First Hawaiian Bank has the prescription for HMA members. It includes free and discounted personal and business banking services, discounted mortgage loan fees, reduced rates on business loans, equipment and vehicle leasing, free consultation and reduced fees on financial planning, and a Business Banker to help you with it all. It’s exactly what you need to keep your finances in excellent health. If you’re an HMA member, sign up by calling 525-6262 (or call collect from the neighbor islands).
## Contents

**Editorial**
Norman Goldstein MD ................................................................. 28

**Book Review of “Medicine in Quotations: Views of Health and Disease Through the Ages”**
Dawn Charlaire ............................................................................. 28

**Medical School Hotline**
Anthony P.S. Guerrero MD .......................................................... 29

**Out-Patient Parenteral Antibiotic Therapy (OPAT): Clinical Outcomes and Adverse Events**
Steven J. Berman MD and E. William Johnson MPH ....................... 31

**Substance Abuse and Dependence in a Public Hospital: Hawaii**
F.M. Baker MD, MPH, FAPA and William F. Haning, III, MD .......... 35

**Barriers to Good End-of-Life Care: A Physician Survey**
Reiko Kayashima MPH and Kathryn L. Brain DrPH ....................... 40

**News and Notes**
Henry N. Yokoyama MD .............................................................. 46

**Classified Notices** ..................................................................... 49

**Weatherwane**
Russell T. Stodd MD ................................................................... 50

---

Cover art by Dietrich Varez, Volcano, Hawaii. All rights reserved by the artist.

*Wa’a Humu*

Wa’a Humu means “sewn canoe.” Not all Polynesian voyaging canoes were dugouts. Some were “sewn” together out of planks.
Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Editorial February 2001

Our first two manuscripts this month deal with medications. The first by Berman and Johnson described a form of therapy with which many physicians may not be familiar, “OPAT” (Out-Patient Parenteral Antibiotic Therapy).

Homecare companies now provide and manage outpatient services such as fluid replacement, supplemental nutrition, and pain management. With OPAT, homecare companies can provide this service, with the physician monitoring management of the antibiotics.

The authors reviewed 302 courses of OPAT administered to 221 patients in a six-year study from Steve Berman’s busy infectious disease practice. OPAT was successful in 94 percent of the episodes. Major advantages of OPAT include significantly less disruption of the patient’s life, in hospital confinement and far more economical care.

The second manuscript discusses substance abuse and dependence. Dr. F.M. Baker served as Chief, In-Patient Services at the Hawaii State Hospital at Kaneohe. She recently relocated to Salisbury, Maryland, but we will hear from her again, as she has submitted several other manuscripts to the Journal.

Sixty-six percent of the patients studied had multiple drug dependences: alcohol, cannabis, crystal methamphetamine and/or cocaine. Despite the fact that this was a small study of only 35 patients, the authors clearly identified the specific type of intervention performed in the Kaneohe State Hospital.

The physician survey about the barriers to good end-of-life care by Braun and Kayashima should be read by every physician and other “health care providers.” The majority of the responding physicians (367) had attended to terminally ill patients within the past year and felt the physician should be the first to tell a patient that he or she is dying. Kathryn Braun, a member of the ad hoc committee on living and dying with dignity and her co-author Reiko Kayashima add yet another important study and review of an ever increasing medical dilemma: physician-assisted suicide (P.A.S.) and physician-assisted death (P.A.D.).


Book Review

Medicine in Quotations: Views of Health and Disease Through the Ages


Editor’s Note

As a bibliophile and voracious reader, I ordered Medicine in Quotations from the American College of Physicians. After receiving the book, I placed it on my desk, then opened my mail only to find a review by Dawn Chalaire in Science Editor September-October 2000. I had planned to review the book for the Hawaii Medical Journal, but Ms. Chalaire did it for me very well. We reprint it here with her permission.

Norman Goldstein, M.D., F.A.C.P.

Perusing a copy of Medicine in Quotations: Views of Health and Disease Through the Ages, one cannot help being struck by the sheer volume of literature written through the centuries about physicians and their profession.

For those who lack the time or inclination to read all of the more than 2500 works referred to in its pages, however, Huth and Murray offer an edited version – a collection of 3000-plus excerpts from some of the world’s greatest writers and thinkers. The result is a book that contains wit, insight, humor, and profundity in unusual abundance.

As the editors explain in their introduction, quotations were chosen not only for their relevance to medical concepts and practice, but also for their relevance to all human affairs. (They were not chosen for their conformity to the editors’ views.) The entries appear under topic headings from miracles to myositis ossificans, from circulation to civilization, and from preventive medicine to publishing. Although diverse, the topics as a whole serve to illustrate how inextricably health and medicine are woven into almost every aspect of life.

The book’s topic headings are arranged alphabetically. Quotations appear chronologically under each heading (with the person to whom a quotation is attributed noted at the beginning and the work in which it was found at the end) to show the progression of thought on each topic through time. This allows each quotation to be viewed separately and as part of an expanding larger context: Quotations listed under a single heading make up a complete unit, each topic contributes to the book as a whole, and the book contains hundreds of references to other works that, when viewed collectively, provide an even more complete picture of the human condition.

A large number of quotations appear under some topic headings, including doctors, physicians, medicine, and medical practice. This is only proper given the book’s subject, but many of these quotations are very similar, and several could be eliminated without sacrificing

Continues on p. 49
During the third year, all students are required to rotate through the 7-week psychiatry clerkship, where they gain experience in general inpatient and outpatient psychiatry, as well as in some of the psychiatric specialties (e.g., child and adolescent psychiatry, addiction psychiatry). From the beginning, the relevance of psychiatry to general medical practice is emphasized. Discussed during the orientation, are: the relatively high prevalence of mental health conditions (e.g., the 17% lifetime prevalence of major depression\(^5\); the significant morbidity caused by mental health conditions (even in comparison to other chronic general medical conditions\(^6\)); the significant mortality caused by mental health conditions (e.g., homicide and suicide as two of the top three causes of death in adolescents\(^7\)); the importance of recognizing life-threatening medical conditions (e.g., alcohol withdrawal, intracranial bleeds) with behavioral manifestations; and the treatability (shown in the scientific literature) of psychiatric conditions. Students are taught the basic psychiatric interview as an essential tool of the safe physician, who can establish optimal rapport with patients in various contexts and who will not overlook conditions, which could threaten the safety of either the patient, the physician, or anyone else. The clinical experiences, along with supplementary PBL tutorials, ensure that students acquire the knowledge and skills necessary to manage – at the level of a “generic physician” – patients with common psychiatric symptoms. All Department of Psychiatry faculty are required to participate in the clerkship – either through direct supervision of patient care or through participation in the PBL tutorials.

Finally, fourth year students have the opportunity to take month-long electives in various specialties of psychiatry (e.g., child and adolescent psychiatry, addiction psychiatry, consult-liaison psychiatry, psychiatric aspects of obstetrics and gynecology, etc.) All medical students are encouraged to take electives, which can be helpful to them, in whatever specialty they choose.

The faculty’s role in undergraduate medical education would not be complete without efforts to enhance recruitment into psychiatry. Although the main objective is to collaborate with other departments in the training of humanistic, competent physicians, Psychiatry, as a community-oriented department, is ever mindful of the acute shortage of psychiatric services. As an example, the current supply of 6300 child psychiatrists in the United States is anywhere from 4000 to 24000 short of what is actually needed, based on workforce demands\(^8\). In Hawaii, there is an acute need for more child psychiatrists to care for children with special educational needs.

Misconceptions, which could adversely affect career choice, must be addressed. According to Cutler\(^9\), many medical students eliminate psychiatry as a specialty option because they perceive it to be “too stressful.” Psychiatrists care for medical conditions which affect those things which are at the core of our human-ness (e.g., how we think, feel, and relate with others) and, for this reason, many believe that psychiatry is a particularly “stressful” specialty because it seems to “hit so close to home” as one’s own emotions are engaged. However, an important part of training in psychiatry is learning to handle appropriately such emotions and, in fact, to use them skillfully for the therapeutic benefit of not just “psychiatric” patients but also patients with general medical conditions. Through increasing skills in recognizing and managing these emotions (which
introducing
the only daily facial moisturizer containing Parsol® 1789.

Cetaphil® Daily Facial Moisturizer with SPF 15

- Filters UVA and UVB rays for maximum sun protection
- Offers gentle moisturization for all skin types
- Can be worn under makeup — lightweight and non-greasy
- Non-comedogenic
- The OTC Skincare line most recommended by dermatologists*

The final word in serious skin care. Cetaphil®.

www.cetaphil.com

* Data on file, Galderma Laboratories, L.P. ©1999 Galderma Laboratories, L.P. GALDERMA is a registered trademark. CET-249-1199
Abstract

A chart review was conducted of patients in a program featuring self-directed, home infusion of antibiotics for serious infections utilizing an out-patient medical office for teaching, mixing of drugs, and monitoring of patients. 302 courses of out-patient parenteral antibiotic therapy (OPAT) were administered to 221 patients. Therapy was successful in 94% of the episodes. Objective adverse events were noted in 25% of patients. To maximize the chance for a successful outcome, treatment plans should be individualized and structured to include systematic monitoring for adverse effects.

