I was naked in Hawaii when I felt the earth move

I had just returned from a run, completed my triple-S (ask a guy) and was getting dressed when a large truck drove by, vibrating the condo. Being from BC, as the sound and violent shaking built I quickly recognized this as an earthquake. As objects began to launch themselves from the walls my dilemma became clear. Run for safety in my birthday suit or tempt possible death by taking time to put on underwear and shorts—I chose death. I later discovered that my boxer briefs had been on backwards all day. Living along a fault line, I had experienced minor quakes before but nothing like this 6.7 on the Richter scale monster I survived on the Big Island of Hawaii in 2006 (I know this information because it was on the T-shirt I purchased the next day—you have to love free enterprise). The thing that surprised me more than the obvious earth moving was the loudness of it—a little like standing by a 747 jet at takeoff.

Haiti was recently devastated by a much more powerful 7.0 quake, and then Chile was hit by an 8.8 quake, then Turkey was struck by a 5.9 quake. The world has mobilized its resources to try and help these countries. It's amazing how other nations and their populations respond in such a positive way during events like these. It gives my tenuous belief in the future of humanity a large, positive boost and got me thinking about charity.

Charity is defined as kindness, generosity, helpfulness, and understanding toward others, or as the voluntary giving of money or other help to those in need. Does charity really begin at home? I wonder how many people have walked by some homeless guy to give or mail a donation to Haiti.

As physicians we are in the unique situation of being aware of our suffering patients' many needs. I am embarrassed to admit that I have an amazing capacity to ignore these needs and carry on as if there is nothing I can do to help.

Many of my colleagues demonstrate outstanding examples of charity. One physician I know gives supermarket gift cards anonymously to deserving patients. Another pays his patient's tabs at local eateries when they are unaware of his presence. Yet another purchases food and leaves it for the local homeless to consume. This is true philanthropy—giving help with no expected reward. Contrast this to our elected officials, who give away our money and take credit for it. I would respect them far more if they led by example and gave from their own pockets without trumpeting their apparent benevolence.

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Each of us should strive to make a small difference by giving more of ourselves. If charity is defined as kindness, this could be as little as taking the time to sit down and connect with a patient. Try it; go on I dare you. Perform some random act of charity and see how it feels.

One warning: put on your clothes first.

—DRR

Lung attack: A call to arms

In February the Canadian Thoracic Society published a comprehensive report called *The Human and Economic Burden of COPD.* The report points out that COPD is the most underdiagnosed chronic disease in our society yet is the leading consumer of hospital beds and health care dollars. The average admission for an acute exacerbation of COPD lasts 10 days and costs $10 000. These are Canadian data and Canadian dollars. Recent research has suggested that up to 10% of Canadians have COPD, which the CTS defines as "a respiratory disorder largely caused by smoking, characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations."

There is a movement in respiratory medicine to call a COPD exacerbation a "lung attack" to call attention to the seriousness of such an event and the implications it has for patient morbidity and mortality. When lung attacks result in hospitalization, they carry the same mortality as a heart attack: 8% die during the hospitalization and 25% die within the following 12 months. There is overwhelming data that show decreased hospitalizations from good, comprehensive COPD care, including smoking cessation, pulmonary rehabilitation, and appropriate medications. Yet few patients receive such care due to lack of diagnosis, lack of comprehensive COPD clinics, and lack of recognition of the cost of this disease.

COPD is not difficult or expensive to diagnose. Spirometry done pre- and post-bronchodilators can make the diagnosis in the vast majority of cases—this costs less than $50 and should be available in most hospitals in Canada. It is recommended that any present or ex-smoker over the age of 40 with any respiratory symptom be sent for spirometry as a screen for COPD because the sooner a diagnosis is made and appropriate care begun, the better the prognosis.

This report challenges everyone in the health care system—administrators, physicians, and patients—to become more aware of the huge human and economic burden of COPD and to act now.

—LML