HAWAI'I MEDICAL JOURNAL

December 2006 Volume 65, No. 12 ISSN: 0017-8594

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HAWAI'I MEDICAL JOURNAL
(USPS 237-640)

Published monthly by the
Hawai'i Medical Association
Incorporated in 1856 under the Monarchy
1360 South Beretania, Suite 200
Honolulu, Hawai'i 96814-1520
Phone (808) 536-7702; Fax (808) 528-2376

Contents

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"TARO"

Depicting taro, the mainstay staple food of old Hawai'i from which poi is made.

HAWAI'I MEDICAL JOURNAL

Let's Syndicate The Weathervane

Norman Goldstein MD, FACP Laureate
Editor Emeritus, Hawai'i Medical Journal

In every Journal, I enjoy every word of The Weathervane. Since 1988, when it first appeared, it has proven to be the most well-read page in Journal history.

Some of our newer readers may not know the man behind the popular monthly column. Dr. Russell T. Stodd was born in 1930, received his medical degree from Oregon University, served his residency in ophthalmology at Gorgas Hospital in the Canal Zone, and in 1974 began private practice in Kahului, Maui. That same year Dr. Stodd became president of the Maui County Medical Society. In 1983, under the auspices of the U.S. Agency for International Development, Dr. Stodd shared his ophthalmologic expertise in a Sudanese clinic, and in 1984 purchased the first ophthalmology laser on Maui, permitting qualified Fellows use of this high-tech instrument. The following year, Dr. Stodd became president of the Hawai'i Medical Association. Today, he serves as the medical director of the Aloha Surgical Center on Maui.

I don't know where he gets his material, but the breadth of his subject matter is astounding. In the August issue, the Weathervane lead item "Life is uncertain; eat dessert first" had me laughing out loud. It reminded me of dinner with Arthur Murray – dance industry entrepreneur, art collector, tennis whiz, and quick wit well into his 8th decade. "I always have dessert first," Arthur declared, "It's my favorite part and, at my age, I'm not sure if I'll make it through the meal!" But, I digress.

Of course, the Hawai'i Medical Journal contributes a wealth of well-written scientific studies to physicians in Hawai'i, as it has for 65 years, but contributing editor Russ Stodd injects well-reasoned diversity. Doctors nationwide could use a healthy dose of Dr. Stodd's insight. Let's syndicate The Weathervane.

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Notes on the Hawai'i Medical Association 2006 Annual Meeting

Russell T. Stodd MD

The 2006 annual meeting of the Hawai'i Medical Association, celebrating HMA's 150th Anniversary, was held at the Hawai'i Convention Center in Honolulu, October 20, 21, and 22. It was superlative in every way but, like so many of our annual meetings, was enjoyed by too few members. The meeting combined an excellent education program, a meeting of the House of Delegates, and a marvelous Ola Pono Ike inauguration dinner program.

The Ola Pono Ike dinner party featured a speech by mountaineer Lou Whittaker, plus a warm address from the outgoing HMA President Patricia Blanchette MD and an entertaining slide presentation by incoming President Linda Rasmussen MD. We were honored by a visit from American Medical Association President William Plested III MD who provided the honors for the swearing-in ceremony. The festivities included a wine tasting party and silent auction. Thomas Kosasa MD was recognized as physician of the year for his tireless efforts for the Hawai'i Medical Association as well as his volunteer activities in the community, including service as a pilot for emergency medical flights. Orthopedic surgeon John Smith MD was given the President's award for his long and faithful service to the medical community. All in all, it was a marvelous evening.

The education planning committee co-chairpersons, Kalani Brady MD and Myron Shirasu MD, and their 10 co-workers, constructed an excellent three-day educational program, entitled "Leading the Way...Building on 150 Years of Leadership". Each session was nicely complemented by a luncheon or light breakfast, beverages, and snacks. Additionally, the generous participation of exhibitors made each day very satisfying. The organization committee and HMA staff deserve a powerful thank you for putting on such a marvelous show.

The kick-off was a pre-conference presentation on "New Horizons in Addiction Medicine" that featured Edwin A. Salsitz MD, FASAM, medical director of office-based opioid therapy, Department of Medicine, Beth Israel Medical Center, New York City; Lynn R. Webster MD, FACPM, FASAM, medical director, Lifetree Clinical Research and Pain Clinic, Utah; Christopher Linden MD, family practitioner from the Big Island; and Gerald McKenna MD, medical director of Ke Ala Pono Recovery Center, Kauai. The educational intent was to explain and understand the neuro-biology of addiction, varying degrees of vulnerability to addictive disease, and the pharmacology of addiction. The prevalence of prescription drug abuse was discussed, including patient risk factors. Dr. McKenna noted that addiction is the only medical disease for which a patient can be incarcerated. Points of intervention were presented with newer pharmacological agents available for use in addictive disease, especially in the treatment of alcoholism.

The Saturday morning, October 21 program featured a dynamite oration by AMA President William Plested III MD, and a supporting speech by J.P. Schmidt, Esq. Hawai'i insurance commissioner. The issue was tort reform and how a MICRA law for Hawai'i can predict malpractice premiums to protect physicians and preserve access to care for patients. After that opening, Danial Bucsko MBA, assistant vice president for Doctor's Company; Judith Huerta MA, of Medical Insurance Exchange of California; and Norm Slaustas, Executive Vice President for HAPI, discussed how to minimize the risk of being sued. They all emphasized that the best defense for a physician in a malpractice complaint is a careful and well-documented medical record. Recording phone calls when away from the office, messages, lab reports, call coverage, etc., all are part of necessary documentation.

Also in the Saturday morning program was a new system of health care financing presented by Stephen Foreman PhD, JD, MPA. His primary point was that first dollar coverage offered by so many plans virtually ensures that patients will over utilize. He emphasized that employer provided insurance coverage removes individual responsibility. He described the need to write medical coverage that will take care of catastrophic medical expenses, but give patients the option to buy a cheaper plan with a significant deductible. By allowing individual decisions for first dollar expense, utilization will be realistic. In essence, he endorsed the medical insurance savings plans which have been pushed by the AMA for several years.

Luncheon on Saturday featured the ABCs of chronic kidney disease with management pearls for the primary care physician presented by Ramona Wong MD, medical director of the National Kidney Foundation of Hawai'i. The speaker emphasized the need for increased awareness of co-morbidities, especially cardiovascular risk and mortality. Local resources are available to help primary care doctors achieve optimal management of chronic kidney disease.

Richard Whitten MD, FACP, contract medical director for Medicare part B for Hawai'i; Richard Chung MD, senior VP for HMSA; and Eric Z. Matayoshi MD, FACS, chief of general surgery at Kaiser Permanente Hawai'i, combined to explain the P4P (pay for performance) plan which will impact physicians in Hawai'i. This will prove to be a headache for all in private practice until the system becomes functional, and even then the variables will cause concern. How does one define good performance—number of patients cared for? Dollar performance? Medical/surgical outcomes?

Electronic medical records (EMR) are looming on the horizon so Dan Heslinga MD, director of the Bridging the Adoption Gap Project, presented a program of getting started with EMRs. He

described how preventative services and disease management can be improved, and noted that the office practice will become more efficient, but there are difficulties to surmount when implementing a system. In addition, he cautioned against signing an EMR services contract before giving it careful scrutiny and consideration. Naive physicians can be easily exploited.

The final offering for the Saturday session was a discussion of the benefits of information technology. Dale Glenn MD, Straub Kailua Family Health Center; Grant Okawa MD, Kaiser Permanente; plus Richard Whitten MD and Dan Heslinga MD combined on a panel to relate the value of EMRs as an important tool in providing quality health care. Ease of obtaining patient history and profiles, even for patients not known, can be expedient and safe. A question and answer session followed.

Strengthening the safety net and caring for the uninsured and underinsured was detailed by Hawai'i Health Director Chiome Fukino MD and Human Services Director Lillian B. Koller, Esq. as the initial presentation on Sunday morning. In particular, the role of the community health clinics and the Hawai'i Health Systems Corporation facilities were presented. The financial limitations due to low reimbursement force a constant appeal to the Hawai'i legislature to provide appropriate subsidies in order to maintain the staff and keep the doors open.

A blue ribbon collection of hospital chiefs followed featuring Danelo Canete MD, President and CEO Hawai'i Medical Center (St. Francis); Arthur A. Ushijima, President and CEO Queen's Medical Center; Raymond P Vara, Jr. EVP and CEO operations Hawai'i Pacific Health; and Gary K. Kajiwara, President and CEO Kuakini Medical Center. They each discussed their current roles and challenges in the medical community, emphasizing past and especially future expectations.

The final portion of the program was devoted to Integrative and Complementary Medicine (CAM), featuring Roseanne Harrigan EdD, APRN, Chair, Complementary and Alternative Medicine Department, University of Hawai'i; Thanh V. Huynh MD, University of Hawai'i Cancer Research Center; Ira D. Zunin MD, Medical Director, Hawai'i Consortium for Integrative Health; and Carolyn Gotay PhD, Director, Prevention and Control Program, University of Hawai'i Cancer Research Center. These speakers outlined the rapid evolution of this fascinating and emerging area of medicine, including therapies for cancer patients. The National Institutes of Health has allocated $300 million per year for studies in integrative medicine. The impact and effectiveness of CAM is increasingly recognized and being melded into conventional medical care.

So, to anyone who took the time to read this far, this is but a scratch on the surface to describe an excellent program of continuing medical education. It was a great effort by the staff and members of the Hawai'i Medical Association and visiting faculty.

Pattern of Birth Defects Delivered to Non-Residents in Hawai'i, 1986-2002

Mathias B. Forrester BS and Ruth D. Merz MS

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Ruth D. Merz MS

This research was supported by a contract with the State of Hawai'i Department of Health, Hawai'i Birth Defects Special Fund (HRS 321, Act 252, 2002), Hawai'i State Department of Health, Children With Special Health Needs Branch, Centers for Disease Control and Prevention, Ronald McDonald Childrens' Charities, March of Dimes Birth Defects Foundation, George F. Straub Trust, Queen Emma Foundation, Pacific Southwest Regional Genetics Network, and Kamehameha Schools/Bishop Estate.

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Abstract

Using birth defects registry data, this study examined whether deliveries to residents and non-residents differed. The non-resident rate was significantly higher among those infants/fetuses with more than one major birth defect, pregnancy outcomes that did not result in live births, multiple births, deliveries in the City and County of Honolulu, and pregnancies where prenatal diagnostic procedures had been performed.

Introduction

There is tremendous variation in the operations and activities among birth defects registries in the United States.[1] For example, of the 45-50 state birth defects registries reported to be in existence in 2004, only around 12 appear to include deliveries within the state to non-residents. Although inclusion of non-resident deliveries are not essential for such birth defects registry activities as calculation of baseline rates and cluster and environmental investigations, they may be important for such activities as planning, referral, and utilization of services, prevention, education, economic impact evaluations, and clinical research.

In spite of the potential importance of non-resident births to birth defects registries, there is limited information on such deliveries. Review of the literature identified only one article that briefly discussed the topic, and this was by the current authors.[2] The intent of the current investigation was to describe in more detail the patterns of non-resident deliveries included by a birth defects registry.

