HAWAII MEDICAL JOURNAL

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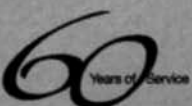

Choices for a Healthier Hawaii

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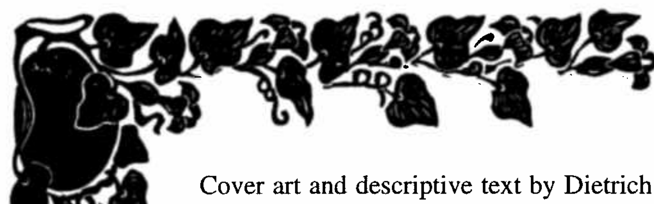

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Ē Wa'a Ē

Depicting the Hawaiian canoe (wa'a) and related ceremonial as well as utilitarian functional paraphanalia.

A Call to Physician Authors

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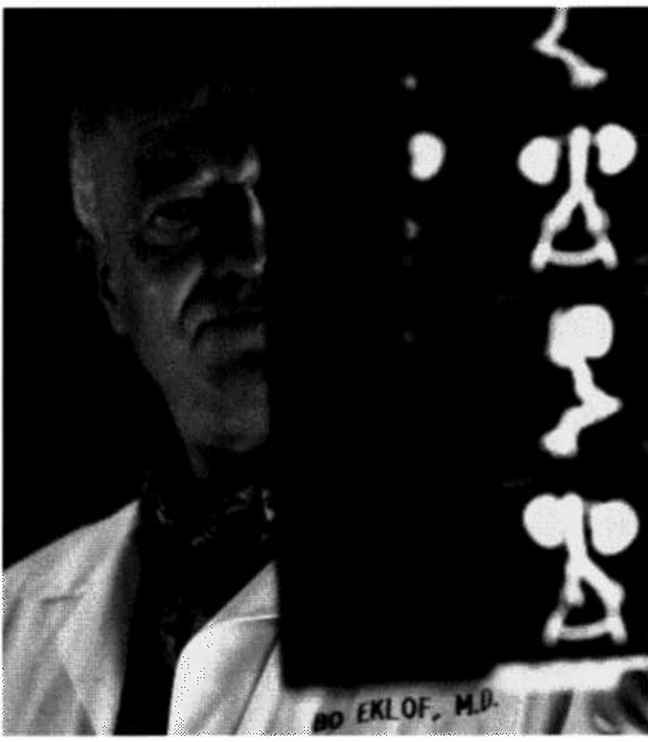

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– Friday Noon Conference –

Environment of Care Trends for the 90's: "An Abbreviated Study of Issues Which Impact the Environment of Care for Patients and Employees

Kevin Matsukado, Rose Arpon, Clayton Takara and Michelle Fisher

June 19, 1998, 12:30 - 1:30 p.m.

Doctors Dining Room

Learning Objectives

At the conclusion, participants will be able to:

- Describe specific environment of care issues that may impact daily practice.
- Understand and identify infection control, tuberculosis and bloodborne pathogens.
- Summarize radiation safety, hazard communications, fire safety, chemical spills, body mechanics and general safety.

– Friday Noon Conference –

Luncheon

Update in Prostate Cancer Screening

Stephen K. B. Chinn, MD

July 17, 1998, 12:30 - 1:30 p.m.

Doctors Dining Room

Learning Objectives

At the conclusion, participants will be able to:

- Review of pros/cons of prostate cancer screening.
- Summarize results to date of prostate cancer screening.
- Describe new screening tests for prostate cancer.

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

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

Editorial

Governor's Blue-Ribbon Panel on Living and Dying with Dignity

Norman Goldstein MD, Editor

After a year-and-a-half of monthly meetings, the Governor's Blue-Ribbon Panel on Living and Dying with Dignity completed its report to the Governor on May 11, 1998. The Panel approved unanimously the following six recommendations.

1. That spiritual counseling be made more available to individuals who are afflicted with life-threatening illnesses by integrating those services more fully into the healthcare system.
2. That the public and healthcare professional education programs be designed and implemented to increase awareness of the choices available to the dying.
3. That the content of Advance Directives for Healthcare including living wills be made more specific, their use more widespread and their provisions more binding.
4. That hospice care be made more available and offered more expediently to the dying.
5. That effective pain management and other symptom control programs be required in all licensed healthcare institutions.
6. That involuntary euthanasia should continue to be a crime.

Because we in Hawaii live in a pluralistic society with many religious and cultural perspectives, it is important that no one perspective be allowed to impose its beliefs and mores on another. The Panel was not unanimous in its opinion on two major options to be presented to the Governor and our next Legislature:

- Physician-Assisted Suicide (PAS) - the physician provides the agent with which the patient ends his or her life.
- Physician-Assisted Death (PAD) - the physician actually participates in the administration of a lethal agent with the intent to cause the death of the patient.

With strict controls so that there will be no reasonable fear of a "slippery slope" down which patients may be pushed against their will, Doctor-Assisted Death with Dignity - DADD (my preferred term) would provide legal means for assisted death. As in Switzerland and the Netherlands, many voters who have chosen DADD do not in the end actually use their legal right, but they do have the choice. A ballot referendum in Hawaii would permit residents to cast their vote on this important issue.

The Gallup organization recently did a survey based on telephone interviews with 1,200 adult Americans,[1] and found that we:

Support making it legal under a wide variety of specific circumstances - 33%
Support making it legal in a few cases but oppose it in most circumstances - 31%
Oppose making it legal for any reason - 31%
Don't know or refused to answer - 3%

George Gallup, Jr. presented survey results:

- **The Clergy:** The survey is a wake-up call for the clergy. Not many see the clergy as capable of providing broad spiritual support.
- **The Family:** Throughout the study, the family emerged as a central source of comfort and support. This suggests a strong need, in turn, to support the family. Hospice care is one important means of supporting the family.
- **Young Adults:** The survey uncovers a strong need among younger people to understand what lies ahead. The level and breadth of the concern young people expressed about death calls for a response from those who care about and work with them.
- **The Medical Profession:** The study suggests that medical education should prepare physicians to engage the human, spiritual dimensions of the dying process as well as its clinical realities; and overall, to understand and integrate the spiritual beliefs that so often guide their patients.

The New England Journal of Medicine (the other peer-reviewed medical journal) published a special article on "a national survey of physician-assisted suicide and euthanasia in the United States."[2] Questionnaires were mailed to a stratified probability sample of 3,102 physicians in the ten specialties in which doctors are most likely to receive requests from patients for assistance with suicide or euthanasia. The authors received 1,902 replies (61%). They reported that about 6% of the physicians actually complied with their parents' requests at least once. The *New England Journal of Medicine* Survey results follow:

39% would write a prescription for a lethal dose of medication if legal
11% would write a prescription under current legal constraints
18% have received a request for assistance
3.3% have written a prescription for a lethal dose of medication
24% would give a lethal injection if legal
7% would give a lethal injection under current legal constraints
11% have received a request for a lethal injection
4.7% have given a lethal injection

On March 24, 1998, the *Honolulu Star-Bulletin* published the results of a telephone survey done for the newspaper and the NBC News 8 TV station between March 12 - 17, 1998. 419 registered voters statewide were asked the question, "Would you favor or oppose a law which would permit physician-assisted death under carefully controlled circumstances in Hawaii?"

Favor 281 - 67.1%
Oppose 82 - 19.6%
No sure 56 - 13.4%
Total 419 - 100%

The Hawaii Medical Association president, Leonard Howard, asked for a ballot of physicians in the February 1998 *Hawaii*

Continued on Next Page

Medical News. All that was required was one check mark and a signature.

[ ] I support legislation preventing physician-assisted suicide
[ ] I support legislation legalizing physician-assisted suicide

Out of 1,900 ballots sent out, only 36 responded: 21 opposing and 15 in favor. Judging by the comments made to me in hospital halls, at medical meetings, and on the phone, physicians in Hawaii do have opinions on physician-assisted suicide - usually very firmly, but are reluctant to state their personal views for the record.

Thanks to Dr. Ann Catts for bringing the Gallup poll to my attention. Thanks also to the Blue-Ribbon Panel members, our diplomatic and tireless Chairman Hideto Konno, Marilyn Seely and her staff who kept us well-supplied with reams of documents, photocopies and references, and also kept our coffee cups full.

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1. Gallup, G.H. - "Spiritual Beliefs and the Dying Process: a Report in a National Survey," George H. Gallup International Institute, 1997.
2. Meier, D.E. et al - A National Survey of Physician-Assisted Suicide and Euthanasia in the United States, *N. Eng. Med.* 1998; 338: 1193-1201.

Father's Day Poem

Proud Father

I saw them standing there
It's been so many years—
Years of change and tears
Since I had seen them there.

Standing side by side,
Different postures each—
Those two I'd tried to teach
To stand tall side by side.

I'd longed to see them grin
As even now they did—
So little change since kids,
When I loved to see them grin.

Walking just ahead—
Both in blazers blue,
Clowning as they used to do—
Walking or jumping in bed.

I felt a father's pride
In two such handsome sons—
Collegiate work all done.
I felt a father's pride

As I saw them standing there.

Robert Swaim Flowers MD

Letters to the Editor

Aloha Dr Goldstein,

This is to thank you for your excellent and eloquent piece in Saturday's Star Bulletin.[1] It has been my observation that back during my nursing career I was expected to do to my patients things that might have gotten me arrested had I done them to another species of animal. Sad indeed that our patients are dying, tragic that they are forced to do so on the rack, shorn of their dignity and personalities.

