possessed by a physician and surgeon in the general practice of his profession, with an extensive and constant practice in hospitals and the community" (*Rush v. Akron General Hospital*, 171 N.E.2d 378 [Ohio Ct. App. 1987]).

However, not all courts have embraced the dual standard of review. In a recent case out of New Jersey, the Superior Court held that licensed residents should be judged by a standard applicable to a general practitioner, as any reduction in the standard of care would set a "problematic precedent" (*Clark v. University Hospital*, 914 A.2d 838 [N.J. Super. 2006]). In this case, the residents allegedly failed to reinsert a nasogastric tube, which caused the patient to aspirate.

Should the applicable standard for a resident physician be even higher? In *Pratt v. Stein*, a second-year resident was judged by a specialist standard after he had allegedly administered a toxic dose of neomycin to a postoperative patient, which resulted in deafness. Although the lower court had ruled that the resident should be held to the standard of an "ordinary physician," the Pennsylvania appellate court disagreed, reasoning that "a resident should be held to the standard of a specialist when the resident is acting within his field of specialty. In our estimation, this is a sound conclusion. A resident is already a physician who has chosen to specialize, and thus possesses a higher degree of knowledge and skill in the chosen specialty than does the nonspecialist" (*Pratt v. Stein*, 444 A.2d 674 [Pa. Super. 1980]).

However, a subsequent decision from the same jurisdiction suggests a retreat from this unrealistic standard. An orthopedic resident allegedly applied a cast with insufficient padding to the broken wrist of a patient. The plaintiff claimed this led to soft tissue infection with *Staphylococcus aureus*, with complicating septicemia, staphylococcal endocarditis, and eventual death. The court held that the resident's standard of care should be "higher than that for general practitioners but less than that for fully trained orthopedic specialists. … To require a resident to meet the same standard of care as a fully trained specialist would be unrealistic. A resident may have had only days or weeks of training in the specialized residency program; a specialist, on the other hand, will have completed the residency program and may also have had years of experience in the specialized field. If we were to require the resident to exercise the same degree of skill and training as the specialist, we would, in effect, be requiring the resident to do the impossible" (*Jistarri v. Nappi*, 549 A.2d 210 [Pa. Super. 1988]). ■

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It's never too early to have the "insulin talk"

Some conversations may be hard to initiate. Take the "insulin talk," for example. According to the American Diabetes Association, insulin is the most effective agent for lowering blood glucose.[1] It works as part of an overall diabetes treatment plan, which may include diet, exercise, and other diabetes medication. Having the "insulin talk" early may help patients accept insulin as a potential treatment option to help them achieve their A1C goals.[2]

The results of having a positive "insulin talk" can be impactful: in a survey, about 80% of patients with type 2 diabetes on OADs said they'd consider taking insulin if their doctor recommended it.[3] So by starting the dialogue now, you can help your patients have a better understanding of insulin as an effective treatment option for lowering blood glucose.

Insulin—a chance for successful glycemic control, not a punishment for failure

Patients may focus on blaming themselves for their uncontrolled blood glucose, but you can help them focus on turning this negative mindset into positive action for managing their disease.[2] The United Kingdom Prospective Diabetes Study showed that by the time patients with type 2 diabetes are diagnosed, they may already have lost up to 50% of their beta-cell function, and this function may continue to decline.[4]

Because the disease is progressive, many patients with type 2 diabetes may eventually need insulin to achieve or maintain glycemic control.[2,5] But by the time patients with type 2 diabetes are prescribed insulin, they may have had diabetes for 10 to 15 years and may already have complications due to a prolonged period of uncontrolled blood glucose.[6] Starting insulin earlier in the disease continuum for appropriate patients can help improve glycemic control. Controlling blood glucose can reduce the risk of diabetes-related complications.[5,6]

Treatment plans and glycemic targets should be individualized for each patient.

Insulin is indicated to help improve glycemic control in patients with diabetes mellitus.

Important Safety Information About Insulin

Possible side effects may include blood glucose levels that are too low, injection site reactions, and allergic reactions, including itching and rash. Other medications and supplements could change the way insulin works. Glucose monitoring is recommended for patients with diabetes.

THE "INSULIN TALK"

Have the talk early and as needed, to help destigmatize insulin[2]

- Reassure patients that using insulin doesn't mean failure and that insulin may help replace what the body is no longer adequately making
- Turn the negative mindset of failure into a positive opportunity to take personal control of A1C

Put insulin therapy in context

- Explain the benefits of maintaining blood glucose goals and the risks associated with insulin therapy
- Talk about how insulin may be worth the effort—insulin is an effective treatment option that works as part of an overall treatment plan to lower blood glucose

Identify patients' personal obstacles and help defuse the "scary" factor[2]

- Today's insulin injections generally cause little discomfort and are administered using small, thin needles[2,6]
- Insulin pens make insulin more convenient to administer and are discreet[2]
- Insulin dose may need to be adjusted up or down over the course of treatment depending on how a patient's body responds[5]

INSULIN

IMPROVING BLOOD GLUCOSE CONTROL SHOULDN'T WAIT

Learn more at www.RethinkInsulin.com

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More Patients Tell Physicians About CAM Use

FROM THE ANNUAL MEETING OF THE AMERICAN ACADEMY OF DERMATOLOGY

MIAMI — The use of complementary and alternative medicine is increasing among patients with self-reported skin disease, and patients are also discussing this use more with their physicians, supplementary data from the 2007 National Health Interview Survey indicate.

Data from the survey of nearly 23,400 adults showed that of 2,374 respondents with a skin disorder, 85% reported complementary and alternative medicine (CAM) use in the past year. When vitamin and mineral supplements were excluded, 58% reported CAM use in the past year, up from 49% in a nearly identical survey in 2002, Dr. Nana Smith reported at the meeting.

In the 2007 survey, 52% of respondents said they discuss their CAM use with their physician, compared with just 16% in 2002, said Dr. Smith, a dermatology resident at the University of Rochester (N.Y.).

Patients with skin diseases in the recent survey were significantly more likely to use CAM than were those without skin diseases (odds ratio 2.5), Dr. Smith said.

However, only about 1% of those with skin diseases said they used CAM specifically for their dermatologic condition. Most said they use CAM for general wellness, Dr. Smith noted.

—Sharon Worcester

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