Methods

This was a retrospective study using data from the Hawai'i Birth Defects Program (HBDP). The HBDP is a population-based birth defects registry with inclusion criteria consisting of all infants and fetuses of any pregnancy outcome (live birth, fetal death, elective termination) of any gestational age where a birth defect was diagnosed between conception and one year after delivery and the delivery occurred in Hawai'i.[1] Thus the HBDP includes in-state deliveries to state residents and non-residents; the HBDP does not include out-of-state deliveries to state residents.

HBDP staff identify eligible subjects and collect data through a multiple-source ascertainment system that involves review of logs and medical records at all delivery and tertiary care hospitals, facilities that perform elective terminations secondary to prenatal diagnosis of birth defects, genetic counseling offices, cytogenetic laboratories, and all but one of the prenatal ultrasound facilities in Hawai'i. Among the information collected is the address of the mother's residence at the time of delivery. For most subjects, this information is obtained from the birth or fetal death certificate. For those subjects where such certificates are not available, the address is obtained from the medical record, primarily the admission sheet at the time of delivery.

Other variables may also be found in both the medical record and birth or fetal death certificates. If a variable differs between the two sources, the information in the birth or fetal death certificate is recorded, except in those situations where the information in the medical record is obviously more accurate. For instance, if the birth certificate states that the mother did not smoke while the prenatal care records in the medical record make repeated mention of the mother smoking, the HBDP will record that the mother smoked.

Cases were all infants and fetuses with major birth defects delivered during 1986-2002 where the residence at delivery was known. Major birth defects are those birth defects the Centers for Disease Control and Prevention recommends always be collected by birth defects registries.

The proportion of cases that were resident and non-resident deliveries was determined. Using data from the Hawai'i Department of Health Office of Health Status Monitoring, the total number of live births delivered to residents and non-residents was used to calculate the total birth defect rate for the two categories. The distribution of non-resident delivery cases by state or country of residence was described. The reason a non-resident delivered in Hawai'i was not systematically collected by the HBDP; however, for those cases where the reason for delivery in Hawai'i was known, the proportions that were intentional and unintentional Hawai'i deliveries were determined.

The non-resident delivery rates were assessed for selected variables relating to the infant/fetus (number of major birth defects, pregnancy outcome, sex, plurality), mother (race/ethnicity, age, number of prior

Table 1.— Deliveries of infants/fetuses with birth defects to non-residents by various infant/fetus factors, Hawai'i, 1986-2002

Infant/fetus factor	Total No.	Non-residents No. (%)	Rate ratio	95% confidence interval
Number of major birth defects				
1	8,330	64 (0.77)	reference	
2	2,688	47 (1.75)	2.28	[1.53,3.37]
3	1,357	25 (1.84)	2.40	[1.45,3.86]
4	761	15 (1.97)	2.57	[1.36,4.55]
5	394	9 (2.28)	2.97	[1.30,6.00]
>5	805	22 (2.73)	3.56	[2.09,5.85]
Pregnancy outcome				
Live birth (survived to one year)	12,450	126 (1.01)	reference	
Live birth (expired within one year)	726	26 (3.58)	3.54	[2.23,5.43]
Fetal death	502	16 (3.19)	3.15	[1.75,5.32]
Elective termination	654	14 (2.14)	2.12	[1.12,3.68]
Infant/fetus sex				
Boy	8,497	93 (1.09)	reference	
Girl	5,718	85 (1.49)	1.36	[1.00,1.84]
Plurality				
Singleton	13,687	169 (1.23)	reference	
Multiple birth	532	13 (2.44)	1.98	[1.03,3.48]

pregnancies, education), delivery (location of delivery hospital), prenatal care and diagnosis (prenatal care, prenatal diagnostic procedure utilization, prenatal diagnosis of a defect, cytogenetic analysis attempted), and presence of 54 selected birth defects. The specific birth defects were chosen because they were relatively common, fairly easy to diagnosis, and/or impacted morbidity and mortality.

Race/ethnicity was included in the investigation because most of the population of Hawai'i and nations in the Pacific Basin consists of a variety of non-white racial/ethnic groups. In addition, rates for a number of birth defects have been found to vary by race/ethnicity. Whites were used as the reference population in the race/ethnicity analysis because whites are the racial/ethnic group most frequently cited in articles that examine racial/ethnic differences in birth defects.

The variables were not always available for all of the cases; thus the sum of the subgroups may not equal the total number of cases. Comparisons between the groups were made by calculating rate ratios and 95% confidence intervals (CIs) using Poisson probability.

Results

The HBDP identified 14,335 infants/fetuses with major birth defects and known delivery residence among 1986-2002 deliveries. Hawai'i residents accounted for 14,153 (98.73%) of these cases and non-residents for 182 (1.27%) of these cases. During the same time period, there was a total of 315,313 live births delivered to residents and 1,195 live births delivered to non-residents. Thus the birth defect rate was 15.23% for non-residents and 4.49% for residents (rate ratio 3.39, 95% CI 2.92,3.93).

Among the deliveries to non-residents, 93 (51.10%) were to US-residents from 23 different states and territories. The most frequently represented states and territories were Guam (n=32) and California (n=23). Seventy-four (40.66%) of the non-resident deliveries were to residents of other countries, the most common being Japan (n=32), Marshall Islands (n=11), and Korea (n=10). The remaining 15 (8.24%) deliveries to non-residents had military addresses; thus it was unclear whether their residence was in the United States outside of Hawai'i or in another country.

The reason for delivery in Hawai'i was known for 78 (42.86%) of the non-residents. In 22 (28.21%) of these cases, the mother had been visiting Hawai'i when she had gone into labor and delivered. In 56 (71.79%) of these cases, the mother had specifically been transported to Hawai'i to deliver.

Table 1 illustrates the non-resident rates for selected infant/fetus variables. The non-resident rate was significantly higher among those cases where more than one major birth defect had been diagnosed. Moreover, the non-resident rate increased with the number of major birth defects. When pregnancy outcome was examined, the non-resident rate was substantially greater among those pregnancy outcomes that did not result in live births that were known to be alive after one year of age. Although the non-resident rate was higher among girls than boys, the difference was not statistically significant. The non-resident rate was substantially higher among multiple births.

Table 2 presents the non-resident rate for maternal factors. When compared to whites, the non-resident rate was substantially lower for Hispanics, Asians, and Pacific Islanders. However, when one specific subgroup of Pacific Islander was examined, the non-resident rate among Guamanians was significantly greater than that among whites. Non-resident rates tended to be greater with increasing maternal age; however, the trend was not statistically significant (p=0.056). The non-resident rates tended to be lower among women who had had one or more prior pregnancies, and to increase with maternal education, but these patterns were not statistically significant.

Table 3 contains the non-resident rates for various delivery and diagnostic factors. The non-resident rates were substantially higher for deliveries in hospitals in the City and County of Honolulu when compared to the other three counties. The non-resident rate was greater among women who had had no reported prenatal care, although this difference was not significant. In contrast, the non-resident rates were substantially higher among those cases where prenatal diagnostic procedures had been performed, a birth defect had been prenatally diagnosed, or cytogenetic analysis of the infant/fetus had been attempted.

Table 4 compares the non-resident rate for 54 specific birth defects to the rate among all birth defects. The

non-resident rate varied from 0.00% to 10.81%. The rate was higher than the general rate for 32 (59.26%) of the specific birth defects and significantly higher for eight of the specific birth defects (spina bifida, hydrocephaly, small intestinal atresia and stenosis, renal agenesis and hypoplasia, cystic kidney, obstructive genitourinary defect, situs inversus, trisomy 18).

Discussion

This investigation described the non-resident deliveries with birth defects identified by a population-based birth defects registry in Hawai'i over a seventeen-year period. Review of the literature failed to identify any similar studies. Most birth defects registries in the United States do not appear to include non-resident deliveries in their ascertainment criteria in spite of the observation that non-resident deliveries may be important to some of the activities the registries may want to perform. The present study may provide some indication of the potential impact of inclusion of non-resident deliveries on various registry activities.

The primary limitation of this application is its applicability to other states. Hawai'i is unlike other states in that it is isolated with no borders with other states or countries. Only similar studies by other states will determine whether the results of this study may be transferable to other states.

Another limitation is the manner in which variables such as the residence at delivery was determined as outlined in the Methods. The purpose of a given variable may differ between the medical record and birth or fetal death certificates. However, in the interest of efficiency, the HBDP records only one value for a given variable.

This study found that only slightly more than 1% of all identified deliveries involving birth defects in Hawai'i were to non-residents. This would suggest that overall the inclusion or exclusion of non-resident deliveries would have little impact on the potential activities of the HBDP. However, the non-resident rate was higher for particular subgroups. Thus, non-resident deliveries may need to be considered if these subgroups are pertinent to particular birth defects activities. For example, 5% of spina bifida deliveries in Hawai'i were to non-residents. A woman who has had an infant or fetus affected by a neural tube defect (NTD) such as spina bifida is at increased risk of having a subsequent infant or fetus with a NTD.[3-5] As a result of studies suggesting that periconceptional use of folic acid by women reduces the risk of having infants and fetuses with NTDs, it has been recommended that women who have had a prior infant or fetus with a NTD should take folic acid.[6] If NTD recurrence education and prevention activities in Hawai'i were provided solely to those spina bifida deliveries to Hawai'i residents, then one out of every twenty spina bifida deliveries would be excluded from these activities.

Table 2.— Deliveries of infant/fetuses with birth defects to non-residents by various maternal factors, Hawai'i, 1986-2002

Maternal factor	Total No.	Non-residents No. (%)	Rate ratio	95% confidence interval
Maternal race/ethnicity				
White	3,787	92 (2.43)	reference	
Black	530	16 (3.02)	1.24	[0.68,2.13]
Hispanic	348	1 (0.29)	0.12	[0.00,0.68]
Native American	139	3 (2.16)	0.89	[0.18,2.68]
Asian	5,109	34 (0.67)	0.27	[0.18,0.41]
Pacific Islander	4,268	28 (0.66)	0.27	[0.17,0.42]
Guamanian	41	11 (26.83)	11.04	[5.33,20.70]
Maternal age (years)				
≤19	1,470	14 (0.95)	0.74	[0.37,1.36]
20-24	3,596	43 (1.20)	0.92	[0.60,1.42]
25-29	3,705	48 (1.30)	reference	
30-34	3,106	36 (1.16)	0.90	[0.56,1.41]
35-39	1,921	26 (1.35)	1.05	[0.62,1.72]
≥40	532	14 (2.63)	2.03	[1.03,3.75]
<35	11,877	141 (1.19)	reference	
≥35	2,453	40 (1.63)	1.37	[0.94,1.96]
Number of prior pregnancies				
0	4,128	58 (1.41)	reference	
1	3,710	46 (1.24)	0.88	[0.59,1.32]
>1	6,241	76 (1.22)	0.87	[0.61,1.24]
Maternal education (years)				
<12	1,488	6 (0.40)	0.51	[0.18,1.22]
12	5,088	40 (0.79)	reference	
>12	4,913	46 (0.94)	1.19	[0.76,1.87]

Half of the non-resident deliveries involving birth defects in Hawai'i were to residents of other US states and territories, and two-fifths were residents of other countries. This pattern is likely due to Hawai'i being a tourist destination for residents from all over the United States as well as other countries all over the world. Moreover, Hawai'i has a unique position in the middle of the Pacific Ocean where it is closer to US territories such as Guam and other countries such as Japan and Korea than are other states. Thus, if it were decided that a woman in the western Pacific needed to deliver in the United States, then Hawai'i may be a primary choice of delivery location.