I am appending a sonnet written by a family member on the occasion of his father's death due to intractible liver cancer—he chose to leave before the full horrors of hepatic illness descended on him—

Last Rites

"Now is the time," you said, as we three sat
Around your bed, the supper dishes done,
Your young, new wife, your sister and your son,
Just settled down for quiet evening chat.
"Now is the time," you said, making your great,
Last choice—ours to abet, yours to command—
The means beside you just as you had planned,
Resolved to die still managing your fate.
Mindful of Socrates, you took the draught,
The glass in your own hand, "Why so sad?"
You asked. "Sit close and let us all be glad
Together in our love." And so we laughed,
or tried to, holding hands until you slept.
Then we went to separate rooms and wept.

Name withheld at request of author, a registered nurse.

References

1. Goldstein, N, Letting Go with Dignity Can be Our Finest Hour. *Honolulu Star-Bulletin*, 1998 (Feb 14), B2.

Medical School Hotline

The John A Burns School of Medicine (JABSOM) Status Report on Finances and Contributions

Sherrel L. Hammar, M.D.
Interim Dean

1998 marks the 31st Anniversary of the University of Hawaii John A. Burns School of Medicine (JABSOM). Nearly every year, certain vocal segments of our community raise their clarions calls to partially or completely abolish the medical school. These groups fail to acknowledge how much this School contributes both to the health of Hawaii's people and to the economy of this state.

Students:

A vision of the late Governor John A. Burns made it possible for our diverse multi-cultural population of young people of Hawaii, from all socio-economic levels, to have an opportunity to achieve a professional education in Medicine. This medical school has been very successful in fulfilling this mission. Enrolled currently are 226 medical students, 271 post M.D. residents in training, 128 graduate students and 50 undergraduate students. The ethnic composition of each class represents the racial diversity of Hawaii. The first year class of 56 students is made up of 27 women and 29 men; 15 are Japanese, 9 Chinese, 7 Hawaiian, 6 Caucasian, 5 Filipino and 14 mixed ancestry. Forty-nine are Hawaii residents, two are from the mainland, four from Guam and one from Saipan. The majority of this class was selected from 1,228 applicants who graduated from some of the best mainland universities (42) and from UH Manoa (12). All have BA degrees, 8 have Masters degrees and 1 has a Ph.D. Many applied to JABSOM because of the Problem Based Learning Curriculum.

Currently there are over 1,500 JABSOM alumni. Nearly 60% of the physicians in Hawaii are either graduates of JABSOM, the UH Integrated Residency Programs or both.

Faculty:

The basic science faculty has been the hardest hit by retirements and resignations in recent years. In 1987-88, there were 70 full-time compensated faculty; presently there are 42 faculty. In the clinical departments there were 58 compensated full-time faculty in 1987-88. Currently there are 129 full-time compensated faculty. With the assistance of 1,139 volunteer faculty in the basic science and clinical departments, instruction of medical students are maintained at a high level. The Medical School has attracted and retained outstanding academic physicians to the faculty. These faculty and the graduates of residency programs have helped to raise the quality of medical care in this State.

Finances:

The Liaison Committee on Medical Education recently granted the medical school full accreditation but expressed grave concerns about its financial stability, particularly related to funds provided by the State. JABSOM has the reputation of being the most underfunded and understaffed medical school of the 125 U.S. and Canadian

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Do Hawaii Residents Support Physician-Assisted Death? A Comparison of Five Ethnic Groups

Kathryn L. Braun, DrPH*

Abstract

Surveyed were 250 adults in five ethnic groups—Caucasian, Chinese, Filipino, Hawaiian, and Japanese—on questions about physician-assisted death. When asked if there were any conditions under which physician-assisted death should be allowed, 52% said yes, 19% said perhaps, and 29% said no. Differences in response were seen, however, by ethnicity (with less support among Filipinos and Hawaiians), by religious affiliation (with less support among Catholics), and by educational attainment (with greater support among college graduates). Given the controversial nature of this topic, more public education and debate are needed. Meanwhile, physicians are urged to expand discussions with patients on their expectations about and options for end-of-life care.

Introduction

Several demographic and social trends are converging that make the issues surrounding death and dying very controversial. First, the population is aging, with life expectancy in Hawaii among the highest in the world: 76 for men and 82 for women.[1] Second, medical technology has advanced to the point of allowing us to greatly prolong life artificially, often at great cost and loss of life quality.[2] Third, the cost of health care continues to rise and various forms of health care rationing are being proposed.[3] Finally, we see increased attention to human rights and self-determination, even in dying. Taken together, these issues are forcing us to become more aware of the various options available for end-of-life decision making and advanced planning. While many citizens are advocating for more protection of their "right to die," perhaps an equal number of citizens are concerned about the establishment of policy to protect people from being coerced into refusing treatment or committing suicide.[2-4]

Over the past few decades, a number of surveys on attitudes toward euthanasia have been conducted. For example, in a 1977 study, 65% of white respondents indicated support for legalizing physician-assisted death; this percentage rose to 71% in 1989.[5] Since then, several states have taken the issue to their polling places and courts. The 1992 California Death with Dignity Act, a voter initiative to legalize physician-assisted death in that state, was defeated by voters by a 54% majority. However in 1994 and again in 1997, Oregon voters approved measures that would allow physicians to assist competent, terminally ill patients commit suicide. Meanwhile, court-upheld prohibitions on assisted death in Washington State and New York were sent to the Supreme Court, challenging the constitutionality of these prohibitions. The U.S. Supreme Court reviewed these cases together and, in June 1997, unanimously held that terminally ill people do not have a constitutional right to physician-assisted suicide. Specifically, the Court found that the New York and Washington state laws (that make it a crime for doctors to give life-ending drugs to mentally competent but terminally ill patients who no longer want to live) did not violate either the "due process clause" or the "equal protection rights" guaranteed under the 14th Amendment to the U.S. Constitution. The rulings in these cases, however, left room for continued debate and future policy initiatives at the state level.[6]

To help states that may want to develop guidelines for physician-assisted death, a nine-member panel of scholars from law, medicine, philosophy, and economics proposed a model statute for the regulation of legalized physician-assisted death.[7] The model act suggests that physician-assisted death be allowed for individuals who are at least 18 years of age, who have "a terminal illness or an intractable and unbearable illness" (as verified by the primary and a consulting physician), and who are mentally competent to make decisions. Assurances are required that the patient fully understands his/her prognosis and treatment (including palliative care options), that he/she has the opportunity to consult a social worker about available services, and that he/she be advised to inform his/her family. There must be documentation from a psychiatrist or psychiatric social worker that the request is not a result of "undue influence" or "a distortion of the patient's judgment due to clinical depression or any other mental illness." The request must be witnessed by at least two adults (one of which is unrelated and has nothing to gain by the death), "repeated without self-contradiction on two separate occasions at least 14 days apart," and recorded on paper, audiotape, or videotape.[7, 26-29]

Despite what appears to be growing support of the legalization of physician-assisted death, it is important to note that this concept does not carry the same appeal in all ethnic groups. For example, a number of authors have found that the level of support among African Americans is much lower than among white Americans, by as much as 20%.[5, 8-10] Given Hawaii's multi-cultural population, is it

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safe to assume that different cultures have different outlooks on this issue? In previous research by the author, focus groups and key informant interviews were conducted to begin exploring differences among Hawaii's ethnic groups on death practices and end-of-life issues.[11-12] Differences were seen among, and within, ethnic groups based on the respondent's religious beliefs, level of education, experience with artificial life prolongation in family members, and number of generations his/her family had been in the U.S. Focus group questions asked about euthanasia, but not physician-assisted death per se.

To assist Hawaii with its own debate of this issue, Governor Benjamin Cayetano established a Blue Ribbon Panel on Living and Dying with Dignity in February 1997. Its charge was to discuss issues related to death and dying, including physician-assisted death, and make recommendations for policy development. To inform the Governor's committee and future debate in Hawaii, this study built on the earlier, qualitative work to collect opinions from Hawaii residents about physician-assisted death and potential safeguards if this end-of-life option becomes legal.

Method

The study design called for surveys to be administered to 50 adults (25 older adults and, for each, an adult child) in each of five ethnic groups—Caucasian, Chinese, Filipino, Hawaiian, and Japanese—for a total sample of 250. Student interviewers were of the same ethnic background as the group they were assigned to interview except for the student assigned to interview the Hawaiian group; he was a young Caucasian born and raised on the Windward side. Interviewers first identified older adult participants through senior centers and religious organizations in neighborhoods with high proportions of the ethnic group, e.g., Japanese seniors were recruited through centers and temples in the Moiliili area, Filipinos from Waipahu, Hawaiians from Waimanalo and Papakolea, etc. Participating seniors were then asked to identify an adult child willing to participate.

