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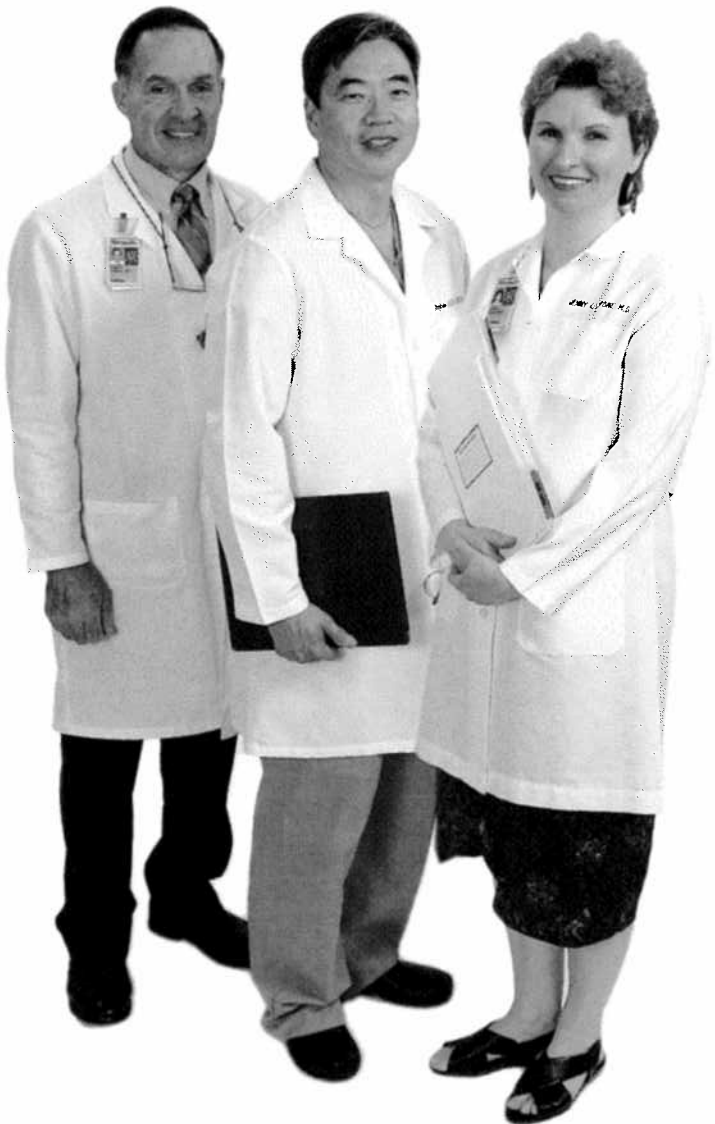


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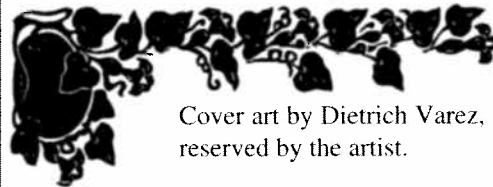
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Cover art by Dietrich Varez, Volcano, Hawaii. All rights reserved by the artist.

Aku Boat

Shown here is a typical scene on a tuna fishing boat in Hawaii.



Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

This month we feature a manuscript on an all too familiar topic, the problem of box jellyfish in Hawaii waters.

We published an earlier study by Craig Thomas MD and Susan Scott RN and their associates in the April 2001 issue of the Journal dealing specifically with the effects of hot or cold packs on box jellyfish stings. In this follow-up manuscript, emergency room physician Craig Thomas MD, Honolulu Star-Bulletin marine science writer Susan Scott RN, working with Daniel Galanis PhD, an epidemiologist with the Hawaii Department of Health, and Ralph Goto BEd, the very experienced water safety administrator with the City and County of Honolulu Parks and Recreation Department, study the efficacy of some popular remedies of box jellyfish stings.

Aldoph Meat Tenderizer has been used ever since the late Harry Arnold Jr. MD proposed its trial in the late 1960s. Despite the negative results of the study, beach-goers will undoubtedly continue to use this treatment for their stings. Other home remedies such as the application of figs, mustard, manure and perhaps the most common urine, will also persist. Hopefully, the work of these authors will help get the message out that they just don't work!

The most effective method of relief recommended by the authors is to spray or pour vinegar on the stung areas to inactivate the nematocysts, then flush the remaining tentacles with fresh or salt water, and either apply hot or cold packs or take hot or cold showers, "whichever makes the victims feel better."

The troika of books by Craig Thomas and Susan Scott: "All Stings Considered: First Aid and Medical Treatment of Hawaii's Marine Injuries", "Pests of Paradise" and "Poisonous Plants of Paradise" belong in every physician's office, first-aid station, school nurse's office, and hospital emergency room in our state. If you don't have them yet, I strongly urge that you add them to your library.

"Our AMA" or "How to cover collective assets"

Many of our readers go right to the back page to start reading the Hawaii Medical Journal. Just in case you don't read it back to front, or if you missed the item by our Contributing Editor Russell Stodd MD go to it right now.

The AMA needs leaders that lead. The AMA and HMA have lost too many members. Fortunately the HMA is on the road to recovery, but we need a more active membership. We need your commitment.



Commentary

Today's Health Crisis: A Laughing Matter?
Karyn Buxman RN, MSN, CSP

According to a recent study, one of every three U.S. nurses surveyed under age 30 planned to leave their jobs within the next year. One in five nurses plans to leave the profession within five years because of unsatisfactory working conditions. According to the Bureau of Labor Statistics, 450,000 additional registered nurse will be needed to fill the present demand through the year 2008. Experts worry about the year 2020, when the registered nurse shortage is projected to reach 500,000 positions, coinciding with the increasing needs of healthcare in an aging US population.

It is obvious that the state of health care today is no joke. But it may be a laughing matter, if one understands the premise that humor oftentimes is generated by painful circumstances. There is nothing funny about unlimited resources, job security or a physician who responds quickly and cheerfully to a nurse's request. The things that make nurses laugh tend to be the very things that drive nurses crazy.