Introduction

Parenteral antibiotics are indicated when no effective oral antibiotic exists or when the seriousness of infection mandates a high and reproducible serum concentration. The treatment of serious infections with outpatient parenteral antibiotic therapy (OPAT) has major advantages over inpatient infusion. The experience is less disruptive to the patient’s life than hospital confinement, and by any standard, the expense is less. Early success treating chronic infections, such as osteomyelitis and pneumonia associated with cystic fibrosis, showed the potential of this format. OPAT was promoted for a variety of infections including brain abscess, endocarditis, community acquired pneumonia, skin and soft tissue infections, pyelonephritis, and pelvic inflammatory disease. Much of the OPAT process was removed from direct physician control as government regulations restricted physicians from utilizing infusion services in which they had ownership because of a potential conflict of interest. The delivery of OPAT was then assumed by home care companies as part of their outpatient services, similar to fluid replacement, supplemental nutrition, and pain management. As with other home care services the physician was responsible for ordering the medications and for complications and outcome of treatment, but was not directly involved in monitoring the quality of care. An exception to this general rule does, however, allow physicians to provide OPAT as a direct extension of their clinical practice. The material for this paper is drawn from this model.

Methods

A retrospective review of all the records of patients in an infectious disease practitioner’s outpatient practice who were treated between 1991 and 1996 with self directed home infusion of OPAT was performed. Patients considered for the OPAT program were able to come to the medical office as needed, and had support at home should they require assistance with infusions. A registered nurse taught each patient the mechanics of self-infusion in intensive training sessions. Care of the venous access site, administration and storage of the antibiotic solutions and recognition of side effects were reinforced until the patient was comfortable with the process. The nurse and a physician were available at all times to respond to questions or problems. The patients came to the office at least twice a week for dressing changes, interval history focusing on infusion problems and adverse events, and re-supply of premixed antibiotics. The physician examined the patient at least once a week to assess their clinical status, review laboratory results, and to make changes in medications.

Each infectious episode constituted a separate study case, thus the same patient could be represented multiple times for different infections. Episodes were censored from the analysis if no data was available for follow-up (8 episodes). Each treatment episode was a success when the course of parenteral antibiotics was completed, even if the patient was switched to oral antibiotics. Treatment failures resulted in hospitalization of the patient prior to conclusion of therapy or discontinuation of treatment due to unmanageable adverse effects.

Adverse effects met the following criteria:

1) Nephrotoxicity: a rise in creatinine of 0.5 mg/dL if the pre-treatment baseline was abnormal or a 0.5 mg/dL rise above normal standards.
2) Anemia: hemoglobin decrease of 2 g/dL from pre-treatment baseline.
3) Diarrhea: >3 loose stools per day.
4) Eighth nerve toxicity: onset of dizziness or imbalance with the presence of nystagmus or Romberg’s sign.
5) Fever: >100.0 F degrees.
6) Thrombocytopenia: platelet count of <100,000 g/L or >50% drop if pretreatment baseline was below 100,000 g/L.
7) Neutropenia: new onset of a white blood cell count <2,500 cu/cm or a drop of >50% from pre-treatment baseline if entry status was below 2,500 WBC/cm.
8) Hepatic dysfunction: transaminase (ALT) value twice the upper limit of normal or increase from pre-treatment baseline if abnormal.
Results – Patient Population
During the six-year study period, 302 courses of OPAT were administered to 221 patients. The median duration of therapy was 18 days, ranging from 3 to 307 days. Two-thirds of the patients were male and the median age was 40.8 years. Other medical conditions co-existed in 60% of the 302 treatment episodes including solid organ transplantation, acquired immune deficiency syndrome (AIDS), diabetes mellitus, chronic obstructive pulmonary disease (COPD), or cancer of a solid organ. [Table 1].

Results – Clinical Infections
Bacterial infections were treated most often (76%), [Table 2]. Gram-positive bacteria accounted for 59% of isolates (140 of 236), including S. aureus (38), S. epidermidis (28). Almost forty percent (93/236) of the pathogens were gram-negative bacteria; pseudomonas aeruginosa was the most frequent pathogen under treatment (38/93). Forty-one patients had a polymicrobial infection, [Table 3].

Viral infections were treated in 63 episodes, including 39 episodes of cytomegalovirus infection in patients with a transplanted organ. Eighteen other episodes with cytomegalovirus infection were treated in patients with AIDS. Other viral infections in patients with AIDS included six episodes of herpes proctitis or herpes esophagitis. Patients with AIDS were also treated for fungal esophagitis (4), and pneumocystis carinii pneumonia (8). Atypical mycobacterium pulmonary infections not associated with HIV were treated on 5 occasions.

Results – Anti-Infective Medications
Cephalosporins accounted for 49% (152) of the 389 courses of antibiotics. Vancomycin was used 48 times against methicillin resistant staphylococci. Other antibiotics included aminoglycosides, ureidopenicillins, imipenem, clindamycin, and ciprofloxacin. Anti-viral agents utilized were ganciclovir, foscarinet, and acyclovir. Pentamidine was also administered, [Table 4].

Results – Treatment Outcome
OPAT was successful in 94% (283/302) of the episodes. No further anti-infective therapy was necessary in 236 cases; step-down to oral therapy occurred in the remaining 47. Antibiotics were changed during treatment in 3 patients because of drug resistance and in 12 patients because of intolerable side effects.

Treatment failed in 19 episodes. Of these, 16 episodes required hospitalization. Clinical deterioration occurred in nine patients with bacterial infections (osteomyelitis, wound infection, pyelonephritis, pelvic abscess, septic bursitis, paratyphoid fever, orchitis, cholangitis, and line sepsis). Five patients were hospitalized for progression of HIV infection. One patient could not cope with home infusion and one patient required a surgical procedure unrelated to the infection. Therapy was terminated in 3 patients because the side effects of drug outweighed the benefit of further treatment: in one patient pentamidine caused vestibular and renal dysfunction; pentamidine caused hypoglycemic reactions in another patient; and ganciclovir induced thrombocytopenia in the third patient. Overall, patients with HIV infection experienced significantly higher rates of treatment failure (26%) compared to the rest of the study population (4%).

Table 1.— Co-Morbid Conditions

<table>
<thead>
<tr>
<th>Underlying Disease</th>
<th>Patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Underlying Disease</td>
<td>122</td>
<td>40%</td>
</tr>
<tr>
<td>Renal Transplant</td>
<td>56</td>
<td>19%</td>
</tr>
<tr>
<td>AIDS</td>
<td>31</td>
<td>10%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>20</td>
<td>7%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>14</td>
<td>5%</td>
</tr>
<tr>
<td>Solid Organ Cancer</td>
<td>16</td>
<td>5%</td>
</tr>
<tr>
<td>Heart Transplant</td>
<td>13</td>
<td>4%</td>
</tr>
<tr>
<td>Chronic Skin and Soft Tissue Infection</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>4%</td>
</tr>
</tbody>
</table>

Table 2.— Clinical Diagnosis of Infection

<table>
<thead>
<tr>
<th>Clinical Diagnosis</th>
<th>Episodes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytomegalovirus</td>
<td>57</td>
<td>19%</td>
</tr>
<tr>
<td>Soft and Soft Tissue</td>
<td>42</td>
<td>14%</td>
</tr>
<tr>
<td>Lower Respiratory Tract</td>
<td>36</td>
<td>13%</td>
</tr>
<tr>
<td>Septicemia</td>
<td>33</td>
<td>11%</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>29</td>
<td>10%</td>
</tr>
<tr>
<td>Ear, Nose, and Throat</td>
<td>23</td>
<td>8%</td>
</tr>
<tr>
<td>Pyelonephritis</td>
<td>19</td>
<td>6%</td>
</tr>
<tr>
<td>Post-Operative Wound</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>Intra-abdominal Abscess</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>Septic Arthritis</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>Endocarditis</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Herpes Virus</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>5%</td>
</tr>
</tbody>
</table>

Table 3.— Microbiology

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Episodes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>P aeruginosa</td>
<td>38</td>
<td>38%</td>
</tr>
<tr>
<td>S aureus</td>
<td>34</td>
<td>34%</td>
</tr>
<tr>
<td>S epidermidis</td>
<td>28</td>
<td>28%</td>
</tr>
<tr>
<td>E coli</td>
<td>18</td>
<td>18%</td>
</tr>
<tr>
<td>E faecalis</td>
<td>14</td>
<td>14%</td>
</tr>
<tr>
<td>Streptococcus sp.</td>
<td>14</td>
<td>14%</td>
</tr>
<tr>
<td>S pyogenes</td>
<td>12</td>
<td>12%</td>
</tr>
<tr>
<td>Enterobacter sp.</td>
<td>12</td>
<td>12%</td>
</tr>
<tr>
<td>K pneumoniae</td>
<td>12</td>
<td>12%</td>
</tr>
<tr>
<td>Pseudomonas sp.</td>
<td>9</td>
<td>9%</td>
</tr>
<tr>
<td>Bacteroides sp.</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Mycobacteria sp.</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Other (23 organisms)</td>
<td>49</td>
<td>49%</td>
</tr>
</tbody>
</table>

Table 4.— Anti-Infective Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Episodes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cephalosporins</td>
<td>152</td>
<td>39%</td>
</tr>
<tr>
<td>Ganciclovir</td>
<td>54</td>
<td>14%</td>
</tr>
<tr>
<td>Vancomycin</td>
<td>48</td>
<td>12%</td>
</tr>
<tr>
<td>Aminoglycosides</td>
<td>41</td>
<td>11%</td>
</tr>
<tr>
<td>Ureidopenicillins</td>
<td>29</td>
<td>7%</td>
</tr>
<tr>
<td>Foscarinet</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td>Imipenem</td>
<td>13</td>
<td>3%</td>
</tr>
<tr>
<td>Pentamidine</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Acyclovir</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>3%</td>
</tr>
</tbody>
</table>

Other: Amphotericin B, Doxycyline
Results - Adverse Events
Quantifiable adverse events were documented in 74/302 episodes (25%). The most frequently encountered verifiable new findings included renal dysfunction, drug rash, anemia, diarrhea, vestibular dysfunction, drug fever and bone marrow depression, [Table 5]. In addition, 18% of the patients (55 episodes) complained of constitutional symptoms reporting fatigue (20), headache (12), anorexia (5), as well as nausea (19), weakness (2), palpitations (1), sleepiness (1), and insomnia (1).

