lost the use of half of his body two decades before as the result of a stroke, he was now confined to bed with very little bodily movement possible. Dad was also consumed with extremely painful, terminal lung and prostate cancer. He repeatedly emphasized that he wanted "no pipes, no tubes, no surgery, no hospital." He just wanted to be pain-free at the end of his life. As a physician, I had no difficulty getting his gerontologist to prescribe a strong, long-lasting pain medication that enabled him to remain conversant, comfortable and content, even on his last day at home. On that day, my children, my wife and I were sitting around his bed "talking story" for several hours. As always, he remained mentally very alert and witty. When the sun began to set, Dad told us that he was beginning to get tired, and suggested that the rest of us go out to a neighboring restaurant to enjoy dinner, so we did. Half an hour later, his caretaker called to say "he went to sleep."

Dad passed away in his own time, naturally, peacefully, pain-free and at home, just as he had hoped that it would be. He was indeed a lucky guy at 88! And we continue to remember him with the twinkle in his eye.

The discussion of physician-aid-in-dying is the most important medical, legal, and moral issue in human history; more important even than abortion. Dying is everyone's fu...
tute. No matter what the U.S. Supreme Court determines in July, we in Hawaii must be prepared to care for our elders and the terminally ill with compassion and love, allowing them to retain their dignity and following their heartfelt wishes until the end.

II. Expectations

Because of Hawaii’s multicultural population, we have a special obligation to be empathetic to all of our people with admiration and respect for their diversity. Understandably, this may be difficult for some.

That’s why laws need to be enacted to protect physicians who support their parents’ will during the dying portion of life. It is understood that when rational, terminally ill patients have effective pain medication, and the knowledge to self-administer it, only rarely do they choose suicide over living. Just the security of knowing that they have control, to end their agony, is a real blessing for them.

III. Issues to Discuss

A. The necessary discourse between physicians and clergy to examine all aspects of death with dignity

The family, as well as the patient, has pain. Family physicians, internists, geriatricians and others should be made more aware of the suffering everyone experiences in end-of-life situations.

B. The legalization of prescribing sufficient pain medication to relieve suffering.

It is inhumane to withhold pain relief from a dying patient, even if the dosage required to do so exceeds the usual and customary amount.

C. The respect of the religious and moral wishes of the patient

When a physician chooses not to adhere to the dying patient’s wishes, a referral to another physician is in order.

D. The dialogue between physicians and family to try to enable the patient’s return to a home setting in their final days.

It’s not always practical or possible, but it merits discussion.

E. The broadening of the Hospice program

Information about Hospice should be disseminated by the Hawaii Medical Association, the County Medical Societies, through clinics and physicians’ offices. The felt need for additional services will carry the cause to the neighbor islands.

F. The dissemination of additional information about D.A.D.D. (Doctor-Assisted Death with Dignity)

Those who request additional information should be put in contact with the local Hemlock Society, which provides educational brochures, books, and video tapes.

G. The general regard for all cultures and religions in Hawaii

No matter what the outcome of the June/July 1997 position paper by the U.S. Supreme Court, our leaders in politics, medicine, law and religion must develop ASAP clear and direct recommendations about aiding our aging population. The baby-boomers will be next in line and in need of our comfort and support.
President's Message

John S. Spangler MD

As we approach the House of Delegates meeting in April please help by communicating with the task force committee and reading the information available to you at the medical association.

Please mark your calendar for March 29 for the program planned by the HMA Alliance. This needs your support.

The legislative process continues with close monitoring by HMA and the need for your input into this most important function of the medical society. Many important bills are presented each year which may have a direct impact on your practice. Please help in anyway you can.

Medical School Hotline

Modifications to the Problem-Based Learning (PBL) Curriculum Increase Opportunities for Learning Basic Sciences

By Leslie Q. Tam, Ph.D.
Director Office Medical Education

Recent trends in medical education across the country include a shift from traditional teacher-centered, lecture-based curricula to student-centered, problem-based curricula. In 1989, the John A. Burns School of Medicine switched to a problem-based learning (PBL) curriculum, and recently it was identified as one of eight medical schools leading reform of medical education in the United States. The PBL curriculum was adopted, in part, because the basic sciences, given traditionally by lecture format in the first two years, was considered excessive and fragmented. In the original PBL curriculum obtained from McMaster University, very few lectures were given. However, the curriculum has been modified each year, based on input from students and faculty. Recent modifications have increased opportunities for students to learn basic sciences in the first two years.

What is Problem-Based Learning? Problem-based learning is an approach in which students learn basic sciences in the context of solving clinical problems. Instead of meeting in large auditoriums to hear faculty give basic science lectures, students meet in small groups of five or six, each with a faculty tutor. Rather than lecture, faculty facilitate inquiry and critical-thinking. Students are urged to discuss uncertainties, think critically, ask questions, and research answers independently. Over the first two years, students investigate about 70 health care problems (HCPs) divided into five curricular units.

Unit 1: Problems in Health and Illness
Unit 2: Respiratory, Cardiovascular, Renal Problems
Unit 3: GI, Endocrine, Hematologic Problems
Unit 4: Musculoskeletal, Brain, Behavioral Problems
Unit 5: Problems in the Ob/Gyn, Pediatric, Adolescent, Geriatric Setting

In Unit 1, for example, students investigate a problem of streptococcal pharyngitis. Students spend the first tutorial reading through the paper problem deciding what they don’t know and need to research. These questions are termed learning issues. The group may ask, “What are Streptococci? What is the anatomy and histology of the pharynx? How does inflammation occur? What is the physiology of pain? How does penicillin inhibit bacterial growth? Who is at risk and can preventive measures be initiated in the community? Tutors are given problem guides beforehand and facilitate student inquiry into important areas if the group is unable to proceed. Learning issues are divided among the students, who then spend the next two days researching answers. Students use standard texts, do medline searches, and seek-out resource faculty. After two weeks of research, they meet together to discuss what was
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\[
\text{CH}_3\hspace{1cm}\text{COOH}\hspace{1cm}\text{CH}_3\hspace{1cm}\text{HO}\hspace{1cm}\text{CH}_3
\]

CLINICAL PHARMACOLOGY: Lactic acid is an alpha-hydroxy acid. It is a normal constituent of tissues and blood. The alpha-hydroxy acids (and their salts) are felt to act as humectants when applied to the skin. This property may influence hydration of the stratum corneum. In addition, lactic acid, when applied to the skin, may act to decrease corneocyte cohesion. The mechanism(s) by which this is accomplished is not yet known.

An in vitro study of percutaneous absorption of Lac-Hydrin Cream using human cadaver skin indicates that approximately 6.1% of the material was absorbed after 60 hours.

APPLICATION AND USAGE: Lac-Hydrin Cream is indicated for the treatment of ichthyosis vulgaris and xerosis.

CONTRAINDICATIONS: None known.

WARNINGS: Use of this product should be discontinued if hypersensitivity to any of the ingredients is noted. Sun exposure (natural or artificial sunlight) to areas of the skin treated with Lac-Hydrin Cream should be minimized or avoided (see Precautions section).

PRECAUTIONS: General: For external use only. Stinging or burning may occur when applied to skin with fissures, erosions, or that is otherwise abraded (for example, after shaving the legs). Caution is advised when used on the face because of the potential for irritation. The potential for post-inflammatory hypopigmentation has not been studied.

Information for patients: Patients using Lac-Hydrin Cream should receive the following information and instructions:

1. This medication may cause stinging or burning when applied to skin with fissures, erosions, or abrasions (for example, after shaving the legs).

2. Patients should minimize or avoid use of this product on areas of the skin that may be exposed to natural or artificial sunlight, including the face. If sun exposure is unavoidable, clothing should be worn to protect the skin.

3. This medication may cause stinging or burning when applied to skin with fissures, erosions, or abrasions (for example, after shaving the legs).

If the skin condition worsens with treatment, the medication should be promptly discontinued.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Carcinogenesis: A long-term photodynamic carcinogenicity study in hairless albino mice suggested that topically applied 12% ammonium lactate cream enhanced the rate of ultraviolet light-induced skin tumor formation. Although the biological significance of these results to humans is not clear, patients should minimize or avoid use of this product on areas of the skin that may be exposed to natural or artificial sunlight, including the face. Long-term dermal carcinogenicity studies in animals have not been conducted to evaluate the carcinogenic potential of ammonium lactate.

Pregnancy: Teratogenic effects: Pregnancy Category C. Animal reproduction studies have not been conducted with Lac-Hydrin Cream. It is also not known whether Lac-Hydrin Cream can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Lac-Hydrin Cream should be given to a pregnant woman only if clearly needed.

Nursing Mothers: Although lactate is a normal constituent of blood and tissues, it is not known to what extent this drug affects normal lactate levels in human milk. Because many drugs are excreted in human milk, caution should be exercised when Lac-Hydrin Cream is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of Lac-Hydrin Cream have not been established in pediatric patients less than 12 years old. Potential systemic toxicity from percutaneous absorption has not been studied. Because of the increased surface area to body weight ratio in pediatric patients, the systemic burden of lactic acid may be increased.

ADVERSE REACTIONS: In controlled clinical trials of patients with ichthyosis vulgaris, the most frequent adverse reactions in patients treated with Lac-Hydrin Cream were rash (including erythema and irritation) and burning/stinging. Each was reported in approximately 10-15% of patients. In addition, itching was reported in approximately 5% of patients. In controlled clinical trials of patients with xerosis, the most frequent adverse reactions in patients treated with Lac-Hydrin Cream were transient burning, in about 3% of patients, stinging, dry skin, and rash, each reported in approximately 2% of patients.

DOSAGE AND ADMINISTRATION: Apply to the affected areas and rub in thoroughly. Use twice daily or as directed by a physician.