While nurses often have no control over all the stressful events that happen in their lives, they do have a choice in how they respond to those happenings. No single strategy will be appropriate for every situation, so a healthy individual must have a repertoire of responses. Numerous means of coping with stress in a healthy manner are available, but one of those ways is with humor.

There are three primary functions of humor in the healthcare setting: psychological, social, and communicational.

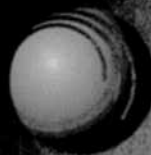
Psychological: As nurses become more anxious and their focus becomes narrower, they become less creative and are more easily angered. Stress may not come from the event itself, as much as from the nurse's perception of that event. Humor provides a perceptual flexibility that can increase one's sense of control. Learning techniques such as *catastrophizing the event*, where one takes the situation at hand and looks for the absurdity by asking, "How could this be worse?" may help the nurse put the event into its proper perspective.

Social: As Victor Borge, a well-known comedian, said so eloquently, "Laughter is the shortest distance between two people." When two or more can share in amusement, there is a commonality experienced among them, thus creating a bond. Some types of shared humor, such as self-effacing humor, reveal one's own flaws, 'humanness' and vulnerability. This 'revelation' creates an environment where the listener feels that it's safe to share, helping to develop rapport and establish or strengthen relationships. For that moment, the humor helps to diminish the perceived hierarchy, such as nurse/patient, doctor/nurse, or teacher/student while all involved participate in the fun.

Communicational: Sometimes a joke is just a joke. But often, true words are spoken in jest. It may be helpful for the nurse to know that frequently people will present a serious concern in the guise of a joke. A patient may joke about an embarrassing or frightening

Continued on p. 212

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BRIEF SUMMARY

47002/Issued: December 2000

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Ointment 0.1%**

**FOR DERMATOLOGIC USE ONLY
NOT FOR OPHTHALMIC USE**

INDICATIONS AND USAGE:

PROTOPIC Ointment, both 0.03% and 0.1% for adults, and only 0.03% for children aged 2 to 15 years, is indicated for short-term and intermittent long-term therapy in the treatment of patients with moderate to severe atopic dermatitis in whom the use of alternative, conventional therapies are deemed inadvisable because of potential risks, or in the treatment of patients who are not adequately responsive to or are intolerant of alternative, conventional therapies.

CONTRAINDICATIONS:

PROTOPIC Ointment is contraindicated in patients with a history of hypersensitivity to tacrolimus or any other component of the preparation.

PRECAUTIONS:

General

Studies have not evaluated the safety and efficacy of PROTOPIC Ointment in the treatment of clinically infected atopic dermatitis. Before commencing treatment with PROTOPIC Ointment, clinical infections at treatment sites should be cleared.

While patients with atopic dermatitis are predisposed to superficial skin infections including eczema herpeticum (Kaposi's varicelliform eruption), treatment with PROTOPIC Ointment may be associated with an increased risk of varicella zoster virus infection (chicken pox or shingles), herpes simplex virus infection, or eczema herpeticum. In the presence of these infections, the balance of risks and benefits associated with PROTOPIC Ointment use should be evaluated.

In clinical studies, 33 cases of lymphadenopathy (0.8%) were reported and were usually related to infections (particularly of the skin) and noted to resolve upon appropriate antibiotic therapy. Of these 33 cases, the majority had either a clear etiology or were known to resolve. Transplant patients receiving immunosuppressive regimens (e.g., systemic tacrolimus) are at increased risk for developing lymphoma; therefore, patients who receive PROTOPIC Ointment and who develop lymphadenopathy should have the etiology of their lymphadenopathy investigated. In the absence of a clear etiology for the lymphadenopathy, or in the presence of acute infectious mononucleosis, discontinuation of PROTOPIC Ointment should be considered. Patients who develop lymphadenopathy should be monitored to ensure that the lymphadenopathy resolves.

The enhancement of ultraviolet carcinogenicity is not necessarily dependent on phototoxic mechanisms. Despite the absence of observed phototoxicity in humans (see **ADVERSE REACTIONS**), PROTOPIC Ointment shortened the time to skin tumor formation in an animal photocarcinogenicity study (see **Carcinogenesis, Mutagenesis, Impairment of Fertility**). Therefore, it is prudent for patients to minimize or avoid natural or artificial sunlight exposure.

The use of PROTOPIC Ointment may cause local symptoms such as skin burning (burning sensation, stinging, soreness) or pruritus. Localized symptoms are most common during the first few days of PROTOPIC Ointment application and typically improve as the lesions of atopic dermatitis heal. With PROTOPIC Ointment 0.1%, 90% of the skin burning events had a duration between 2 minutes and 3 hours (median 15 minutes). Ninety percent of the pruritus events had a duration between 3 minutes and 10 hours (median 20 minutes). The use of PROTOPIC Ointment in patients with Netherton's Syndrome is not recommended due to the potential for increased systemic absorption of tacrolimus. The safety of PROTOPIC Ointment has not been established in patients with generalized erythroderma.

Information for Patients

(See patient package insert)

Patients using PROTOPIC Ointment should receive the following information and instructions:

1. Patients should use PROTOPIC Ointment as directed by the physician. PROTOPIC Ointment is for external use only. As with any topical medication, patients or caregivers should wash hands after application if hands are not an area for treatment.
2. Patients should minimize or avoid exposure to natural or artificial sunlight (tanning beds or UVA/B treatment) while using PROTOPIC Ointment.
3. Patients should not use this medication for any disorder other than that for which it was prescribed.
4. Patients should report any signs of adverse reactions to their physician.
5. Before applying PROTOPIC Ointment after a bath or shower, be sure your skin is completely dry.

Drug Interactions

Formal topical drug interaction studies with PROTOPIC Ointment have not been conducted. Based on its minimal extent of absorption, interactions of PROTOPIC Ointment with systemically administered drugs are unlikely to occur but cannot be ruled out. The concomitant administration of known CYP3A4 inhibitors in patients with widespread and/or erythrodermic disease should be done with caution. Some examples of such drugs are erythromycin, itraconazole, ketoconazole, fluconazole, calcium channel blockers and cimetidine.