A portion of birth defects deliveries in Hawai'i to non-residents were unintentional, i.e., the woman happened to be in Hawai'i when she delivered. However, in the majority of non-resident deliveries involving birth defects with known intent, the mother was deliberately transferred to Hawai'i for the delivery. This would indicate that in the majority of instances the pregnancy was known to be at risk for an adverse outcome. The anticipated adverse outcome may not necessarily have been a birth defect; other prenatal conditions such as

Table 3.— Deliveries of infant/fetuses with birth defects to non-residents by delivery and diagnostic factors, Hawai'i, 1986-2002

Delivery or diagnostic factor	Total No.	Non-residents No. (%)	Rate ratio	95% confidence interval
County of birth hospital				
Honolulu	11,711	170 (1.45)	reference	
Hawai'i	1,105	6 (0.54)	0.37	[0.14,0.83]
Maui	926	3 (0.32)	0.22	[0.05,0.66]
Kaua'i	511	2 (0.39)	0.27	[0.03,0.99]
Prenatal care				
Yes	13,783	174 (1.26)	reference	
No	252	5 (1.98)	1.57	[0.50,3.74]
Prenatal diagnostic procedures				
Yes	10,868	154 (1.42)	reference	
No	3,467	28 (0.81)	0.57	[0.37,0.86]
Prenatal diagnosis of a defect				
Yes	2,261	85 (3.76)	4.68	[3.46,6.33]
No	12,074	97 (0.80)	reference	
Cytogenetic analysis attempted				
Yes	3,497	86 (2.46)	2.89	[2.12,3.94]
No	10,342	88 (0.85)	reference	

Table 4.— Deliveries of infants/fetuses with birth defects to non-residents by type of birth defect, Hawai'i, 1986-2002

Diagnosis	**Total No.**	**Non-residents No. (%)**	**Rate ratio**	**95% confidence interval**
Anencephaly	118	1 (0.85)	0.67	[0.02,3.77]
Spina bifida	153	8 (5.23)	4.12	[1.75,8.29]
Encephalocele	67	0 (0.00)	0.00	[0.00,4.38]
Holoprosencephaly	41	1 (2.44)	1.92	[0.05,10.84]
Hydrocephaly	367	15 (4.09)	3.22	[1.77,5.45]
Microcephaly	327	3 (0.92)	0.72	[0.15,2.15]
Anophthalmia/ Microphthalmia	102	4 (3.92)	3.09	[0.83,8.05]
Cataract	39	2 (5.13)	4.04	[0.49,14.80]
Glaucoma	11	0 (0.00)	0.00	[0.00,26.68]
Anotia/Microtia	140	1 (0.71)	0.56	[0.01,3.17]
Truncus arteriosus	24	1 (4.17)	3.28	[0.08,18.52]
Transposition of great arteries	138	3 (2.17)	1.71	[0.35,5.08]
Tetralogy of Fallot	124	2 (1.61)	1.27	[0.15,4.66]
Single ventricle	28	0 (0.00)	0.00	[0.00,10.48]
Ventricular septal defect	1,338	17 (1.27)	1.00	[0.57,1.65]
Atrial septal defect	704	12 (1.70)	1.34	[0.68,2.40]
Endocardial cushion defect	76	2 (2.63)	2.07	[0.25,7.60]
Pulmonary valve atresia and stenosis	311	6 (1.93)	1.52	[0.55,3.37]

hypertension, obesity, and diabetes may increase infant morbidity and mortality without necessarily resulting in birth defects.[7-9] However the high birth defect rate among non-resident deliveries suggests this is one of the primary reasons for transfer to Hawai'i for delivery. If this is true, then the presence of a birth defect must have been known or suspected prior to transfer. This assertion is supported by the observations of significantly higher rates of non-resident deliveries with use of prenatal diagnostic procedures and prenatal diagnosis of a defect. But not only must a birth defect have been known or suspected, but it must have been believed that the birth defect placed the fetus or infant at increased risk of morbidity and mortality or required specialized treatment. This contention is corroborated by the substantially increased non-resident rates among pregnancy outcomes associated with fetal and infant death, higher numbers of diagnosed major birth defects, and attempted cytogenetic analysis. Moreover, the eight birth defects with significantly higher non-resident rates can all be prenatally diagnosed and are associated with increased morbidity and mortality or may require specialized treatment.

The non-resident delivery rates varied among the racial/ethnic groups studied. This is likely related to the racial/ethnic composition of the states and countries from which the mothers originated. Of particular note was the very high non-resident delivery rate among Guamanians. This should not be surprising considering that the highest number of infants/fetuses with birth defects born to non-residents from US states and territories involved mothers who came from Guam.

The non-resident delivery rate was also higher with increased maternal age but lower number of prior pregnancies. This pattern is unusual because of the observation that maternal age is associated with increased gravidity and that older women are at increased risk of adverse pregnancy outcomes.[10] The greater non-resident delivery rate among women with more education may be a consequence of more highly educated women being more likely to use prenatal care and prenatal diagnostic procedures.

The non-resident delivery rate was substantially higher in the City and County of Honolulu than compared to the other counties in Hawaii. This observation is not surprising considering that most of the genetic counseling and pediatric tertiary care facilities in the state are in the City and County of Honolulu.

The non-resident rates varied greatly by specific type of birth defect but were higher than the general rate for three-fifths of the specific birth defects studied. Thus the impact of inclusion or exclusion of non-resident deliveries may depend on the type of birth defect of interest. As noted previously, those birth defects with significantly higher non-resident rates tended to be birth defects that can be prenatally diagnosed and can impact morbidity and mortality. However, it should be noted that other birth defects such as anencephaly and trisomy 13 that can be prenatally diagnosed and impact morbidity and mortality had lower non-resident rates.

In conclusion, this study found that only slightly more than 1% of deliveries in Hawai'i of infants and fetuses with birth defects were to non-residents. The majority of non-resident deliveries with known reason for delivering in Hawai'i were intentional. Higher non-resident rates were found with selected birth defects, increasing number of diagnosed birth defects, fetal or infant death, multiple births, older maternal age, lower number of prior pregnancies, higher maternal education, prenatal diagnosis, and attempted cytogenetic analysis. Since the applicability of these results to other US birth defects registries is unknown, similar studies by other registries are recommended.

Acknowledgements

We wish to thank Edward R. Diaz for his computer assistance, A. Michelle Weaver and Amy M. Yamamoto for their data collection activities, and the 34 participating Hawai'i health facilities who allowed us access to their patient data.

References

1. National Birth Defects Prevention Network. State birth defects surveillance program directory. Birth Defects Res A Clin Mol Teratol. 2004;70:609-676.
2. Forrester MB, Merz RD. Residence, delivery and referral patterns of infants and fetuses with birth defects delivered in Hawaii, 1986-1999. Public Health. 2003;117:128-134.
3. Little J, Elwood JM. Epidemiology of neural tube defects. In: Kiely M, ed. Reproductive and Perinatal Epidemiology. Bocu Raton, Florida: CRC Press Inc, 1991:251-336.
4. McDonnell RJ, Johnson Z, Delaney V, Dack P. East Ireland 1980-1994: epidemiology of neural tube defects. J Epidemiol Community Health. 1999;53:782-788.
5. Stevenson RE, Allen WP, Pai GS, Best R, Seaver LH, Dean J, Thompson S. Decline in prevalence of neural tube defects in a high-risk region of the United States. Pediatrics. 2000;106:677-683.
6. Centers for Disease Control and Prevention. Use of folic acid for prevention of spina bifida and other neural tube defects - 1983-1991. MMWR Morb Mortal Wkly Rep. 1991;40:513-516.
7. Cedergren MI. Chronic hypertension and the risk for adverse pregnancy outcome after superimposed pre-eclampsia. Int J Gynaecol Obstet. 2004;86:7-11.
8. Lucas MJ. Diabetes complicating pregnancy. Obstet Gynecol Clin North Am 2001;28:513-536.
9. Vanek M, Sheiner E, Levy A, Mazor M. Chronic hypertension and the risk for adverse pregnancy outcome after superimposed pre-eclampsia. Int J Gynaecol Obstet. 2004;86:7-11.
10. van Katwijk C, Peeters LL. Clinical aspects of pregnancy after the age of 35 years: a review of the literature. Hum Reprod Update. 1998;4:185-194.

Diagnosis	Total No.	Non-residents No. (%)	Rate Ratio	95% confidence interval
Tricuspid valve atresia and stenosis	55	2 (3.64)	2.86	[0.34,10.50]
Ebstein's anomaly	16	0 (0.00)	0.00	[0.00,18.35]
Aortic valve stenosis	40	1 (2.50)	1.97	[0.05,11.11]
Hypoplastic left heart syndrome	56	1 (1.79)	1.41	[0.04,7.94]
Coarctation of aorta	77	0 (0.00)	0.00	[0.00,3.81]
Interrupted aortic arch	15	1 (6.67)	5.25	[0.13,29.63]
Anomalous pulmonary venous return	43	1 (2.33)	1.83	[0.05,10.34]
Choanal atresia and stenosis	41	0 (0.00)	0.00	[0.00,7.16]
Cleft palate	237	3 (1.27)	1.00	[0.20,2.96]
Cleft lip with or without cleft palate	411	5 (1.22)	0.96	[0.31,2.28]
Esophageal atresia and/or tracheoesophageal fistula	70	0 (0.00)	0.00	[0.00,4.19]
Pyloric stenosis	254	1 (0.39)	0.31	[0.01,1.75]
Small intestinal atresia and stenosis	90	5 (5.56)	4.38	[1.40,10.40]
Rectal and large intestinal atresia and stenosis	163	3 (1.84)	1.45	[0.30,4.30]
Hirschsprung's disease	69	0 (0.00)	0.00	[0.00,4.25]
Biliary atresia	33	1 (3.03)	2.39	[0.06,13.47]
Malrotation of intestines	91	4 (4.40)	3.46	[0.93,9.02]
Hypospadias and epispadias	867	10 (1.15)	0.91	[0.43,1.71]
Renal agenesis and hypoplasia	151	6 (3.97)	3.13	[1.13,6.95]
Cystic kidney	145	8 (5.52)	4.35	[1.85,8.75]
Obstructive genitourinary defect	464	13 (2.80)	2.21	[1.15,3.87]
Bladder exstrophy	10	0 (0.00)	0.00	[0.00,29.35]
Persistent cloaca	5	0 (0.00)	0.00	[0.00,58.70]
Congenital hip dislocation	313	1 (0.32)	0.25	[0.01,1.42]
Polydactyly	562	4 (0.71)	0.56	[0.15,1.46]
Syndactyly	278	4 (1.44)	1.13	[0.31,2.95]
Reduction deformity of upper limbs	117	2 (1.71)	1.35	[0.16,4.93]
Reduction deformity of lower limbs	48	0 (0.00)	0.00	[0.00,6.12]
Craniosynostosis	162	2 (1.23)	0.97	[0.12,3.56]
Diaphragmatic hernia	81	3 (3.70)	2.92	[0.60,8.66]
Omphalocele	93	4 (4.30)	3.39	[0.91,8.82]
Gastroschisis	110	2 (1.82)	1.43	[0.17,5.25]
Situs inversus	37	4 (10.81)	8.51	[2.30,22.18]
Trisomy 21	481	9 (1.87)	1.47	[0.66,2.86]
Trisomy 13	62	1 (1.61)	1.27	[0.03,7.17]
Trisomy 18	154	6 (3.90)	3.07	[1.11,6.81]
Total	14,335	182 (1.27)	reference	

Excessive Sweepstakes Participation in Patients with Dementia in Hawai'i: A Case Series

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Abstract

We report a case series of 11 patients with excessive sweepstakes participation on initial geriatric consultation in Honolulu. Ten of these patients had dementia, mostly Alzheimer's disease, with Folstein MiniMental Status Exam scores ranging from 17-29/30. Money lost ranged from $6,600 to $200,000-400,000. Physicians need to have a high index of suspicion and the public needs to be educated about simple preventive strategies.