AIDS as an underlying condition was associated with a significantly higher rate of verifiable adverse events (58%) compared to patients with transplanted organs (26%) or patients with no underlying disease (19%). The impact of underlying disease upon objective adverse events can be seen by comparing the treatment of cytomegalovirus infections with ganciclovir in patients with AIDS and organ transplantation. The incidence of adverse events was much higher in ganciclovir-treated patients with HIV infection, 56% (5/9) compared to 33% (14/43) in patients with organ transplantation receiving the same drug.

Other opportunistic infections in patients with AIDS were also associated with a very high incidence of adverse effects during treatment (>50%). Adverse events were noted in 4 of 6 patients on pentamidine for pneumocystis carinii pneumonia, 2 of 3 patients on co-trimoxazole, 4 of 8 patients on foscarnet, 4 of 6 patients treated for refractory herpes infection with acyclovir, and 3 of 4 patients with fungal esophagitis treated with Amphotericin B.

Adverse events from antibiotics used to treat bacterial infections were also common and resulted in a change of drug in 10 episodes but did not necessitate termination of OPAT. The incidence of adverse events was greatest with imipenem and ureidopenicillins (>20%), although clinically significant side effects occurred with vancomycin (19%), cephalosporins (13%), and aminoglycosides (5%) as well.

### Table 5.— Adverse Events

<table>
<thead>
<tr>
<th>Adverse Events</th>
<th>Occurrence</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal Toxicity</td>
<td>21</td>
<td>7%</td>
</tr>
<tr>
<td>Drug Rash</td>
<td>13</td>
<td>6%</td>
</tr>
<tr>
<td>Anemia</td>
<td>13</td>
<td>4%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>13</td>
<td>4%</td>
</tr>
<tr>
<td>Eighth Nerve Toxicity</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>Fever</td>
<td>9</td>
<td>3%</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>7</td>
<td>5%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Other significant</td>
<td>15</td>
<td>5%</td>
</tr>
</tbody>
</table>

Other: Thrush, Bleeding, Orthostatic Hypotension, Blurred Vision, Hematuria, Brady-cardia, Hypoglycemia

### Table 6.— Adverse Events and Medication

<table>
<thead>
<tr>
<th>Medication</th>
<th>Occurrence</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pentamidine/Co-trimoxazole</td>
<td>1/1</td>
<td>100%</td>
</tr>
<tr>
<td>Foscarnet/Ganciclovir</td>
<td>4/5</td>
<td>80%</td>
</tr>
<tr>
<td>Amphotericin B</td>
<td>3/4</td>
<td>75%</td>
</tr>
<tr>
<td>Co-trimoxazole</td>
<td>2/3</td>
<td>67%</td>
</tr>
<tr>
<td>Pentamide</td>
<td>4/6</td>
<td>67%</td>
</tr>
<tr>
<td>Acyclovir</td>
<td>4/8</td>
<td>67%</td>
</tr>
<tr>
<td>Foscarnet</td>
<td>4/8</td>
<td>67%</td>
</tr>
<tr>
<td>Impenem</td>
<td>5/13</td>
<td>39%</td>
</tr>
<tr>
<td>Ganciclovir</td>
<td>16/48</td>
<td>33%</td>
</tr>
<tr>
<td>Extended Penicillins</td>
<td>6/29</td>
<td>21%</td>
</tr>
<tr>
<td>Vancomycin</td>
<td>9/48</td>
<td>19%</td>
</tr>
<tr>
<td>Cephalosporins</td>
<td>19/152</td>
<td>13%</td>
</tr>
<tr>
<td>Aminoglycosides</td>
<td>2/41</td>
<td>5%</td>
</tr>
</tbody>
</table>

Discussion
OPAT was successful in 94% of the treatment episodes with an adverse event rate of 25%. The outcome of therapy in this paper is similar to that previously reported but not the rate of adverse events or side effects. Adverse events, in earlier publications, were considered significant when there was a change in therapy; the dose of antibiotic was adjusted, or the antibiotic was discontinued. Monitoring organ function for changes of potential clinical significance is the standard of practice when treating infections in patients who are hospitalized and is probably more important in the outpatient setting where face to face encounters between the patient and the treating physician or staff nurse are less frequent. Quantifying the etiology of any recognized adverse events represents a challenge to the clinician as the factors of drug, underlying disease, and current infection can each play a significant role.

As illustrated in this paper, underlying disease can have a profound impact on the morbidity and outcome of therapy. The formal structure of all OPAT programs must include careful monitoring of the patient for adverse events and be tailored to the patient, their infection, treatment, and underlying disease.

References
Women who smoke get MORE DATES WITH DOCTORS.

Smoking, more than any other controllable behavior, contributes to a woman’s risk of heart disease and stroke. Which means that if you smoke, you stand a better chance of spending time in the company of doctors. Unfortunately, it might not be the kind of date you had in mind. To learn more about reducing your risk through smoking cessation, heart-healthy eating and exercise, visit www.americanheart.org or call 1-800-AHA-USA1.

American Heart Association®
Fighting Heart Disease and Stroke
Substance Abuse and Dependence in a Public Hospital: Hawaii

F.M. Baker MD, MPH, FAPA and William F. Haning III, MD

Abstract

A pilot study of the prevalence of substance abuse disorders was completed on the only open unit of the only state psychiatric hospital in Hawaii to address the following questions: 1) What were the substances of abuse and dependence in this population? 2) What was the pattern of abuse and/or dependence in this sample? 3) How did these patterns compare to the patterns observed in the published literature? 4) What was the predominant Stage of Change of these patients? 5) Was the staff perception that these patients were in denial an accurate perception?

Methodology: All patients admitted to the unit between 1st June and 31st August 1999 comprised the sample, N=35. Each patient was assigned diagnoses based upon the DSM-IV criteria and level of change was assessed. Results: The demographic characteristics of the sample follow: 60% were ages 20-39, 89% were male; 92% were currently single, 71% had an education of high school or college, and 66% had a diagnosis of schizophrenia or schizoaffective disorder. The racial composition reflected the diversity of Hawaii. Although 20% of the sample had no substance abuse problem, 66% of the remaining patients were multiply dependent upon alcohol, cannabis, crystal methamphetamine, or cocaine with 48% of these patients in the Precontemplative Stage of Change (denial). The patterns of multiple substances of abuse and dependence were higher than in the published literature. Further studies are needed.

Introduction

The recent “Mental Health: A Report of the Surgeon General” reported that “in one year 3% of the adult United States population had both a mental disorder and an addictive disorder and 6% had addictive disorders alone.” Studies of mentally ill persons in the United States have demonstrated that more than 70% of persons with schizophrenia have high rates of co-occurring nicotine dependence. Among alcohol and drug abusers in treatment 80% are smokers of nicotine. As many as 50% of schizophrenic patients in treatment have been identified as having alcohol or illicit drug dependence. Investigators have suggested that the substance use among schizophrenic patients may moderate the side effects of traditional antipsychotic medication, specifically akathisia and extrapyramidal side effects, and/or moderate auditory hallucinations and paranoid delusions. Thus, patients with mental illness, particularly schizophrenia, are at an increased risk of dependence upon nicotine, alcohol, and/or other illicit substances, i.e., cannabis or cocaine.

In comparison to many mainland cities, the state of Hawaii is more culturally diverse. No single racial group forms the majority of its population, which is comprised of Asian (34.2%), Caucasian (22.1%), Native Hawaiians and Pacific Islanders (21.4%), Mixed not including part Hawaiian (21.4%), and Others (African American and Puerto Rican) (1.5%). The island of Oahu has 75% of Hawaii’s population and the only public psychiatric hospital for the state. In order to establish the pattern of substance abuse and dependence among patients in this setting, a pilot study was completed to address the following questions. First, what substances are used in this population? Second, what is the pattern of abuse and dependence? Third, how do these findings compare to the patterns observed in the published literature? Fourth, what is the predominant stage of change of our patients? And, fifth, would a treatment initiative focused on the culture of the patient be helpful?

Methodology

All 36 patients on the only open, in-patient unit of the Hawaii State Hospital comprised the study sample. As the only open, psychosocial (psychiatric) rehabilitation unit, it was anticipated that patients would be actively working toward their discharge through active participation in their treatment program. The psychiatric rehabilitation program included specific groups to address the skills needed by the patient to be successful in the patient’s discharge environment based upon the patient’s strengths and weakness identified through a detailed functional assessment. The groups included psychoeducational groups on mental illness and psychoactive medication, basic living skills training, social skills training, prevocational assessment, and community reintegration activities. Patients with substance abuse problems participated in Substance Abuse Education groups as well as Alcoholics Anonymous and Narcotics Anonymous groups.

These data were obtained as part of a Quality Assurance Survey based upon chart review. The Quality Assurance Survey was implemented to provide data about the perception that a number of substance abuse patients, though in treatment on a psychiatric rehabilitation unit, were not actively working in their substance abuse treatment programs. A chart abstraction form was utilized to record the demographic data, Axis I diagnoses, specific substances of abuse and substances of dependence based upon Axis I diagnoses, the Psychiatric Evaluation, the Addiction Psychiatry Evaluation, and the identified stage of recovery documented in the Addiction Psychiatry Evaluation.

Correspondence to:
F.M. Baker MD, MPH, FAPA
Medical Director, Lower Shore Clinic
505 East Main Street,
Salisbury, MD 21804
Phone: 410-341-3420
Fax: 410-341-3397
The "Changing for Good" six-stage program (see Table 1 and Figure 1) provides a conceptual model for understanding the progressive stages of change from dependence to living a "clean and sober" life style. It serves both diagnostic and heuristic purposes.