Ease of recruiting varied by group. Caucasian and Japanese participants were easily identified, although Caucasians preferred being interviewed in person while Japanese preferred to be interviewed by phone. The Filipino student interviewer lived in Waipahu and had no problem working through her family and neighborhood connections to recruit participants. Hawaiian and Chinese participants were harder to recruit; the two students interviewing these groups estimated that they asked four adults for each one who agreed. The Chinese group interviewer reported that the high refusal among Chinese was due to discomfort with the topic. The student interviewing Hawaiians reported high levels of distrust, which took time to overcome. In nine cases, a direct parent-child pair could not be interviewed, sometimes because the adult child did not have time to participate or lived out-of-state and did not respond to a mailed survey. In these cases, an effort was made to interview a niece, nephew, or adult grandchild of the older adult. Data collection was completed within 5 months and useable surveys were obtained from 125 seniors and 120 adult children.

The full survey instrument included 85 questions in four parts. Part 1 consisted of questions about age, gender, birthplace, educational attainment, marital status, living arrangements, number of children, religious affiliation, self-rated health, and experience with life-threatening illness among family and close friends. In Part 2 participants were asked if they had any advance directives, such as a living will, and their reasons for completing them or not. Part 3 asked respondents how strongly they agreed or disagreed (5-point Likert scale) with statements about advance planning and decision making, e.g., it's bad luck to plan for death, a person should prepare by writing a living will, a person can trust family to make the right decisions, etc. The final section, Part 4, focused on physician-assisted death, starting by giving a definition. Then respondents were asked: Is there any condition under which physician-assisted death should be allowed? Possible responses were yes, perhaps, and no. If the participant answered no, questioning was concluded. If the participant answered yes or perhaps, another 18 questions were asked about possible conditions, e.g., should the requester be over 18? be mentally competent? have a terminal illness? be in pain? have a diagnosis for which physical or mental deterioration is expected? need a second opinion? need witnesses to the request? etc. Another 11 questions asked about conditions in which a request for physician-assisted death should not be honored, e.g., if the family disagreed, if the physician disagreed, etc. At the conclusion of the interview, the participant was thanked and offered a $10 Longs Drug Store gift certificate. Data management and preliminary analysis were done in Epi-Info, a public-domain data management program produced by the Centers for Disease Control. Reported here are the bivariate analyses of responses related to physician- assisted death.

Findings

Demographics. The demographic characteristics of the sample are provided in Tables 1a (by ethnicity) and 1b (by generation). The differences found among the ethnicities and between generations were not surprising, e.g., the 125 seniors had a higher mean age than the 120 adult children (73 vs. 42 years) and a larger proportion of adult children had college degrees (29% of seniors vs. 65% of adult children). Among ethnicities, the Filipino group was most likely to be married (82% vs. 42-59% of other groups) and least likely to have experienced a life threatening illness themselves or within their families (30% vs. 67-94% of other groups). Only 30% of the Filipino group were college graduates, compared to 38% of Hawaiians, 45% of Japanese, 56% of Caucasians, and 60% of Chinese. As expected 90-98% of the Japanese and Hawaiian respondents were Hawaii-born, compared to 75% of Chinese, 30% of Filipino, and only 23% of Caucasian respondents. In terms of religious affiliation, 88% of Filipinos were Catholic, 59% of Japanese were Buddhists, and the majority of others were Protestant. It is interesting to note that a number of individuals claimed no religious affiliation—4% of Caucasians, 10% of Hawaiians, 14% of Japanese, and 27% of Chinese. While the selection of survey participants was non-random, ethnic distributions for religious affiliation, educational attainment, and birthplace within the sample are in line with state averages. The greater proportion of female than male respondents is also not surprising, as more females than males survive to old age and elders in our sample were more confident that their daughters, rather than their sons, would agree to the second family interview.

Physician-Assisted Death. When asked if there were any conditions under which physician-assisted death should be allowed, 52% of the 245 respondents said yes, 19% said perhaps, and 29% said no. Tables 2a and 2b display the responses to the question by ethnicity

Table 1a.—Demographic characteristics of the sample, by ethnicity (N=215)	CA n=48	CH n=48	FI n=50	NH n=50	JA n=49	p-val
Mean age (yrs)	61	56	55	57	58	ns
% female	73%	58%	74%	66%	67%	ns
% married	58%	54%	82%	42%	59%	.04
% Hawaii-born	23%	75%	30%	98%	90%	.00
% college grad	56%	60%	30%	38%	45%	.00
% exp lifethreat	67%	74%	30%	94%	80%	.00
Religion						.00
Catholic	27%	13%	88%	26%	0	
Oth Christian	65%	54%	12%	64%	27%	
Buddhist	0	6%	0	0	59%	
None	4%	27%	0	10%	14%	

Table 1b.—Demographic characteristics of the sample, by generation (N=215)	Seniors n=125	Adult Children n=120	p-value
Mean age (yrs)	73	42	.00
% female	62%	73%	ns
% married	55%	63%	ns
% Hawaii-born	58%	63%	ns
% college grad	29%	65%	.00
% exp lifethreat	65%	65%	ns
Religion			ns
Catholic	31%	31%	
Other Christian	49%	43%	
Buddhist	14%	13%	
None	6%	13%	

and generation, respectively. The responses varied significantly by ethnicity. Specifically, the Filipino and Hawaiian groups were less likely to say "yes" (26% and 46%, respectively) and more likely to say "no" (54% and 44%, respectively) than the other groups. The Japanese respondents were most supportive, with 71% saying "yes" and only 8% saying "no." About 60% of the Caucasian and Chinese groups said "yes" but about 20% of each of these groups also said "no." No significant differences were seen in responses by generation.

Table 2a.—Are there conditions under which physician-assisted death should be permitted, by ethnicity?	CA n=48	CH n=48	FI n=50	NH n=50	JA n=49	p-val
Yes	58%	65%	26%	46%	71%	.00
Perhaps	21%	17%	20%	10%	21%	
No	21%	18%	54%	44%	8%	

Table 2b.—Are there conditions under which physician-assisted death should be permitted, by generation?	Seniors n=125	Adult Children n=120	p-val
Yes	49%	58%	ns
Perhaps	17%	18%	
No	34%	24%	

For Whom is Physician-Assisted Death Appropriate? As noted earlier, only individuals who answered "yes" or "perhaps" were asked for their opinions about the type of patients who should be permitted to request physician-assisted death and possible safeguards that should be required if physician-assisted death were legal in Hawaii. These included 38 of 48 (79%) of the Caucasians, 39 of 48 (82%) of the Chinese, 23 of 50 (46%) of the Filipinos, 27 of 50 (55%) of the Hawaiians, and 45 of 49 (91%) of the Japanese. By generation, 82 (66%) of the seniors and 90 (77%) of the adult children answered these further questions. To show the responses to the more detailed questions about physician-assisted death, Tables 3, 4, and 5 present two percentages: 1) those who answered "yes" as a percentage of those who were asked the question (first row of numbers) and 2) those who answered "yes" as a percentage of the total sample (second row of numbers).

For example, as shown in Table 3, very few of the respondents, regardless of ethnicity, believed that a person who was depressed should be allowed to pursue physician-assisted death. The Chinese group had a small, but significantly larger, proportion who approved of physician-assisted death for people with depression—21% of those Chinese who responded to the question, representing 17% of the entire Chinese sample. On the other hand, the majority of the Caucasian, Chinese, and Japanese groups felt that a person with a terminal illness accompanied by untreatable pain should be allowed to pursue physician-assisted death. For example, 90% of Chinese who answered the question (representing 73% of the entire sample of Chinese) felt that this person should be allowed to get help to die. While 78% of the Hawaiians who answered this question also agreed, that represented only 42% of the full Hawaiian sample (because only 27 of the 50 Hawaiians answered these questions). Small percentages of Filipinos agreed—35% of those who answered the question, representing 16% of the entire Filipino sample. Looking generally at Table 3, it appears that Filipinos and Hawaiians were less likely than the other three groups to agree that physician-assisted death should be allowed. In all groups, however, respondents were most likely to see physician-assisted death as appropriate

Table 3.—A should a person be allowed to get help to die in these conditions, by ethnicity? (% yes)	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
Term, pain						
-answerers	76%	90%	35%	78%	84%	.00
-full sample	60%	73%	16%	42%	77%	.00
Term, no pain						
-answerers	24%	33%	22%	19%	35%	ns
-full sample	19%	27%	10%	10%	32%	.02
Not Term, pain						
-answerers	63%	59%	22%	63%	51%	.02
-full sample	50%	48%	10%	34%	47%	.00
Phy dis, now						
-answerers	68%	67%	30%	41%	58%	.01
-full sample	54%	54%	14%	22%	53%	.00
Phy dis, now						
-answerers	42%	62%	26%	11%	44%	.00
-full sample	33%	50%	12%	6%	40%	.00
Ment dis, later						
-answerers	39%	62%	26%	19%	49%	.00
-full sample	31%	50%	12%	10%	45%	.00
Depression						
-answerers	3%	21%	0	0	11%	.02
-full sample	2%	17%	0	0	10%	.05

for individuals in pain and least likely to see it as appropriate for individuals with depression. Responses to these questions were also compared between seniors and adult children, revealing no significant differences (not shown in a table).

Who Should Agree with the Request? Tables 4a and 4b presents the answers to questions about who should agree with the person's request for physician-assisted death. Significant inter-ethnic differences are shown in Table 4a, with the Japanese group most interested, and the Hawaiian group least concerned with, having physicians and spouses agree with the decision. None of the groups were very concerned about having a psychiatrist agree (10-30%) or having their children agree (8-33%). Almost half of the Chinese also said that "no one" should have to agree with the patient's decision, i.e., that the patient's decision should be honored even if no one else agreed with it. Table 4b presents the answers to these questions by generation, revealing a number of significant differences. For example, the seniors were more likely than their adult children to want agreement from their physicians, spouses, and children.