HOW SUPPLIED: Lac-Hydrin Cream is available in canisters of 280 g (2-140 g plastic tubes). Store at controlled room temperature, 15-30°C (59-86°F).

skills course, therefore, focuses on an introduction to the physical exam and the throat. Students then move to a problem involving the chest, and the gross anatomy and clinical skills follows accordingly. The course was introduce in response to student concerns that course in gross anatomy was essential for every medical student. Student feedback has been very positive, and this successful course in now an integral part of the curriculum.

Two Basic Science Electives Per Week. Students may meet with up to two basic science preceptors per week. Each elective course meets for two hours per week and are enrichment opportunities which expand on Unit themes. They are not independent courses. For example, Unit 2 (12 weeks) deals with respiratory, cardiovascular, and renal HCPs. In the Unit 2 Infectious Disease elective, about 15 students examine infections that are not covered in the “core” HCPs. Students who take the elective are encouraged to share new information with other students. Electives are offered in anatomy, histology, pathology, physiology, pharmacology and biochemistry, microbiology, and immunology, among other subjects. Enrollment in electives generally average about 10-15 students, but in the second year Pathology elective given by Dr. John Hardman, virtually all students enroll. Students may design their own electives, which may touch on any subject, including public health, laboratory science and clinical skills, provided arrangements can be made with faculty.

Basic Science Foundations. Last year, faculty offered a series of “Foundation Lectures” each Friday afternoon in Unit 1. In these lectures, overviews of each basic science discipline were presented. Students were offered a lecture on humoral vs. cell-mediated immunity as part of the immunology foundation series, for example. Student feedback has been mixed, and faculty are now considering ways to improve the foundation series. This is simply the most recent example of how faculty are responding to student feedback in ongoing attempt to improve the curriculum.

Outcomes. In recent years, JABSOM students have scored at or above the national average in the USMLE. This would suggest that the PBL curriculum at the JABSOM, with the modifications described, is effective. Recently, 1200 tutors in 22 U.S. and Canadian medical schools were evaluated regarding overall attitudes and opinions about PBL. Respondents rated PBL more positively than traditional methods in areas of student interest and enthusiasm, student reasoning, and preparation for clinical rotations. The two methods were judged to be equally efficient for learning, and traditional methods were judged to be superior for teaching for factual knowledge in the basic sciences. The recent modifications of the JABSOM PBL curriculum are hoped to enhance learning of the basic sciences in the first two curricular years. The curriculum continues to be modified as students and faculty search for the right balance between between lectures and independent study.

The learning of basic science is but one dimension of the PBL curriculum. Faculty will strive to produce physicians who retain the qualities of the lifelong learner, independent thinker, compassionate humanitarian, and modern scientist who can live with the ambiguities demanded in the art of healing.

References

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Military Medicine

Cardiothoracic Surgery at Tripler Army Medical Center

Michael E. Nellstein MD, CDR US Navy
Thomas G. Carr MD, MAJ US Army
Stephen D. Jones MD, LTC US Army

The cardiac surgery program at Tripler Army Medical Center was started in 1985. In the ensuing 11 years, the program’s steady growth has culminated in a mature, stable open heart surgical service. The Cardiothoracic Surgery Service consists of two military cardiac surgeons, three full-time perfusionists and one secretary. The operating and administrative duties are those customary to a military hospital. The team includes dedicated operating room technicians and nurses, anesthesiologists and is supported by a fully equipped surgical intensive care unit.

Tripler Cardiothoracic Surgery actively participates in quality assurance reviews both at Tripler and across all Department of Defense health care facilities. Tripler participates in The Society of Thoracic Surgeons National Database for Cardiac Surgery, allowing tracking of outcomes and a comparison of Tripler’s results to a national standard. Regular consultation with civilian and military cardiac surgeons is utilized to advantage, including consultant visits from civilian congenital heart surgeons. The service contributes to Tripler’s teaching mission by participation in the education of general surgery residents.

The cardiac surgery service at Tripler supports a busy cardiology service which includes full interventional capacity. Together, the Cardiology and Cardiothoracic Surgery Services care for a wide range of cardiac patients from the Hawaiian Islands, the south Pacific and the Far East. Cardiac surgery patients include active duty military members and their families as well as military retirees and civilian patients from the Marshall Islands and other Trust Territories. Under a cooperative agreement between the Department of Defense and the Department of Veteran’s Affairs, VA patients from the Hawaiian Islands have also received open heart surgery at Tripler. The geographic diversity and widespread catchment area underscore both the unique nature of this cardiac surgery practice and its contribution to the health and well-being of Tripler’s diverse patients population.

Tripler Cardiothoracic Surgery supports the “Island Program.” This program is congressionally funded, and was spearheaded by U.S. Senator Daniel Inouye. It finances medical care for severely ill patients from the Federated States of Micronesia, Samoa, the Republic of the Marshall Islands, Guam, Saipan, and the Republic of Palau. A Tripler cardiac surgeon and a cardiologist go to these destinations on a quarterly basis to identify critically ill patients with congenital or acquired cardiac disease. These patients are then brought back to Tripler where they undergo surgery and remain for a brief convalescence before returning home.

Tripler also provides a complete range of non-cardiac thoracic services to include esophageal, lung and mediastinal surgery. Both of Tripler’s thoracic surgeons are recently trained in the most up-to-date techniques of video assisted thoracoscopic surgery. The nature of Tripler’s patient population has provided the service a wide range of experience treating advanced and complicated infectious and malignant thoracic disease processes.

No description of a cardiac surgery program is complete without mention of surgical results. In the last two years, over 200 open cardiac procedures have been done by Tripler’s Cardiac Surgery Service, with impressive results. During 1996, there were no deaths on either elective coronary procedures or elective valve procedures. These results compare favorably with the national average mortality of 2% for coronary bypass and 5% for valve surgery.

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The Death of an Innocent

Larry Fontanilla Jr, MS-II
John A. Burns School of Medicine

It is ironic that moments which hold the promise for life’s greatest joys, necessarily hold a similar capacity to become our most devastating sorrows. Call it cosmic irony, the flip side of the coin, or balance of yin and yang, it is the tragedy which inspires art and the real substance of our lives’ experiences. Take for example that you are an expecting parent.

Think of it, the day of your child’s birth. For nine months, you have been anticipating this day; perhaps imagined this very moment. For nine months, you have been through morning sickness, cravings, weight gain, lower back pain, incontinence, and fetal Tae Kwon Do (as mother or father). For nine months, you have begun dreaming for your child... blonde or brunette, poet or physician, birthdays, graduations, and christenings. And for weeks now, you’ve felt that strange mix of nervous, gut-wrenching anxiety coupled with an ebullient expectancy for the sheer joy, that’s just around the corner. Then the moment arrives, and thus begins the chaotic rush, which you know you won’t ever be able to fully recall, but which you also know, you’ll never forget. But wait... isn’t this taking a little long? What did that nurse just say? What was that? ...a little girl? ...but, -wait, wait, where are you taking her? Wait, what did you just say? What’s wrong?

The doctor has quietly come out and explained,”...your wife has given birth to a six pound baby girl. However, there are problems. Your wife is fine, and you can go in and see her as soon as we are done. However, your daughter is in the neonatal intensive care unit. As far as we can tell at this time, she has a condition known as hypoplastic left heart syndrome. It is lethal, if left untreated. Weren’t you made aware of this by your obstetrician? -Oh, you’re Jehovah’s witness.”

And there, the worst moment of your life just got worse. You see, the only chance your newborn child has for life, are a series of surgeries known as the Norwood procedure, or a complete heart transplant... both of which will never be performed without a blood transfusion. Yet, this is just not an option. It cannot be. Not for you. Not as a Jehovah witness.

Now, try a change in perspective. What would you do here as a physician? Would you seek a court order, and have the child treated? Or would you leave the decision to the parents, well knowing that this may mean death for the newborn?

However, before you make your decision, you should know a few unique points about this scenario. First, the Norwood procedure, which may partially repair the child’s heart and prolong her life, is by no means curative. Also, because of the issues surrounding transfusion, the doctors may not place the child on the waiting list for a heart transplant. The likely legal delays could very well keep the heart from another needy child. Lastly, both the Norwood procedure and the heart transplant carry high mortality rates. Therefore, probability indicates that there will be little difference in outcome between treatment and non-treatment. After nasty legal maneuvers, a healthy trampling of the constitution, and amidst all of the emotion and turmoil on both sides, the child will most likely die. Now then, what should you do?

Why pose this question, some ask? Why such a detailed and specific scenario? Isn’t it so complex and hypothetical that the discussion is moot? In actuality, this scenario is not hypothetical at all, but occurred this year in Irving, Texas. The surgeons in charge decided to leave the decision for treatment in the hands of the parents, and no court order was sought. In a statement from the University of Texas Southwestern Medical Center at Dallas, the surgeons explained, “whether treated or not, (her condition) has a high mortality risk and has little chance of a cure...In cases with such a grave prognosis, where non-treatment is a reasonable option, we believe the decision to pursue treatment is best made by the families involved” (Young, 1996, A8). Valerie Marie Hernandez died on January 25, 1997.

There is also another reason to discuss this case in specific, and it is because it is unique. The very complexity which makes the case nearly moot, makes it difficult to cite standard decisions, and forces the doctors to make an ethical choice of their own. Cases that are black and white are both less common and of less personal interest. It is what we choose, less as a profession, but more as an individual that will define the doctors that we are or will become. It is the decision we make: with the 72 year old, with only a tendency to wander, refusing treatment; with the 61 year old couple seeking in vitro fertilization with an egg donor; with a colleague you’ve witnessed perform some type of professional indiscretion; or something as little as making a sexual history a standard part of your work up, regardless of comfort level.