Introduction

Participation in sweepstakes can have severe financial consequences for people. The Federal Bureau of Investigation estimates fraudulent telemarketers represent 10% of the industry.[1] What's more, a lot of sweepstakes organizations target the elderly. The American Association of Retired Persons (AARP) estimates annual U.S. losses from telemarketing fraud at 40 billion dollars.[3] Under the unfair- or deceptive-practice law, fraudulent telemarketing is a crime. If convicted, a person in Hawai'i can be fined up to $10,000 per violation. The penalty is doubled if the victim is a senior citizen.[1] There are no good statistics to measure the scope of the problem in Hawai'i, but in 1997 the Office of Consumer Protection received 100 telemarketing complaints, which was felt to be the tip of the iceberg.[2] The AARP released a survey of 2000 Hawai'i members that showed perhaps 25% have been victimized by fraud. The national average is estimated to be somewhat less, approximately 20%. In that same survey only one in six filed complaints with the state.[3] Avoiding large losses of money requires intact judgment. People with dementia have impairment of judgment and therefore are at greater risk.

This is a case series of 11 patients with dementia who had participated excessively in sweepstakes and had lost substantial savings.

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Methods

This is a retrospective chart review study of 11 patients from the Kaiser Permanente of Hawai'i Outpatient Clinic and the Geriatrics Clinic at Kuakini Medical Center, who were noted to have lost substantial amounts of money on sweepstakes during geriatric consultation. Characteristics of each patient were recorded including age, sex, ethnicity, marital status, other household members, dementia type, stage of dementia, MMSE score, dollar amount lost, and if sweepstakes participation was the presenting sign. All chart reviews were performed by a single physician (lead author).

Institutional Review Board approval was obtained from Kaiser Permanente and Kuakini Medical Center. Since this was a retrospective chart review study, informed consent was not obtained from subjects.

Results

Demographic and medical characteristics of the cases in our series are reported in table 1. Six of 11 subjects (55% of the population) were female. Subjects were of several ethnic backgrounds including Caucasian (3/11, 27%), Asian/Pacific Islander (7/11, 64%), and mixed descent (1/11, 9%). Regarding marital status, 4/11 (36%) were married, 2/11 (18%) were divorced, and 5/11 (45%) were widowed. The majority of patients (7/11, 64%) lived with family members; however two of these patients did not receive supervision. Of the remainder 3/11 (27%) lived alone, and 1/11 (9%) lived in a care home. Ten of the 11 patients had a diagnosis of dementia, 8/11 (73%) had Alzheimer's disease, and 2/11 (18%) had fronto-temporal dementia. One person had an initial diagnosis of depression, and no follow-up, so it is unknown if she developed dementia at a later time. Scores on the MMSE[5] ranged from 17/30 to 29/30 with the mean score being 25/30. Dollar amount lost ranged from $6,600 to $200,000-$400,000. Some patients did not have an exact dollar amount lost listed on the chart. For example, the chart noted that one person lost so much that "she was evicted from her condominium and was assisted by catholic charities to find public housing." In 8/11 (73%) of cases, sweepstakes participation was one of the presenting symptoms of dementia, in 2/11 (18%) there was a prior diagnosis of dementia, and in 1/11 (9%) it was unclear.

Discussion

There is very little literature available on this subject. The authors did a literature search through medline,

Table 1.— Demographic and Medical Characteristics of Cases									
Pt #	M/F	Race	Marital Status	Living Situation	Diagnosis	MMSE Score	Amount of Money Lost	Medications Started	Was sweepstakes presenting sign?
1	F	Caucasian	Divorced	By herself	AD	26/30	Doesn't say. "evicted from condo"	Donepezil	Doesn't say. Seems disorganization and memory loss were first.
2	M	Hawaiian	Married	Wife & daughter	AD	22/30	$39,000	Donepezil	Yes. 10 yrs prior to consult.
3	M	Caucasian	Married	Wife, but on separate floors	AD	26/30	$40,000	Divalproex for hypomania	No. 5 yrs prior to consult. Memory impairment and repetition. 2 yrs. prior to consult sweepstakes started.
4	M	Caucasian/ African	Married	Wife	FTD	25/30	$200,000-$400,000	Divalproex, Donepezil considered	Yes. 7 yrs prior to consult. Also paranoia.
5	F	Hawaiian	Widowed	Son & daughter	AD	17/30	"Large amounts"	Haloperidol for behavior	Yes. In addition to memory impairment 3-4 yrs prior to consult.
6	F	Japanese	Married	By herself	AD	25/30	?	Donepezil	Yes. In addition to memory impairment 5 yrs prior to consult.
7	F	Chinese	Widowed	Daughter & granddaughter	AD	23/30	"Several thousands"	Paroxetine and Donepezil	Yes. "several yrs" prior to consult in addition to memory problems.
8	M	Japanese	Married	Wife who has dementia, daughter, granddaughter	AD	23/30	?	Considering Donepezil	Yes. In addition to memory impairment 3 yrs prior to consult.
9	M	Finnish	Widowed	Pohainani Care Home	Depression, FTD	29/30	> $12,000	Sertraline for depression	Yes. In addition to short term memory loss, 1 yr prior to consult.
10	F	Japanese	Widowed	Grandson, but does not supervise	AD	27/30	$6600 documented	None	Not sure. 3 yrs prior to consult had memory impairment; on "recent review" found sweepstakes, so could have been.
11	F	Japanese	Widowed	Herself, until 1997	Depression	29/30	$30,000	Continue Fluoxetine	Yes. 3 yrs prior to consult. Was first sign.

AD: Alzheimer's Disease. FTD: Frontotemporal Dementia

pubmed, and used key words "sweepstakes," "gambling," and "dementia." Only one article was found titled "Excessive Sweepstakes Participation by Persons with Dementia" by Mendez et al.[4] In this letter to the editor, they evaluated three patients with excessive sweepstakes participation as the presenting symptom of vascular dementia. Patient number one had an MMSE of 24/30, had multiple hyperintensities on MRI, and was treated with olanzapine, trazadone, and behavioral therapy. Patient number two had an MMSE of 23/30, had multiple hyperintensities on MRI, and was treated with haloperidol. Patient number three had an MMSE of 22/30, had multiple hyperintensities on MRI, and was treated with olanzapine. There were many differences between their letter and our report. All three of their patients were diagnosed with vascular dementia, while 8/11 or 73% of this study's patients were diagnosed with Alzheimer's disease. Their patients' MMSE scores ranged from 22/30-24/30, while this study's had a wide range of anywhere from 17/30 to 29/30 with a mean score of 25/30. Lastly, all three of their patients had paranoid delusions on presentation while only one out of eleven of this study's patients had paranoid delusions. This case series demonstrates that excessive sweepstakes participation can be seen in patients with any type of dementia.

What can be done to help this situation? First of all, physicians should have a high index of suspicion. In retrospect, 73% of patients in this series had excessive sweepstakes participation as one of the presenting signs of dementia. Early diagnosis of dementia through routine screening may be helpful to prevent this problem. Secondly, physicians should listen to the family. More than a few families specifically stated that the patient would have never succumbed in this fashion if they were not cognitively impaired. For example, one patient's family stated that he would have never done these kinds of activities before in his life as he was an analytical thinker, and would have known that there was little chance of winning in that form of sweepstakes. Thirdly, physicians should not assume that because there are other family members in the house, that it would prevent this from happening, since 64% of these subjects lived with one or more other persons in the house.

These are some educational tips that need to be relayed to the public: (1) be suspicious if you are told you have won a free gift, vacation, or prize, but you need to pay for postage, handling, taxes or anything else; (2) be suspicious if you must send money, give credit card numbers or bank account numbers, or have a check picked up by courier before you have had a chance to consider the offer carefully or if you are told you can't miss this "high profit" or "no risk" offer; and (3) If you have really won a prize, you would not receive word via bulk mail postage. Notification would be through registered, certified, or first class mail.

There are some general rules which should be relayed to patients: (1) don't buy by phone from unfamiliar companies. Always ask and wait for written material on any offer, charity, or expensive investment; (2) take time to make decisions. Legitimate companies shouldn't pressure you; (3) never send money or give credit card or bank account numbers to unfamiliar companies; and (4) you can

always contact the Better Business Bureau if you have questions. There are advising lines to check for tips on prizes, contests, and sweepstakes offers.

Once a physician has identified that a patient has been a victim, these are some possible strategies to offer the patient and family: (1) change to an unlisted phone number; (2) limit credit cards to only small amounts, i.e. several hundred dollars; (3) limit the amount in checking accounts; (4) have joint accounts and/or require 2 signatures on checks; (5) review credit card and bank statements monthly for unusual charges; (6) family members should interrupt suspicious calls tactfully; and (7) purchase a Post Office Box for mail deliveries.

Patients and families can contact the Office of Consumer Protection or the Better Business Bureau to report problems and warn others. The Office of Consumer Protection website is www.hawaii.gov/dcca/ocp. Call and write to these organizations to take names off the respective mailing lists:

Mail Preference Service
Direct Marketing Association, P.O. Box 9008
Farmingdale, NY 11735-9008

Telephone Preference Service
Direct Marketing Association, P.O. Box 9018
Farmingdale, NY 11735-9014

However, only organizations that participate with these groups will be affected. One can tell telemarketers not to call; the federal trade commission states it is illegal for a company to call asked to stop. Lastly, physicians should contact Adult Protective Services if they feel a patient is a target. In Hawai'i and many other states, physicians are mandated to report such cases of suspected elder abuse.

Acknowledgements

This project was supported in part by the John A. Hartford Foundation Center of Excellence in Geriatrics Grant, Department of Geriatric Medicine, John A. Burns School of Medicine, University of Hawai'i.

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References

1. Ohira, Rod "State Targets Telemarketing Fraud" Honolulu Star Bulletin Sept 10, 1998.
2. Watanabe, June "Help Authorities Stop Telemarketing Fraud" Honolulu Star Bulletin July 30, 1998.
3. Morse, Harold "AARP Battles Con Artists Targeting Isle Seniors" Honolulu Star Bulletin May 23, 2000.
4. Mendez et al. Excessive Sweepstakes Participation by Persons with Dementia *J of Am Geri Soc* Jul 2000; 48(7).
5. Folstein MF, Folstein SE, McHugh PR. MiniMental State: a practical method for grading the cognitive state of patents for the clinician. *J Psychiatr Res.* 1975; 12: 189-198.