Carcinogenesis, Mutagenesis, Impairment of Fertility

No evidence of genotoxicity was seen in bacterial (*Salmonella* and *E. coli*) or mammalian (Chinese hamster lung-derived cells) *in vitro* assays of mutagenicity, the *in vitro* CHO/HGPRT assay of mutagenicity, or *in vivo* clastogenicity assays performed in mice. Tacrolimus did not cause unscheduled DNA synthesis in rodent hepatocytes.

Reproductive toxicology studies were not performed with topical tacrolimus.

Pregnancy:

Teratogenic Effects: Pregnancy Category C

There are no adequate and well-controlled studies of topically administered tacrolimus in pregnant women. The experience with PROTOPIC Ointment when used by pregnant women is too limited to permit assessment of the safety of its use during pregnancy.

There are no adequate and well-controlled studies of systemically administered tacrolimus in pregnant women. Tacrolimus is transferred across the placenta. The use of systemically administered tacrolimus during pregnancy has been associated with neonatal hyperkalemia and renal dysfunction. PROTOPIC Ointment should be used during pregnancy only if the potential benefit to the mother justifies a potential risk to the fetus.

Nursing Mothers

Although systemic absorption of tacrolimus following topical applications of PROTOPIC Ointment is minimal relative to systemic administration, it is known that tacrolimus is excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from tacrolimus, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

PROTOPIC Ointment 0.03% may be used in pediatric patients 2 years of age and older. Two phase 3 pediatric studies were conducted involving 606 patients 2-15 years of age: one 12-week randomized vehicle-controlled study and one open-label, 1 year, long-term safety study. Three hundred and thirty (330) of these patients were 2 to 6 years of age.

The most common adverse events associated with PROTOPIC Ointment application in pediatric patients were skin burning and pruritus (see **ADVERSE REACTIONS**). In addition to skin burning and pruritus, the less common events (< 5% of varicella zoster (mostly chicken pox), and vesiculobullous rash were more frequent in patients treated with PROTOPIC Ointment 0.03% compared to vehicle. In the long-term 1 year safety study involving 255 pediatric patients using PROTOPIC Ointment, the incidence of adverse events, including infections, did not increase with increased duration of study drug exposure or amount of ointment used. In 491 pediatric patients treated with PROTOPIC Ointment, 3(0.6%) developed eczema herpeticum. Since the safety and efficacy of PROTOPIC Ointment have not been established in pediatric patients below 2 years of age, its use in this age group is not recommended.

Geriatric Use

Twenty-five (25) patients ≥ 65 years old received PROTOPIC Ointment in phase 3 studies. The adverse event profile for these patients was consistent with that for other adult patients.

ADVERSE REACTIONS:

No phototoxicity or no photoallergenicity was detected in clinical studies of 12 and 216 normal volunteers, respectively. One out of 198 normal volunteers showed evidence of sensitization in a contact sensitization study.

In three randomized vehicle-controlled studies and two long-term safety studies, 655 and 571 patients respectively, were treated with PROTOPIC Ointment.

The following table depicts the adjusted incidence of adverse events pooled across the 3 identically designed 12-week studies for patients in vehicle, PROTOPIC Ointment 0.03%, and PROTOPIC Ointment 0.1% treatment groups, and the unadjusted incidence of adverse events in two one year long-term safety studies, regardless of relationship to study drug.

Incidence Of Treatment Emergent Adverse Events

	12-Week, Randomized, Double-Blind, Phase 3 Studies						Open-Label Studies (up to 1 year)	
	12-Week Adjusted Incidence Rate (%)						0.1% Tacrolimus Ointment Incidence (%)	
	Adult		Pediatric		Adult	Pediatric		
	Vehicle n=212	0.03% Tacrolimus Ointment n=210	0.1% Tacrolimus Ointment n=209	Vehicle n=116	0.03% Tacrolimus Ointment n=118	n=316	n=255	
Skin Burning ¹	26	46	58	29	43	47	26	
Pruritus ¹	37	46	46	27	41	25	25	
Flu-like symptoms ¹	19	23	31	25	28	22	35	
Allergic Reaction	8	12	6	8	4	22	15	
Skin Erythema	20	25	28	13	12	12	9	
Headache ²	11	20	19	8	5	10	16	
Skin Infection	11	12	5	14	10	11	11	
Fever	4	4	1	13	21	2	18	
Infection	1	1	2	9	7	14	8	
Cough Increased	2	1	1	14	18	3	15	
Asthma	4	6	4	6	6	5	16	
Herpes Simplex	4	4	4	2	0	12	5	
Eczema Herpeticum	0	1	1	0	2	2	0	
Pharyngitis	3	3	4	11	6	5	10	
Accidental Injury	4	3	6	3	6	4	12	
Pustular Rash	2	3	4	3	2	6	8	
Folliculitis ³	1	6	4	0	2	11	2	
Rhinitis	4	3	2	2	6	5	5	