In this case, the chance for a child’s life is weighed against parental rights and freedom of religion. In cases similar to this, where treatment is assured to benefit the child, the solution seems time tested. Typically, a family court issues an order taking custody away from the parents, and placing the child in protective services. Once this is established, by order of the court, the child will receive the medical procedures deemed necessary, and within the best interest of the child. After recovery, the situation is reevaluated and the child may be returned to the parents’ care.

However in this case, what exactly is the best interest of the child? It is not as simple as choosing life or death. Instead, the choice lies between two courses of action which probability determines will end with the same result... death of the infant. In such a situation then what makes anyone’s opinion anymore justifiable than that of the child’s own parents. Wouldn’t it be simpler for all, to allow these parents what little time they might have with their child, free from legal, religious, and medical battles? (But then again, what’s simple, is rarely what’s “right.”)

Still, isn’t a chance at life better than assured death? If there were only a one percent chance of survival with the proper medical treatment (Norwood palliation followed with subsequent transplant), wouldn’t that 1 in a 100 chance be worth taking for this child’s life? If not, would two percent be enough? How about five? Ten? How high would the success rate have to climb for us to take action on behalf of this innocent, this patient, who is unable to take any action for herself? It is a serious question, which everyone
involved must come to answer on their own.

Say that a court order was obtained, and that the best case scenario ensued. Who stands to gain?

Some might say the parents, simply because they have a daughter, where they might have lost her. However, after they’ve gone through the hurt and pain of having a child diagnosed with a lethal disease, they then lose custody of that child to the state. Furthermore, the state and the hospital proceed to violate that child and essentially damn her in the life hereafter. For the rest of their lives, they’ll live with that knowledge, and in some sense guilt. And after all is said and done, it is questionable whether they can get their daughter back. Have they gained? Not in their eyes.

The daughter then, surely has gained. She is alive. Yes, but she will always live with two hard facts. First, should she grow and adopt her parents’ religion, she will live her life with the knowledge that she is damned in the afterlife, through no fault of her own. Furthermore, (despite how piously she may live) there is nothing she will ever be able to do to remedy that. Second, regardless of what religion she may adopt, she will have to live with the knowledge that her parents were willing to allow her to die. There aren’t many who can imagine the horrific ramifications that might entail, nor should anyone have to. Aside from these facts, she will probably wrestle with a host of issues including alienation, isolation, and poor self-body image. This all rests on the assumption that she is returned to her parents and does not become a ward of the state. Has she gained? Surely, this is difficult to say.

The state, perhaps it has gained. It has won the battle and saved the life of this child, too helpless to defend herself. However, it had to overcome two significant freedoms in order to do this. First, it berated (at the least) the freedom of religion. These parents believed that their child’s mortal life was worth the sacrifice, if the alternative meant eternal damnation. Of course, a lengthy theological debate could ensue, but the issue at stake here is not whether the belief is “right,” but whether the parents have the right to this belief. For the court order to be issued, someone outside of this family said that this belief or value is wrong or unfounded, probably just because they do not share it. Surely, the court would deny this. However, how else can one sensibly respect such a religious belief (as is guaranteed by the Constitution) and still act against the parents?

One might answer that the child did not have the chance to choose this religion. How can it be assumed that she would hold the same belief? This brings up the second right temporarily overlooked by the court system, parental rights. Should the state ever have a say in the choices that parents may make for their children? If a parent’s choices are not in the best interest of the child, then the state must protect that child from the parent. Clearly, this holds true for obvious instances of abuse or neglect. However, aren’t Valerie’s parents trying to make the best possible choice for their child? I suggest that if the state is allowed to intervene here, logical progression of such a stance may include the state garnishing a family’s wages to pay for orthodontics that it deems “in the best interest of the child.” Else, it may take children away from poorer families and place them with richer families, if it considers that “in the best interest of the child.” Furthermore, most drastically, for the sake of the children, the state might mandate who may and may not have children. These hyperboles may seem ridiculous, but they do illustrate the difficulty in assessing whether parents’ rights to speak and act for their children should be overridden. Has the state gained then? It could be said so, but only at the expense of two pillars of its foundation.

The medical community, then, must have gained. This finally might be true. Another life has been saved. The statistics for the procedures and for the surgeons have risen. The medical center gains positive publicity for its dedication to a helpless, desperate infant. And laurels, respect, and new business are rolling in from around the country. All they needed to sacrifice was the enlarged divide between the medical community and a minority religion. It is not unreasonable to say that actions like the proposed court order may keep future patients away. They may elect to seek alternative treatments, or faith healing (which would not damn their souls), rather than turn to an institution which they know will not honor their own beliefs and values. However, let’s neglect this hypothetical outcome for a moment to assess the status of the medical community. Yes, it has gained, but is this reason enough to put all other parties through their tortments?

Recall also that this was a best case scenario. In all likelihood, in the midst of the battles and emotions, the personal struggles and pain, little Valerie would remain as dead as if she were left in peace.

It is my opinion then, that the doctors at the University of Texas Southwestern Medical Center at Dallas made the proper decision in not seeking a court order, for a number of reasons. First and foremost, since the prognosis of treatment and non-treatment are so similar, in cases without religion as an issue, many institutions leave the decision in the hands of the parents. There should be no reason to change this attitude simply because of a family’s religion. Next, there are the pain and lifelong struggles with personal and religious issues that would plague both parents and child. Yes, the child may live, but at what cost to them? Third, in order to obtain a court order, significant civil rights must be violated. These issues themselves are not without ramifications. Lastly, such a court order could only further divide the chasm growing between the medical community and certain religious groups. It is a difficult question, but is this one case, worth the many other future cases that would never arrive at our attention, because of a Jehovah’s witness’ fear of being violated by our values and protocols, and not their own? It is sad, and it is difficult, but perhaps, the only ethical thing to do is to honor the parents’ religion and choice, even if it means the death of an innocent.

Reference
We have over 200 specialists who can immediately turn to one another for assistance. But we’re not here just for each other. Straub would like to be a valuable resource to other physicians in Hawaii as well. Many of our specialists regularly visit the neighbor islands and are available for consultations.

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Bank of America
Assisted Suicide in Switzerland
When is it Permitted?

Prof. Dr Meinard Schar, President, EXIT, Swiss Society for Humane Dying, Zurich
Presentation at the Hemlock Hawaii Annual Meeting
November 2, 1996, Honolulu, Hawaii

Editor’s Note:
Dr Schär was Professor of Social and Preventive Medicine and Professor of Pharmacology at the University of Zurich for 20 years. He has also served as Vice-Director of the Swiss Federal Office of Public Health. Prior to his presentation at Hemlock Hawaii, Dr Schär participated in the 11th International Congress of the World Federation of Right-to-Die Societies in Melbourne.

When I began to collate information on the progress made with regard to the legalization of assisted suicide I felt very optimistic. Especially encouraging were reports from Oregon and other U.S. states as well as from the Northern Territory of Australia. But my optimism was soon dampened by press releases from the same countries; Let me mention just a few of them:

Under the title: "U.S. doctors reaffirm opposition to Euthanasia" the British Medical Journal reports on the annual delegates meeting of the AMA in Chicago in July 1996. Some 430 delegates voted against euthanasia with the argument that doctors should be healers, not killers. The AMA delegates admitted that individuals have every right to control their own destiny. This does not mean, however, that they have a right to have their physician, their trusted partner in health, assist them to die. At the meeting of the AMA in Chicago there was only one doctor opposing this motion. The physician, in question, Ulrich Danckers, said doctors should not substitute their judgment for that of their patients:

“It is intellectually dishonest for us to collectively get on our high moral horse by declaring the practice unethical and then look the other way when our members in even larger numbers quietly endorse the practice at the bedside.”

This is also our opinion! As you will hear a little later, the Swiss medical Academy is strictly opposed to active voluntary euthanasia and physician assisted suicide, however, it sanctions indirect bedside euthanasia.

In August 1995 the Editor of the Star-Bulletin of Hawaii gave an update on the right-to-die movement which puts the issue of euthanasia in proper perspective. He summarized the situation in those days (August 1995) as follows:

“A year ago the right-to-die movement was energized by its effort to persuade Oregon voters to approve the first legislation in America authorizing assisted suicide. It prevailed by 51 to 49 but has not gone into effect. All across America, states are still waiting for court decisions.”

Under the title “Police and People” the British Journal “Lancet” writes: The Northern Territory’s Rights of the Terminally ill Act came into operation this week despite a challenge to its validity by the Northern Territory branch of the Australian Medical Associa-

<table>
<thead>
<tr>
<th>Table 1.—Some Statistical Data on Switzerland</th>
</tr>
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<tbody>
<tr>
<td>1900</td>
</tr>
<tr>
<td>1990</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Persons 65 and over</td>
</tr>
<tr>
<td>General mortality</td>
</tr>
<tr>
<td>Infant mortality</td>
</tr>
<tr>
<td>Life expectancy</td>
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<td></td>
</tr>
</tbody>
</table>

tion. On a national level, the issue has led to a constitutional debate about the powers of states and territories to make laws. In the meantime the legislation has come into force. The doctor of 65-year-old Max Bell is searching for the required second doctor whose declaration, together with that of a psychiatrist, will enable Bell to be assisted to die. (In the meantime—as I am told—Mr Bell died in a natural way).

In an article which appeared recently (September 1996) in the Honolulu Advertiser, Geoff Spencer of the Associated Press writes:

"The Northern Territory’s legislature became the first in the world to pass a voluntary euthanasia law last year. It took effect July 1st but its future is uncertain."

Then Spencer describes the case of the 66-year-old Mr Dent who died with dignity with his wife, Judy, by his side.

I am sure that you know the story of Mr Dent, and certainly you have heard of Dr Nitschke the inventor of the computerized death machine. But was Mr Dent really the first person to kill himself legally under the world’s only voluntary euthanasia law?