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John A. Burns School of Medicine Class of 2010 Profile

Satoru Izutsu PhD, Senior Associate Dean
Chair, Admissions Committee, and
Marilyn Nishiki, Registrar

On August 4, 2006, at the "While Coat Ceremony", sixty-two students were inducted into the medical school. At the ceremony, alumni from the Class of 1981 placed on each in-coming student's shoulder a white coat, "cloak of compassion", and, in unison, students and all physicians present stood to recite the Hippocratic Oath.

The newly admitted students, 31 men and 31 women, were selected from a total of 1, 629 applicants from Hawai'i (219) and through out the mainland and Canada (1410). Of the total number, 173 non-residents and 164residents passed the academic screen and qualified to be interviewed.

Of the 62 in-coming class, 13 are re-applicants. Fifty-seven are residents of Hawai'i. Median age is 23. Self-declared ethnicity are: 16 Native Hawaii an/Other, 13 Mixed Asians, 8 Whites, 6 Japanese, 4 Chinese, 4 Filipino/Others, 3 Koreans, 2 Japanese/Other, 1 in each of the following: Guamanian/Chomorro, Korean/White, Thai/White, Samoan, Vietnamese, and 1 declined to respond.

Thirty-eight are graduates of private high schools and 24 are from public high schools. Forty-one completed their undergraduate colleges on the mainland U.S., 20 are from Hawai'i (2 Hawai'i Pacific University and 18 from the University of Hawai'i System), and one from the University of Guam. The mainland colleges represented are: Stanford University, University of Washington, Brigham Young University-Utah, Harvard University, Tufts University, University of California (UC)-Irvine, Baylor University, Brown University, Colgate University, Creighton University, Dartmouth College, Duke University, Eastern Washington University, Gonzaga University, Loyola Marymount University, MIT, Pepperdine University, St. Cloud State University, St. Mary's College of California, Santa Clara University, Seattle University, UC-Berkeley, UC-Davis, UCLA, UC-Santa Cruz, University of Southern Main, Washington University in St. Louis, Washington University, Wellesley College, Willamette University, and Yale University.

All students earned their Bachelor of Arts and/or Sciences Degrees. In addition, eight have their Masters Degrees. The largest number (19) are majors in Biology/Biological Sciences. Regardless of college majors that range from emphasis in subjects such as Chemistry, English, Real Estate, to Nursing, all students fulfilled the pre-medicine requirements as delineated in the website: http://jabsom.hawaii.edu/.

The academic credentials of the entering class are: Medians, Cumulative GPA, 3.62; Science GPA, 3.51: MCAT components, Verbal Reasoning, 9; Physical Sciences, 10; Writing Sample, Q; and, Biological Sciences, 10.

Seventy Interviewers, regular and clinical faculty, and fourth-year medical students conducted interviews on a one on one basis from September 2005 to March 2006. Each interviewer received an orientation conducted by the Chair of the Admissions Committee prior to seeing the first applicant. Interviewers were assigned 8-10 candidates and furnished with documents that included: personal history statement that the applicant wrote for the American Medical Colleges Admissions Service (AMCAS) and essays that addressed, "Why Medicine as a career choice" and "Why the John A. Burns School of Medicine." Interviewers had no knowledge of scores or personal data. The "bottom line" for interviewers was to advise the Admissions Committee as to whether the applicants will "make a physician." The interviewers explored, with each applicants, issues such as: leadership skills, interpersonal relationships, compassion to help others, and the strength and stamina to go through eight years of medical education and training. The interviewers' final recommendations included her/his selection of a category: "strongly recommend", "recommend with reservation", "recommend", or "do not recommend", accompanied by a confidential written explanation of why a specific recommendation was selected.

The documents from the Interviewers were submitted to the twelve-member Admissions Committee, 6 men and 6 women, 9 of whom are clinicians, two basic scientists, and one social scientist. They represented the major ethnic groups in Hawai'i as well as various age levels. In twenty-one meetings the Committee processed 337 qualified applicants.

Prior to each Admissions Committee's meeting, the Registrar assigned randomly the dossier to be discussed by a committee member. Members go on line, with a pre-assigned password to review the web-based AMCAS applications. The dossier includes: AMCAS application, MCAT scores, GPA scores and transcripts, letters of recommendations, interviews reports, and essays written by the applicants. Highlights of each section of the folder are reported sequentially to the Admissions Committee, after which there is a period for questions/answers and discussion. The Chair will call for a secret rating of 1-10 for each applicant reviewed. The confidential ratings are submitted to the Registrar. Three hundred thirty-seven (337) applicants were ranked. The top 53 were offered admission. Nine from the Imi Ho'Ola post-baccalaureate program joined to complete the roster of 62.

At the White Coat Ceremony of the Class of 2010, Dr. Damon Sakai, the keynote speaker, as he addressed the importance of professionalism, excellence in science, compassion and honor, reminded the class, "While compassion for ourselves and those we love enrich our lives, first and foremost, as physicians, we must nurture and protect the compassion we have for our patients. For when all is said and done, what they'll remember about us is our compassion."[1]

With those words, the 62 were inducted into the profession of medicine as MS1 (first year medical students) in the John A. Burns School of Medicine, University of Hawai'i. A rewarding future awaits them.

Reference

1. Sakai, Damon. (2006) "White Coat Ceremony Keynote Address" in the Hawai'i Medical Journal. Vol. 65.

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Public Health Approaches to Cancer Prevention

Jay E. Maddock PhD, Department of Public Health Sciences and Cancer Research Center of Hawai'i, University of Hawai'i, and Lola Irvin MEd, Healthy Hawai'i Initiative, Hawai'i Department of Health

Cancer is a major public health concern with over 564,000 cancer deaths predicted in the United States in 2006.[1] Most of these cancer deaths are preventable. The American Cancer Society estimates that in 2006, 170,000 cancer deaths are expected to be caused by tobacco use and an additional 188,000 caused by physical inactivity, poor nutrition, and overweight or obesity.[1] Immoderate sun exposure, heavy alcohol use, and sexually transmitted diseases also all contribute to the cancer burden in the United States.

To address this burden, population-based strategies are needed to alter human behaviors to reduce cancer risk. To impact the population, an intervention must not only be effective but must have substantial reach into the population.[2] For instance, a smoking cessation clinic with a quit rate of 85% that reaches 2,000 smokers per year results in a smaller impact than a social marketing campaign with a quit rate of 5% and a reach of 500,000 smokers. However, despite their promise, population-based mass media approaches alone have had little impact on health behaviors.[3]

In 1986, the first international conference on health promotion was held in Ottawa, Ontario, Canada. At this meeting, the Ottawa Charter for Health Promotion was developed. The Ottawa Charter expands the definition of health promotion to include creating supportive environments, building healthy public policy, strengthening community action, developing personal skills, and reorienting health services to promote health.[4] Out of this broader focus of health promotion and in reaction to a victim blaming ideology of personal responsibility for health and illness, the Social-Ecological model was developed.[5] The Social-Ecological Model is a theoretical model that takes a broad view of behavior and works from the premise that human behavior is determined by a combination of individual skills, abilities and psychosocial constructs as well as factors in the social and physical environment.[5] This ecological perspective highlights the need for approaching public health challenges on multiple levels and stresses interaction and integration of factors within and across levels. The levels of influence within the social-ecological model include:

1. *Public Policy:* local, state, and federal government policies, regulations and laws
2. *Community:* social networks, norms, standards and practices
3. *Institutional/Organizational:* rules, policies, procedures, environment, and informal structures within an organization or system
4. *Interpersonal:* family, friends, peers who provide social support and identity
5. *Individual:* awareness, knowledge, values, beliefs, attitudes, preferences

Research has shown that behavior change is more likely to endure when both the individual and the environment undergo change simultaneously.[6] Community programs to increase physical activity and healthy eating will be more effective when the environment and public policies are in place that provide safe places to walk and healthy food choices.[7] Together, the multilevel approaches create synergy and have a far greater influence on individuals, organizations, communities, and society as a whole, than either individual or environmental strategies could alone.

An excellent case example of the social ecological model is tobacco control efforts over the past 20 years. National as well as state and local efforts have reduced the adult prevalence of tobacco from 42.4% in 1965, to 30.1% in 1985 to 20.9% in 2004.[8] This reduction is due in part to a three pronged strategy focusing preventing initiation among youth, helping smokers to quit, and protecting non-smokers from second-hand smoke.[9] This effort has focused on each level of the social ecological model including public policy (i.e. cigarette taxes), community (i.e. enforcement of no tobacco sales to minors, tobacco quit lines), institutional/organizations (i.e. smoke-free workplaces), interpersonal (i.e. quit groups, youth anti-tobacco movements) and the individual (i.e. social marketing campaigns). The levels also work synergistically. Longitudinal research has shown that after the implementation of smoke-free workplace regulations, workers are more likely to support further legislation and are less likely to smoke.[10,11]

In Hawai'i, the social-ecological model has been used to address physical inactivity and poor nutrition through the Healthy Hawai'i Initiative. The tobacco settlement provided a unique opportunity for Hawai'i to address the problems of physical inactivity and poor nutrition. In 1999, the state legislature passed legislation mandating that the Hawai'i Department of Health (DOH) allocate 25% of the State's tobacco settlement money for disease prevention programs targeting tobacco, physical activity, and nutrition. The state used these funds to create the Healthy Hawai'i Initiative (HHI), a partnership between the DOH, the University of Hawai'i, Department of Public Health Sciences, and the Department of Education.

The overall goal of the HHI is to increase years of healthy life for all people of Hawai'i and reduce existing health disparities. The protective and risk factors addressed are tobacco, nutrition, and physical activity. The social-ecological model is employed to create sustainable changes that promote healthy lifestyles. Interventions are targeted at the individual, social, and environmental level and use a variety of channels including public education, education of health professionals, school-based programs, and community

Continued on p. 352

HAWAI'I MEDICAL JOURNAL

Issues in Medical Malpractice VI

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University of Hawai'i

QUESTION: During her hospital stay, an elderly patient noticed burn marks and abrasions on her extremities. She believed they resulted from the use of wrist and ankle restraints but could not prove it.

A. This is a case of *res ipsa loquitur* or 'the thing speaks for itself,' analogous to the leaving of surgical instruments in the abdomen.
B. If an unexpected adverse event occurs in the hospital, a good case of *res ipsa* can be made because the hospital team is in full control of the patient.
C. This is not a case of *res ipsa,* as the injuries may have resulted from excessive rubbing on the bed-sheets.
D. *Res ipsa* is good circumstantial evidence and the plaintiff will no longer need a medical expert to win her case.
E. The hospital cannot be liable because restraints were necessary to prevent the patient from thrashing around and posing a risk to herself and others.