Otitis Media	4	0	1	6	12	1	7
Sinusitis ⁴	1	4	2	8	3	3	7
Diarrhea	3	3	4	2	5	4	6
Urticaria	3	3	6	1	1	5	5
Lack of Drug Effect	1	1	0	1	1	10	2
Bronchitis	0	2	2	3	3	3	6
Vomiting	0	1	1	7	6	1	5
Maculopapular Rash	2	2	2	3	0	4	3
Rash ¹	1	5	2	4	2	2	5
Abdominal Pain	3	1	1	2	3	1	5
Fungal Dermatitis	0	2	1	3	0	2	6
Gastroenteritis	1	2	2	3	0	4	2
Alcohol Intolerance ²	0	3	7	0	0	6	0
Ache ¹	2	4	7	1	0	2	4
Sunburn	1	2	1	0	0	4	4
Skin Disorder	2	2	1	1	4	1	4
Conjunctivitis	0	2	2	2	1	4	2
Pain	1	2	1	0	1	4	3
Vesiculobullous Rash ¹	3	3	2	0	4	2	2
Lymphadenopathy	2	2	1	0	3	2	3
Nausea	4	3	2	0	1	1	2
Skin Tingling ¹	2	3	8	1	2	2	1
Face Edema	2	2	1	2	1	3	1
Dyspepsia ²	1	1	4	0	0	1	4
Dry Skin	7	3	3	0	1	0	1
Hypoaesthesia ¹	1	3	7	0	0	3	0
Skin Neoplasm							
Benign ¹	1	1	1	0	0	2	3
Bak Pain ¹	0	2	2	1	1	3	1
Peripheral Edema	2	4	3	0	0	2	1
Varicella Zoster ¹							
Herpes Zoster ¹	0	1	0	0	5	1	3
Contact Dermatitis	1	3	3	3	4	1	1
Asthma	1	2	3	0	0	2	1
Pneumonia	0	1	1	2	0	1	2
Eczema	2	2	2	0	0	3	0
Insomnia	3	4	3	1	1	1	0
Exfoliative Dermatitis	3	3	1	0	0	0	2
Dysmenorrhea	2	4	4	0	0	0	2
Periodontal Abscess	1	0	1	0	0	3	0
Myalgia ¹	0	3	2	0	0	1	0
Cyst ¹	0	1	3	0	0	0	0

¹ May be reasonably associated with the use of this drug product

² Four cases of chicken pox in the pediatric 12-week study; 1 case of "zoster of the lip" in the adult 12-week study; 7 cases of chicken pox and 1 case of shingles in the open-label pediatric study; 2 cases of herpes zoster in the open-label adult study.

³ Generally "warts".

Other adverse events which occurred at an incidence greater than or equal to 1% in any clinical study include: alopecia, ALT or AST increased, anaphylactoid reaction, angina pectoris, angioedema, anorexia, anxiety, arrhythmia, arthralgia, arthritis, bilirubinemia, breast pain, cellulitis, cerebrovascular accident, cheilitis, chills, constipation, creatinine increased, dehydration, depression, dizziness, dyspnea, ear pain, ecchymosis, edema, epistaxis, exacerbation of untreated area, eye disorder, eye pain, furunculosis, gastritis, hernia, hyperglycemia, hypertension, hypoglycemia, hypoxia, laryngitis, leukocytosis, leukopenia, liver function tests abnormal, lung disorder, malaise, migraine, neck pain, neuritis, palpitations, paresthesia, peripheral vascular disorder, photosensitivity reaction, procedural complication, routine procedure, skin discoloration, sweating, taste perversion, tooth disorder, unintended pregnancy, vaginal moniliasis, vasodilatation, and vertigo.

OVERDOSAGE:

PROTOPIC Ointment is not for oral use. Oral ingestion of PROTOPIC Ointment may lead to adverse effects associated with systemic administration of tacrolimus. If oral ingestion occurs, medical advice should be sought.

DOSAGE AND ADMINISTRATION:

ADULT

PROTOPIC Ointment 0.03% and 0.1%

Apply a thin layer of PROTOPIC Ointment 0.03% or 0.1% to the affected skin areas twice daily and rub in gently and completely. Treatment should be continued for one week after clearing of signs and symptoms of atopic dermatitis.

The safety of PROTOPIC Ointment under occlusion which may promote systemic exposure, has not been evaluated. **PROTOPIC Ointment 0.03% and 0.1% should not be used with occlusive dressings.**

PEDIATRIC

PROTOPIC Ointment 0.03%

Apply a thin layer of PROTOPIC Ointment 0.03% to the affected skin areas twice daily and rub in gently and completely. Treatment should be continued for one week after clearing of signs and symptoms of atopic dermatitis. The safety of PROTOPIC Ointment under occlusion, which may promote systemic exposure, has not been evaluated. **PROTOPIC Ointment 0.03% should not be used with occlusive dressings.**

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Deerfield, IL 60015-2548
47002/Issued: December 2000

Box jellyfish (*Carybdea alata*) in Waikiki

The analgesic effect of Sting-Aid, Adolph's meat tenderizer and fresh water on their stings: A double-blinded, randomized, placebo-controlled clinical trial.

Craig S. Thomas MD*, Susan A. Scott RN, BA**, Daniel J. Galanis PhD***, and Ralph S. Goto BA****

Abstract

The study measured the analgesic effects of three popular Hawaii remedies for stings from the box jellyfish, *Carybdea alata*. Analysis of data showed that aerosol sprays of Sting-Aid (an aluminum sulfate solution), Adolph's meat tenderizer dissolved in water, and fresh water neither increased nor decreased the pain of box jellyfish stings more than the control (seawater).

Introduction

Each month, swarms of spawning¹ box jellyfish, *Carybdea alata*, appear in the nearshore waters and on the beaches of Honolulu on the 9th or 10th days after the full moon.² It is not known why this occurs in this area.

Carybdea alata is about 3 to 4 inches high and about 2 inches wide, and has pinkish tentacles trailing from the four corners of the square bell. The tentacles, which measure about 2.5 feet long, bear stinging cells called nematocysts, which sting and immobilize jellyfish prey. These nematocysts also sting people when the two species inadvertently collide.

Each nematocyst consists of a barbed, toxin-bearing tubule folded inside a fluid-filled capsule. A touch to the outside wall of the capsule causes hydrostatic pressure inside to evert the tubule and force toxin through the barbs and into the skin. This eversion and discharge occurs within 3 microseconds making it one of the fastest known events in biology.³ A nematocyst, therefore, can be thought of as a lightning-fast shotgun, the capsule being the cartridge case, the tubule being the shell, and the toxin-loaded barbs the buckshot.

The rash and pain caused by these box jellyfish stings are self-limited, usually disappearing with no treatment from 20 minutes to one day. A few victims suffer generalized reactions, persistent pain and/or recurring, itching rash. No confirmed deaths have occurred in Hawaii from box jellyfish stings, but the pain they inflict can be severe.