Assisted Suicide in Switzerland
Switzerland, one of the smaller countries of Europe, has seven million inhabitants. Since one-seventh of the Swiss population is more than 65 years old a high morbidity rate is to be expected. The chronic-degenerative diseases are the main cause of increased morbidity and mortality. Medical technology can prolong the lives of the elderly and the chronically ill but it cannot keep them independent, free of health troubles, or competent to manage their own affairs. Medical technology can also improve palliative care, that is, care whose aim is the control of symptoms. However, we must remember that in 5 to 10% of the cases of cancer symptoms cannot be relieved of all or only at the cost of loss of individual personality.

Continued on Page 67
Benzamycin® works faster

For visible results in as little as 2 weeks.¹

- More than 12 million prescriptions written in the U.S. since introduction.²
- Large size (46.6 g) for added convenience.
than the speed of life.

Adverse conditions infrequently reported include dryness, erythema, and pruritus. Artistic representation, not an actual case. Treatment outcomes vary. Please see references and prescribing information on adjacent page.

BENZAMYCIN® Topical Gel
(3% erythromycin, 5% benzoyl peroxide)
Better results faster
Benzamycin®
(erythromycin-benzoyl peroxide topical gel)
Topical gel: erythromycin (3%), benzoyl peroxide (6%)
For Dermatological Use Only – Not for Ophthalmic Use
Reconstitute Before Dispensing

DESCRIPTION
Benzamycin® Topical Gel contains erythromycin [(3R, 4S, 6S, 8R, 9R, 11R, 12R, 13S, 14R)-4-(2, 6-Dideoxy-3-C-methyl-3-0-methyl-L-r-ribo-hexopyranosyl)-oxy]-14-ethyl-7, 12, 13-trihydroxy-3, 5, 7, 9, 11, 13-hexa-methyl-6-[3(4, 6-trideoxy-3-(diethylamino)-D-xylo-hexopyranosyloxy)oxo]octadecyl-2, 10-dione]. Erythromycin is a macrolide antibiotic produced from a strain of Saccharopolyspora erythraea (formerly Streptomyces erythreus). It is a base and readily forms salts with acids.

Chemically, erythromycin is (C_{28}H_{41}NO_{13}). It has the following structural formula:

![Erythromycin Structure](attachment:image)

Erythromycin has the molecular weight of 733.94. It is a white crystalline powder and has a solubility of approximately 1 mg/mL in water and is soluble in alcohol at 25°C. Benzamycin® Topical Gel also contains benzoyl peroxide for topical use. Benzoyl peroxide is an antibacterial and keratolytic agent.

Chemically, benzoyl peroxide is (C_{13}H_{30}O_{2}). It has the following structural formula:

![Benzoyl Peroxide Structure](attachment:image)

Benzoyl peroxide has the molecular weight of 242.23. It is a white granular powder and is sparingly soluble in water and alcohol and soluble in acetone, chloroform and ether. Each gram of BENZAMYCIN® Topical Gel contains, as dispensed, 30 mg (3%) of erythromycin and 50 mg (5%) of benzoyl peroxide in a base of purified water USP, carbomer 940 NF, alcohol 20%, sodium hydroxide NF, docusate sodium and fragrance.

CLINICAL PHARMACOLOGY
The exact mechanism by which erythromycin reduces lesions of acne vulgaris is not fully known; however, the effect appears to be due in part to the antibacterial activity of the drug. Benzoyl peroxide has a keratolytic and desquamative effect which may also contribute to its efficacy. Benzoyl peroxide has been shown to be absorbed by the skin where it is converted to benzoic acid.

MICROBIOLOGY
Erythromycin acts by inhibition of protein synthesis in susceptible organisms by reversibly binding to 50 S ribosomal subunits, thereby inhibiting translation of aminoaic acid transfer-RNA and inhibiting polypeptide synthesis. Antagonism has been demonstrated in vitro between erythromycin, lincomycin, chloramphenicol and clindamycin.

Benzoyl peroxide is an antibacterial agent which has been shown to be effective against Propionibacterium acne, an anaerobe found in sebaceous follicles and comedones. The antibacterial action of benzoyl peroxide is believed to be due to the release of active oxygen.

INDICATIONS AND USAGE
Benzamycin® Topical Gel is indicated for the topical treatment of acne vulgaris.

CONTRAINDICATIONS
Benzamycin® Topical Gel is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNINGS
Pseudomembranous colitis has been reported with nearly all antibacterial agents, including erythromycin, and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by Clostridium difficile is one primary cause of “antibiotic-associated colitis.” After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation and treatment with an antibacterial drug clinically effective against C. difficile colitis.

PRECAUTIONS
General: For topical use only; not for ophthalmic use. Concomitant topical acne therapy should be used with caution because a possible cumulative irritant effect may occur, especially with the use of peeling, desquamating or abrasive agents. If severe irritation develops, discontinue use and institute appropriate therapy. The use of antibacterial agents may be associated with the overgrowth of nonsusceptible organisms including fungi. If this occurs, discontinue use and take appropriate measures.

Avoid contact with eyes and all mucous membranes.

Information for Patients: Patients using BENZAMYCIN Topical Gel 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. Avoid contact with the eyes, nose, mouth, and all mucous membranes.
2. This medication should not be used for any disorder other than that for which it was prescribed.
3. Patients should not use any other topical acne preparation unless otherwise directed by physician.
4. Patients should report to their physician any signs of local adverse reactions.
5. BENZAMYCIN Topical Gel may bleach hair or colored fabric.
6. Keep product refrigerated and discard after 3 months.

CARCINOGENESIS, MUTAGENESIS AND IMPAIRMENT OF FERTILITY
Data from a study using mice known to be highly susceptible to cancer suggests that benzoyl peroxide acts as a tumor promoter. The clinical significance of this is unknown.

No animal studies have been performed to evaluate the carcinogenic and mutagenic potential or effects on fertility of topical erythromycin. However, long-term (2-year) oral studies in rats with erythromycin ethylsuccinate and erythromycin benzoate did not provide evidence of tumorigenicity. There was no apparent effect on male or female fertility in rats fed erythromycin base (at levels up to 0.25% of diet).

Pregnancy: Teratogenic Effects: Pregnancy CATEGORY C: Animal reproduction studies have not been conducted with BENZAMYCIN® Topical Gel or benzoyl peroxide. There was no evidence of teratogenicity or any other adverse effect on reproduction in female rats fed erythromycin base (up to 0.26% diet) prior to and during mating, during gestation and through weaning of two successive litters. There are no well-controlled trials in pregnant women with BENZAMYCIN® Topical Gel. It also is not known whether BENZAMYCIN® Topical Gel can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. BENZAMYCIN® Topical Gel should be given to a pregnant woman only if clearly needed.

Nursing Woman: It is not known whether BENZAMYCIN® Topical Gel is excreted in human milk after topical application. However, erythromycin is excreted in human milk following oral and parenteral erythromycin administration. Therefore, caution should be exercised when erythromycin is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of this product in pediatric patients below the age of 12 have not been established.

ADVERSE REACTIONS
In controlled clinical trials, the total incidence of adverse reactions associated with the use of BENZAMYCIN® Topical Gel was approximately 3%. These were dryness and urticarial reaction. The following additional local adverse reactions have been reported occasionally: irritation of the skin including peeling, itching, burning sensation, erythema, inflammation of the face, eyes and nose, and irritation of the eyes. Skin discoloration, dryness and tenderness of the skin have also been reported.

DOSAGE AND ADMINISTRATION
Benzamycin® Topical Gel should be applied twice daily, morning and evening, or as directed by a physician, to affected areas after the skin is thoroughly washed, rinsed with warm water and gently patted dry.

How Supplied and Compounding Directions:

<table>
<thead>
<tr>
<th>Size</th>
<th>Benzoyl Peroxide Powder</th>
<th>Ethyl Alcohol (70%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(as dispensed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.3 grams 0510-23</td>
<td>20 grams 0.8 grams 3 mL</td>
<td></td>
</tr>
<tr>
<td>46.6 grams 0510-46</td>
<td>40 grams 1.6 grams 6 mL</td>
<td></td>
</tr>
</tbody>
</table>

Prior to dispensing, tap vial until powder flows freely. Add indicated amount of ethyl alcohol (70%) to vial (to the mark) and immediately shake to completely dissolve erythromycin. Add this solution to gel and stir until homogeneous in appearance (1 to 1½ minutes). BENZAMYCIN® Topical Gel should then be stored under refrigeration. Do not freeze. Place a 3-month expiration date on the label.


Caution: Federal (U.S.A.) law prohibits dispensing without prescription.

U.S. Patent Nos. 4,387,107 and 4,497,794
Manufactured by Rhône-Poulenc Rorer Puerto Rico Inc.
Mayalt, Puerto Rico

For DERMIX LABORATORIES, INC.
A Rhône-Poulenc Rorer Company
Collegeville, PA 19426

References: 1. Data on file, Dermick Laboratories, Inc. 2. Data on file, Dermick Laboratories, Inc. 3. Faster and better results than either component alone.
The Right to Die with Dignity

In Swiss public polls about dignified dying there is always a majority in favor of active euthanasia and assisted suicide and nearly 100% agree with passive euthanasia. The results of polls with physicians or religious groups are in stark contrast. Whereas 60% of physicians who are members of the Swiss society for humane dying (EXIT) agree with active euthanasia under certain circumstances, the physicians who are not members of EXIT are mainly against active euthanasia and assisted suicide. In all countries suicide is not forbidden but in almost all countries assisted suicide will be prosecuted by law. (In Britain the penalty for assisting a suicide is up to 14 years imprisonment). Why can a suffering person commit suicide and why is it forbidden to provide professional guidance to him or to her?

As early as 1937 a law was enacted in Switzerland which allowed assisted suicide under certain conditions. Article 115 of the Swiss penal code reads as follows:

A person who, for selfish motives, persuades or assists another person to commit suicide will be punished with imprisonment up to five years.