Safeguards. Table 5 presents how the five ethnic groups responded to questions about assuring that a person requesting physician-assisted death understands all the options. In general, individuals who responded to this question believed that the patient should be at least 18 years old and mentally competent and that his/her wishes should be expressed repeatedly, in front of witness, and put in writing. About half of the answerers agreed that the person should be seen by a psychiatrist and about half of the Filipino, Hawaiian, and Japanese respondents felt that the person should be counseled by his/her minister as well. A third of respondents were supportive of having the person try anti-depressants and about half felt the

Table 4a.—Who should agree with the person's request for physician-assisted death, by ethnicity? (% yes)	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
Primary MD						
-answerers	63%	44%	43%	33%	77%	.00
-full sample	50%	36%	20%	18%	71%	.00
2nd MD						
-answerers	58%	51%	35%	44%	60%	.04
-full sample	46%	42%	16%	24%	55%	.00
Psychiatrist						
-answerers	24%	21%	22%	22%	33%	ns
-full sample	19%	17%	10%	12%	30%	ns
Spouse						
-answerers	47%	51%	48%	19%	58%	.02
-full sample	37%	41%	22%	10%	53%	.00
Children						
-answerers	32%	38%	39%	15%	36%	.03
-full sample	25%	31%	18%	8%	33%	.05
No one						
-answerers	37%	59%	35%	44%	36%	.00
-full sample	29%	48%	16%	24%	33%	.02

patient should try increasing pain medications before proceeding. (The Filipino group was least supportive of pharmaceutical interventions.) Small percentages in each group supported the idea of a waiting period. A common comment was "after you have the person do all those other things, a waiting period is unnecessary." There were no significant differences by generational group and so these data are not shown in a table.

Discussion

The data suggest that Hawaii's major ethnic groups have different responses to the legalization of physician-assisted death, with greater support seen among Chinese, Japanese, and Caucasian residents and less support seen among Filipino and Hawaiian residents. On first pass, it is interesting to note that the level of acceptance among groups is roughly related to the groups' life expectancies. Specifically, Chinese and Japanese in Hawaii have the longest life expectancy, while Hawaiians have the shortest.[1] On the other hand, the Filipino group, which is the third most longevous of the five groups, had a very low acceptance level, and this is most likely attributable to the high percentage of Filipinos who are Catholic. In fact, a separate analysis of religion and support of physician-assisted death showed that Catholics were more likely to say "no" while Buddhists and Protestants were more likely to say "yes" ($p<.001$). The "yes" group was also likely to have more years of schooling than the "no" group ($p<.001$). Unexpectedly, few differences were seen when the data were analyzed by generation, i.e., seniors vs. adult children. Future multivariate analysis of these data will examine the relative effects of ethnicity, religion, education, and experience with life-threatening illness in self and loved ones on attitudes toward physician-assisted death.

Also of interest are some of the details about who should be allowed to get help to die and what safeguards should be put in place.

Do Hawaii Residents Support Physician-Assisted Death? A Comparison of Five Ethnic Groups

Kathryn L. Braun, DrPH*

Abstract

Surveyed were 250 adults in five ethnic groups—Caucasian, Chinese, Filipino, Hawaiian, and Japanese—on questions about physician-assisted death. When asked if there were any conditions under which physician-assisted death should be allowed, 52% said yes, 19% said perhaps, and 29% said no. Differences in response were seen, however, by ethnicity (with less support among Filipinos and Hawaiians), by religious affiliation (with less support among Catholics), and by educational attainment (with greater support among college graduates). Given the controversial nature of this topic, more public education and debate are needed. Meanwhile, physicians are urged to expand discussions with patients on their expectations about and options for end-of-life care.

Introduction

Several demographic and social trends are converging that make the issues surrounding death and dying very controversial. First, the population is aging, with life expectancy in Hawaii among the highest in the world: 76 for men and 82 for women.[1] Second, medical technology has advanced to the point of allowing us to greatly prolong life artificially, often at great cost and loss of life quality.[2] Third, the cost of health care continues to rise and various forms of health care rationing are being proposed.[3] Finally, we see increased attention to human rights and self-determination, even in dying. Taken together, these issues are forcing us to become more aware of the various options available for end-of-life decision making and advanced planning. While many citizens are advocating for more protection of their "right to die," perhaps an equal number of citizens are concerned about the establishment of policy to protect people from being coerced into refusing treatment or committing suicide.[2-4]

Over the past few decades, a number of surveys on attitudes toward euthanasia have been conducted. For example, in a 1977 study, 65% of white respondents indicated support for legalizing physician-assisted death; this percentage rose to 71% in 1989.[5] Since then, several states have taken the issue to their polling places and courts. The 1992 California Death with Dignity Act, a voter initiative to legalize physician-assisted death in that state, was defeated by voters by a 54% majority. However in 1994 and again in 1997, Oregon voters approved measures that would allow physicians to assist competent, terminally ill patients commit suicide. Meanwhile, court-upheld prohibitions on assisted death in Washington State and New York were sent to the Supreme Court, challenging the constitutionality of these prohibitions. The U.S. Supreme Court reviewed these cases together and, in June 1997, unanimously held that terminally ill people do not have a constitutional right to physician-assisted suicide. Specifically, the Court found that the New York and Washington state laws (that make it a crime for doctors to give life-ending drugs to mentally competent but terminally ill patients who no longer want to live) did not violate either the "due process clause" or the "equal protection rights" guaranteed under the 14th Amendment to the U.S. Constitution. The rulings in these cases, however, left room for continued debate and future policy initiatives at the state level.[6]

To help states that may want to develop guidelines for physician-assisted death, a nine-member panel of scholars from law, medicine, philosophy, and economics proposed a model statute for the regulation of legalized physician-assisted death.[7] The model act suggests that physician-assisted death be allowed for individuals who are at least 18 years of age, who have "a terminal illness or an intractable and unbearable illness" (as verified by the primary and a consulting physician), and who are mentally competent to make decisions. Assurances are required that the patient fully understands his/her prognosis and treatment (including palliative care options), that he/she has the opportunity to consult a social worker about available services, and that he/she be advised to inform his/her family. There must be documentation from a psychiatrist or psychiatric social worker that the request is not a result of "undue influence" or "a distortion of the patient's judgment due to clinical depression or any other mental illness." The request must be witnessed by at least two adults (one of which is unrelated and has nothing to gain by the death), "repeated without self-contradiction on two separate occasions at least 14 days apart," and recorded on paper, audiotape, or videotape.[7, 26-29]

Despite what appears to be growing support of the legalization of physician-assisted death, it is important to note that this concept does not carry the same appeal in all ethnic groups. For example, a number of authors have found that the level of support among African Americans is much lower than among white Americans, by as much as 20%.[5, 8-10] Given Hawaii's multi-cultural population, is it

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safe to assume that different cultures have different outlooks on this issue? In previous research by the author, focus groups and key informant interviews were conducted to begin exploring differences among Hawaii's ethnic groups on death practices and end-of-life issues.[11-12] Differences were seen among, and within, ethnic groups based on the respondent's religious beliefs, level of education, experience with artificial life prolongation in family members, and number of generations his/her family had been in the U.S. Focus group questions asked about euthanasia, but not physician-assisted death per se.

To assist Hawaii with its own debate of this issue, Governor Benjamin Cayetano established a Blue Ribbon Panel on Living and Dying with Dignity in February 1997. Its charge was to discuss issues related to death and dying, including physician-assisted death, and make recommendations for policy development. To inform the Governor's committee and future debate in Hawaii, this study built on the earlier, qualitative work to collect opinions from Hawaii residents about physician-assisted death and potential safeguards if this end-of-life option becomes legal.

Method

The study design called for surveys to be administered to 50 adults (25 older adults and, for each, an adult child) in each of five ethnic groups—Caucasian, Chinese, Filipino, Hawaiian, and Japanese—for a total sample of 250. Student interviewers were of the same ethnic background as the group they were assigned to interview except for the student assigned to interview the Hawaiian group; he was a young Caucasian born and raised on the Windward side. Interviewers first identified older adult participants through senior centers and religious organizations in neighborhoods with high proportions of the ethnic group, e.g., Japanese seniors were recruited through centers and temples in the Moiliili area, Filipinos from Waipahu, Hawaiians from Waimanalo and Papakolea, etc. Participating seniors were then asked to identify an adult child willing to participate.

Ease of recruiting varied by group. Caucasian and Japanese participants were easily identified, although Caucasians preferred being interviewed in person while Japanese preferred to be interviewed by phone. The Filipino student interviewer lived in Waipahu and had no problem working through her family and neighborhood connections to recruit participants. Hawaiian and Chinese participants were harder to recruit; the two students interviewing these groups estimated that they asked four adults for each one who agreed. The Chinese group interviewer reported that the high refusal among Chinese was due to discomfort with the topic. The student interviewing Hawaiians reported high levels of distrust, which took time to overcome. In nine cases, a direct parent-child pair could not be interviewed, sometimes because the adult child did not have time to participate or lived out-of-state and did not respond to a mailed survey. In these cases, an effort was made to interview a niece, nephew, or adult grandchild of the older adult. Data collection was completed within 5 months and useable surveys were obtained from 125 seniors and 120 adult children.