Home remedies for treating the pain of jellyfish stings are regional. Throughout the world people apply figs, mustard, manure and other substances on stings to ease the pain. Urine, usually the victim's own, is a widespread remedy common throughout the world, including Hawaii. Numerous Hawaii residents report that as

children they were taught to urinate in a jar at home and then take the jar to the beach to pour on stings. Meat tenderizer is also an accepted remedy in Hawaii. Beach-goers commonly keep bottles of it in their vehicles or beach bags to treat stings.

Another sting treatment in the U.S. emerged in 1991. A Pompano Beach Florida company, Knight Industries, began selling Sting-Aid, a solution marketed to "relieve the pain from stings and bites of sea lice, jellyfish, hydroids, stingrays, spiked fish, stinging nettles, fire coral, wasps, bees, ants, ticks, mosquitoes and sand fleas." Hawaii lifeguards began using Sting-Aid on jellyfish and Portuguese man-of-war stings and it was sold in some Hawaii dive shops and drug stores.

The authors undertook this study because neither Adolph's meat tenderizer, Sting-Aid nor fresh water had been studied as sting treatments in controlled, blinded clinical trials. Fresh water was included because some people report that taking a fresh water shower at the beach or at home after a sting relieved their pain. Others, however, report that applying fresh water to box jellyfish stings increased their pain. Before this study was done, it was not known if these treatments increased, decreased or had no effect on the pain of a sting.

Besides the value of this trial to victims, lifeguards and health care workers, Sting-Aid and Adolph's meat tenderizer have been a significant expense to the Honolulu City and County's Division of Ocean Safety.

Methods

This is the second part of an ongoing study examining the efficacy of different temperatures and solutions in treating the pain of box jellyfish (*Carybdea alata*) and Portuguese man-of-war (*Physalia* spp.) stings in Hawaii. The authors have neither applied for nor received funding to conduct or support any part of this study, which has been approved by The University of Hawaii's Human Subjects Committee.

This part of the study was carried out from January 1999 through December 2000 at Waikiki lifeguard towers 2C and 2D. During these two years, no ambulance service was required for any victims in the study.

Each patient 7 years old or older who came to a lifeguard tower complaining of pain from a sting, and was not in need of emergency assistance (as determined by the lifeguards), was sprayed with vinegar. Immediately after the liberal spraying, the researchers sprayed one of four solutions in unmarked, opaque spray bottles labeled A, B, C, and D. Field workers chose one of the four bottles

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randomly by reaching into a container and choosing the first one at hand. The spray bottles contained: A. fresh water, B. seawater (control) C. Sting-Aid, a commercial pain reliever consisting of water, detergent and aluminum sulfate (alum) and, D. Adolph's meat tenderizer, a commercial food compound consisting of more than 99 percent salt, sugar, food starch and less than 1 percent papain. A mixture of one part Adolph's powder in four parts of tap water produced a saturated solution.

Although applying a victim's own urine to his or her stings and marine injuries is one of the most common local remedies used in Hawaii, the authors deemed that testing it was inappropriate at a public beach.

After receiving the unmarked sprays, the victim made a single mark on a visual analog (VAS) pain scale from 1 to 100 millimeters at 0, 5, 10, and 15 minutes.

Results

Sample and Data Analysis

The dataset contained information on 63 individuals. However, one (in the fresh water group) dropped out after the vinegar dousing. The sample size for the analysis of pain score after treatment is therefore 62.

More serious sample attrition begins by the 5-minute mark. Only 56 participants gave complete data at 5 minutes, and only 32 at 10 minutes. Only 12 participants provided pain scores at 15 minutes, too few for analysis of treatment effects.

Thus, the most reliable results are those from the pain scores at 0 and 5 minutes. There were no clear associations between the treatment group and the rate of dropping out.

Starting at the 5-minute pain score, two different analytic methods were used: one which considered only the data actually collected, and another method in which missing pain scores were imputed with the last pain score recorded. Both methods give results that are limited in comparison to the results from the pain score at 0 minutes. The former method does not take into account any treatment effect on dropping out, and the latter relies on imputed pain scores.

The pain scores were analyzed as both continuous and binary outcomes. Graphical analyses indicated the pain scores were somewhat skewed, so a square root transformation was used for the analysis of covariance. The results were similar to those with the untransformed data, however, so the latter are presented here for ease of interpretation. Nonparametric statistical tests also corroborated the results obtained with the untransformed data. The analysis of covariance described the inter-treatment differences in the mean pain scores at 0, 5, 10 and 15

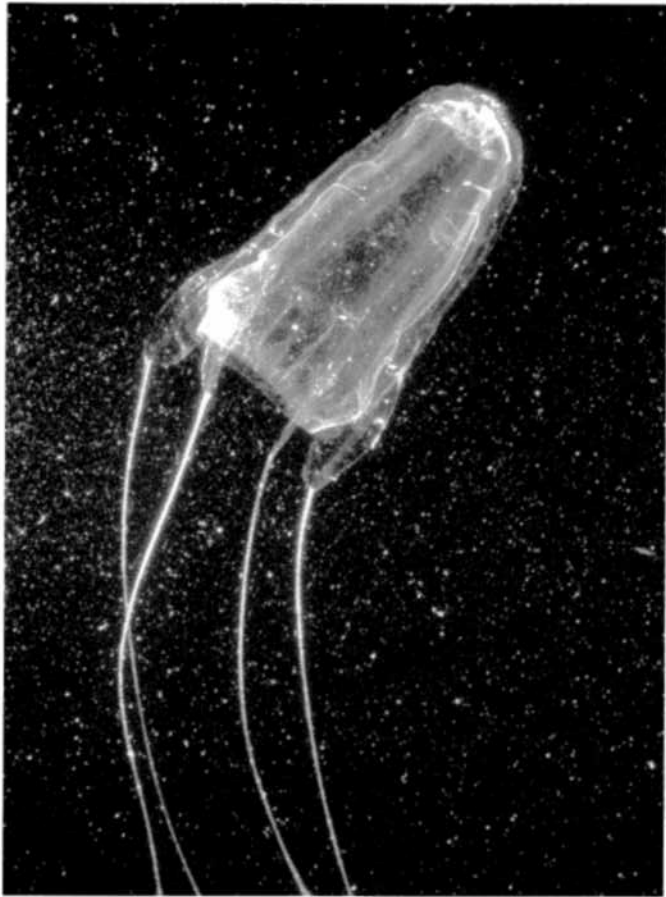
minutes, with statistical control for the pain score at 0 minutes for the last 3 outcomes.