Thus, assisted suicide seems no longer to be a problem. That is, in reality not the case. There is much opposition to this liberal law. The Swiss Academy of Medical Sciences e.g. clearly states that helping a person to commit suicide is not task for a physician. The predication is that a physician is the only qualified person for giving help to a seriously ill patient who wants to die. Whereas the aforesaid academy is against assisted suicide, it agrees with indirect euthanasia. The physician is allowed to give a terminally ill person high doses of drugs for the relief of pain or other serious symptoms but not to shorten the life of the patient. (The physician may kill a patient with an overdose of morphine and he will not be prosecuted by law if it was his intention to treat symptoms only; however if his intention was to terminate the life of the patient, then he may be punished by a prison term of at least five years. It would be preferable to allow controlled, documented voluntary euthanasia, than to prohibit the practice officially while allowing it to be carried out clandestinely without any controls.)

The practice of assisted suicide

EXIT issues a manual for competent but incurably ill patients who request help in dying. Adult persons who are members of EXIT for at least three months can obtain this booklet from the headquarters of the organization. It contains all the necessary information regarding the help EXIT can offer, and a detailed description of the procedure. Formerly a brochure was handed out to members who asked for instructions about the means and methods for committing suicide. (This brochure was withdrawn from sale about five years ago.) Recently a “Drug Booklet” has been issued by two European Right-to-Die Societies which contains detailed instructions on the various methods of suicide. This booklet may be useful for hypochondriacs but is certainly of no practical help for seriously ill patients who do not want to suffer any longer from unbearable pain and other serious symptoms.

Serious sick people need help! They cannot wait for weeks before they can commit suicide. All the medication listed in the aforementioned drug booklet can be obtained on prescription only. The patient, who anyway will have a guilty conscience, would have to lie to his physician or deceive the pharmacist. In addition he cannot be sure that the recommended substance reacts the same way in all persons, and then, there is the risk of vomiting with resultant loss of efficacy of the administered medication. These are the main reasons why we withdrew such booklets and why we do not recommend lists of drugs which might be used for self-delivery.

The EXIT-procedure for assisted suicide

1. The patient personally (not relatives of friends) makes contact with the headquarters of EXIT (day and night service).

2. A collaborator of EXIT visits the patient in order to establish that it is the genuine wish of a person of sound mind who decides and that he is not coerced or influenced by a third person. Then a date for assisted suicide is fixed.

3. The patient will be invited to ask his physician for a certificate of the diagnosis and—if possible—prognosis.

4. The decision as to whether assistance in dying can be offered is taken by a physician of EXIT. (In doubtful cases a group of three collaborators—a lawyer, a physician and a psychiatrist—decide).

5. An EXIT helper then visits the patient and assists him to self-delivery. He promises the patient that he will stay with him until death has occurred. (This is very important because seriously sick and suffering patients are not afraid of death, rather their greatest fear is that they will wake up in an intensive care unit of a hospital). There is always a witness present, mostly a relative to whom the suicidal person has close contact. The patient is then given two tablets of Dramamine. (He or she becomes completely relaxed and talks freely about his or her life. There is no fear and no anxiety about dying). After half hour the patient is given 10g of sodium-pentobarbital (a barbiturate) dissolved in about 100 to 150ml of tap water (No mineral water!, because the carbon dioxide precipitates the barbiturate and therefore prolongs the absorption time).

6. Within less than 5 minutes the patient will fall into a deep sleep and within 2 hours—with few exceptions—he will die peacefully.

7. Immediately after death we call the police. The prosecution attorney, the coroner, a criminologist and other “officials” will show up in order to find out whether or not laws have been
violated. Up to now no collaborator of EXIT has had to appear before the court from helping a person to commit suicide.

What is EXIT?
EXIT of the German speaking part of Switzerland is a registered association for humane dying. (An identical association exists in the French speaking part of the country.

EXIT
- Respects the right of self-determination of every human being.
- Respects the right to self-deliverance of seriously and hopelessly ill patients.
- Issues “Advance Directives” to its members and assures them legal protection in case of disregard of the “Living Will” of a patient.
- Issues a manual for assisted suicide to its members and offers assistance to those members who are terminally ill and who wish to die.
- Establishes hospices for terminally ill patients where palliative care is offered.
- Publishes a quarterly bulletin and establishes contact to other organizations with similar aims.
- Is a member of the World Federation of Right-to-Die Societies.

EXIT was founded in 1982 and has currently more than 60,000 members. Two-thirds of the members are aged over 50 years and about 60% are women.

Since the ‘Living Will’ issued by EXIT is respected by physicians and the nursing staff of hospitals, EXIT had only rarely to interfere with hospital treatment of its members.

One of the main tasks of EXIT is the counseling of patients and assisting seriously sick and terminally ill patients to die. The number of members asking for assisted suicide is steadily increasing but there is no corresponding increase of the total number of deaths due to suicide. The trend, however, is clear: more elderly persons die from assisted suicide but a decreasing number die as a result of inhumane methods of suicide, such as shooting, hanging or drowning.

On average 100 to 120 patients/year commit assisted suicide in Switzerland. The most frequent diagnoses are: cancer (70%); cardiovascular diseases (10%); neurological disorders, including disseminated sclerosis and ALS (10%); skeletal disorders (5%) and AIDS (5%).

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**Table 4.**—Preconditions for Assisted Suicide (EXIT, Swiss Society for Humane Dying, Zurich)

<table>
<thead>
<tr>
<th>The person applying for assisted suicide has to be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ 18 years old or older</td>
</tr>
<tr>
<td>■ Mentally competent</td>
</tr>
<tr>
<td>■ Member of EXIT</td>
</tr>
<tr>
<td>■ Resident of Switzerland</td>
</tr>
<tr>
<td>■ Suffering from a serious illness and/or unbearable health troubles with poor prognosis</td>
</tr>
<tr>
<td>■ Willing to die with the help of EXIT</td>
</tr>
</tbody>
</table>

The diagnosis of the disease and its prognosis have to be confirmed by a physician.

**Table 5.**—Suicide in Switzerland 1993 (Swiss statistical yearbook)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Cases</th>
<th>Mortality Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>1010</td>
<td>28.3</td>
</tr>
<tr>
<td>Women</td>
<td>403</td>
<td>10.3</td>
</tr>
<tr>
<td>Men 65 years old and older</td>
<td>235</td>
<td>58.7</td>
</tr>
<tr>
<td>Women 65 years old and older</td>
<td>114</td>
<td>18.7</td>
</tr>
</tbody>
</table>

**Table 6.**

<table>
<thead>
<tr>
<th>Method of Suicide</th>
<th>Number of Cases</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Medicaments</td>
<td>No: Cases</td>
<td>%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Gassing</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Hanging</td>
<td>62</td>
<td>25</td>
</tr>
<tr>
<td>Drowning</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Shooting</td>
<td>75</td>
<td>32</td>
</tr>
<tr>
<td>Stabbing</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Fall</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>Vehicular Impact</td>
<td>No: Cases</td>
<td>%</td>
</tr>
<tr>
<td>(Train/Car)</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Burning</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

| Total | 235 | 100 | 113 | 100 |

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**Smoking Kills**

- Smoking killed about 417,000 Americans in 1990
- Smoking is linked to 175,000 to 200,000 of all heart and blood vessel disease deaths
- Smoking costs the U.S. about $50 billion in annual medical care
- Every day about 3,000 young Americans start smoking

©1996, American Heart Association

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Until there's a cure, there's the American Diabetes Association.
Voluntary Euthanasia in The Northern Territory—Australia

The Honorable Marshall Bruce Perron
Former Chief Minister of the Northern Territory
Darwin, Northern Territory
Address to the National Press Club, Canberra, October 16, 1996

Editor’s Note:
Marshall Perron, as Chief Minister of the Australian Northern Territory, was responsible for the first legislation in the world to permit active voluntary euthanasia. Mr Perron, who has now retired from politics, was a member of the Northern Territory Parliament for 21 years, and Chief Minister from 1988 to 1995.

The cast of characters:
John Howard, Prime Minister of Australia; Kevin Andrews, Member of the Federal Parliament who is attempting to overturn the Northern Territory legislation; and Bob Dent, the first person assisted to die under the Northern Territory law.

Bob Dent’s often-quoted words:

“What right has anyone, because of their own religious faith to which I do not subscribe, to demand that I must behave according to their rules?”

Thanks to Marshall Perron for permission to reproduce his address and the Australian statistics.

There are many reasons quoted for the escalating world-wide debate about voluntary euthanasia.
An educated, assertive patient population, less in awe of doctors than ever before. An aging community, less religious authority and increasing deaths from cancer and AIDS.
The most compelling factor to my mind, is that advances in medicine have brought us to the point where, when and how a patient dies is increasingly the outcome of a deliberate human decision.

Decisions to withdraw life support equipment, not to resuscitate or withholding antibiotics from a patient in advanced stages of terminal illness, are all instances of the intentional termination of life that is routine in developed countries today.
The sad part is—most of those who die by human intervention or deliberate non-intervention, have no say in the decision. By the time a decision needs to be made, they are in no state to participate.
The majority of Australians don’t want decisions about when they will die being made for them by doctors, after they have lost competence or the ability to communicate. They want the option to arrange the timing of their own death if, like Bob Dent, things get really bad.

John Howard has access to voluntary euthanasia. Why should the rest of the community be denied?

While illegal euthanasia and assistance to suicide is practiced in all the states and territories, only the most assertive, articulate and resourceful patients are likely to be able to enlist the help of a doctor prepared to risk everything.

Kim Beazley, Tim Fischer, Kevin Andrews, indeed every one of the politicians about to decide if the Northern Territory Rights of the Terminally III Act is scuttled, can access doctors who will fulfill their request to die if circumstances warrant.