ANSWER: Only C is correct. For *res ipsa* to be applicable, three conditions must be met: 1) the injury would not have occurred in the absence of someone's negligence, 2) the plaintiff was not at fault, and 3) the defendant had total control of the instrumentality that led to the injury. In some jurisdictions, *res ipsa* shifts the burden of proof to the defendant (normally the plaintiff has the burden of proof), and plaintiff will not need an expert witness to testify that there has been a breach of the standard of care. However, in most jurisdictions, *res ipsa* is considered mere circumstantial evidence that is rebuttable, and plaintiff will need an expert to prove causation and damages. D is therefore incorrect. The facts here are insufficient to constitute a clear case of *res ipsa,* making A and B incorrect.

Medical mishaps in the hospital occur under complex circumstances, which is why most courts are reluctant to invoke the *res ipsa* doctrine except in very special situations, e.g., sponge left in peritoneal cavity.

Answer E is also incorrect. Use of patient restraints, either physical or chemical, is taboo under current JCAHO standards. Pleading this line of defense is therefore unlikely to prevail. Studies indicate that injuries are more, not less, apt to occur with restraints, which literally deprive patients of their physical freedom. Other means of treating the patient must be found, e.g., baby-sitters.

The best answer is C. So long as defendant's negligence cannot be confidently assumed to be the cause of injury, invoking *res ipsa* will fail.

Res Ipsa Loquitur

The doctrine of common knowledge, more technically called *res ipsa loquitur* or 'the thing speaks for itself,' holds that where *"the plaintiff's evidence of injury creates a probability so strong that a lay juror can form a reasonable belief,"* a plaintiff may be entitled to a waiver of the requirement of expert testimony.[1] This doctrine is invoked rarely, usually in obvious examples of medical injuries such as amputation of the wrong limb, lung puncture following routine shoulder injection, or removal of the wrong vertebral disc. In one not so obvious example, the court allowed the case to go to the jury without benefit of expert testimony on the basis of common knowledge. The case involved the severance of a patient's ureter during a complicated hysterectomy.[2] The *res ipsa* doctrine was also allowed in a case where the plaintiff sustained injuries to the peroneal and tibial nerves after knee surgery.[3] On the other hand, an Illinois court disallowed a plaintiff from claiming that it was common knowledge that someone should be referred to a cardiologist for a heart condition.[4]

Res ipsa had its genesis in the classic 1863 English case where a barrel of flour fell upon the plaintiff from a window above a shop. Despite no other evidence, the court ruled for the plaintiff, opining that the circumstances constituted *prima facie* evidence of negligence (A *prima facie* case means the plaintiff has met the burden of going forward with evidence on the legal issue):

> *"I think it apparent that the barrel was in the custody of the defendant who occupied the premises, and who is responsible for the acts of his servants who had control of it; and in my opinion the fact of its falling is prima facie evidence of negligence . . ."*[5]

The *res ipsa* doctrine is most useful when the plaintiff has insufficient evidence of what caused the negligent act, but circumstances clearly indicate that the defendant was negligent. It is applicable only when three conditions are met:

1). The event, under the circumstances of the case, ordinarily does not occur in the absence of someone's negligence
2). The event must be caused by a means within the exclusive control of the defendant
3). The plaintiff did not contribute to the event

In most jurisdictions, *res ipsa* permits the jury to infer that a negligent act had taken place, but the defense may still be able to rebut the evidence. Courts are usually hostile to the use of the *res*

ipsa doctrine to prove medical malpractice, unless the circumstances clearly warrant the application of the doctrine. Even a case of dysuria in association with a deformed penis was deemed insufficient evidence to indicate negligent circumcision.[6]

In the well known California case of *Ybarra v. Spangard*, the court permitted the use of the *res ipsa* doctrine against multiple defendants in the operating room after the plaintiff developed shoulder injuries following an appendectomy.[7] Since the plaintiff was unconscious, the court felt it was appropriate to place the burden on defendants to explain how the shoulder injury occurred.

Courtroom eloquence concerning *res ipsa* was at its best in *Cassidy v. Ministry of Health*, an English case from the 1950s. In *Cassidy*, a patient suffered significant deformity of his hand following surgery for Dupuytren's contracture. His attorney asserted: *"At the outset, only two of the plaintiff's fingers were affected; all four are now useless. There must have been negligence — res ipsa."* The Court of Appeal agreed, Lord Denning taking the position that it raised a *prima facie* case against the hospital. However, Lord Denning also indicated that the doctrine could only be invoked against a doctor in extreme cases.[8]

The use of *res ipsa* is governed by statutes in some states. Georgia and North Dakota, for example, disallow the use of *res ipsa* in medical negligence cases.

This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is excerpted from the author's book, *"Medical Malpractice: Understanding the Law, Managing the Risk"* published in 2006 by World Scientific Publishing Co. You may contact the author, S.Y. Tan MD, JD, at email: siang@hawaii.edu or call (808) 526-9784 for more information.

References

1. *Gordon v. Glass*, 785 A.2d 1220 (Conn. App. 2001).
2. *Cangemi v. Cone*, 774 A.2d 1262 (Pa. Super. Ct. 2001).
3. *Hale v. Venuto*, 137 Cal.App.3d 910 (Cal.App. 1982).
4. *Evanston Hospital v. Crane*, 627 N.E.2d 29 (Ill. App. 1993).
5. *Byrne v. Boadle*, 2 H. & C. 722, 159 Eng. Rep. 299 (Court of the Exchequer 1863).
6. *Walker v. Skiwski*, 529 So.2d 184 (Miss. 1988).
7. *Ybarra v. Spangard*, 154 P.2d 687 (Cal. 1944).
8. *Cassidy v. Ministry of Health*, 2 KB 343 (1951).

"Cancer Research Center Hotline," from p. 350

initiatives.[12] During the development of the HHI, tobacco has been funded differently from the other risk behaviors due to the existence of a coordinated, ongoing tobacco prevention and control program within the HDOH. Interventions for nutrition and physical activity to date have included a social marketing campaign, teacher training for health and physical education standards, development of a coordinated school health program, community-based programs to increase access to safe places for physical activity, and a program to train physicians to provide counseling to patients on eating healthy and getting active. Evaluation results from 2000-2004 show the program is having an impact on low-fat milk consumption, fruits and vegetables intake, weight control, and physical activity.[13] However, much work still remains to be done. In 2006-2007, several additional programs are planned including the release of the state physical activity and nutrition plan, comprehensive community campaigns on walking and fruit and vegetable intake, a training program with pediatricians, and the development of state and county coalitions. The new programs reflect the need to continue increasing the capacity across the state to identify and implement strategic changes at the environmental, policy, and systems level to support individual behavioral change. The program was recognized by the Innovations in Prevention Award by the U.S. Department of Health and Human Services in 2006 as a model government program to address the obesity problem.

The social-ecological model appears to be a promising strategy for addressing cancer prevention at the population level. While there is much enthusiasm for this approach, there are still many areas in need of research. One of the key questions is how to assess the synergy between the levels of intervention. Also this model is a broad approach that differs greatly by behavior, so behavior specific models by nutrition and physical activity will need to be developed. With further development, the social ecological model should be an important tool to reduce the burden of cancer in our communities. For more information on the Cancer Research Center of Hawai'i, please visit its website at www.crch.org.

References

1. American Cancer Society. Cancer Facts and Figures 2006. Atlanta: American Cancer Society; 2006.
2. Glasgow, RE, Vogt, TM Boles SM. Evaluating the public health impact of health promotion interventions: The RE-AIM framework. *Am J Public Health*, 89:1323-27, 1999.
3. Task Force on Community Preventive Services. The Guide to Community Preventive Service: What Works to Promote Health? New York: Oxford University Press; 2005.
4. World Health Organization. Ottawa Charter for Health Promotion. International Conference on Health Promotion, Ottawa, Ontario, Canada, 1986.
5. McLeroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Ed Q*, 15, 351-77, 1988.
6. Sallis JF, Owen N. Ecological models of behavior. In K.Glanz, B. Rimer & F. Lewis (eds.) Health Education and Behavior 3rd. edition. San Francisco: Jossey-Bass; 2002.
7. Brownson RC, Haire-Joshu D, Luke DA. Shaping the Context of Health: A Review of Environmental and Policy Approaches in the Prevention of Chronic Diseases. *Annual Review Public Health*, 27:341-370, 2006.
8. Office on Smoking and Health, Centers for Disease Control and Prevention. Smoking Prevalence among US Adults. Accessed on-line on October 17, 2006 at www.cdc.gov/research_data/adults_prev/prevali.htm.
9. Warner KE. The need for, and value of, a multi-level approach to disease prevention: the case of tobacco control. In B.D. Smedley & S.L. Syme (eds.) Promoting Health: Intervention Strategies from Social and Behavioral Research. Washington, National Academy Press, 2000.
10. Tang H, Cowling DW, Stevens CM, Lloyd JC. Changes of knowledge, attitudes, beliefs and preference of bar owner and staff in response to a smoke-free bar law. *Tobacco Control*, 13, 87-9: 2004.
11. Heloma A, Jaakkola MS. Four-year follow-up of smoke exposure, attitudes, and smoking behavior following enactment of Finland's national smoke-free workplace law. *Addiction*, 98: 1111-7; 2003.
12. Hawai'i Department of Health. The Healthy Hawai'i Initiative: Progress Report. Honolulu, HI, 2000.
13. Maddock JE, Takeuchi L, Nett B, Tanaka C, Irvin L, Matsuoka C, Wood B. Evaluation of a statewide program to reduce chronic disease: the Healthy Hawai'i Initiative, 2000-2004. *Evaluation and Program Planning*, 29, 293-300, 2006.

Index to Hawai'i Medical Journal Volume 65, 2006

Compiled by Carolyn S.H. Ching MA, MLIS, AHIP and Laura E. Gerwitz MA, MLIS
of the Queen's Medical Center, Hawai'i Medical Library

AUTHORS INDEX

KEYWORD INDEX

Hawaii Medical Journal (Instructions to Authors)

Manuscripts

Submit scientific articles, essays, letters and other manuscripts to *Hawaii Medical Journal,* 1360 South Beretania Street, Suite 200, Honolulu, Hawaii 96814.

Manuscripts are reviewed by the editor, the peer review panel, and other experts in the particular specialties. Please be aware that your article will be edited to comply with the AMA style, corrected for grammar, and recommendations could be made by the peer reviewers.

- Please submit **five copies** on 8-1/2 x 11 paper. It is recommended the article be submitted on a floppy disk or CD with the manuscript. Please indicate what software you are using (Microsoft Word or Word Perfect). Submit only articles that have not been submitted elsewhere.
- Use Times font in 10 point size.
- Please do not underline and do not use full caps.
- Use double spaces between lines. Do not use 1-1/2 spacing.
- Number pages consecutively beginning with the title page.
- Graphs, tables and figures must be sized by the author, up to 7-1/2 inches in width. Please submit graphs, tables, and figures separate from text, do not embed them in the text.

A cover should contain the name of the author with whom HMJ will correspond, include an address, phone number, fax number and email, along with a statement that the manuscript has been seen and approved by all authors.

Note: Keep manuscripts to 3,000 words maximum.

Title and Authors' Names

Please keep the title short, specific and *catchy* if possible. If the title submitted is too long, it will be edited. List first name, middle initial and last name of each author with highest academic degrees; name of department and institution to which the work should be attributed; name and address of author to whom requests for reprints will be addressed, or statement that reprints are not available; the source of support in the form of grants, equipment, drugs, or all of these.