Results
All patients on the open HSH unit between 1st of June to the 31st of August 1999 comprised the sample (N=35). Some 17% of the sample (N=6) were Asian (Filipino or Japanese), 26% (N=9) were Caucasian, 26% (N=9) were of Mixed Race (2 or more racial groups, i.e. Chinese, Caucasian), 23% (N=8) were Hawaiian or Pacific Islander (Samoan, Tongan), and 8% (N=3) were Other (e.g., African American, Portuguese, Puerto Rican). Ninety-four percent (N=33) of the sample were men. One of the 2 women was of Mixed heritage age 30-39 and the second woman was of Other heritage and age 40-49. Seventeen percent (N=6) of the sample were aged 20-29, 43% (N=15) were aged 30-39, 26% (N=9) were aged 40-49, and 14% (N=5) were aged 50-59. Sixty-nine percent (N=24) were single, 23% (N=8) were separated or divorced, and 8% (N=3) were married. Some 9% (N=3) of the sample had completed a Bachelor or Master degree, 42% (N=15) had attended community college, and 20% (N=7) had completed high school or earned a GED diploma. Some 20% (N=7) of the sample had completed the 7th to the 11th grade and 9% (N=3) were functionally illiterate or had attended ungraded special education classes. Diagnosis by race is shown in Table 2. Twenty percent (N=7) of the sample had no substance abuse or dependence diagnoses. Fourteen percent (N=5) of the sample abused 2 or more substances (e.g., alcohol and marijuana); but did not meet dependence criteria. Sixty-six percent (N=23) of the sample was both dependent upon and abusing substances. Of these patients 43% (10 of 23) were dependent on 2 or more substances (e.g., crystal methamphetamine, marijuana, and alcohol) and 52% (12 of 23) were abusing 2 or more substances. Table 3 gives the number of patients who were dependent upon various substances in this sample. The majority of patients with an Axis I diagnosis of a non-substance disorder and an Axis I substance disorder, the dually diagnosed, were mainly Schizophrenic (Table 4). Table 5 presents the percentage of patients and their Stage of Change. The majority of substance abusing and/or dependent patients were in the Precontemplative Stage.

Discussion
The racial composition of our sample reflected the cultural diversity of Hawaii. In contrast to the cocaine epidemic of the mainland, (smokable) crystal methamphetamine was the amphetamine-like substance of concern. The epidemic of crystal methamphetamine abuse had been identified as a major public health problem in Hawaii for several years. In contrast to the Baltimore sample of dually diagnosed, chronically mentally ill patients,14 these patients were better educated with 66% (23 of 35) patients having a high school education or beyond. The pattern of abuse and dependence in this sample was more complex than found in a sample of chronically mentally ill patients with dual diagnosis.14 Dually diagnosed patients with a diagnosis of a psychotic disorder were found to be dependent on alcohol, cannabis, crystal methamphetamine, and nicotine or to be dependent on alcohol and nicotine and to be abusing cannabis and crystal methamphetamine. In this study most dually diagnosed patients had one Axis I psychotic disorder and four Axis I substance use disorders.
Although these investigators initially questioned the need for a culture specific treatment program, the data in the charts revealed that the level of readiness for change was Precontemplative and characterized by denial in almost all of the patients with substance abuse disorders. This resulted in a failure of these patients to engage in therapy so that the question of cultural appropriateness did not even arise. A partial explanation for this pattern of multiple dependences and/or multiple substances of abuse may be a tolerance for the use of cannabis in some of the islands that comprise the state of Hawaii. It was not unusual for some patients to report that their parents’ “cash crop” was cannabis, which they gave to the patient in childhood. Several patients, also, reported the early use of alcohol with parental encouragement. The majority of the Caucasian patients were not born in Hawaii, but emigrated from the mainland. Patterns of substance abuse begun on the mainland were continued in Hawaii and for some patients escalated in amount and multiplied in type of substances used.

The clinical impression of the treatment team that the patients with substance abuse/dependence were in denial was confirmed. Only 23% (N=8) of the patients were in Contemplative, Preparatory, or Action phases of change readiness. Although the remainder were attending substance abuse education classes and AA/NA meetings, they denied that they had substance abuse problems and a few stated that they anticipated drinking alcohol or using cannabis upon discharge.

This pilot study facilitated the identification of the specific type of intervention needed in our setting. In addition to the Substance Abuse Education groups, the Addiction Psychiatry Service initiated a new series of groups based upon the “Changing for Good” six-stage model. Beginning with a group for all patients in the Precontemplative Stage, patients remained in this group until they reached the Contemplative Stage. Then, they were advanced to the Contemplation Stage group and so on until the sixth stage. The Addiction Psychiatry Service modified the definition of the sixth stage, the Termination Stage, to a Relapse Stage that fit better with the model of addiction as a chronic, progressive, relapsing disorders, similar to rheumatoid arthritis or diabetes mellitus. This proved compatible with motivational enhancement approaches increasingly favored in this population with psychotic Comorbidity.

Although establishing a treatment program directed to the cultural concerns of our patients was considered, the psychosocial rehabilitation program contained two group experiences which described Native Hawaiian and Pacific Islander culture, relationships, dietary preferences, and religious beliefs as well as contrasting other Asian cultures with Native Hawaiian culture. The development of a Precontemplative Group was identified as the optimum utilization of resources to address the significant resistance to treatment found in patients with substance abuse problems in this study.

The prevalence of multiple substances of dependence and abuse in the same patient in this Hawaiian in-patient population was somewhat surprising for those clinicians whose primary practice was not substance abuse disorders. Although the co-occurrence of substance abuse and mental disorders has been well established from the 1980s, the extent of alcohol, marijuana and crystal methamphetamine dependencies with episodic cocaine abuse in a patient with schizophrenia or schizoaffective disorder was unanticipated. The need to provide in-service staff education to facilitate better...
treatment interventions with these patients was established by the Addictive Psychiatry Service. The involvement of treatment team members as co-leaders of the "Changing for Good" groups provided direct clinical experience with the techniques of interventions targeted to the specific state of readiness of the patient to address the patient’s pattern of substance dependence and abuse. We look forward to presenting the outcome of a longitudinal study involving this type of intervention with the total hospital population.

References

Check out the Hawaii Medical Association website at www.hma-assn.org

Hospice Hawaii & The Queen's Medical Center present

Dr. Ira Byock
caring for our patients as they die

Friday, February 23, 2001 8 a.m.
Kamehameha Auditorium
Queen's Medical Center

Dr. Ira Byock, a palliative care physician and advocate for improved end-of-life care, is a Past President of the American Academy of Hospice and Palliative Medicine. His research contributed to the Missoula-VITAS Quality of Life Index, which is a tool for measuring the quality of life at the end of life, and he is the author of Dying Well: The Prospect for Growth at the End of Life.

Until there's a cure there's the American Diabetes Association.
With early detection, nine out of ten men can be successfully treated for prostate cancer. Yet every year thousands die needlessly, many of them too embarrassed to take a quick, painless examination that can spot the disease soon enough for a wide array of life-saving treatments. So please, take a moment for the rest of your life. Get it checked. Like George Foreman does.

For more information call 1 800 ACS-2345
Barriers to Good End-of-Life Care: A Physician Survey

Reiko Kayashima MPH and Kathryn L. Braun DrPH

Abstract
Surveyed about barriers to good end-of-life care were 804 Hawaii physicians in specialties most likely to care for dying patients. Responses were received by 367 (46%). The majority attended terminally ill patients within the past year and felt that the physician should be the first to tell a patient that he/she is dying. Yet 86% identified barriers to talking about end-of-life preferences and 94% identified barriers to providing good end-of-life care. Perceived as major barriers were family conflict about the best course of action, patient/family discomfort with or fear of death, and cultural/religious beliefs of the patient or family. Since relatively few respondents supported the concepts of physician-assisted suicide (32%) or physician-assisted death (18%), the alternative is for physicians to join with other concerned entities to help overcome the attitudinal, behavioral, educational, and economic barriers to providing appropriate, humane, and compassionate care for the dying.

Introduction
Improving end-of-life care has been the topic of national and local interest. Many Americans are afraid that they “will receive more medical care and less pain relief than they want” when they are dying.1,14 These fears are not unfounded. A national survey found that 47% of responding physicians acted against their conscience in providing care to the terminally ill, and were more concerned about the provision of overly burdensome treatment than about undertreatment.1 Validating fears of the public, the SUPPORT study reported that half of the patients who died in the hospital died in moderate to severe pain.2

What are barriers to providing good end-of-life care? Unfortunately, there are many. Whereas most Americans want to die at home, about 60% die in hospitals and another 17% die in nursing homes.3-5 Death in the hospital, however, often is prolonged due to pressures to use heroic and aggressive treatment that, not coincidentally, generates more revenue than discussion and palliative care.6 Hospice care can improve the quality of one’s death, but nationally, less than 15% of in-home deaths are attended by hospice.4 In Hawaii, about 20% of deaths occur under hospice although many of these individuals are referred to hospice in the last weeks or days before death.9

Several physician-related barriers have been identified as well. First, few medical textbooks include information about death and dying, and few medical schools and residency programs offer distinct courses or provide mentored experiences in caring for dying patients.8-12 The SUPPORT study documented serious shortcomings in communication between physicians and patients, and found that many physicians had no knowledge of patients’ preferences at the end of life.2 Other studies have found that physicians lack knowledge about assessing and controlling death-related symptoms such as pain and psychological distress.12,13

Most patients lack knowledge about the realities of dying and the limitations (as well as the abilities) of technology.15 When physicians cannot communicate these realities, patients may not realize that they are on a short death trajectory or may not suspect the increasing futility of the care being offered. Finally, attitudes and practices relative to death and dying are influenced by culture and religion, and may affect the quality of care physicians provide to dying patients and their families.10 Previous Hawaii-based studies of consumers found significant ethnic differences in willingness to talk about death, completion of advance directive, desire to die at home, and opinions regarding the use of hospice services.9,17

There is concern that the public’s support of physician-assisted suicide (PAS) and physician-assisted death (PAD) stems from their fears about being kept alive after much functioning and intellect are gone, dying in pain, and burdening loved ones at the end of life.12 In fact, consumer support for PAS and PAD appears to be on the increase in the United States, although support is lower among minority Americans than among Caucasian Americans.16 A population-based consumer survey in Hawaii suggested that two-thirds of adults support PAS and PAD. However, when asked if policy efforts should be focused on improving end-of-life care, rather than on legalizing PAS, 52% agreed.8 From the physician side, a 1996 study found that less than 30% of Hawaii doctors would agree to personally perform PAS or PAD.19

For several years, Hawaii has been looking at the “living and dying with dignity” issue and a governor-supported commission has called for improvement. In 1999, a statewide coalition called Kokua Mau, comprised of about 150 agencies and individuals, was funded by the Robert Wood Johnson Foundation to continue research, increase access to spiritually and culturally acceptable care at the end of life, and initiate public and professional education in order to improve care of the dying. The current survey was developed in part to assess physicians’ perceptions of barriers to good end-of-life care, and it is hoped that our data can support the development of interventions which will help overcome these barriers.