Sadly, the same access is not available to most of our citizens in their hour of need. If you have to take the next doctor on shift at the public hospital, or you can’t get a doctor to treat you in your own home, or you do not have the resources to go shopping among doctors, then your chance of finding a sympathetic doctor who will break the law is about nil.

I don’t object to John Howard saying he believes voluntary euthanasia is wrong and that he would never consider it for himself, but he has no more right to deny me or you the voluntary euthanasia option than does the Pope, Archbishop, the President of the A.M.A., or Kevin Andrews.

You see, the situation is exactly as it was before enlightened abortion laws were adopted. The rich and famous were always able to find qualified professionals prepared to do the job. For the rest of the population, it was just ‘too bad’—or they went to the backyards, or attempted the job themselves.

Often with disastrous results.
So too it is with euthanasia today.

Not only is this issue firmly on the agenda to stay, demands for individual autonomy over end-of-life decisions will become stronger with the advances in medicine which give doctors the ability to ward off death longer and longer while physical and mental degeneration continues.

Changes in social systems and standards of living have extended average life spans considerably. In 1900 we lived to about 51 years.

Most deaths at the time were due to communicable diseases such as influenza, cholera, scarlet fever, measles, smallpox and tuberculosis. Such ailments are characterized by either recovery or death in hours, days or weeks.

It was not until the development of microbial drugs in the 1930’s that doctors could begin to cure the disease, rather than simply try to relieve the symptoms.

The average life expectancy in Australia is now 75 years for males and over 80 for females.

Today, death in developed societies is mainly due to the effect of degenerative diseases like cancer, strokes and heart disease.

Although heart attacks and strokes sometimes cause rapid death, degenerative diseases like cancer result in gradual and increasing debilitation.

We have never lived so long, or died so slowly, occasionally with horrifying symptoms.

The advances that will bring welcome cures for diseases will extend the time it takes to die even further. This will mean a corresponding increase in the frequency of decisions to cease treatment to allow death to occur or to actively induce death.

Concern is expressed today that some patients are kept alive way...
past any possible useful purpose. What if, in the next decade, we have the ability to keep everyone alive in a coma for years?

My resolve to promote the decriminalization of voluntary euthanasia stems from the fact that despite searching for one, I have never found a rational argument for insisting that an individual continue to endure pain, indignity and suffering when they would prefer to die.

I reject the notion that our quality of life, no matter how wretched, miserable or painful, is never so bad that any of us will be allowed to put an end to it.

It is preposterous that a patient like Bob Dent, after a five year battle with prostate cancer, having had several operations, unsuccessful hormone therapy, 25 kg. lighter, impotent, unable to urinate, losing bowel control, under 24-hour nursing care and still on a roller coaster of pain despite a regime of 30 tablets a day, could have died on the day he did from the effect of a doctor administering pain killing drugs.

The Pope, the Archbishop, the A.M.A. and Kevin Andrews would consider that as spiritually acceptable, morally responsible and lawful.

However, because Bob Dent asked a doctor to provide him the means to die, took a second opinion, considered palliative options, submitted himself to psychiatric examination, considered the implications for his family, endured a cooling off period and was then given the means to take his own life.

The hard core Christian minority was outraged.

The Vatican described Dent’s death as “an absurd act of total cruelty”

Cardinal Clancy said it was murder.

Northern Territory Bishop Collins said it was immoral.

No humane compassionate person could condemn Bob Dent or the way he died. If you are one of those who would have denied him a final moment of control and dignity, that chance to cry with his wife—then you have no heart!

And you have no right to preach morals to me.

I have found nothing in the religious arguments, which demand the imposition of a belief on others, or the implausible claims that voluntary euthanasia will lead to patients being put to death against their will, to change my mind. Neither doctor, Church or family, should be allowed to override the patient in regard to the right to die.

Have you ever wondered how many doctors who find themselves with one of those awful diseases which invariably result in a painful, undignified death, endure the suffering until death comes naturally?

Or do they arrange with a trusted colleague, a time when death will be comfortably induced in private?

If this occurs, and we can be sure that it does, then it is only just and fair that the same option should be available to every citizen with the same symptoms.

We should not compel those doctors who are willing to assist suffering patients to shroud their actions in secrecy, away from potential witnesses and to falsify the death certificate to avoid criminal proceedings.

This clandestine activity, without safeguards or scrutiny, brings with it a potential for undetected error or abuse which should concern us all.

It is claimed that palliative care exists which can adequately handle all death situations and that there are no ‘bad’ deaths—only incompetent doctors.

It is not true. The utopian palliative care service exists only in the minds of the very religious.

Even if the perfect service was available to everyone, it would never satisfy those who find the concept of total dependency so unacceptable that they would rather be dead.

I agree that voluntary euthanasia is not a substitute for best practice palliative care, but the reverse applies as well.

The advent of voluntary euthanasia would bring benefits to many more people in our community than will ever exercise the option.

Elderly Australians advise me that the option of voluntary euthanasia would relieve them of a great burden. Whilst in reasonable health now, many experience anxiety every day, knowing that aging process cannot be halted. The possibility of a miserable lingering death is constantly on their mind.

Their submissions appealed to all Territory politicians to understand that simply by having an option, hopefully never to be taken, they could face each day with the comfort of knowing that they will not experience the suffering that they have witnessed in others.

As one ninety-year-old wrote, “I do not fear death. I fear the way death will come.”

I have had other letters and phone calls from terminally ill people who have obtained drugs to use committing suicide. In each case they were angry that they must take their lives prematurely for fear of losing control through hospitalization. They must die secretly and alone to avoid implicating family and friends.

As one such woman said to me, “My prognosis is, I will slowly become a blind vegetable. What would you do?”

We will never know how many suicides could have been at least delayed if the knowledge that the voluntary euthanasia option was there if things got really bad.

For example, in 1994 there were 137 suicides by people 75 or older, 31 of them by people 85 or older. Do we think some of these lonely suicides by the elderly might have been related to how they thought they would die if they did not take control?

I suspect, everyone of them.

And what of those poor souls who botch it, merely succeeding in killing half their faculties?

The intangible benefits, to the elderly and the sick, of reduced anxiety and trauma should not be overlooked in this debate.

There are Australians who have taken the life of a suffering terminally ill relative or friend at their request, following the doctor’s refusal to help because it is illegal.

Examples of these tragic circumstances have been presented to me in recent times—medically unqualified Australians driven by compassion and frustration to kill a loved one.

I refer to cases which have never been investigated, where the family keeps the secret bottled up inside. I am sure you have all read of other sad cases of mercy killing which have made the courts.

Opponents to voluntary euthanasia claim there can be no safeguards which would protect us from the so-called ‘slippery slope’, that voluntary euthanasia must inevitably lead to involuntary euthanasia.

Their arguments, in my view, having read volumes on the subject, are strong on rhetoric and short on facts.

If ever there was a situation ripe for abuse, it has to be the situation prevailing in Australia today where some doctors assist some patients to die but there are no controls or safeguards.

How come the ‘slippery slopes’ are not yelling about that?

There is no doubt in my mind that adequate safeguards can be devised to ensure that those patients Parliament dictates should have access to voluntary euthanasia are the only ones legally able to receive the service.

We could, for example, restrict voluntary euthanasia to patients who had been assessed by two psychiatrists, two specialists in the disease, two palliative care experts, the approval of next of kin, three independent witnesses, a three month cooling off period, the con-
Hawaii Emergency Physicians Associated, Inc.

HEPA

Serving:
Castle Medical Center
Wahiawa General Hospital
Hilo Medical Center
North Hawaii Community Hospital

Established: 1971

HEPA Is a Participating Provider With:

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Veteran's Administration
Worker's Compensation
HMSA - 65C Plus
StraubCare Quantum
Queen's Hawaii Care
Aloha Care Quest
Kaiser Quest
HMSA Quest
PGMA
HMAA
Queen's HMSA Premier Health Plan
Physicians Health Hawai'i Inc.
University Health Alliance/HDS
Kapiolani Health Hawaii
The occurrence of a Supreme Court judge, and the whole process videotaped.

Obviously we don’t have to go that far. The example is simply to demonstrate that safeguards can be put in place which prevent people who might opt for voluntary euthanasia simply because they are temporarily depressed, or who are being coerced by others, from being legally able to be assisted.

And if you want to be super conservative, legislation could require a patient to have signed an advance directive before they are diagnosed as terminally ill and/or require self-administration of the lethal drug.

In my view, the claim that decriminalizing voluntary euthanasia must lead to the widespread use of euthanasia without patient consent, or even against the wishes of a patient, is unconvincing.

Such action would contradict the very basis on which voluntary euthanasia is proposed—the principle of respect for human freedom and autonomy.

Voluntary euthanasia is patient driven. The N.T. law dictates that the patient must personally initiate the process, consider the options for treatment and palliative care, be psychologically assessed, sign a request, obtain second options, consider the affect on the family, use qualified interpreters if necessary and endure a cooling off period. The patient can of course change their mind at any time and stop the process instantly.

Additionally, detailed records must be kept. Government regulations must be followed. The Coroner must be informed and has a statutory responsibility to report to the Attorney General and Parliament any concern regarding the operation of the legislation.

To kill another without these conditions being fulfilled is to commit murder under the Northern Territory Crime Code—penalty mandatory life in prison.

The scare that deformed or retarded babies, patients in mental institutions and homes for the aged will inevitably be unwilling victims is repeated by opponents at every opportunity in the debate.

The claim that it will lead to the practices adopted by the politically corrupt Germany in the 1930’s and 40’s has long been a major tactic of those opposed to voluntary euthanasia.

It is an insult to Australian doctors and others in the medical profession to pretend that they would be associated with such a wicked scenario.

The same applies to the media, our politicians, police and coroners.

