

Letters to the Editor

Reminiscing upon twelve and a half years of treating DM in Guam: life in the trenches

When I first came to Guam to work in a HMO setting from Eastern Oregon, I was amazed and appalled by the spectrum of AODM and obesity, which confronted me. I was further amazed at the numbers of thirty and forty-year old individuals who appeared in the obituary columns of the local paper. It soon became clear that there was a relationship. Most of the physicians I knew seemed to feel that:

"As long as the Blood Sugar was below 250 mg.%, then there was nothing to worry about."

At that time, there was no firm evidence to contradict this view! There were studies from the Joslin Group from Ohio promoting tight control, but against these were many other studies supporting the prevailing view on Guam. This never made much sense to me, as I have long felt that Mother Nature generally knows better than me what "normal" is. The group that I was with aggressively combated infections associated with DM, however. Extensive protocols to treat these infections with outpatient antibiotic regimens were put in place and succeeded in reducing in-patient costs to the HMO. The HMO also had an excellent Patient Education/Dietary Management program. Unfortunately, it was woefully under utilized, as I, a Family Physician with a broad panel of patients, was the number one referral source for the program during the years I was with the HMO. This was due, I think, to resistance from patients to change long established lifestyles, and from physicians who felt that this line of therapy, in light of patient views and their past limited experiences with such referrals, was largely futile. As I did not see great numbers of Diabetics in my practice, I remained insulated to the extent of the actual morbidity from this disease on Guam.

After leaving the HMO, and going into private practice, it soon became clear that DM was a bigger problem than I had imagined. This was particularly true when I began seeing patients who had limited financial and intellectual resources, who had been naturally selected out by HMO premiums. In addition, I could no longer rely on Health Educators or

Dieticians, as even those patients with health coverage were not covered for this. Insurance carriers were more than willing to pay for expensive medications, but could not see the need for Dietary instruction. After joining the Guam Diabetes Advisory Body and personally going to the Governmental Director in charge of insurance coverage for governmental employees, I was finally able to convince enough people that funding this type of treatment made both financial and medical sense. Now every insurance carrier on the island provides this coverage for their subscribers. A similar situation existed for home glucose monitoring devices. This battle was largely fought and won in the U.S., although coverage for NIDDM glucose monitoring is still not universal on Guam. There also may be limitations on the strips used to measure the results, which means that having a machine does not ensure that measurements are done, as these strips are quite expensive.

Three and one-half years ago, I began working for a Community Health Center through Public Health. This Clinic is required to accept all who present, but patients are charged on an ability to pay basis. Since the clinic I work at is remotely located on Guam, roughly one-third of our patients have private insurance coverage, as it is more convenient for them to see us than to drive thirty to forty-five minutes to see the next closest provider, one-third are covered by MIP/welfare, and one-third have no health coverage at all. We are also the de facto referral destination for the Island's Community-based Hospital and its ER. As such, we see more than our share of Diabetics. Our clinic was fortunate enough to enter into several situations and relationships soon after my arrival, which revolutionized my care of Diabetic patients. We were able to computerize much of our operation, which made retrieval of patient information much easier. We also entered into a partnership with Mountain-Pacific Quality Health Foundation (MPQHF) out of Montana who provided a computer program and treatment guidelines dedicated to DM. We have also worked with the CDC on a somewhat similar program for a portion of the time I have been with the clinic. This has provided us with up-to-date information on our patients and with current treatment strategies, which have helped me to adjust my treatment practices in many ways. As those who treat DM know, this is a constantly changing field with new treatments and ideas appearing regularly. Having access to groups with experience and a wide knowledge base is very helpful for a Family Practitioner who has practiced in isolated settings for most of my professional life.