Abstract (see Synopsis-Abstract)

The second page of the manuscript should include an abstract no longer than 60 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Style

Use *JAMA* style or consult the AMA *Manual of Style*. Use the objective case, such as "the team determined" or "the study involved," not I or we, and avoid medical jargon. Use generic drug names unless citing a brand name relevant to your findings. Do not use abbreviations in the title and limit their use in the text. Use human terms, i.e. "men" and "women" instead of "males" and "females." Also place a comma before "and" in a series.

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Text

HMJ recommends that articles be divided into sections with headings:

Introduction.—The purpose of the article and rationale for the study. Do not review the subject extensively.

Methods.—Describe the patients or experimental animals clearly. Identify the methods, apparatus, and procedures in sufficient detail to allow other physicians to reproduce the results.

Results.—Present the results in logical sequence in the tables, illustrations, and tables. Do not repeat all of the data in the text, summarize important observations.

Discussion.—Emphasize the new and important aspects of the study and conclusions taken from them. Do not repeat data in Results section. State new hypotheses when warranted, but clearly label them as such. Recommendations may be included.

Illustrations, Tables, Graphs and Figures

Tables and graphs must be prepared in Microsoft Word or Excel. Numerical data should accompany graphs. Please limit the number of illustrations, tables, graphs, and figures.

Each figure or illustration should have a label pasted on the back indicating the figure number, name of authors, and the top of the figure. Do not write on the back, or scratch or mar them with paper-clips.

Illustrations must be clear, distinct, and unmounted.

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Type legends for illustrations starting on a separate page with arabic numbers corresponding to the illustrations. When symbols, arrows, numbers or letters are used to identify parts of the illustration, identify and explain each one clearly in the legend. Explain internal scale and identify method of shining in the photographs.

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All references must be cited in the text and should be arranged in the order in which they are cited—not alphabetically. Please use the JAMA style for the references:

1. Jones J. Necrotizing Candida esophagitis. *JAMA*. 1982,244:2190-2191.
2. Style L. *Biochemistry*. 2nd ed. San Francisco, Calif: WH Freeman Co; 1981:559-596. [Not CA]
3. Kavet J. Trends in the utilization of influenza vaccine: an examination of the implantation of public policy in the United States. In: Selby P, ed. *Influenza: Virus, Vaccines, and Strategy*. Orlando, Fla: Academic Press Inc; 1976:297-308.

Footnotes

Place footnotes outside of punctuation marks. (e.g. These include diabetes,[5] hypertension, orthopedic complications,[6] asthma, sleep apnea,[7] eating disorders[8] and psychosocial problems.[9])

Acknowledgments

Acknowledge only persons who have made substantial contributions to the study. Authors are responsible for obtaining written permission from everyone acknowledged by name; readers might believe those acknowledged are endorsing the study and conclusions.

Reprints

Authors may order article reprints for a fee; however, a copy of the *Journal* will be sent to each author from which photo-copies may be made.

Synopsis-Abstract

In this age of electronic data retrieval, a well-written synopsis-abstract has become increasingly important in directing readers to articles of potential clinical and research value. The synopsis-abstract summarizes the main points of an article: (1) the purpose of the study, (2) the basic procedures followed, (3) the main findings, and (4) the *principal* conclusions. Expressions such as "X is described," "Y is discussed," "Z is also reviewed" should be avoided in favor of a *concise* (limited to 135 or 150 words in AMA's journals) statement. A few specific guidelines to consider in preparing a synopsis-abstract follow:

- Do not begin the abstract with repetition of the title.
- Omit ***P*** values.
- Cite no references.
- Avoid abbreviations.
- Use the salt or ester of a drug at first mention.
- If an isotope is mentioned, when first used spell out the name of the element and then, on line, give the isotope number.
- Avoid the use of trademarks or manufacturers' names unless they are essential to the study.
- Include major terms in the abstract, since the abstract can be text searched in many data retrieval systems. This will enable the article to be retrieved when relevant.

References to Books

Complete Data.–A complete reference to a book includes (1) authors' surnames and initials; (2) surname and initials of editor or translator, or both, if any; (3) title of book and subtitle, if any; (4) number of editions after the first; (5) place of publication; (6) name of publisher; (7) year of publication; (8) volume number, if there is more than one volume; and (9) page numbers, if specific pages are cited.

Example:
1.Stryer L. *Biochemistry*. 2nd ed. San Francisco, Calif: WH Freeman Co; 1981:559-596.

References to Website Example

1. Roth AE. Report on the design and testing of an applicant proposing matching algorithm, and comparison with the existing NMRP algorithm [design review of the National Resident Matching Program home page]. December 6, 1996. Available at: http://www.pitt.edu/~alroth/phase.1html. Accessed August 1, 1997.

For assistance with tables, figures, charts, and graphs you may contact Drake Chinen, at (808) 383-6627.

Table Sample

Table 1.— Age Structure of the Study Population

Age	Ebeye CHC Study Population	%	Ebeye Census	%
30-39	302	43%	1227	45.5%
40-49	206	30%	843	31.2%
50-59	110	16%	391	14.5%
60-74	52	7.5%	193	7.2%
≥ 75	22	3.1%	40	1.5%
Total	692		2694	

Comparison of age structure of study population with age structure of residents of Ebeye as recorded in 1999 Census.

Figure Sample

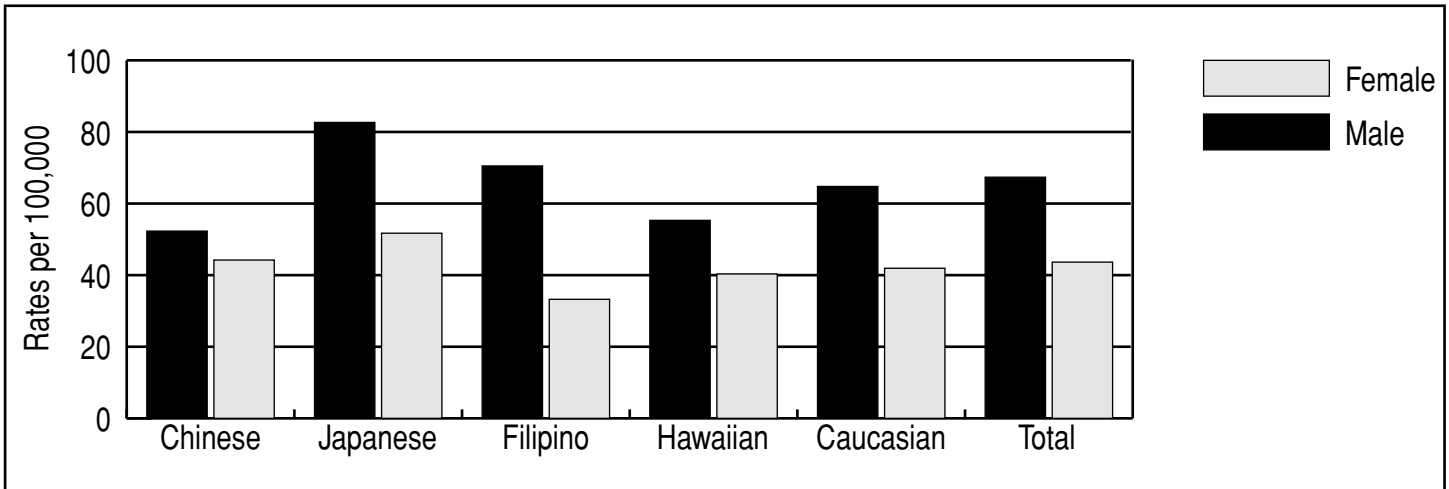

Figure 1.— Incidence of Invasive Colorectal Cancer, Hawaii 1996-2000 (Age-adjusted to the US 2000 Population)

UPCOMING CME EVENTS

Date	Specialty	Sponsor	Location	Meeting Topic	Contact
January 2007					
1/17-1/22	D	American Academy of Dermatology	Wailea Beach Marriott Resort & Spa, Wailea, Maui	3rd Annual Advances in Cosmetic & Medical Dermatology	Tel: (312) 321-0150 Web: www.acmd-derm-hawaii.com
1/19-1/20	Multi	Queen's Medical Center	Hilton Waikiki Prince Kuhio Hotel	Surf the Neuro Challenge 2	Tel: (808) 547-4731
1/20-1/24	PCC	American Lung Association of Hawai'i, Hawai'i Thoracic Society	Maui Prince Hotel, Maui	7th Annual Symposium: Current Concepts in Pulmonary and Critical Care	Tel: (480) 301-4580 Web: www.ala-hawaii.org
1/21-1/25	ON, FM	American Association for Cancer Research	Hilton Waikoloa Village, Waikoloa	In the Forefront of Basic and Translational Cancer Research AACR/JCA 7th Joint Conference	Tel: (215) 440-9300 Web: www.aacr.org
1/21-1/25	GS, SPI	Mayo Clinic College of Continuing Medical Education	Hapuna Beach Prince Hotel, Kohala Coast	International Spine Surgery Symposium 2007	Tel: (480) 301-4580 Web: www.mayo.edu/cme
1/22-1/25	CD	Mayo Clinic College of Continuing Medical Education	Hapuna Beach Prince Hotel, Kohala Coast	Arrhythmias & the Heart in Hawai'i	Tel: (480) 301-4580 Web: www.mayo.edu/cme
1/29-2/3	R, N	NYU School of Medicine	Four Seasons Resort, Hualalai	Neuroradiology (and Head & Neck) on the Big Island	Tel: (212) 263-5295 Web: www.radcme.med.nyu.edu
February 2007					
2/14-2/18	OBG	Ian MacDonald Inter-University of Medical Unltrasound Hawai'i & Department of OB/GYN and Women's Health, JABSOM	Hyatt Regency Waikiki Resort & Spa, Honolulu	Evidence-based OB/GYN: Practical Application of New Advances	Tel: (808) 203-6528 Email: ckawahar@hawaii.edu
2/14-2/18	OBG	Ian MacDonald Inter-University of Medical Unltrasound Hawai'i & Department of OB/GYN and Women's Health, JABSOM	Hyatt Regency Waikiki Resort & Spa, Honolulu	Contemporary Ob/Gyn Ultrasound: Recent Advances and Clinical Practice	Tel: (808) 203-6528 Email: ckawahar@hawaii.edu
2/2-2/3	P	Mayo Clinic College of Continuing Medical Education	Sheraton Kauai Resort, Poipu Beach, Kauai	Psychiatric Pharmacogenomics	Tel: (480) 301-4580 Web: www.mayo.edu/cme
2/3-2/4	OPH	Hawai'i Ophthalmological Society	Halekulani Hotel, Honolulu	23rd Annual Hawai'i Ophthalmological Spring Update	Tel: (808) 521-3535 Email: mwseminar@yahoo.com
2/4-2/9	GS, VS, TS	Mayo Clinic College of Continuing Medical Education	Wailea Beach Marriott Resort & Spa, Wailea, Maui	Mayo Clinic Interactive Surgery Symposium	Tel: (480) 301-4580 Web: www.mayo.edu/cme
2/10-2/16	PD	University Childrens Medical Group	The Westin Maui	Pediatric Potpourri State of the Art 2006	Tel: (800) 354-3263 Web: www.ucmg.org/cme.html
2/10-2/16	NPM	Keck School of Medicine of USC	The Westin Maui	Perinatal Medicine 2007	Tel: (800) 872-1119
2/12-2/16	IM, FM	Mayo Clinic College of Continuing Medical Education	Sheraton Keauhou Resort, Kona	Selected Topics in Internal Medicine	Tel: (480) 301-4580 Web: www.mayo.edu/cme
2/17-2/24	OTO	Otolaryngology Research Foundation	Hilton Hawaiian Village, Honolulu 2/17-2/20 Hyatt Regency Hotel, Kaanapali Beach, Maui 2/21-2/24	Otolaryngology Updates	Tel: (916) 923-0820
2/18	R	Mayo Clinic College of Continuing Medical Education	Hapuna Beach Prince Hotel, Kohala Coast	Advanced Radiology Life Support Course	Tel: (480) 301-4580 Web: www.mayo.edu/cme
2/18-2/23	R	University of California, San Francisco	Fairmont Orchid Hawai'i, Kamuela	Body Imaging in Paradise	Tel: (415) 476-5808 Web: www.cme.ucsf.edu
2/18-2/23		University of California, San Francisco	Grand Hyatt, Kaua'i	Infectious Disease in Clinical Practice	Tel: (415) 476-5808 Web: www.cme.ucsf.edu