It is surely preferable to have voluntary euthanasia tolerated in particular circumstances with stringent safeguards and a degree of transparency, than to continue to prohibit it officially while allowing it to be carried out in secret without any controls.

The quote “hard cases make bad law” is occasionally heard in this debate.

The Rights of the Terminally Ill Act is a law for hard cases. Only hard cases.

Yet it is a law that does not make anybody do anything.

It is generally conceded that about 2% of the dying experience symptoms which are difficult or impossible to relieve, hence the term ‘hard’ death. For those unfortunate people, even the best palliative care is of little value.

From the Northern Territory’s population, an estimated 16 people per year fall into that category and may opt for assistance to die under the Act.

The figure for the rest of the country is 2,500 die ‘hard’ each year (7 people everyday).

In desperation, a few will consider traveling to the N.T. to seek help—sick, dying Australians moving from their homes, friends and relatives, in a bid to find the relief denied them elsewhere.

To Kevin Andrews MHR, from his safe seat in Melbourne—all this is too much. He was appalled at news that a West Australian man would take such extreme measures to die with dignity, and demanded that the option be removed.

How is that for sympathy and compassion from one of those charged with the welfare of the nation?

John Howard’s support has made voluntary euthanasia a national issue. From now on every MHR and Senator is required to take a stand. Every candidate for federal parliament will be hounded until their views are known by the electorate.

Many, particularly those in marginal seats, will try hard to avoid taking a position, concerned that whatever side they take opponents will work hard to unseat them. And they will. I predict a substantial block of abstainers from the vote on Kevin Andrews’ private member’s bill.

Contrary to Kevin Andrews’ assertion, the N.T. has not legalized voluntary euthanasia for the whole of Australia, any more than S.A. did when they were the first to legislate for termination of pregnancy. Of course, what terrifies
Andrews and the Church hierarchy is that, like that example, voluntary euthanasia will be made legal across Australia. And they are absolutely right. It is easy to get angry about the moral minority who raise this challenge to the decision of a democratically elected parliament acting within its powers.

The self-righteous minority who believe they have a monopoly on wisdom about death and dying.

The hypocritical minority who believe in democracy only if they agree with decisions made.

The hard core Christian minority who can justify in their minds any human suffering no matter how great, who seek to impose their moral preferences on us all.

I have a message for them. It is not only members of the N.T. Legislative Assembly who support voluntary euthanasia. There are ten million adult Australians out there who want that option.

How can you say to the terminally ill,

"As long as there is a flicker of life in your decaying body—you must stay with us—you have no choice?"

How can you tell them you know better than the doctors, the nurses and the palliative care experts with a lifetime of experience with the dying?

If the real answer is—that you can never agree to voluntary euthanasia under any conditions because you have a fundamental religious objections, because you believe that only God can give life and only God can take it, then be honest and say so. No one will criticize you for that!

When you have made that admission, get out of the way so the rest of us can get on with adopting some compassionate, humane laws for those who do want the voluntary euthanasia option.

There are more academics, doctors, nurses, judges, lawyers, engineers, taxi drivers or whatever, who believe voluntary euthanasia should be decriminalized than believe it should not be.

Every major poll taken in the western world confirms similar public support. Significantly, support also come from 69% of people who identify as Catholic, 73% Presbyterians, 76% Methodists and 81% Anglicans.

We are not asking you to lead public opinion Mr Howard, we are asking you to catch up with it.

In fact you are being asked to bow out!

Over 70% of all Australians support what the N.T. has done.

They do not accept that the value judgments of our federal politicians are morally superior to those of state or territory politicians.

Voluntary euthanasia is not an issue for Federal Parliament. It is constitutionally an issue for the states and when, not if, a state legislates in this field, there will be nought the Federal Parliament can do about it.

The citizens of the Northern Territory elected just 3 of the 224 politicians who will decide if they can retain the right they currently have to voluntary euthanasia.

Ironically, the 214 federal politicians elected by the 6 states will have no say in whether the eighteen million Australians who reside in those states, gain the same rights.

Is it any wonder we in the Northern Territory think Kevin Andrews’ bill is an outrage?

If his bill is passed, it will be a victory for the Church over democracy. A classic case of arrogant politicians ignoring the clear will of the electorate in favor of religious dogma. It would mean that to get voluntary euthanasia laws passed, we will need to weed out those who follow the dictates of the Church hierarchy at preselection or election.

I was never a student of political history but now I know why there must be a separation between the Church and the State.

A message to those elected to run our country. Most of the things you have done in public life, the candidate you defeated would have done just as well, or just as badly.

Only occasionally in history do you have the opportunity to do something that will make a profound difference to the lives of your constituents.

This is one of those occasions. Don’t mess it up.

I close with a comment about the vocabulary which is used throughout these debates. We always describe the client group quite coldly as "patients."

The terminally ill are mothers, fathers, brothers, sisters, sons, daughters, wives and husbands. They are not just ‘patients.’

They are people. People like you and me. People like Bob Dent. That is who we are talking about.

We should never forget that.
Rxemedy Survey of 30,000 Americans Age 55 and Over Indicates Strong Support for the Right to Die

Sal Cataldi and Cori Case
Westport, Connecticut

Rxemedy, Inc., a four-year-old information data base marketing company based in Bridgeport, Connecticut, studied the health practices and concerns of 55-year-olds and older consumer in 1.2 million households. Over 100,000 households returned the survey distributed via Rxemedy, its bimonthly health magazine. 30,000 surveys were selected to create the balanced sample that is nationally projectable. All respondents were aged 55 or older with a median of 71 years.

Here are the highlights of this very interesting study supplied by Rxemedy Inc. The complete results of the 44 question survey dealing with Living Wills and Euthanasia will be reported later.

• 65% of the 30,000 mature Americans surveyed agree that the terminally ill should have a legal right to commit suicide with a doctor’s assistance, and 64% favor enacting legislation to give people this right.

• 53% agree that physicians should be allowed to give people instructions on how to end life, 33% disagree.

• Religious beliefs are somewhat more of an obstacle for men than women; 43% of male respondents (vs 33% of female) say their faith would prevent them from considering suicide for themselves; even more, 48% of men (vs 43% of women) say their beliefs would prevent them from helping a terminally ill friend commit suicide.

**Rxemedy, Inc. Right-to-Die Survey—December 1996. Projected Survey Results**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>People should have the legal right to commit suicide with a physician's assistance if they have a terminal disease, such as cancer.</td>
<td>29%</td>
<td>36%</td>
<td>10%</td>
<td>8%</td>
<td>17%</td>
</tr>
<tr>
<td>I favor legislation allowing terminally ill patients to request a physician's assistance in ending their life.</td>
<td>29%</td>
<td>35%</td>
<td>9%</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>Physicians should not be allowed to give people instructions (such as how many pills to take) on how to end life.</td>
<td>10%</td>
<td>14%</td>
<td>24%</td>
<td>29%</td>
<td>17%</td>
</tr>
<tr>
<td>Religious beliefs would prevent me from helping someone to commit suicide.</td>
<td>23%</td>
<td>20%</td>
<td>17%</td>
<td>23%</td>
<td>29%</td>
</tr>
</tbody>
</table>
Life in These Parts
The Hawaii Diet

The results of the three week Hawaii Health Program were quite remarkable:
• Group weight loss was an average of 10.8 lbs per person
• Average cholesterol dropped 24% (average of 205 to 157 mg/dl)
• Average blood pressure fell from 130/79 to 120/75.
(The 23 participants included community leaders and individuals of Hawaiian ancestry)

Governor Ben Cayetano lost a total of 12 lbs and his triglyceride level dropped from 617 to 83; and his cholesterol level from 234 to 162.

Terry Shintani MD, director of the Hawaii Health Program and co-founder of the Hawaii Health Foundation said, “If Hawaii is to become a world center for health, its leaders need to be healthy. The Hawaii Health Program, rather than being simply a ‘diet’ is a life-style change program. It lowers the fat content in Hawaii’s popular ethnic dishes and aims to increase the awareness of the health needs of native Hawaiians. Optimal health is achieved through whole person diet and life-style changes based on universal, multicultural principles expressed in Hawaiian values of ‘aloha’, ‘lokahi’ (oneness) and ‘pono’; (righteousness/justice).”

Our Aging Population
The population in Hawaii aged 60 and above increased by 52.5% between 1980 and 1990; while the total population grew 14.9 percent. The oldest segment of this population, 85 years and older, increased 87 percent during this same period. (Statistics from the state’s Executive Office on Aging).

By the year 2010, the 60-plus group is expected to grow by 53 percent to 265,800, or one in every five people. The 85-plus group will grow by 167 percent to 27,800 by 2010 and by 2020, this 85-plus group may grow by 242%, second highest in the nation behind only Nevada.

This rapidly growing elderly population in Hawaii is creating a massive demand for more personalized care and medical services. The financial strains on families, the elderly, private and government health insurance companies and medical and long term care facilities. (From an article in PBN by Malia Zimmerman)

Doctor Jokes
“ ‘The best thing for you,’ the doctor said, ‘is to cut out all sweets and fatty foods, give up alcohol and stop smoking.’

‘I see,’ the patient said, ‘To be honest, I don’t deserve the best. What’s second best?’”

“I can’t do the things I used to do,” the patient said to the doctor. “I wish you had some magic way of making me younger.”

“You got it wrong,” the doctor said. “My job is to see that you get older.”

Doctor: “I can’t do anything about your condition. I’m afraid it’s hereditary.”

Patient: “In that case, send the bill to my parents.”

“It’s just a cold,” the doctor said. “There is no cure, and you just have to live with it until it goes away.”

“But Doctor,” the patient whined, “It’s making me so miserable.”

The doctor rolled his eyes toward the ceiling. Then he said, “Look, go home and take a hot bath. Then put a bathing suit on and run around the block three or four times.”