The full survey instrument included 85 questions in four parts. Part 1 consisted of questions about age, gender, birthplace, educational attainment, marital status, living arrangements, number of children, religious affiliation, self-rated health, and experience with life-threatening illness among family and close friends. In Part 2 participants were asked if they had any advance directives, such as a living will, and their reasons for completing them or not. Part 3 asked respondents how strongly they agreed or disagreed (5-point Likert scale) with statements about advance planning and decision making, e.g., it's bad luck to plan for death, a person should prepare by writing a living will, a person can trust family to make the right decisions, etc. The final section, Part 4, focused on physician-assisted death, starting by giving a definition. Then respondents were asked: Is there any condition under which physician-assisted death should be allowed? Possible responses were yes, perhaps, and no. If the participant answered no, questioning was concluded. If the participant answered yes or perhaps, another 18 questions were asked about possible conditions, e.g., should the requester be over 18? be mentally competent? have a terminal illness? be in pain? have a diagnosis for which physical or mental deterioration is expected? need a second opinion? need witnesses to the request? etc. Another 11 questions asked about conditions in which a request for physician-assisted death should not be honored, e.g., if the family disagreed, if the physician disagreed, etc. At the conclusion of the interview, the participant was thanked and offered a $10 Longs Drug Store gift certificate. Data management and preliminary analysis were done in Epi-Info, a public-domain data management program produced by the Centers for Disease Control. Reported here are the bivariate analyses of responses related to physician- assisted death.

Findings

Demographics. The demographic characteristics of the sample are provided in Tables 1a (by ethnicity) and 1b (by generation). The differences found among the ethnicities and between generations were not surprising, e.g., the 125 seniors had a higher mean age than the 120 adult children (73 vs. 42 years) and a larger proportion of adult children had college degrees (29% of seniors vs. 65% of adult children). Among ethnicities, the Filipino group was most likely to be married (82% vs. 42-59% of other groups) and least likely to have experienced a life threatening illness themselves or within their families (30% vs. 67-94% of other groups). Only 30% of the Filipino group were college graduates, compared to 38% of Hawaiians, 45% of Japanese, 56% of Caucasians, and 60% of Chinese. As expected 90-98% of the Japanese and Hawaiian respondents were Hawaii-born, compared to 75% of Chinese, 30% of Filipino, and only 23% of Caucasian respondents. In terms of religious affiliation, 88% of Filipinos were Catholic, 59% of Japanese were Buddhists, and the majority of others were Protestant. It is interesting to note that a number of individuals claimed no religious affiliation—4% of Caucasians, 10% of Hawaiians, 14% of Japanese, and 27% of Chinese. While the selection of survey participants was non-random, ethnic distributions for religious affiliation, educational attainment, and birthplace within the sample are in line with state averages. The greater proportion of female than male respondents is also not surprising, as more females than males survive to old age and elders in our sample were more confident that their daughters, rather than their sons, would agree to the second family interview.

Physician-Assisted Death. When asked if there were any conditions under which physician-assisted death should be allowed, 52% of the 245 respondents said yes, 19% said perhaps, and 29% said no. Tables 2a and 2b display the responses to the question by ethnicity

Table 1a.—Demographic characteristics of the sample, by ethnicity (N=215)

	CA n=48	CH n=48	FI n=50	NH n=50	JA n=49	p-val
Mean age (yrs)	61	56	55	57	58	ns
% female	73%	58%	74%	66%	67%	ns
% married	58%	54%	82%	42%	59%	.04
% Hawaii-born	23%	75%	30%	98%	90%	.00
% college grad	56%	60%	30%	38%	45%	.00
% exp lifethreat	67%	74%	30%	94%	80%	.00
Religion						.00
Catholic	27%	13%	88%	26%	0	
Oth Christian	65%	54%	12%	64%	27%	
Buddhist	0	6%	0	0	59%	
None	4%	27%	0	10%	14%	

Table 1b.—Demographic characteristics of the sample, by generation (N=215)

	Seniors n=125	Adult Children n=120	p-value
Mean age (yrs)	73	42	.00
% female	62%	73%	ns
% married	55%	63%	ns
% Hawaii-born	58%	63%	ns
% college grad	29%	65%	.00
% exp lifethreat	65%	65%	ns
Religion			ns
Catholic	31%	31%	
Other Christian	49%	43%	
Buddhist	14%	13%	
None	6%	13%	

and generation, respectively. The responses varied significantly by ethnicity. Specifically, the Filipino and Hawaiian groups were less likely to say "yes" (26% and 46%, respectively) and more likely to say "no" (54% and 44%, respectively) than the other groups. The Japanese respondents were most supportive, with 71% saying "yes" and only 8% saying "no." About 60% of the Caucasian and Chinese groups said "yes" but about 20% of each of these groups also said "no." No significant differences were seen in responses by generation.

Table 2a.—Are there conditions under which physician-assisted death should be permitted, by ethnicity?

	CA n=48	CH n=48	FI n=50	NH n=50	JA n=49	p-val
Yes	58%	65%	26%	46%	71%	.00
Perhaps	21%	17%	20%	10%	21%	
No	21%	18%	54%	44%	8%	

Table 2b.—Are there conditions under which physician-assisted death should be permitted, by generation?

	Seniors n=125	Adult Children n=120	p-val
Yes	49%	58%	ns
Perhaps	17%	18%	
No	34%	24%	

For Whom is Physician-Assisted Death Appropriate? As noted earlier, only individuals who answered "yes" or "perhaps" were asked for their opinions about the type of patients who should be permitted to request physician-assisted death and possible safeguards that should be required if physician-assisted death were legal in Hawaii. These included 38 of 48 (79%) of the Caucasians, 39 of 48 (82%) of the Chinese, 23 of 50 (46%) of the Filipinos, 27 of 50 (55%) of the Hawaiians, and 45 of 49 (91%) of the Japanese. By generation, 82 (66%) of the seniors and 90 (77%) of the adult children answered these further questions. To show the responses to the more detailed questions about physician-assisted death, Tables 3, 4, and 5 present two percentages: 1) those who answered "yes" as a percentage of those who were asked the question (first row of numbers) and 2) those who answered "yes" as a percentage of the total sample (second row of numbers).

For example, as shown in Table 3, very few of the respondents, regardless of ethnicity, believed that a person who was depressed should be allowed to pursue physician-assisted death. The Chinese group had a small, but significantly larger, proportion who approved of physician-assisted death for people with depression—21% of those Chinese who responded to the question, representing 17% of the entire Chinese sample. On the other hand, the majority of the Caucasian, Chinese, and Japanese groups felt that a person with a terminal illness accompanied by untreatable pain should be allowed to pursue physician-assisted death. For example, 90% of Chinese who answered the question (representing 73% of the entire sample of Chinese) felt that this person should be allowed to get help to die. While 78% of the Hawaiians who answered this question also agreed, that represented only 42% of the full Hawaiian sample (because only 27 of the 50 Hawaiians answered these questions). Small percentages of Filipinos agreed—35% of those who answered the question, representing 16% of the entire Filipino sample. Looking generally at Table 3, it appears that Filipinos and Hawaiians were less likely than the other three groups to agree that physician-assisted death should be allowed. In all groups, however, respondents were most likely to see physician-assisted death as appropriate

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	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
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-answerers	76%	90%	35%	78%	84%	.00
-full sample	60%	73%	16%	42%	77%	.00
Term, no pain						
-answerers	24%	33%	22%	19%	35%	ns
-full sample	19%	27%	10%	10%	32%	.02
Not Term, pain						
-answerers	63%	59%	22%	63%	51%	.02
-full sample	50%	48%	10%	34%	47%	.00
Phy dis, now						
-answerers	68%	67%	30%	41%	58%	.01
-full sample	54%	54%	14%	22%	53%	.00
Phy dis, now						
-answerers	42%	62%	26%	11%	44%	.00
-full sample	33%	50%	12%	6%	40%	.00
Ment dis, later						
-answerers	39%	62%	26%	19%	49%	.00
-full sample	31%	50%	12%	10%	45%	.00
Depression						
-answerers	3%	21%	0	0	11%	.02
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for individuals in pain and least likely to see it as appropriate for individuals with depression. Responses to these questions were also compared between seniors and adult children, revealing no significant differences (not shown in a table).

Who Should Agree with the Request? Tables 4a and 4b presents the answers to questions about who should agree with the person's request for physician-assisted death. Significant inter-ethnic differences are shown in Table 4a, with the Japanese group most interested, and the Hawaiian group least concerned with, having physicians and spouses agree with the decision. None of the groups were very concerned about having a psychiatrist agree (10-30%) or having their children agree (8-33%). Almost half of the Chinese also said that "no one" should have to agree with the patient's decision, i.e., that the patient's decision should be honored even if no one else agreed with it. Table 4b presents the answers to these questions by generation, revealing a number of significant differences. For example, the seniors were more likely than their adult children to want agreement from their physicians, spouses, and children.