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Russell T. Stodd MD

❖ **BEAUTY COMES FROM WITHIN – JARS, TUBES, SYRINGES.**
Historically, Allergan Inc., of Irvine, California, has been known for its ophthalmic products. Not any longer! Ocular medications now seem to be relegated to a sideline. Along came *Botox* for paralyzing facial muscles and smoothing wrinkles, and now with the introduction of *Juvederm*, an injectable cosmetic product recently approved by the Food and Drug Administration, Allergan is deeply into facial aesthetics. Juvederm, a hyaluronic acid dermal filler, is used to treat the deep skin folds that run lateral to the nose and down to the corners of the mouth. The effect is to plump up the creases by adding subcutaneous volume, but like Botox, Juvederm will wear off in approximately six months. For baby boomers, there is no need to fear geezerhood. Facial remodeling can keep the AARP population looking youthful indefinitely, but like as with dental appointments, patients will have to see their cosmetic surgeon twice a year otherwise one morning they may look in the mirror and see the portrait of Dorian Gray. Allergan's TV consumer advertising budget jumped from zero three years ago to $120 million per year.

❖ **ON BRITISH AIRWAYS IT'S LIFE-RISK VS. COST BENEFIT ANALYSIS.**
Just seconds after take off from Los Angeles, California, last July the number two jet engine of a a British Airways Boeing 747 with 351 souls aboard burst into flame and had to be shut down. The air traffic controllers immediately prepared to bring the huge jet back to the airport, but instead the flight crew contacted headquarters in Britain for advice. To the shock of the tower controllers, the captain was advised that the aircraft was certified to fly on three engines and to continue on its regular flight plan! The airplane continued across the United States, the Atlantic Ocean and eventually landed in Manchester, England, short of its destination because of worries about fuel consumption. Wow, is that legal? Not according to Federal Aviation Administration rules, but apparently okay by British air regulations. British Airways denied that the cost involved was a consideration, but admitted that $30,000 of fuel would have had to be dumped, and about $250,000 in passenger penalties and reroutes could have ensued. And if another engine had burst into flame over the Atlantic what would that cost? This is a disgraceful example of money trumping the safety of human cargo.

❖ **THE CLOSEST THING TO IMMORTALITY ON EARTH IS A GOVERNMENT BUREAU.**
Nice work if you can get it, and you can get it if you happen to be in the right place with the right spouse. Mrs. Barack Obama, wife of the charismatic Illinois senator, suddenly found herself promoted to Vice President in the University of Chicago Hospitals system, and her salary jumped from $121,910 to $316,962 in her role as liaison with the south side community. President Michael Riordan who scheduled the promotion stated that he had planned for the role to expand to VP level to demonstrate greater outreach in south Chicago. Michelle Obama earned a bachelors degree from Princeton and law degree from Harvard and is surely worth the money. However, one wonders about the other sixteen veeps who are all paid between $291,000 to $364,000 in the not-for-profit system.

❖ **PACK MY BAGS, SWEETIE. I'M GOING TO BERMUDA AND GET A NEW LIVER.**
The *Joint Commission on Accreditation of Healthcare Organizations* (JCAHO) began accepting applications from overseas hospitals early in the 1990s. Now more than 100 hospitals in twenty countries on five continents have received JCAHO approval including fourteen new hospitals this year. Cities as diverse as Hyderabad, India; Milan, Italy; and Izmir, Turkey, provide services where satisfied patients claim the quality of care is superior to what they received here. Medical tourism is now a commonplace event as patients (and third party payers) seek huge discounts for various operations. Procedures such as vascular bypass and shunt will cost you USA $62,000, overseas $8,750; CABG USA $63,000, overseas $15,000; kidney transplant USA $73,000, overseas $28,000. As the saying goes, "follow the money." Obviously, there are risks in traveling abroad for major surgery, such as not understanding medical standards, surgical training, credentialing, and post-operative care. Moreover, what happens with complicated follow-up; does the patient return to India or Singapore or Brazil? And if a procedure is botched what is the recourse and venue for the unfortunate injured patient?

❖ **I CHANNEL SURFED FROM C-SPAN TO HOME SHOPPING NETWORK AND ACCIDENTALLY BOUGHT A CONGRESSMAN.**
It requires some sort of blinders to be a politician. House Speaker Dennis Hastert was told by aides and members of his own party more than two years ago that Florida Representative Mark Foley was engaging in e-mail conversations of a sexual nature with under age Capitol pages. With Foley it was like when Hastert read ex-Senator Packwood's diary – he couldn't wait to get to the bottom of the page. Apparently, when Hastert was informed, he is quoted as saying "It's been taken care of." Now he claims he only knew of the problem on Friday, September 30, 2006. Come on, Mr. Speaker. Surely Ted Kennedy and Bill Clinton would advise you to get on with honest damage control immediately. Denial or delay hoping the sin will disappear is ineffective, stupid, and exposes one as a liar. Motive in this case could be that Hastert was fearful of losing a vital seat in the House of Representatives.

❖ **HONESTY IS THE BEST POLICY, UNLESS YOU ARE A VERY GOOD LIAR.**
South Carolina revised its medical practice act last June, and the new law requires that an out-of-state physician must obtain a license before being able to offer testimony as an expert witness. Also, it is policy of the American Medical Association that providing expert testimony is considered the practice of medicine. The intention is to get medical-legal prostitutes off the street. It is no surprise that no such law has ever been suggested in Hawai'i. Now three attorneys have filed a lawsuit against the South Carolina Board of Medical Examiners claiming that the license requirement violates state and federal constitutional guarantees of equal protection, due process, and free speech. And professional integrity, how about protecting that, counselor?

❖ **ONE TEQUILA, TWO TEQUILA, THREE TEQUILA, FLOOR.**
A story in the *South Florida Sun Sentinel* stated that a 47-year-old off duty police officer was arrested for driving 90 MPH on the Florida turnpike when she swerved and almost collided with a police cruiser. She had a large open bottle of *Southern Comfort* on the seat and was naked from the waist down. When asked where her pants were, she replied, "I don't know." She refused to take a breath test, but failed the roadside sobriety test after donning a pair of sweat pants. Her job with the police department: DUI training for police recruits!

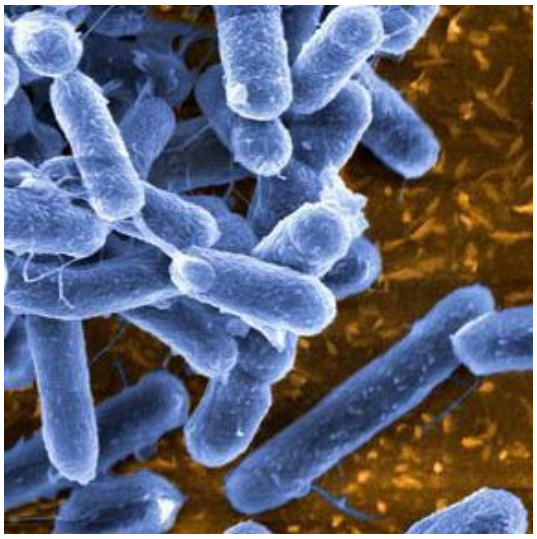
❖ **WHERE ARE YOU CALLING FROM? CAN YOU HEAR ME NOW?**
The Washington Post reported that four men held in a maximum security prison in El Salvador had inserted cell phones, including chargers and chips, into their rectums in order to communicate while in prison. Suspicious police officers ordered X-rays which revealed the presence of foreign objects "in the body cavity."

ADDENDA
- ❖36% of Americans between the ages of 18 to 29 have at least one tattoo.
- ❖It is not too late. You can still join the 728 people who are members of the I Hate Cilantro club.
- ❖We are born wet, naked, and hungry. After that things get worse.

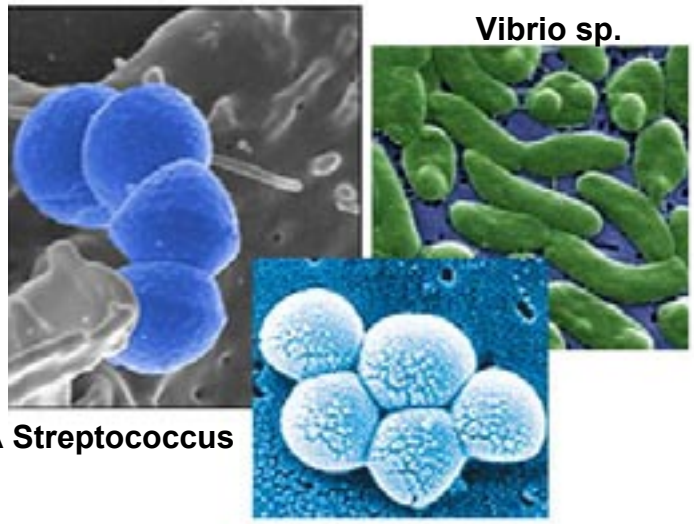
ALOHA AND KEEP THE FAITH — rts■

Contents of this column do not necessarily reflect the opinion or position of the Hawai'i Ophthalmological Society and the Hawai'i Medical Association. Editorial comment is strictly that of the writer.

Did you know all of these are reportable diseases?



E. Coli O157:H7



Vibrio sp.

Group A Streptococcus

Staphylococcus aureus

Health care providers in Hawaii are required to report clinically diagnosed complications of common infectious diseases such as:

Hemolytic Uremic Syndrome (HUS) & Necrotizing Fasciitis (NF)

To report an infectious disease *or* outbreak, call 24/7

Department of Health
Disease Outbreak Control Division

Oahu: (808) 586-4586
Maui: (808) 984-8213
Kauai: (808) 241-3563

East Hawai'i: (808) 933-0912
West Hawai'i: (808) 322-4877

For the most current information, visit the Department of Health website:
www.hawaii.gov/health/about/rules/rules/11-156.pdf

Hawaii State Department of Health

Medical Insurance Exchange of California (MIEC)

www.miec.com