Correspondence to:
Reiko Kayashima MPH
John A. Burns School of Medicine,
University of Hawaii,
1960 East-West Road, Biomed C-106,
Honolulu, HI 96822,
e-mail kayashim@hawaii.edu.
Methods
Respondents
We selected respondents from a Hawaii Medical Association database that includes both members of the organization and nonmembers. We excluded retired physicians, trainees, and physicians practicing outside of the state. We included physicians in specialties most likely to be involved in the care of patients with terminal illness, such as family practice and internal medicine with all of its subspecialties (e.g., oncology, cardiology, pulmonology, geriatrics). We excluded physicians in specialties least likely to be involved in end-of-life care (e.g., dermatology, obstetrics/gynecology, psychiatry, surgery).4,20-22 Of the 867 physicians sent questionnaires, 18 had retired, 13 had moved out of state or had no forwarding address, 26 were participating in an excluded specialty, and 6 returned empty envelopes or blank surveys. Of the remaining 804 physicians, 367 (46%) returned a completed questionnaire.

Measures
Our 19-item questionnaire was based on the literature22 and pilot testing. The survey asked about: respondent characteristics (age, sex, ethnicity), professional activities (practice, specialty), number of terminally ill patients cared for in the past year and their place of death; use of hospice; respondent opinion on when to begin discussions about end-of-life preferences and who should first tell a patient about a terminal condition; perceived barriers to talking about end-of-life preferences; barriers to providing good end-of-life care; training in end-of-life care; knowledge of a new 1999 Hawaii law on advance directives; preferences for receiving medical information; and support of the concepts of physician-assisted suicide and physician-assisted death. Questions to barriers were given on a five-point Likert scale ranging from 1=not much a barrier to 5=very much a barrier. The survey defined physician-assisted suicide as “providing a competent, dying patient who requests it with a prescription for medicine for the patient to use with the primary intention of ending his/her own life” and physician-assisted death as “giving a competent dying patient who requests it a lethal injection with the primary intention of ending the patient’s life.”4

Following approval by the University of Hawaii Human Subjects Committee, the survey was mailed to the 867 eligible physicians on June 1, 2000. Reminder postcards were mailed 2 weeks later, followed by a second questionnaire mailed to nonrespondents a month after the initial mailing. All responses received before August 15, 2000 were included in the analysis. The physicians were assured that their responses would be confidential and anonymous in the cover letter. Nonrespondents were tracked by the use of code numbers preprinted on return envelopes. When each questionnaire was returned, the researcher removed it from the envelope, logged in the code number, and then destroyed the envelope. The questionnaires were then assigned consecutive identification numbers for the purpose of data entry and analysis. We were not able to compare the characteristics of the respondents and nonrespondents, as no demographic data were available on nonrespondents.

Statistical Analysis
Responses were entered into Epi-Info, a public-domain program, and subsequently converted into SPSS-PC for statistical analysis. Means and frequencies were calculated. For the questions on barriers, we collapsed the Likert-scaled ratings into two categories: a rating of 4 or 5 was recoded as “agree” and all other responses recoded as “disagree.” Differences between subgroups of physicians (e.g. by ethnicity, religion, and number of terminal patients cared for in past year) were tested using chi-square. Bivariate correlation tests were used to gauge the strength of association between selected variables.

Results
Respondent Characteristics
The characteristics of respondents based on primary specialty, ethnicity, and religion are provided in Table 1. The majority were from internal medicine (72%) or family practice (23%). To discern place of practice, we asked where they saw most of their patients; 74% reported seeing most of their patients in their private offices, 14% said HMO, 9% said hospital or long-term care facility, and 9% said clinic (11 respondents checked two response options). Ethnically, 31% were Caucasian, 26% were Japanese, 18% were Chinese, 8% were Filipino and 6% were Hawaiian. In terms of religion, 10% were Buddhist, 19% Catholic, 37% other Christian, 15% other religions, and 9% reported no formal religious affiliation. Average years in practice was 18.4 years (range 1 to 64 years). Number of terminally ill patients seen in the past year varied; 11% reported seeing none, 27% reported seeing 1 to 4, 45% reported seeing 5-14, and 17% reported seeing 15 or more terminally ill patients.

Place of Death and Use of Hospice
We asked physicians who reported seeing terminally ill patients in the past year to estimate which percentage died in various settings; averaging responses suggested that 48% of patients died in acute care, 34% at home, and 28% in nursing/care homes. Hospice care is provided in all three of these settings, and 21% of respondents reported that over half of their terminally ill patients were attended by hospice at death. Correlating years practicing medicine and percent of patients referred to hospice, we found a significantly negative relationship between the two variables, suggesting that more recently graduated physicians were referring more patients to hospice (r = -.22, p < .01). We also found a significant correlation between percent of patients dying at home and percent of dying patients attended by hospice (r = .44, p < .01). No association was found between use of hospice services and physician religion or ethnicity.

Barriers to Providing and Talking about End-of-Life Care
Almost all (95%) respondents stated that physicians should be the first to tell a patient that he/she is dying (not shown in table). When asked about the best time to approach patients regarding end-of-life preferences, 35% of respondents chose middle age, regardless of health status. Other options included greater than 65 years of age (19%), when diagnosed with serious illness (18%), when patient/family suggests the middle (11%), less than 6-month prognosis (9%), and clearly near death (5%). Respondents were asked to rate the extent to which specific issues were barriers to providing good end-of-life care and talking to patients about end-of-life preferences (Table 2). The most fre-
Table 1.—Sample characteristics (n=367)

<table>
<thead>
<tr>
<th>Primary specialty</th>
<th>n (%) of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM</td>
<td>263 (71.7)</td>
</tr>
<tr>
<td>FP</td>
<td>83 (22.6)</td>
</tr>
<tr>
<td>GP</td>
<td>14 (3.8)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (1.9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>n (%) of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>115 (31.3)</td>
</tr>
<tr>
<td>Chinese</td>
<td>66 (18.0)</td>
</tr>
<tr>
<td>Filipino</td>
<td>28 (7.5)</td>
</tr>
<tr>
<td>Japanese</td>
<td>96 (25.9)</td>
</tr>
<tr>
<td>Hawaiian</td>
<td>21 (5.7)</td>
</tr>
<tr>
<td>Other</td>
<td>14 (3.8)</td>
</tr>
<tr>
<td>Missing data</td>
<td>10 (2.7)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th>n (%) of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhist</td>
<td>37 (10.1)</td>
</tr>
<tr>
<td>Catholic</td>
<td>69 (18.6)</td>
</tr>
<tr>
<td>Other Christian</td>
<td>135 (36.8)</td>
</tr>
<tr>
<td>Other religion</td>
<td>55 (15.3)</td>
</tr>
<tr>
<td>No religion</td>
<td>33 (9.0)</td>
</tr>
<tr>
<td>Missing data</td>
<td>37 (10.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average years in practice</th>
<th>18.4 (range 1-64)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Place of practice</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td>32 (8.7)</td>
</tr>
<tr>
<td>Private office</td>
<td>272 (74.1)</td>
</tr>
<tr>
<td>In-HMO</td>
<td>46 (12.7)</td>
</tr>
<tr>
<td>Acute or LTC setting</td>
<td>35 (9.5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># terminally-ill patients cared for in past year</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>37 (10.1)</td>
</tr>
<tr>
<td>1-4</td>
<td>96 (26.1)</td>
</tr>
<tr>
<td>5-14</td>
<td>162 (44.1)</td>
</tr>
<tr>
<td>15+</td>
<td>63 (17.2)</td>
</tr>
<tr>
<td>Missing data</td>
<td>9 (2.4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mean percent of deaths in each setting</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>34.3</td>
</tr>
<tr>
<td>Nursing/care home</td>
<td>28.4</td>
</tr>
<tr>
<td>Acute care</td>
<td>46.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of patients who died under hospice</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td>174 (49.2)</td>
</tr>
<tr>
<td>25-49</td>
<td>61 (17.2)</td>
</tr>
<tr>
<td>50-75</td>
<td>50 (14.1)</td>
</tr>
<tr>
<td>&gt;75</td>
<td>24 (6.8)</td>
</tr>
<tr>
<td>Missing data</td>
<td>45 (12.7)</td>
</tr>
</tbody>
</table>

| Family conflict about best course of action | 264 (71.9) |
| Patient/family discomfort with or fear of death | 260 (70.8) |
| Cultural or religious beliefs of patient or family | 172 (46.9) |
| Provider time constraint | 96 (26.2) |
| Financial barrier | 133 (36.2) |
| Patient | 75 (20.4) |
| Provider discomfort with or fear of death | 112 (30.5) |
| Language barrier | 73 (19.9) |
| Lack of continuity of care across settings | 97 (26.7) |
| Lack of provider knowledge of hospice and palliative care | 92 (25.1) |
| Fear of litigation | 81 (22.1) |
| Lack of hospice and palliative care services | 71 (19.3) |