Safeguards. Table 5 presents how the five ethnic groups responded to questions about assuring that a person requesting physician-assisted death understands all the options. In general, individuals who responded to this question believed that the patient should be at least 18 years old and mentally competent and that his/her wishes should be expressed repeatedly, in front of witness, and put in writing. About half of the answerers agreed that the person should be seen by a psychiatrist and about half of the Filipino, Hawaiian, and Japanese respondents felt that the person should be counseled by his/her minister as well. A third of respondents were supportive of having the person try anti-depressants and about half felt the

Table 4a.—Who should agree with the person's request for physician-assisted death, by ethnicity? (% yes)

	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
Primary MD						
-answerers	63%	44%	43%	33%	77%	.00
-full sample	50%	36%	20%	18%	71%	.00
2nd MD						
-answerers	58%	51%	35%	44%	60%	.04
-full sample	46%	42%	16%	24%	55%	.00
Psychiatrist						
-answerers	24%	21%	22%	22%	33%	ns
-full sample	19%	17%	10%	12%	30%	ns
Spouse						
-answerers	47%	51%	48%	19%	58%	.02
-full sample	37%	41%	22%	10%	53%	.00
Children						
-answerers	32%	38%	39%	15%	36%	.03
-full sample	25%	31%	18%	8%	33%	.05
No one						
-answerers	37%	59%	35%	44%	36%	.00
-full sample	29%	48%	16%	24%	33%	.02

patient should try increasing pain medications before proceeding. (The Filipino group was least supportive of pharmaceutical interventions.) Small percentages in each group supported the idea of a waiting period. A common comment was "after you have the person do all those other things, a waiting period is unnecessary." There were no significant differences by generational group and so these data are not shown in a table.

Discussion

The data suggest that Hawaii's major ethnic groups have different responses to the legalization of physician-assisted death, with greater support seen among Chinese, Japanese, and Caucasian residents and less support seen among Filipino and Hawaiian residents. On first pass, it is interesting to note that the level of acceptance among groups is roughly related to the groups' life expectancies. Specifically, Chinese and Japanese in Hawaii have the longest life expectancy, while Hawaiians have the shortest.[1] On the other hand, the Filipino group, which is the third most longevous of the five groups, had a very low acceptance level, and this is most likely attributable to the high percentage of Filipinos who are Catholic. In fact, a separate analysis of religion and support of physician-assisted death showed that Catholics were more likely to say "no" while Buddhists and Protestants were more likely to say "yes" ($p<.001$). The "yes" group was also likely to have more years of schooling than the "no" group ($p<.001$). Unexpectedly, few differences were seen when the data were analyzed by generation, i.e., seniors vs. adult children. Future multivariate analysis of these data will examine the relative effects of ethnicity, religion, education, and experience with life-threatening illness in self and loved ones on attitudes toward physician-assisted death.

Also of interest are some of the details about who should be allowed to get help to die and what safeguards should be put in place.

Table 4b.—Who should agree with the person's request for physician-assisted death, by generation? (% yes)

	Seniors n=82 n=125	Adult Children n=90 n=120	p-val
Primary MD -answers	70%	42%	.00
Primary MD -full sample	46%	32%	ns
2nd MD -answerers	65%	40%	.00
2nd MD -full sample	43%	30%	ns
Psychiatrist -answerers	27%	23%	ns
Psychiatrist -full sample	18%	17%	ns
Spouse -answerers	58%	36%	.00
Spouse -full sample	38%	27%	ns
Children -answerers	44%	22%	.01
Children -full sample	29%	17%	ns
No one -answerers	42%	43%	ns
No one -full sample	28%	32%	ns

Table 5.—How can we make sure this person understands all the options, by ethnicity? (% yes)

	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
At least 18 yo -answerers	63%	51%	78%	62%	66%	ns
At least 18 yo -full sample	50%	41%	36%	33%	61%	.03
Competent -answerers	82%	85%	87%	85%	87%	ns
Competent -full sample	65%	69%	40%	46%	80%	.00
Psychiatrist consult -answerers	32%	56%	43%	63%	51%	.03
Psychiatrist consult -full sample	25%	46%	20%	34%	47%	.04
Relig consult -answerers	34%	38%	52%	52%	58%	ns
Relig consult -full sample	27%	31%	24%	28%	53%	.03
Inc pain meds -answerers	52%	51%	43%	63%	53%	.01
Inc pain meds -full sample	41%	41%	20%	34%	49%	.03
Anti-depress -answerers	34%	28%	22%	54%	40%	.00
Anti-depress -full sample	27%	23%	10%	29%	36%	.04
Wish written -answerers	87%	74%	96%	92%	87%	.05
Wish written -full sample	69%	60%	44%	50%	80%	.01
Wish witness -answerers	74%	77%	91%	81%	71%	ns
Wish witness -full sample	59%	63%	42%	44%	65%	.05
Wish repeat -answerers	50%	42%	65%	41%	51%	ns
Wish repeat -full sample	40%	34%	30%	22%	47%	.04
Wait period -answerers	34%	38%	26%	22%	36%	.00
Wait period -full sample	27%	31%	12%	12%	33%	.05

The largest proportions of respondents felt that physician-assisted death was acceptable for an individual with untreatable pain, especially if they also were terminally ill. This opinion is in line with the model statute described above.[7] There was very little support for physician- assisted death for depression, which is in concurrence with the model statute and other pro-euthanasia documents that call for a psychiatric evaluation to rule-out depression in requesters.[3,7] This issue is more controversial in the Netherlands where only 3% of patients who request help to die are referred for psychiatric evaluation and where cases in which individuals have been helped to die because they had "intractable depression" have been reported.[13-14] It is gratifying, then, that almost 50% (range 32 to 63%) of respondents in the Honolulu study felt that a requester should consult with a psychiatrist and 34% (range 22 to 54%) felt that a requester should try anti-depressants before proceeding.

Methodologically, the study had several limitations. First, the sampling was not random. Participants were volunteers, recruited through formal organizations in Hawaii's various communities, and therefore were likely to differ from the general population. For example, that the older adults were participants in senior centers and religious organizations probably meant that they represented a healthy and socially active segment of the older adult population for whom these questions might be somewhat academic. Their children were also likely to be healthy. Participants self-selected to be interviewed, and it is suspected that those adults who were uncomfortable with the subject matter, unsure of their feelings about it, or distrustful of the survey process or the topic were likely to refuse. Also, the sample included no residents of the Jewish faith, in part because the Caucasian interviewer had more than enough volunteers before having a chance to recruit participants through Temple Emanu-El. Finally, interviewers reported that the ordering of questions may have created a bias toward answers that upheld an individual's right to free choice, rather than answers that reflected a greater concern for consumer protection. Thus, the survey results probably overestimate the acceptability of physician-assisted death in the state. A next step would be to estimate support of physician-assisted death in the general population through a random sample phone survey, perhaps through the Hawaii Health Survey or a separately-funded effort.

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Regardless of how quickly Hawaii and other states move into the debate about physician-assisted death, individual physicians need to increase their efforts to discuss end-of-life options with their patients. Research suggests that outpatients want their doctors to initiate discussions about advance planning, and that these discussions should occur after their physician-patient relationship is established but while the patient is still well.[15] Conversations should address values and expectations related to life and its artificial prolongation; knowledge and thoughts about palliative care options, such as hospice; and completion of living wills, documents that assign proxy, and code-status forms for hospitalized patients. There is empirical evidence to suggest that these discussions alone provide a "long-lasting sense of improved understanding and being cared for" among patients, as well as giving physicians vital information about their patients' treatment preference.[15, 1066]

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A Quantitative Study of Environmental Asbestos Exposure in Honolulu

Hong-Yi Yang MD*, PhD, Judith Wishart MD, Yolanda Y.L. Yang PhD, James Lumeng MD, Young K. Paik MD

The increased use of asbestos in various industries in past decades has led to increases in environmental asbestos pollution. Incidental exposure to asbestos is inevitable, and has generated public concern. We performed the following study aimed at determining the level of environmental asbestos exposure in Honolulu, and our results indicate that the levels of environmental asbestos in Honolulu are the lowest in the nation.

Introduction

Asbestos consists of a group of widely used fibrous silicates that are well known for causing adverse health effects to exposed occupational workers.[1-2] Asbestos bodies are asbestos fibers coated with iron and protein, and are unique histologic markers for asbestos exposure. These "curious" bodies were first described in patients with asbestosis about 50 years ago.[3] Since then, it has been well recognized that the asbestos body content in the lung is correlated with the degree of asbestos exposure and is considered a necessary finding in establishing the diagnosis of asbestos-related diseases.

The increased use of asbestos in consumer products and in construction materials in past decades has increased the chances of incidental, non-occupational exposure. Studies have confirmed that incidental exposure to asbestos dusts in the general population is also on the rise.[4-5] The health effects of incidental asbestos exposure, particularly in regard to the risk for mesothelioma, is still unknown[6] and has generated much public concern.[7-8]

In Honolulu, the naval shipyard at Pearl Harbor was the main source of local occupational asbestos exposure during the second world war[9] when exposure control was not strictly regulated. In recent years, autopsies have been frequently requested to document previous asbestos exposure of diseased workers. In order to determine the level of incidental, environmental asbestos exposure in our community and to establish a control background level of non-occupational asbestos exposure we sampled lung tissues of random autopsies from St. Francis Medical Center in Honolulu and quantified the asbestos bodies in these lung tissues. In this study, asbestos body counts from patients with known histories of occupational exposure to asbestos from Pearl Harbor naval shipyard are included for comparison.