We now have a nearly three-year history of our efforts to treat Diabetic patients at Southern Region Community Health Center (SRCHC), where an Internist and I provide care. There have been dramatic changes in the care our patients have received. For instance, the number of patients who have had comprehensive foot examinations has risen from thirty-eight percent to above eighty-five percent during this time. Those who have received a pneumococcal

vaccine (a vaccine which previously I only gave to elderly patients or those with a history of splenectomy) have risen from thirty-five percent to above ninety percent. We have also made great strides in evaluating the Lipoprotein status of our Diabetic patients as well as seeing that they received timely retinal exams. Much of this success has been due to systems changes in our office. For instance, every identified Diabetic patient now has their feet evaluated by the nursing staff along with their blood pressure and other vital signs before they see the physician. The nursing staff also takes pains to ensure that Diabetic patients are updated on their immunizations so that if I forget, they are able to catch this and see that treatment is given in a timely fashion. This has required some education on all of our parts, but has greatly reduced the incidence of serious foot problems and other complications, which plague Diabetics on Guam. We have also recently managed to have access to regular Dietician consultation. Despite our advances, when measured by percentage of patients with HgbA1C less than eight percent, we have made little progress since the inception of this program.

The reason for this lies in many areas. We have had a difficult time convincing our patients that lifestyle changes are key to controlling adverse outcomes with DM and other diseases. Morbid Obesity is a common diagnosis in our practice. Spam (sixty-eight percent fat content) is a principal ingredient in many of our patients' diets. While many of our patients are willing to take pills, many have a great fear of insulin. (My auntie was placed on insulin and died soon thereafter.) For an increasing number of our patients, finances are a problem. Our economy has bombed and many people are unemployed or employed in low paying jobs with no health benefits. Taking care of DM in a modern western health care system is an expensive undertaking. Testing for HgbA1C, lipids, doing daily home glucose monitoring, buying several prescription drugs, and seeing specialists for eye care all cost more money than many of our patients can afford. Medications are a particular problem as our Clinic income contracts and ability to provide even basic medications has been compromised several times in the past year. This has meant that a significant portion of our Diabetic population has had to go off their ACE-inhibitors and even their basic oral agents for periods of time. Following diets, which are new, may also be a casualty of contracting family budgets and financial resources.

Plainly, we as Clinicians need to develop new strategies to deal with these issues. We have discovered, as many of our colleagues on other islands of the Pacific, that controlling DM without medications and adequate laboratory and physician referral support is a difficult task. Controlling problems of tobacco co-morbidity remains a problem, although progress is being made. Part of our struggle needs to be effective means of demonstrating that treatments are cost-effective and that our island society stands to benefit from keeping our DM patients under good clinical control.

Guam did have a recent three-day conference for health care professionals as well as the public. This is one step forward as there is now good clinical evidence to show that outcomes can be beneficially influenced by proper treatment. We also need societal changes to help us convince patients that diet and exercise are low cost alternatives to expensive hospitalization, which will inevitably occur if DM is not controlled. These are not all changes which can be effected in our clinical exam rooms. We need to be more effective in the media and political arenas. I remain optimistic that new approaches and hopefully solutions will arise and await tips from my colleagues for control of this difficult clinical problem.

William W. Weare

Family Practitioner working for the Guam Department of Public Health, Southern Region Community Health Center, Guam. E-mail: weare@kuentos.guam.net ■

A tribute to Dr. Maureen Fochtman

A most significant event for Guam and the Pacific Region this year is the retirement of Dr. Maureen Fochtman, Dean of the University of Guam College of Nursing and Health Sciences.

Dr. Maureen Fochtman came to the University of Guam in 1991, as Director of the Nursing Program. Highlights of her accomplishments as Director and then Dean include establishment of the College of Nursing and Health Sciences in 1994, initial accreditation of the Nursing Program by the National League for Nursing Accreditation Commission in 1996 (renewed in 2002), and incorporation of the Social Work and Health, Physical Education, Recreation, & Dance Programs into the College.

Dr. Fochtman made significant contributions to nursing education and practice throughout Guam and the Pacific Region. Distance Education for nurses and health assistants in the Northern Marianas Islands, Republic of Palau, Federated States of Micronesia, and Republic of the Marshall Islands became a reality under her leadership. Dr. Fochtman served on numerous advisory boards throughout Guam and the Pacific, with significant contributions to the American Pacific Nurse Leader's Council (APNLC), and the Pacific Islands Health Officers Association. Dr. Fochtman will be missed by Guam and the Pacific Region, and her influences will be felt for years to come. We thank her for her contributions, and wish her much happiness and good health as she rejoins her family in the United States.

Kathryn M. Wood, R.N.C., M.N.

University of Guam, College of Nursing and Health Sciences, UOG Station, Mangilao, Guam 96913, USA. ■