Training and Knowledge Questions

Overall, 57% of respondents stated that they had received training in end-of-life care in one or more settings, most frequently through Continuing Medical Education but also through medical school or residency/fellowship opportunities. Only 20% (5%) reported having attended the AMA-sponsored program EPEC (Educating Physicians in End-of-Life Care), offered several times a year in Hawaii. The most preferred way to receive information about advances in medicine and healthcare was through journals (42%), followed by 1-hour lunch meetings (33%), seminars (19.3%), internet (10.4%), and CD-Rom (6%). About two-thirds said they were familiar with the 1999 changes in Hawaii law concerning advance directives and healthcare instructions.
Support of Physician-Assisted Suicide (PAS) and Physician-Assisted Death (PAD)

Support for the concepts of PAS and PAD are shown in Table 4. Overall, 32% of respondents supported PAS (providing a competent, dying patient who requests it with a prescription for medicine for the patient to use with the primary intention of ending his/her own life) and 18% supported PAD (giving a competent dying patient who requests it a lethal injection with the primary intention of ending the patient’s life).

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Support PAS</th>
<th>Support PAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian (n=115)</td>
<td>51 (44.3%)</td>
<td>24 (20.9%)</td>
</tr>
<tr>
<td>Chinese (n=66)</td>
<td>20 (30.3%)</td>
<td>13 (19.7%)</td>
</tr>
<tr>
<td>Filipino (n=28)</td>
<td>2 (7.1%)</td>
<td>1 (3.6%)</td>
</tr>
<tr>
<td>Hawaiian (n=21)</td>
<td>6 (28.6%)</td>
<td>1 (4.8%)</td>
</tr>
<tr>
<td>Japanese (n=96)</td>
<td>28 (29.2%)</td>
<td>20 (20.8%)</td>
</tr>
<tr>
<td>Other/Mixed (n=31)</td>
<td>7 (22.6%)</td>
<td>6 (19.4%)</td>
</tr>
</tbody>
</table>

Nationally and locally, about two-thirds of consumers support PAD/PAS, whereas physician support rarely exceeds 40%. There is likely to be multiple reasons why physicians are less supportive of PAS/PAD than consumers. But if consumer support is being driven by consumer fear of poor end-of-life care, physicians will need to join efforts to improve care for the dying.

A method for improving care is to increase physician-consumer dialogue about end-of-life preferences, and to start these discussions before a patient has a health crisis. Physicians are expected to initiate this dialogue for two reasons. First, physicians see end-of-life care as their domain. In a national study of physicians associated with the Veterans Administration system, 82% felt they should be responsible for starting discussions about end-of-life preferences and, in the current survey, 95% of Hawaii physicians said that the physician should be the first to tell a patient he/she is dying. Second, consumers want their physicians to initiate this discussion, and prefer to have it initiated when they are middle-aged and not yet critically ill. Unfortunately, only 35% of our respondents concurred that middle age was the preferred time to begin discussions about preferences. Fully 15% felt they should wait to discuss end-of-life preferences until the patient was close to death (6 months or less) or very near death, and another 18% would wait until the patient was diagnosed with a serious illness.

Family conflict was seen as a major barrier to talking about preferences and providing good end-of-life care. However, if preferences are discussed and a surrogate is appointed early (before a health crisis occurs), perhaps conflict can be avoided or diminished. Hawaii’s 1999 advance directive law (of which only 66% of our respondents were aware) includes a fine against the physician who does not follow a patient’s expressed wishes, regardless of a family’s threats. There will still be cases in which individuals, once ill, may change their minds about a course of action, but the new law allows new preferences to be documented and a new proxy to be appointed. Some family conflict will still occur, and physicians will need to be honest about the dying process and stress that “doing everything” will not change the final outcome and may, in fact, be burdensome and painful to the dying person.

Efforts to increase physician skills in communicating with patients about end-of-life issues are already underway. Nationally, principles for care of patients at the end of life, developed in 1997 by 13 organizations including the American Medical Association (AMA) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), are in the process of being adapted and adopted by specialty groups. The AMA has produced a continuing education program, Educating Physicians on End-of-Life Care, which is offered several times a year in Hawaii. The U.H. John A. Burns School of Medicine requires its first-year students to rotate through hospice and is incorporating more training in patient communication, end-of-life care, and bioethics into its curriculum. The current survey, which found an association between recent graduation from medical school and use of hospice provides evidence for the effectiveness of early training in end-of-life care. It was also gratifying that provider discomfort with or fear of death was not perceived to be a large barrier; only 25% saw it as a barrier to talking about preferences and only 31% saw it as a barrier to providing good end-of-life care.

Even when advance directives are in place and discussions have
occurred, the literature notes that the actual decision making that precedes death is more complicated than just following documented preferences. An article presenting a “rethinking” of the SUPPORT findings lists four reasons why this is so.³⁰ First, patient preferences are not stable; rather they evolve as patients confront new situations and new information is received. Second, many decisions get made in the course of patient care, and it is in retrospect, usually, that a particular set of decisions is seen as pivotal in precipitating the unnecessarily painful or prolonged death. Third, for hospital-based patients, players (patients, families and physicians) tend to go along with “the program” rather than advocate for less aggressive care, and families tend to feel guilty if they do not ask for everything to be done for the dying person. Finally, the SUPPORT investigators now doubt their hypothesis that players want to, or are able to, make care decisions based on prognostic estimates and preferences of a specific patient. Rather, it is more likely that role expectations for doctors and families to do everything to save the life of the patient will prevail.

Thus, the SUPPORT investigators join with other authors to suggest that drastic improvements in end-of-life care may only occur with changes to the structure and financing of care. There is a recognition that the medical culture and the health care environment encourage heroic and aggressive treatment, and that financial incentives often motivate hospitals and doctors to provide invasive interventions to dying patients whether they want them or not, quite in contrast to the model of palliative care where patients are allowed to die in peace and with dignity.⁶,³³,³⁰

Despite this growing recognition of systems barriers to good end-of-life care, it is interesting that the top three barriers for Hawaii physicians were patient/family-related. The survey queried about several potential systems barriers. However, only 20% of physicians felt that lack of reimbursement was a barrier to talking about end-of-life preferences. In relation to providing good end-of-life care, only 36% of physicians saw a patient’s financial constraints and only 22% saw fear of litigation as barriers. In the era of managed care, not surprisingly, 38% found time constraints as a barrier to talking about end-of-life preferences with patients and 26% identified that to be a significant barrier in providing good care. As patients with critical illnesses have multiple specialists caring for them, 26% found lack of continuity of care across settings as a barrier. Although the state is served by seven hospice organizations, 19% of respondents felt that lack of hospice and palliative care services was a significant barrier to providing good care.

Returning to the top three barriers, however, Hawaii physicians reported that patient/family discomfort with death and their cultural/religious beliefs challenged physician ability to talk about and provide end-of-life care. In fact, previous surveys of Hawaii consumers have noted significant ethnic and religious differences in willingness to talk about death, completion of advance directives, preference for place of death, desire for hospice care, and support of PAS and PAD.²⁴,²³ Ethnic and religious differences in support of PAS and PAD were seen for physicians as well. Again, the only way to reduce these barriers is to learn more about cultural and religious beliefs in general, through reading and talking with representatives of those cultures/religions, and to learn more about specific patient/family beliefs by talking to them.²⁷ The issue of cultural difference also raises issues for the legalization of PAS and PAD. Studies from across the country have found that support for these end-of-life options associates significantly with physician characteristics (ethnicity, religion, age, specialty) and attitudes.³⁰,²º Based on this finding, many warn that legalization of PAS and PAD will “open the door to abuses of vulnerable patients on the basis of age, poverty, mental disorders, or lack of resources for palliative care.”¹¹,¹³,¹³

Our study was limited by its relatively low response rate (46%), especially given the efforts taken to follow-up with nonrespondents. Other studies of physician support for PAS/PAD enjoyed response rates in the range of 60-80%.⁴,¹³,²⁰,²² Similarly to other authors, we were unable to test differences between respondents and nonrespondents. It is likely, however, that respondents to the Hawaii survey were more aware of and interested in palliative care approaches than nonrespondents. This is evidenced by the unexpectedly high rate in-home death reported by our respondents. Specifically, respondents said that, on average, 34% of their patients died at home and only 47% of their patients died in the hospital. Data reported by the Department of Health, in contrast, note that only 21% of deaths occur at home and that 63% occur in the hospital.

It is likely that efforts on several fronts will be required to improve care to the dying and, perhaps, reduce consumer support for physician aid in dying. Health professionals need to initiate dialogues with their patients, consumers need to discuss these issues with family members and choose surrogates, and structural changes to health care financing and standards will need to be made. Given that Hawaii physicians’ top three barriers to improving end-of-life care were patient/family-related (conflict, discomfort/fear of death, cultural/religious beliefs), a good place to start is with dialogue and discussion. Educational efforts that facilitate communication must be supported.