Materials and Methods

Lung tissues from random autopsies from St. Francis Medical Center at Liliha, Honolulu were collected during a 10-year period from 1979 to 1988. The data obtained from each autopsy report included age, race, sex, occupational history, history of smoking, and presence or absence of asbestos related diseases. A total of 167 autopsies of patients without histories of occupational exposure to asbestos dusts and 18 cases of patients with known histories of occupational exposure to asbestos were analyzed. Of the 167 cases without occupational exposure to asbestos, 107 were male and 60 were female. Ages ranged from 15 to 93 with a mean age of 64. The ethnic backgrounds of these 167 cases were recorded as follows: 48 Caucasian, 40 Japanese, 31 Filipino, 18 Hawaiian, 15 Chinese, and 13 other or mixed race. Data from 18 patients with known histories of occupational exposure to asbestos were tabulated separately.

Extraction of Asbestos Bodies

Lung tissues were sampled from all 5 lobes. Approximately 10 gm. from each lobe was fixed in a 10% buffered formaldehyde solution. The lung tissue was minced, mixed, and pooled. Asbestos bodies were then extracted from 5 grams of the pooled lung tissue by Smith and Naylor's digestion method.[10] Briefly, the sampled lung tissue was dissolved in a domestic laundry bleach (5.25% sodium hypochlorite). The digested tissue sediment was then washed with chloroform and ethanol to remove organic substances. Following centrifugation, the final sediment that contained asbestos bodies was filtered onto a 5 μm pore size Millipore filter. Asbestos bodies were counted directly under a light microscope.

Only morphologically typical asbestos bodies, i.e., those bodies with a characteristic central transparent fiber core and a golden-brown beaded or segmented iron-protein coat, were counted. Non-asbestos ferruginous bodies or "pseudoasbestos bodies" were carefully excluded from the counting. These non-asbestos ferruginous bodies appeared as aggregates of iron-protein particles without a transparent fiber core or with an irregular non-transparent core.[11]

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Supported by Leahi Foundation Research Grant

Table 4b.—Who should agree with the person's request for physician-assisted death, by generation? (% yes)

	Seniors n=82 n=125	Adult Children n=90 n=120	p-val
Primary MD			
-answerers	70%	42%	.00
-full sample	46%	32%	ns
2nd MD			
-answerers	65%	40%	.00
-full sample	43%	30%	ns
Psychiatrist			
-answerers	27%	23%	ns
-full sample	18%	17%	ns
Spouse			
-answerers	58%	36%	.00
-full sample	38%	27%	ns
Children			
-answerers	44%	22%	.01
-full sample	29%	17%	ns
No one			
-answerers	42%	43%	ns
-full sample	28%	32%	ns

Table 5.—How can we make sure this person understands all the options, by ethnicity? (% yes)

	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
At least 18 yo						
-answerers	63%	51%	78%	62%	66%	ns
-full sample	50%	41%	36%	33%	61%	.03
Competent						
-answerers	82%	85%	87%	85%	87%	ns
-full sample	65%	69%	40%	46%	80%	.00
Psychiatrist consult						
-answerers	32%	56%	43%	63%	51%	.03
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Anti-depress						
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Wish written						
-answerers	87%	74%	96%	92%	87%	.05
-full sample	69%	60%	44%	50%	80%	.01
Wish witness						
-answerers	74%	77%	91%	81%	71%	ns
-full sample	59%	63%	42%	44%	65%	.05
Wish repeat						
-answerers	50%	42%	65%	41%	51%	ns
-full sample	40%	34%	30%	22%	47%	.04
Wait period						
-answerers	34%	38%	26%	22%	36%	.00
-full sample	27%	31%	12%	12%	33%	.05

The largest proportions of respondents felt that physician-assisted death was acceptable for an individual with untreatable pain, especially if they also were terminally ill. This opinion is in line with the model statute described above.[7] There was very little support for physician- assisted death for depression, which is in concurrence with the model statute and other pro-euthanasia documents that call for a psychiatric evaluation to rule-out depression in requesters.[3,7] This issue is more controversial in the Netherlands where only 3% of patients who request help to die are referred for psychiatric evaluation and where cases in which individuals have been helped to die because they had "intractable depression" have been reported.[13-14] It is gratifying, then, that almost 50% (range 32 to 63%) of respondents in the Honolulu study felt that a requester should consult with a psychiatrist and 34% (range 22 to 54%) felt that a requester should try anti-depressants before proceeding.

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A Quantitative Study of Environmental Asbestos Exposure in Honolulu

Hong-Yi Yang MD*, PhD, Judith Wishart MD, Yolanda Y.L. Yang PhD, James Lumeng MD, Young K. Paik MD

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Medical School Hotline

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schools.

The annual budget for the School of Medicine is approximately $54 million. About $16 million are from State General Funds. Twenty-three million dollars are derived from research and training grants and an additional $15 million are generated by medical school faculty from not-for-profit research institutes in local community hospitals and medical centers. The total external funding amounts to $38 million per year.

In addition, through contracts and its collaborative relationships with the community teaching hospitals and Hawaii's health care industry, the medical school receives about $35 million. This is a mutually beneficial relationship in which the medical community gains from the presence of the medical school and the bedside training of medical students and 14 post M.D. residency and fellowship training programs. Every dollar spent by the State on the School of Medicine attracts $2.50 of external funding and an additional $2.50 in community support.

In an effort to assist with support of the medical school, student tuition will continue to increase. Presently, resident tuition is $11,000/year. Non-resident tuition is $24,000. Although these amounts are about average or slightly lower than many state schools, medical students do not have the time to accept employment. Students must rely on scholarships, student loans, and financial aid.

Community and Outreach Activities:

In 1997, JABSOM completed the Pacific Basin Medical Officers Training Program which was located in Pohnpei, Federated States of Micronesia. Seventy-one graduated as medical officers and have been placed for service throughout Micronesia and American Samoa. Other community outreach projects include the Postgraduate Medical Education Program financed by the Okinawa Prefecture Government at Chubu Hospital in Okinawa where JABSOM administers a residency training program for graduates of Japanese medical schools; the Imi Ho'ola Program, a one-year post BA enrichment program for disadvantaged minority students; the Ke Ola O Hawaii, Inc. Community Partnership Program to increase primary health care in Hawaii's medically underserved areas; the Geriatric Education Center; the Center of Excellence for Disaster Medicine; and the Native Hawaiian Center of Excellence

The School of Medicine continues to make a valuable contribution to the State, the medical community and the Pacific Basin. It is an excellent bargain, generating financial support and jobs. It is an example of a partnership of resources between a medical school and a community which deserves to be recognized and protected.

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Announcement

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New Service.—AESTHETICA Plastic and Laser Surgery Center is pleased to announce the incorporation of Ultrasonic-assisted Liposuction into the practice. Call 536-8866 or (800) 488-9855 for information.

Family Practice or Internal Medicine Physician wanted.— in Kapaa, Kauai (Board Certification or elig) Paul T. Esaki MD, 4-1461 Kuhio Hwy., Kapaa, Kauai, HI 96746. (808) 822-9886 Fax (808) 822-0938.

Office Space

Pearl City Business Plaza.—Tenant Improvement Allowances for Long Leases; 680+ sq ft; 24-hr security; free tenant/customer pkg; Gifford Chang 581-8853 DP, 593-9776, 531-3526.

Aiea Medical Office Space for Lease or Share.—Near Pali Momi hospital. 300 to 1000 sq ft. Excellent for branch office or specialty use. Call Dr. Wong at 487-7938.

Office Space for Rent.—769 sq ft, 3538 Waialae Avenue, Rm 203, Call 732-0441.

Locum Tenens

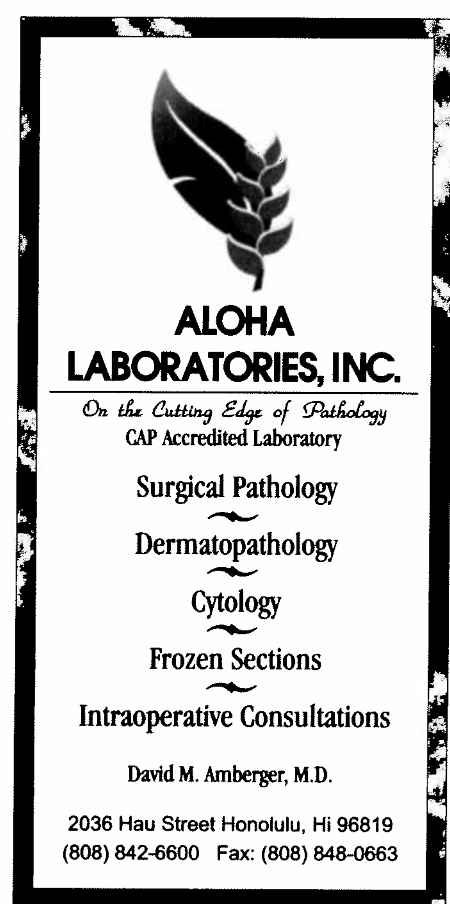
Board Certified family practitioner.—Available for short term practice coverage. Liability insurance provided. Please contact: V. Braslavsky, MD (913) 383-3285. http://www.concentric.net/~locumdr/1.htm.

For Sale

For Sale.—Outstanding outpatient psychiatric practice in Kailua-Kona on the Big Island. 30 hrs/wk and could increase significantly if desired. No Medicaid; fee for service only. Available late June or July, 1998. Call (808) 329-5815.