A binary outcome was also constructed, depending on whether the participant experienced complete cessation of pain or not over the 15 minute testing period. However, only 4 of the 62 participants reported a final pain score of "0", 2 in the salt water group, and 1 each in the fresh water and Adolph's group. (One participant reported a 0 score at 0 minutes, but re-elevated pain scores after 5 and 10 minutes.) Because of this low number, the definition of cessation of pain was widened to include a final pain score of 10, which then included 16 participants. A logistical regression model was used to analyze the odds of the cessation of pain across the treatment groups, while controlling for initial (after vinegar dousing) levels of pain. Results are summarized in the following table. The 4 treatment groups had comparable pain scores after the vinegar dousing, suggesting the treatment randomization resulted in 4 similar groups. There were no statistically significant differences in pain scores between the treatment groups at any of the 3 succeeding pain score estimations: at 0, 5 and 10 minutes. This lack of treatment effect was consistent across both methods of analysis. In Method 1, there were some differences of magnitude between groups at 5 minutes (e.g. Adolph's vs. salt water group) and 10 minutes (e.g. fresh water vs. Sting-Aid), but the corresponding small group sizes by these times make it difficult to detect statistically significant differences. (Note the standard error estimates increase at the 5- and 10-minute marks

Estimated* average pain scores, by 5-minute intervals and treatment group.							
Group	time:	Method 1 ¹			Method 2 ²		
		vinegar dousing	0 min.	5 min.	10 min.	5 min.	10 min.
Adolph's	n	14	14	11	6	14	14
	pain score	40.7	36.5	36.9	38.6	38.4	38.2
	standard error of pain score	6.7	3.7	5.8	9.9	5.1	5.1
Fresh water	n	19	19	18	8	19	19
	pain score	44.3	38.9	34.5	40.7	33.9	32.3
	standard error of pain score	5.8	3.2	4.6	8.8	4.4	4.4
Salt water	n	16	16	14	9	16	16
	pain score	42.5	35.2	28.1	35.2	29.9	29.1
	standard error of pain score	6.3	3.5	5.2	8.0	4.4	4.8
Sting-Aid	n	13	13	13	9	13	13
	pain score	46.9	34.2	35.3	32.8	35.0	30.0
	standard error of pain score	7.0	3.8	5.4	7.9	5.3	5.3

*Estimates at 0, 5, and 10 minutes are adjusted for pain level after vinegar dousing (vinegar dousing).
¹Method 1 utilized only non-missing data in estimation of average pain scores.
²Method 2 imputed missing values after 5 minutes, using the last recorded pain level for all subsequent missing values.

The bottom of a box jellyfish (*Carybdea alata*) bell is almost perfectly square with tentacles about 2 feet long trailing from each of the four corners. These jellyfish swim about 2 miles per hour stinging shrimp and small fish with the abundant nematocysts on their tentacles. (Waikiki Aquarium)



This box jellyfish (*Carybdea alata*) was found swimming vigorously in the Ala Wai Boat Harbor on the 8th day after the full moon. The authors have handled these jellyfish by their bells often and suffered no stings. (Susan Scott)



in Method 1).

Prediction of the cessation of pain, by treatment group

The proportion of participants who experienced the cessation of pain within the study period was highest in the salt water group (6 of 16, or 38%) and lowest in the Adolph's group (2 of 14, or 14%). The proportions in the fresh water and Sting-Aid groups were 26% and 23%, respectively.

A logistical regression model was used to analyze the odds of cessation of pain across the treatment groups, while controlling for initial (after vinegar dousing) levels of pain. However, no significant differences were found for the odds of pain cessation across these 4 treatment groups.

Discussion

Analysis of early data showed that pain relief from the tested solutions was so similar to pain relief from the control (seawater) the authors terminated the study even though the dataset was smaller than needed for statistical significance. Continuing the study was not warranted since even with statistical significance, it was extremely unlikely that clinical significance would be achieved. Clinical

significance was defined according to two emergency department studies on VAS scores that found the minimum clinically significant difference in VAS pain scores was 9 and 11.^{4,5}

In discussing and studying the effects of jellyfish sting treatments, it is important to identify which facet of the sting is being addressed. Medically, there are three:

1. **PREVENTING FURTHER INJURY.** After a sting, invisible, undischarged nematocysts may remain on the skin's surface. To prevent further injury, these need to be inactivated.
2. **CONTROLLING PAIN.** Box jellyfish stings are painful. Sometimes the pain is severe, especially in sensitive areas, such as the face, neck, armpit or groin.
3. **TREATING TOXIC REACTIONS.** A few victims react to Hawaii's box jellyfish toxin more severely than others and have symptoms such as weakness, dizziness, nausea, vomiting and/or shortness of breath.

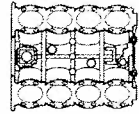
Continues on p. 210



*Based on manufacturer's data. **Based on *Ward's* Upper Luxury Class, comparably equipped models. INFINITI, the INFINITI logo, Accelerating the future, The New Q and INFINITI Model Names are Nissan

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In addition, nematocysts vary between species, so that a treatment that works for one facet of an injury in one species may or may not work for the same facet in another. For example, vinegar inactivates unfired nematocysts in box jellyfish but discharges them in some Portuguese man-of-wars. Because of this variability, and because jellyfish stings in Hawaii are usually self-limiting injuries, it is understandable that victims perceive a wide range of treatments as effective.

Meat tenderizer became a popular treatment in Hawaii after Honolulu dermatologist Harry L. Arnold recommended it for Portuguese man-of-war stings in a 1971 local publication.⁶ Arnold developed this treatment based on a newspaper article he read in 1969 suggesting that meat tenderizer may relieve the pain of insect stings. He advised a patient to dissolve a teaspoon of meat tenderizer in a quarter cup of water and rub the solution into the stings. Because the pain was gone in "a minute or two" and the marks disappeared within 30 minutes, Arnold began treating his patients with meat tenderizer and published a paper recommending it.