Acknowledgments

This survey was conducted under the John A. Hartford/American Federation for Aging Research, Medical Students Geriatric Scholars Program directed by Patricia L. Blanchette, MD, MPH, Professor and Director of the Geriatric Medicine Program, John A. Burns School of Medicine (JABSOM). Additional funding was provided by the Office of Public Health Studies, JABSOM. Acknowledgments are tendered to Kamal Masaki, MD and Victor Valcuro, MD of JABSOM’s Geriatric Medicine Program for their mentorship and support, to Becky Kendro of the Hawaii Medical Association for access to their database, and to Carol Matsumiya of the U.H. Center on Aging for administrative assistance. Special thanks to Drs. Len Howard, Carol Joseph, Richard Kasuya, Anthony Lenzner, Glen Rediger, Damon Sakai, and Seiji Yamada who assisted in pretesting the survey.

References


Continues on p. 47
Mammograms
Not just once, but for a lifetime

The National Cancer Institute has free booklets about breast cancer screening. For answers to your questions about cancer and to order these publications, call NCI’s Cancer Information Service at 1-800-4-CANCER (1-800-422-6237).

Persons with TTY equipment, dial 1-800-332-8615.

Visit NCI’s website for patients and the public at http://rex.nci.nih.gov
Potpourri I...

Giving a sermon one Sunday, I heard two teenage girls in the back giggling and disturbing the people. I interrupted my sermon and announced sternly, “There are two of you here who have not heard a word I’ve said.” That quieted them down...

When the service was over, I went to greet people at the front door. Three adults apologized for going to sleep in church, promising it would never happen again...

Rev William Ross

The husband of one of my OB patients phoned the doctor to ask if it would be OK to make love to his wife while taking medication for an infected foot.

“Yes, that’s fine,” the doctor replied. “Just don’t use your foot.”

Sabrina Henderson

I feel inadequate when talking to a mechanic, so when my car started making a strange noise, I sought the help of a friend who drove the car around the block, listened carefully, and then told me how to explain the difficulty when I took it in for repair.

At the shop, I proudly recited, “The timing is off and there are premature detonations, which may damage the valves.”

As I smugly glanced over the mechanic’s shoulder, I saw him write on his clipboard, “Ladys says it makes a funny noise.”

Potpourri II...

Quick Thinking...

A resident I trained with many years ago was known for his resourcefulness and quick thinking...

One day he was injecting the dye for an IV pyelogram when almost halfway through, he realized the injection had gone “interstitial.”

Without hesitation, he moved to the other arm and started injecting while making the following statement: “And now for the other kidney.”

Dr. Gabriel Thomassae

“Stitches” Sept 2000

As a passenger ship passed a small island, a bearded man could be seen shouting and furiously waving his arms... “What is that?” a passenger asked the captain. “I have no idea,” the captain replied. “But every year when we pass, he goes nuts.”

“Playboy Party Jokes” Sept 2000

The doctor looked up from his papers and said, “I have some good news and some bad news.”

“Well, give me the good news first,” the patient said...

“We’re going to name a new disease after you.”

“Mommy, what’s an orgasm?” the little boy asked.

“I don’t know dear,” the woman replied. “Ask your father.”

Potpourri III...

A married couple was driving down the interstate when the wife said, “Herb, I want a divorce.” The husband said nothing but slowly increased his speed...

“I’ve been having an affair with your best friend,” she continued. “And he’s a better lover than you are. I want the house, the kids, the car, the checking account and the credit cards. Is there anything you want?” she finally asked.

“No, I have everything I need.”

“You do?” she asked wondering...

“Just before they hit the wall at 90 mph he replied, “Yep, I’ve got the air bag.”

Hearing about a dinosaur alive in the rain forests of South America, a professor launched a scientific expedition. After several weeks he stumbles upon a little man clad in loin cloth and standing next to a 300 foot long dead dinosaur...

“Did you kill the dinosaur?” the scientist asked...

“Yup,” replied the rain forest native...

“But it’s so big and you’re so small! How did you kill it?”

“With my club,” the primitive fellow answers...

“How big is your club?”

The little man replies, “Well, there are about 100 of us.”

Q. “How many chiropractors does it take to change a light bulb?”

A. “Only one, but it takes six visits.”

“What makes a man so smart during sex?”

“He’s plugged into a genius.”

Potpourri IV...

An asteroid hits the speakers platform at a Seattle center... Al Gore, George W. Bush and Bill Gates all arrive in Heaven at the same time. They are greeted by God on his golden throne... who first asks Gore what he believes in... “I believe in the Internet and a clean environment.” “Very good,” says the almighty. “Come sit near me.” Then he asks George Bush the same question, “I believe in cutting taxes and taking good care of the military.”


During medical rounds, the attending pointed to an Xray and asked the intern, “As you can see, the patient looks because his left fibula and tibia are both radially arched. Michael, what would you do in a case like this?”

“Well,” pondered the intern, “I suppose I’d limp too.”

Potpourri V...

The doctor noted that his patient had the smallest penis he’d ever seen...

“Do you have any difficulties because of the size?” he asked.

“No,” the guy said. “I have a great wife and three kids. The only problem I have is finding it when I need to pee...

“And your sex life is normal?”

“Of course,” he replied, “because then there are two of us looking for it.”

As he strolled a crowded street fair, the man came upon a palm reader...

“First I’ll read your love line and tell your romantic future,” she said. The man paid the money and the reader looked at his palm...

“I see you don’t have a girl friend.”

“That’s true,” he replied...

Examining his hand further, the seer remarked, “You are extremely lonely.”

“Yes, that’s true,” the man admitted. “You can tell all that from my love line.”

“No, dearie,” she said, “from the calluses.”

A drunk stumbled upon a baptismal service by the river...

“Son, are you ready to find Jesus?” the cleric asked.

“Yes, Preacher, I sure am.”

The minister drenched the fellow under the water and pulled him back up.

“Have you found Jesus?” "No I haven’t" the drunk replied.

The preacher drenched him again for a bit longer.

“Now, brother, have you found Jesus?” "No, not yet Reverend.”

The preacher held him down for a full minute this time. “Have you found Jesus now?”

Gasping for air, the fellow blurted, “Are you sure this is where he fell in?”

Continues on next page
Medical Tidbits I...

Herb Watch

The popular herb echinacea (distant cousin of the ragweed) can produce a severe allergic reaction. Dr. Raymond Mullins (from Australia) reported to the American Academy of Allergy, Asthma and Immunology that echinacea may be responsible for hives, acute asthma or anaphylaxis...

Blood Pressure Alert

The National Heart, Lung & Blood Institute (NHLBI) had to stop its study when one of the drugs was significantly less effective in reducing cardiovascular disease... CARDURA (the alpha blocker dexazosin) had 25% more cardiovascular events and patients were twice as likely to be hospitalized for heart failure...

NHLBI advises that hypertensive patients on alpha blockers (including Hytrin and Minipres) should see their physicians for alternative drugs.

Medical Tidbits II...

Acute respiratory distress syndrome usually occurs in pneumonia, but can also occur in trauma patients, eg auto accidents and patients who had complications in major surgery...

Each year, an estimated 100,000 patients of all ages develop this syndrome and about 1/2 die... A new study shows that physicians in ICU may be able to save many such patients in ICU by lowering the respirator rate...

Thomas Stewart, director of ICU at Mount Sinai, however, says, "Lowering the airway pressure may not be the best treatment for all conditions....."

References, continued from p. 44

otherwise might catch us “off guard”), such training, properly applied, can actually help prevent the emotional “burnout” which could arise from caring for patients in any medical specialty.

Opportunities for graduate medical training at the University of Hawai‘i are available to students interested in a psychiatric career. Responsive to community’s needs, the Department of Psychiatry offers accredited residency programs in general psychiatry as well as in three out of the four psychiatric subspecialties recognized by the American Board of Medical Specialties, child and adolescent, geriatric, and addiction. The University of Hawai‘i is also one of ten programs in the country offering a combined program leading to certification in the specialties of general pediatrics, general psychiatry, and child and adolescent psychiatry. This program strives to train physicians who can improve access to both primary care and mental health care for children and families, especially those who are currently underserved.

Above all, through enthusiasm, example, and mentorship (reaching out to all students, especially those from culturally diverse backgrounds), the faculty strives to be persuasive, rather than coercive, in introducing students to the virtues of psychiatry.

References:
1. Schroeder SA. Improving the health of the American public requires a broad research agenda. Acad Med. 1999;74:530-531
Remember, Inside Every Silver Lining There’s A Dark Cloud.

Already we are in the new year, and the real beginning of the new millennium, as the last days of the 20th century drift into painful-election memory. Good news arrived from the American Academy of Ophthalmology telling us that persistent efforts have increased the 2001 Medicare Fee Schedule conversion factor by 4.5%. Also, changes in practice expense data submitted to HCFA early last year were accepted with positive changes for ophthalmology services. Of course, there is still no recognition that everyone practicing medicine in Hawaii has to accept a 4.17% gross excise tax liability for the privilege of working for our Democrat-run state government.

Okay! Let’s Hear It For The Learned Intermediary?

Historically, pharmaceutical houses have been shielded from litigation for adverse effects from their products under the umbrella of the physician as the “learned intermediary.” The term originated in a 1966 legal case in which a patient suffered retinal damage from chloroquine. The legal ruling established a responsibility tree in which drug companies warn physicians about adverse effects, and physicians must serve as “learned intermediaries” to properly inform patients. Now this doctrine has been significantly altered. In the decision of Perez vs. Wyeth Labs., Inc., the New Jersey Supreme Court ruled that drug companies have no legal obligation to warn about possible side effects does not apply when companies engage in direct-to-consumer advertising. The Court said that the effect of direct advertising of prescription drugs, means that physicians are often relegated to a passive role, and patients become actively involved in the decision to use a medication such as birth control pills, asthma or GI medications, drugs for erectile dysfunction, etc. While some doctors may be pleased that pharmaceutical houses now must share legal burdens, what it also illustrates is that the role of physician is further diminished in providing appropriate medical care.