“What?” the patient exclaimed, “I’ll get pneumonia.”

“We have a cure for pneumonia,” the doctor said.
located at Hilo Orthopedic Center, 45 Mohouli Street announced that they were the official orthopedic surgeons for UH-Hilo Vulcans and Hawaii Winter Baseball-Hilo Stars. OB-GYN physician Lyn Mikala Lam announced she was taking new patients at North Hi Community Hospital, Big Island.

**Sportsmen**

"A few years ago, golfer Sandy Lyle was asked what he thought of Tiger Woods. 'I don’t know,' said Lyle, 'I haven’t played there yet.' Lyle and just about everyone else, now know that Woods is a force of nature—and nurture."

*Time Dec 23 ’96*

**Miscellany**

Tosh and Yosh, avid baseball players were getting old and wondered about baseball in heaven. They pledge to each other that should either one get there first, he would let the other know. Tosh got to heaven first. Tosh came to Yosh at night in a dream.

Tosh: "I have good news and bad news."
Yosh: "Well, give me the good news first."
Tosh: "Yup, there’s baseball in heaven."
Yosh: "What’s the bad news?"
Tosh: "You are pitching tomorrow."

*(As told by our favorite tennis pro, Clay Benham)*

**Visiting professor jokes**

The following is my wife Sheila’s story about why men and women are so different. We were looking for a certain restaurant and I was driving around in circles.

Sheila: "Do you know why it takes 180,000 sperms to impregnate a single egg? It’s because none of them will stop to ask directions."

A HMO director arrived at the Pearly Gates. St. Peter: "We’re delighted to see you. We’ve followed your career carefully. Welcome to Heaven." As he opened the Gate to let the new arrival in, St. Peter added, "I’m sorry to tell you that you are granted three days only."

A farmer stood leaning on a fence at the edge of his property. He watched as a red sports car come over the top of a hill and followed the road up to the spot where he stood.

"Do you know how I can get to Route 91?" the driver asked. The farmer thought for a few seconds. Then he said, "Nope."

"Do you know where the nearest turnpike entrance is?" the driver asked.

"Nope."

"How about the town of Hadley. Do you know which direction it is from here?"

"Nope."

Exasperated, the driver raced his engine. "You don’t know very much, do you?"

"Nope," the farmer said. "But I’m not lost."
Classified Notices

To place a classified notice:

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

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

Rentals Available

For Rent.—3 Bedroom, 2-bath in Aina Haina. Partly furnished. Near school, shopping, bus service. Fruit trees, quiet, view. Yard service provided. $1500/month. Phone 373-3118 or 537-6575.

Office Space

Aiea Medical Bldg.—Fully equipped medical office space to share. Near Pali Momi Hospital. Excellent for specialty use. Call Marie at 487-7938.


Practice For Sale

Practice for Sale.—IM; Moiliili McCully area, 1200 sq ft. Call 949-6452, 12:30-2.

Honolulu Dermatology Practice for Sale.—Well established, excellent location. Doctor has health problems and desires an expedited sale. Reasonable price and terms available. Call Harvey Hartenstein at 808-591-8286.

Services Available

CPA Specializing in Medical Profession. Books, payroll, taxes—Big Six experience, honest & reliable. Call Rose Chan at the Financial Advantage 262-0877 or e-mail cpa@aloha.net.

Medical information at your fingertips.—Physician can set up your computer to give you meaningful clinical information. Call Daniel Saltman MD (808) 528-4951.

For Sale

Misc for sale.—Canon copier model 4050 $2,950; desk 60"x30" $50; Credenza 71"x18" $100. Ask for Nelson 536-7702.

OB/GYN.—Office examining table. Call 955-2222.

Real Estate

Makaha Oceanfront Mansion.—6 yrs old, custom built by owner/contractor $325,000 cost. 4 bdrm/4 baths, swimming pool, jacuzzi, + many extras. 13,825 sq ft, fee simple lot. $635,000 or Rent-to-own. Thomas J. (Tom) Shelby (RA) 808-668-8006 (Res) 808-549-8478 (Digital) Tom Powers & Assoc., Inc. (Broker)

Locum Tenens

Locum Tenens: Family Practice/ Urgent Care.—FPBC physician available for short term Locum Tenens coverage. Please contact: Vadim Braslavsky, MD, 7800 England Dr., #101, Overland Park, Kansas 66204. Phone (913) 383-3285.

Heavenly Hana.—Family practitioner needed to work with newly formed community-based Hana Community Health Center to create a comprehensive medical care program at the Hana Medical Center. This is an opportunity to truly make a difference in this beautiful rural community. Board certified preferred. Physicians also needed for vacation and call cover. Please direct inquiries to: Dan Omer, Hana Community Health Center, P.O. Box 807, Hana, Maui, Hawaii 96713.
"Don't have any credit we don't care—Don't have a bank account, we don't care—don't have any assets, we don't care—don't want to pay us, that's when we care!"

(Carson as Art Fern)

Jayhawk Acceptance Corp. is a used car lender in Dallas, Texas, but now has moved from auto bodies to human bodies. It is offering financial lending packages to patients who would like elective surgery, especially cosmetic, but do not have the capital. These new lenders advertise widely and target poor risks which the bank has refused. Surgeons pay $900 to participate, and are then listed for selection by the patient. Lenders offset their risk with interest rates of 18% to 22.5% where usury laws allow. They also protect themselves by paying the surgeon 60% of the fee with the balance paid after the lender recoups its loan. Of course, there is the problem of how to repossess a blepharoplasty, nose job, or breast augmentation. How about photo-refractive keratectomy?

A little ignorance can go a long way.

A doctor in California admitted to a drug problem, he completed treatment in a rehab program, and he signed a contract, which included monitoring by the hospital. However, he refused to release drug treatment records to the board of medical examiners, and refused to undergo physical and psychiatric evaluations. The board then subpoenaed all related medical records (including peer review actions), but that request was refused on the basis of confidentiality. On appeal, a superior court sided with the board, and only the hospital records were released. Unfortunately, those who desire unlimited access to restricted records, fail to understand that peer review must be based upon confidentiality.

I am making a list of my favorite politicians. This will take some time.

Those wonderful, fun-loving, let-me-spend-your-money people we elected, do so want to practice medicine. Not content to meddle with length-of-stay, drive-by mastectomies, and late term abortions, 16 Congresspersons have introduced a measure to prohibit the use of federal funds in any way that might assist a person in committing suicide. What would we do without them?

We are all in this alone.

There are many sincere people in America who are demanding the "right to die with dignity," and the Supreme Court must consider two landmark cases addressing constitutional questions around assisted suicide. Proponents claim that all that is required is a law allowing the physician to administer a deadly drug ala Jack Kevorkian, the one-time pathologist turned executioner. The AMA House of Delegates has overwhelmingly voted against physician assisted suicide. As AMA past President Bob McAfee said, doctors are not in the business of providing death. In the Netherlands, a law was passed to permit assisted suicide, however, the intent has deteriorated. Euthanasia for those who are terminally ill has moved to euthanasia for the chronically ill, and to euthanasia for psychological distress, and then from voluntary to involuntary euthanasia. The Dutch government's own research has documented that in more than one thousand cases a year, doctors actively cause or hasten death without the patient's request. Those who claim that guidelines will be established to regulate the process, must recognize that in The Netherlands virtually every original guideline has been modified or violated with impunity.

A patriot must always be ready to defend his country from his government.

Both the President and the Republican Congress are tinkering with ideas to alter Medicare, because the present system is headed for bankruptcy. NBC and the Wall St. Journal conducted a poll of 2003 Americans in an attempt to determine what the public wants. Most people said Medicare should be protected, not reformed. A most interesting finding is that much of the public believes that there is no crisis, and as one man said, "The money is there. It’s just been used for many other things." A majority rejected higher payroll taxes, and rejected any increase in beneficiary out-of-pocket costs, or an increase in age eligibility. Forty seven percent opposed reducing payments to doctors and hospitals, while 45% were in favor. Most people over age 50, rejected incentives to join HMOs, but a 60% majority favored a means-test whereby those with incomes over $40,000/year would pay more for their health coverage.

It's not the steak, it's the sizzle.

Going back to the days of President Bush and then HCFA boss, Gale Wilensky, the Administration has been trying to implement "Centers of Excellence," for cataract surgery. Now, after the failures of such pilot programs, a move is underway to include expensive inpatient procedures—joint replacement, and CABG, but not eye surgery. But the biggest insult about "Centers—" is that the term is merely HCFA spin for discounted care, and has nothing to do with excellence, or even with quality. Several things are certain about bureaucracies: among others, they do not listen, they do not care, they are very slow learners, and sadly, we must live with them.

Natural laws have no pity.

It has been said that hitting a baseball is the most difficult task in sports (ask Michael Jordan), and even the most skilled batters are successful in producing hits only 30 to 35% of the time. Not surprisingly, a study reported in the Archives of Ophthalmology found that batters who lose sharp stereopsis, quickly decay at the plate. Hitting stars of the past, George Sisler and Tony Conigliaro, and lately Kirby Puckett, all had to give up the sport when vision deteriorated in one eye. And remember Will Rogers last words to his one-eyed pilot, Wiley Post, "Wiley, you have the patch over the wrong eye!"

He may be a genius. The contrary is, of course, more probable.

A veterinary doctor was caring for a sick cow, and inserted a plastic tube in its rear to test for intestinal gas. He struck a match, and the resulting jet of flame set fire to hay bales, which in turn ignited the building and the entire farm was destroyed with damages at $80,000. The cow survived, but the poor vet was arrested and later fined $200 for irresponsibly starting the fire.

Addenda—

- Intracocular pressures read abnormally low after PRK.
- Muscles come and go; flab lasts and lasts.
- They laughed at Joan of Arc, but she went right ahead and built it.

Aloha, and keep the faith—rts
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