Nine years later, in 1980, Australian researchers discovered that both household vinegar (2–10% acetic acid in water) and acetic acid (1.2%–100% mixed in either water or seawater), rapidly, completely and irreversibly inhibited the discharge of nematocysts on the tentacles of the box jellyfish *Chironex fleckeri*.⁷ Although the effect of vinegar on the nematocysts of *Carybdea alata* has not been published, the treatment is used routinely on those stings in Hawaii. Sometime after 1980, Hawaii residents began mixing Arnold's treatment for the pain of Portuguese man-of-war stings (Aldolph's meat tenderizer) with the Australians' treatment for preventing box jellyfish nematocysts from discharging toxin (vinegar). For years, this mixture of meat tenderizer and vinegar has been the accepted treatment among lifeguards, emergency workers and beach-goers in Hawaii for both Portuguese man-of-war and box jellyfish stings.

In theory, the papain contained in meat tenderizer hydrolyzes the protein components of box jellyfish venom, and therefore, lessens the severity of the sting. In a bee venom study, however, applying Aldolph's meat tenderizer either topically or injecting it beneath the skin on mice with bee stings did not reduce the size of the lesion. Only when papain and bee venom were mixed in a syringe first, and then injected into the mice, was there inhibition of lesion formation.⁸

Because human skin consists of proteins, it was conceivable that applying a proteolytic enzyme to skin might cause further injury to a sting victim. The data did not support this theory, perhaps due to the small amount of papain (less than 1 percent) found in Aldolph's meat tenderizer.

One study testing the effects of substances on live, unfired *Chironex fleckeri* nematocysts, found that freshly collected human urine caused massive discharge after a 1 to 2 minute delay.⁷ This treatment, therefore, is not recommended for stings from the related *Carybdea alata*.

Based on the results of this study, the authors recommend the following treatment, in this order, for *Carybdea alata* stings:

1. Liberally spray or pour vinegar on the sting area to inactivate nematocysts.
2. Flush any clinging tentacles away with either fresh or salt water.

3. Apply either hot or cold packs, or take hot or cold showers (whichever makes the victim feel better) to ease pain.
4. Severe toxic reactions require analgesics and may improve with antihistamines and epinephrine.

Acknowledgements

The authors thank Honolulu lifeguard Landy Blair for his contributions to this study and for his service to the public. His conscientious work in Waikiki helps beachgoers both avoid and cope with the pain of Hawaii's box jellyfish stings.

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The Role Of Accreditation in Medical Education

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The John A. Burns School of Medicine of the University of Hawaii is preparing for reaccreditation, a process that the school must undergo at least every seven years. The reaccreditation process is a major institutional commitment that requires thousands of hours of preparation and extensive documentation. Contemplating the magnitude of the investment required to negotiate successfully the accreditation process, one might ask, "What is the intrinsic value of accreditation?" and "What role does it play in medical education?" Accreditation is mandatory for the 125 medical schools chartered in the United States, but not required for the operation of foreign based schools. In fact, the Kigezi International School of Medicine of Uganda and the Ross University School of Medicine in Dominica recently sought to establish branch campuses in the United States. Neither of these medical schools is accredited. Ross University recently abandoned plans to open a new campus in Casper, Wyoming, intended to enroll somewhere between six hundred and a thousand students annually. Such an influx of students, associated faculty, and staff required to educate them would have provided a significant economic boon to the community of Casper, Wyoming, but what is problematic about the establishment of such an unaccredited medical school is that in order to practice medicine in the United States, individuals must qualify and pass a series of licensing examinations administered by the National Board of Medical Examiners. To qualify, one must have graduated from a U.S. accredited school of medicine or be certified by the Educational Commission for Foreign Medical Graduates.

There are a number of reasons why accreditation is of importance. First, the quality of foreign medical schools is highly variable. This is evidenced by the fact that half of the graduates of foreign schools seeking licensure in the United States fail to pass the licensing examinations. In contrast, less than 5% of graduates of U.S. medical schools fail to pass these examinations. Thus, accreditation promotes a consistent standard of quality across the spectrum of U.S. medical education ensuring that the vast majority of physicians produced by the U.S. system are competent.

Second, requiring U.S. based medical schools to obtain accreditation has the effect of placing rational limits on the number of physicians in practice in the United States. Allowing unaccredited medical schools to open in the United States could potentially flood the physician marketplace with new graduates seeking to establish themselves in practice, thus driving the rapidly escalating cost of healthcare even more quickly. For example, if even half of the 1,000 students a year Ross intended to enroll had passed the licensure examination, the "successful" class size of 500 would far exceed the size of even the largest U.S. medical school.

If accreditation is in fact desirable, what does it consist of and what

role does it play in the healthcare system of our state and nation? The history of accreditation provides some instructive lessons for today's situation. In the years prior to 1900 there were hundreds of medical schools in operation in the United States. Many were small diploma mills that guaranteed a degree to any individual who could pay the money required for tuition. A healthcare system relying on this type of medical education, with no external standards available to insure quality, resulted in medical care that was highly variable, and on the whole, of dubious quality. Around the turn of the century both the American Medical Association and the Association of American Medical Colleges began reviewing medical schools to examine the quality of the medical education. In fact, by 1910, the American Medical Association's Council on Medical Association issued a publication, "The Essentials of an Acceptable Medical College", which listed the suggested standards for medical schools. These included a curriculum of four years duration with two years of basic science instruction and two years of clinical work, supervision of the school by a dean, a required minimum core faculty of graduates from recognized medical colleges with ability as teachers and researchers and adequate facilities for instruction. The existence of standards of this type helped to bring about a consolidation of the number of medical schools in the United States since many of the schools of questionable quality and intent were closed. Those that remained improved their educational programs.