If You Live To Be A Hundred, Your Lucky Number Goes Up By One.

Eye surgeons have seldom been reluctant to perform eye surgery on patients over 100 years, relying primarily on patients’ needs, cerebration and compliance, to determine necessity. But how old is too old for anesthesia and for invasive procedures, major elective or emergency surgery? In a retrospective analysis of surgery on centenarians since 1993 at Methodist Hospital in Brooklyn, N.Y., involving 61 patients averaging 101.5 years (the oldest 111 years), the century mark did not prove a barrier. The mortality rate was 15%, while 51% were discharged to nursing homes, 30% to home health care, and 4% entered rehabilitation. Procedures included orthopedic, gastrointestinal, percutaneous gastroscopies, surgical endoscopies, and 28 other types of operations.

Come Here Kid! You Want Boobs, Big Muscles And Small Cojones?

Following the admission by Mark McGwire, baseball’s home run king, that he takesandrostenedione, an over-the-counter “dietary supplement,” (banned by the NCAA, the NFL, the NBA, and Olympic games) kids have been taking the drug. Supposedly, andro is converted to testosterone in the body which builds muscles, but also has the side effect of facial hair growth and breast enlargement. Moreover, harmful effects can range from liver damage to hypertension and testicular atrophy. Just what you want for growing boys. An additional endocrine threat was noted in the 1999 survey by the group Monitoring the Future, which found that some 8th grade boys are using anabolic steroids! Although such drugs require a prescription, they are fairly easy to obtain underground. These athletes are really acting as their own guinea pigs in their efforts to build muscles. Many of those 250 and 300 lb high school football players bench pressing huge weights, didn’t get that way naturally. Sadly, parents are often not aware that their offspring are taking muscle building drugs. My personal bias is that what eighteen-year-olds need is two years of universal military training. Look what it did for President Clinton —— oh, never mind.

Every Decent Man Is Ashamed Of The Government He Lives Under.

In an end-run around Congress, the Occupational Safety and Health Administration (OSHA) has come up with a new set of rules that will cost businesses billions of dollars a year. The claim is that new ergonomic standards for employers are needed to protect workers from job-related injuries. Such issues as soft tissue problems like carpal tunnel syndrome, aching backs and sore tendons are the targets. A handful of business groups filed suit to block the rules with the claim that OSHA coached paid experts on what to say at the public hearings, and didn’t provide enough time for public comment. Congress made known its opposition to the standards by voting to keep them off the books until October 1, 2001, but that’s not enough to stop the Clinton administration. By executive order Clinton will add 1600 OSHA pages to the federal register. According to the Employment Policy Foundation, businesses will spend an average of $780 per employee to bring work stations into compliance. Meanwhile, OSHA’s own data reveal that ergonomic complaints have dropped from 3 million to 2 million per year since 1992 while lost work days dropped from 750,000 to 500,000 in the same period. Is this a last Clinton bone thrown to the unions who support these rules? What else?

When The Pilot Says Slight Delay Get Out Your Pillow.

Honolulu is not bad, and Kahului is very good, but for some major cities on the mainland, flight delays due to “taxi-out” time are large and growing. Nationwide, the number of delays has increased by 16% in the last four years. In 1999, 40,000 flights were delayed more than one hour after leaving the gate, and 264 flights waited on the tarmac for more than four hours before departure!! Newark, New York, Philadelphia and Chicago were the major offenders, sometimes due to weather, but also frequently due to logistics. Planes must move out of gates to allow space for incoming flights, then must park on the taxiway and wait for clearance from air traffic controllers.

Drive The Legal Speed limit, And Watch The Rest Of The World Roll by.

A recent study by the Insurance Institute for Highway Safety found that SUVs and pickup trucks have relatively high driver death rates in one-vehicle rollovers, which are due in large part to their high centers of gravity (not to mention Firestone tires). The statistics are somewhat skewed because they don’t include other variables (age, sex, alcohol use, etc.), but death in an auto crash may depend on the vehicle you are driving. The most dangerous vehicles for driver death are Chevrolet Camaro, Pontiac Firebird, and Ford Explorer. Passenger vans get the best rates, led by Nissan Quest, Ford Windstar, and Dodge Caravan with the lowest death rates.

To Avoid Paying Taxes, Run For Congress.

According to IRS data, members of Congress and their staffs owe about $10.5 million in back taxes. In October 1999, the nonpayment rate for the House was 8%, and for the Senate 7%. IRS employees can be dismissed for not paying taxes, but no such rule exists for politicians. The balance of income tax owed by all federal employees is estimated at $2.4 billion.

Computers Can Never Replace Real Human Stupidity.

And an example of school rules gone more than slightly berserk, in Sayreville, New Jersey, officials suspended four kindergarten children who were caught playing cops and robbers. They were using their fingers for guns and said they were shooting at one another. That violated the school’s zero tolerance policy toward weapons, and the sinners were sent home for three days!

ADDENDA
• On September 19, 1890, for the very first time, rubber gloves were used during surgery at Johns Hopkins University Hospital.
• 46% of Americans say they are being left behind by technology. Of these, 16% say they don’t care.
• If you eat beans with your Viagra you get a stiff wind.

Aloha and keep the faith ——— www.hawaiiophthalmologicalsociety.org
the scope of the book. Alternatively, many topic headings contain only one quotation. Most of these are obscure disorders or have marginal relevance to medicine. However, those searching for quotations about headaches or impotence, for example, might expect to find more on these subjects.

*Medicine in Quotations* is not the first book of its kind; at least three others have been published, most notably *Familiar Medical Quotations* by Maurice Strauss. As the editors explain in their introduction, this latest effort improves on its predecessors by including more recent quotations, a more detailed history of medical concepts, and more precise citations. Moreover, the book is extremely easy to navigate because the editors have taken pains to explain its arrangement and supply two exhaustive indexes, arranged by subject and author-citation.

Relying too heavily on these extensive reference tools, however, could detract from the reader’s enjoyment of the book. Exciting and unexpected discoveries await those who read it haphazardly, and the search for a quotation under a particular topic heading can easily turn into an hour’s reading of unrelated subjects.

*Medicine in Quotations* is a boon to medical writers, who will find within its pages a ready source of leads, interesting and amusing asides, and dramatic endings for their writing. Those who linger (and it is difficult not to) will also find that their knowledge and understanding of medical history and current issues is expanded as well. Physicians will encounter a steady stream of clinical descriptions, both historic and modern, intermingled with admonitions and affirmations regarding their profession. These selections are sometimes reassuring, sometimes challenging, and occasionally unsettling. Entries under the same topic heading often contain contradictory views, inviting readers to form or reform their own opinions.

As Norman Moore wrote in 1893 (what review of a book of quotations would be complete without a quotation?), “The true use of reading in medicine is to make him think.... Perfect knowledge is that which has been thought over; imperfect knowledge that which has only been remembered.”

**Dawn Chalaire**

*Dawn Chalaire is an Associate Scientific Editor in the Scientific Publications Office and the Managing Editor for the University of Texas M. D. Anderson Cancer Center’s Physicians Newsletter.*

---

**Adjunct Faculty/Staff Members, If Signed and Returned Prior to March 1st, Will Be Eligible for a Complimentary Subscription to *Science & Medicine* for 1 Year.**

---

**Classified Notices**

To place a classified notice:

- **HMA members:** Please send a signed and type-written ad to the HMA office. As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMAJ 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.

**Physician Wanted**

**BIG ISLAND OF HAWAII—** Multi-specialty group practice seeking BC/BE OB/Gyn to service community of 35,000+ in breathtaking upcountry setting. Waimea is 15-20 minutes from beautiful uncrowded beaches and world class golf courses. Various start-up options available with partnership potential. Contact Linda (808) 885-9606 or fax (808) 885-9506. Aloha!

**Locum Tenens**

**LOCUM TENENS—** Board Certified FP available for the summer. Locum Tenens office coverage. Please call Vadim Bralavsky, MD (913) 685-7494 or visit [www.concentric.net/~locumd/1.htm](http://www.concentric.net/~locumd/1.htm).

**Aloha Laboratories, Inc.**

...When results count

**CAP accredited laboratory specializing in Anatomic Pathology Quality and Service**

**David M. Amberger, M.D. Laboratory Directory**

Phone: (808) 842-6600  
Fax: (808) 848-0663  
E-Mail: results@alohalabs.com  
http://www.alohalabs.com
Our pledge to you

As Straub physicians, we welcome your referrals... and pledge to:

• Report our evaluation to you promptly by phone, fax or mail (whatever you prefer).

• Never make secondary referrals without your approval.

• Always direct the patient back to you for continuing care.

To make your referrals easy, we have a Physician Referral Specialist, Kym Kaohi. To contact Kym and to get a binder on Straub specialists and services, call 522-4444.

Straub
Partners in health
straubhealth.com

For assistance, call Kym at 522-4444
Take the high road
When choosing professional liability insurance.

MIEC

Medical Insurance Exchange of California
6250 Claremont Avenue
Oakland, California 94618
800-227-4527
www.miec.com

Hawaii Claims Office:
1360 South Beretania Street,
Honolulu, Hawaii 96814

Rated "A" (Excellent) by A.M. Best

Sponsored by the Hawaii Medical Association

THE SAFEST ROUTE IS
WITH AN EXPERIENCED GUIDE.

In Hawaii, that's MIEC. We are the
West's first physician-owned, not-for-profit
professional liability insurer. For more than
a quarter century, we've protected
doctors with financially secure coverage.
We're also known for our unsurpassed,
consistent track record of returning
dividend credits to policyholders,
when operating results permit. We've
returned over $200 million.

Professional liability insurance is a
long-term business relationship. At MIEC,
we take this commitment seriously.

Choose the genuine original, MIEC.