Baby Scales For Sale.—One almost new $100., one brand new $120. Call 533-2334.

Practice for Sale.—General Practice in Wahiawa. Reasonable. Serious inquires only. Call 734-1016.



The Weathervane Russell T. Stodd MD

It is easy to get along with the Hawaii Supreme Court - if you're fond of children.

As all physicians know, medical liability is already a calamitous crazy-quilt of medical-legal-bureaucratic mine fields. Now the Hawaii Supreme Court in a preposterous decision, has decided that a doctor cannot refer a patient to a consultant for care without providing informed consent for the care provided by that consultant. A Honolulu orthodontist referred a patient to an oral surgeon who could have given a second opinion, but instead elected to operate. The surgery allegedly resulted in facial asymmetry, and neck, back and shoulder pain. The surgeon agreed to a financial settlement, but the plaintiff also sued the orthodontist for lack of informed consent. The Hawaii Supreme Court ruled that the orthodontist was obligated to provide informed consent for the patient prior to referral. Well, why not sue the brother-in-law who first recommended the orthodontist? Almost every day we are reminded that Americans are prisoners of a legal system that ignores logic and is deplorably out of control.

A good politician is about as unthinkable as an honest burglar.

Politicians and bureaucrats simply do not understand the power, dangers and injury potential of the laser. The Veterans' Health Administration's current optometry guidelines permit O.D.s to perform laser and other eye surgeries and to prescribe systemic drugs. The American Academy of Ophthalmology has mobilized in opposition and stimulated grass roots and congressional pressure to rescind the document and develop an appropriate manual for eye care. An even greater sin occurred in Oklahoma where the governor signed into law a bill permitting optometrists to use lasers. Organized ophthalmology tried in vain to educate the politicians, but were unable to stem the well-heeled lobbying forces of optometry. Where was the AMA in the lobbying effort? Reckless latitude in the use of lasers is a challenge for all of medicine, and this egregious Oklahoma law represents a giant step forward for pretenders. Naturopaths, chiropractors, cosmetologists, and even hair stylists, will soon petition for rights to use laser therapy.

Bad news does not improve with age.

As our elderly population increases, eye specialists are becoming an ever greater means of protection for the highway public. With the visual acuity loss of cataract glare, the reduced discrimination of macular degeneration, the field loss of glaucoma and stroke, and the dementia of Alzheimer's, elderly drivers are an ever greater risk on the highways. Many of these people plan their driving to avoid heavy traffic, long distances, bad weather and night driving, but the increased risk remains. To expect this population to self-regulate is not a realistic approach. A recent study in *JAMA* reported that drivers with a loss of 40% or more of visual field are 2.2 times more likely to have a crash. For the doctor, difficulties frequently arise when the patient is informed that his/her driving days have ended. To most people, the automobile is more than a means of transportation, it is also a major part of one's freedom. Loss of the car keys may precipitate a serious confrontation, and that is when our persuasive abilities may be severely challenged.

Don't make love to a stranger.

The federal government through the Center of Disease Control and Prevention (CDC) and the Health Resources and Service Administration (HRSA) have collaborated with the San Francisco Department of Public Health to establish a toll-free hot line to help doctors treat health-care workers who have been exposed to blood borne disease and infection by needle-stick injuries. It is called the Post-Exposure Prophylaxis Hotline (PEP) and is manned 24 hours each day by physicians. It can be accessed from anywhere in the United States by dialing (write this down, now) 888-448-4911.

Where is Jimmy Hoffa when we need him?

In New Jersey, a group of physicians working in an HMO called AmeriHealth petitioned to be represented by the United Food and Commercial Workers union in contract negotiations. The regional director, Dorothy Moore-Duncan, an official of the National Labor Relations Board, ruled that the doctors didn't meet the definition of employees under the NLRB act. Because the doctors treat patients who aren't members of the HMO, and the practices are virtually all professional corporations, and because they control their own expenses, they retain the characteristics of independent businessmen. Collective bargaining remains outside the medical realm, and doctors must individually bend over for the juggernaut insurers and employers.

To live or let die? And I don't mean 007.

Yet another malpractice hazard is the alleged failure to let the patient die, contrary to his/her wishes. A 67-year-old retired meteorologist had amyotrophic lateral sclerosis, and supplied his doctor with a power of attorney, do not resuscitate (DNR) directive. He stated that he did not want to be kept alive by a respirator, and his pulmonologist had arranged for hospice care. However, when he began to gasp for breath, an aide called 911, and he was taken to the emergency room where he requested a tracheotomy. After discharge, he wrote a letter of thanks to the doctor saying, "I am much more a fighter for life than I imagined." Later, the doctor was stunned when he was sued for keeping the patient alive against his wishes! The plaintiff's attorney and the media played it up as ignoring a patient's wish to "die with dignity" case, when in fact it was a "patient changed his mind" case. The jury supported the doctor, but his reputation was publicly smeared. A study in the *Journal of American Geriatrics Society* revealed that of 688 written advance directives, only 22 were specific enough to guide physicians' decisions in whether to use life-extending treatment in the actual situation. Moreover, it was found that only about one-third had even mentioned the directives to their doctors.

The knowledge of courtesy and good manners begets liking, and an inclination to love one another.

The powers in charge of managed care plans, mainly HMOs, are sending their doctors to "communications school." Patient-satisfaction surveys have uncovered widespread resentment over brusque, rude or indifferent doctors. As a result, about 19,000 U.S. doctors, including Kaiser Permanente, PacifiCare Health Systems, Group Health of Minneapolis and Harvard Pilgrim Health Care of New England, have been sent to workshops primarily to learn how to listen, and to be courteous, kind and decent human beings (Civility 101?). One would assume that these qualities are inherrent in the definition of physician, but the assembly line techniques of the HMO do not encourage a caring doctor-patient relationship.

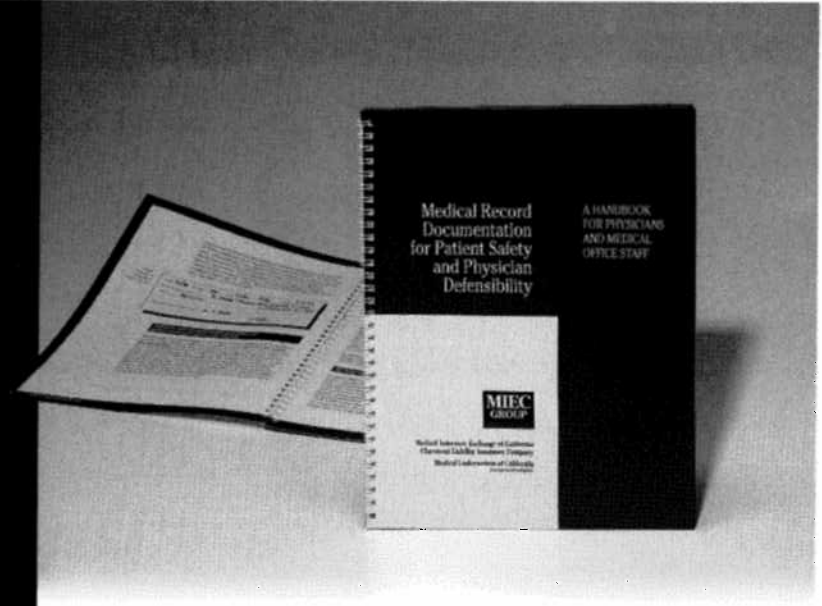
If everything seems to be going well, you have overlooked something.

Serendipity is a word which crept into our lexicon via a fairy tale. Yet it is a good word and useful in describing the faculty of fortunate, valuable and unexpected outcomes, occurring by accident. Pfizer Inc. developed a drug designed to combat heart disease, and labeled it *Viagra*. After seven clinical trials on numerous test subjects, the researchers conceded that the drug was a failure. The program was about to be permanently trashed when the scientists observed something quite unexpected. Test subjects told doctors they experienced more frequent, longer lasting, and more tumescent erections. Many subjects refused to return the pills when their tests ended, and others wanted to purchase the drug out of pocket. At first, it seemed like a side effect rather than a remedy, but *Pfizer* moved into high gear and tested 4,000 patients. Researchers found that the drug helped patients 50% to 80% of the time, depending upon the cause of the erectile dysfunction. The drug has won approval and in just two weeks, *Viagra* has already become one of the fastest selling drugs in the history of medicine. *Pfizer* expects that Viagra will become a household name like *Prozac* and will vault the company to the top of the pharmaceutical business. Serendipity—it really happens.

Addenda—

- ❖ The IRS is currently holding 96,000 tax refunds worth $62 million in unclaimed dollars.
- ❖ Number of cows needed to supply footballs for a single NFL season: 3,000
- ❖ Should vegetarians eat animal crackers? Can fat people go skinny-dipping?

Aloha and keep the faith—rts ■



What's so important about defensible medical records?

Just ask your malpractice insurer...

Accurate, complete and timely medical records provide a solid foundation for the defense of malpractice claims. Poor quality records can force physicians to settle or lose medically-defensible claims. MIEC's Loss Prevention Department's new handbook offers extensive advice about how to keep defensible medical records and avoid documentation deficiencies that can compromise a medical defense. "Medical Record Documentation for Patient Safety and Physician Defensibility" includes useful chart forms, answers to questions about medical records and a self-assessment form, so you can track the quality of your own charts.

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