In 1942, the AMA and the AAMC established the Liaison Committee on Medical Education (LCME) aimed at improving medical education through the establishment of standards. In the early 1980s the LCME became the national authority for the accreditation of medical schools, as recognized by the Council on Post Secondary Accreditation and the U.S. Department of Education. This recognition led to the addition of more accreditation standards in the '80s. Through the '90s, additional standards were added in response to national calls for reform in medical education and, even today, the LCME is actively refining and adding to the accreditation standards.

The accreditation process consists of three parts. The first is the compilation of a large amount of standardized factual data on all facets of medical school operation. This is referred to as the educational database, that forms the basis of the report. The database is designed to give the LCME a comprehensive picture of the state of affairs existing at each medical school at the time of accreditation. In the second part, a medical school conducts an institutional self-study, an analysis of the school's strengths, weaknesses and opportunities for improvement. The self-study is designed so that a large number of faculty and students participate in the work of analysis.

The third component of the accreditation process is a site visit by a team of medical school faculty from across the United States. These individuals are dispatched to the school undergoing accreditation for a five-day visit with the purpose of clarifying questions raised by the materials submitted by the school. The site visit team meets with a wide variety of individuals at the host institution, including administrators, faculty, students and the dean. During the site visit, the team writes a report that focuses on the accreditation standards and the school's compliance with them. The team also prepares a list of strengths and weaknesses of the medical school, which are shared with the dean and the University president at an exit interview.

The site visit team is a recommending body and takes no formal action on accreditation. The LCME reviews the report of the site visit team and makes an accreditation decision. The decision can range from full and unconditional accreditation for seven years to probation for serious violations of the accreditation standards.

The accreditation standards consist of nearly 156 separate requirements.⁵ Of these, approximately 50 apply to teaching, learning and evaluation, i.e. the educational process. A recent initiative of the Association of American Medical Colleges called the Medical Education Standards and Assessment Project examined a number of salient issues in the accreditation process, including the meaning and application of medical accreditation standards, the importance and validity of medical accreditation standards and the influence of accreditation on educational change in U.S. medical schools.

Accreditation requires that medical schools specify their educational objectives, develop resources and programs to accomplish those objectives and track whether those objectives are being achieved through the implementation of evaluation systems. Accreditation is a quality assurance mechanism for medical education in the United States. It requires medical schools to undertake periodic external and internal self evaluations, a process that spurs continual adaptation and evolution on behalf of those institutions. Several reports have concluded that accreditation has had a positive effect on the education of physicians in the United States.^{6,7} The LCME claims that its accreditation standards encourages educational reform, fosters the adoption of pedagogical methods more likely to cultivate habits of self assessment and life long learning, creates greater coherence of instruction across the basic and clinical science years and leads to stronger institutional oversight and accountability for the curriculum.⁸

In conclusion, the process of accreditation of medical schools in the United States has led to an educational system for physicians without peer in the world. This claim is substantiated by hard evidence; 97% of students admitted to United States medical schools subsequently graduate, 95% of graduates are accepted into residency programs, 95% of residents complete their programs and 94% of students and residency graduates pass licensing exams on the first try.² Although the accreditation process is complex, burdensome, resource intensive and time consuming, it does appear to be fostering high quality medical education. For those spending many hours preparing for JABSOM's upcoming reaccreditation, it is of comfort to know that the process has value both as an internal quality control mechanism and an external endorsement of the quality of the education provided. Thus, continuation as a fully accredited medical school is an important priority worthy of the efforts expended.

situation. If the nurse responds in the manner as hoped, the desired outcome has been achieved. However, if the nurse doesn't recognize the serious nature of the comment, then the ability to "save face" is achievable by saying "only joking." The skill for nurses is in learning to listen beyond the laughter, whether the person addressing them is a peer, patient, family member, or doctor.

Physiological effect: In addition to the functions of humor, the physiological effect of humor is identified as a benefit. Most nurses are able to describe at least one negative physiological effect of stress: muscle tension, cold hands, headaches, gastrointestinal disturbances, and many more. While researchers have spent years identifying the negative effects of stress on body systems, they are now looking at the therapeutic effects of humor and laughter on the human body. These include decreased muscle tension, deeper respirations, and positive increases in the immune system.

As nurses practice to improve their abilities to use and appreciate humor, they also enhance their skill. "Humor appreciation involves responding to humor produced by others or being a good audience. On the other hand, humor production involves thinking of things on your own to amuse yourself or others," says Michelle Newman, PhD. When using humor as a coping mechanism, one cannot always count on being able to find an external focus of amusement. "Of the two, humor production is the more portable skill," says Newman and adds, "From the standpoint of coping, it seems to me to be less important whether you can amuse other people than whether you can amuse yourself." The implication for nurses is that while they may gain benefits from humor when enjoying it passively, there are even more benefits in being active participants by producing a humorous state of mind for themselves.

Because everyone's sense of humor is unique, the techniques used to create humor must be highly individualized. The methods need not be flamboyant to be effective. For example, some nurses might be comfortable wearing a small decorative pin with an amusing picture or statement on it, particularly at seasonal times. Colorful clothing with festive accents might be an option if dress codes do not forbid. Some nurses are subtle, wearing Looney Tunes socks or Mickey Mouse jewelry while others walk the halls wearing a red sponge nose or carrying a rubber chicken! Posting cartoons and illustrations can brighten up any nursing unit. Sharing jokes, stories, or embarrassing moments are other ways to generate laughter. Humor baskets, carts and humor rooms are means of creating a more humorous environment.

Many nurses may refrain from using the skill of humor on the grounds that it is not "professional." Humor is not the equivalent of "goofing off." Indeed, it is important for nurses to maintain high standards and high expectations on their units and to take their work seriously. It is also important for nurses to be able to take themselves lightly. Sad is the nurse who cannot learn to separate the two—and that is no joke.

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Cancer Research Center Hotline

Cancer Research Center of Hawaii: 30 Years of Progress in Cancer Research

**Sharon Shigemasa, R.N., M.S.,
Public Information Officer,
and**

**Carl-Wilhelm Vogel, M.D., Ph.D.,
Director, Cancer Research Center of Hawaii**

The year 2001 marks an important milestone in the history of the University of Hawaii's Cancer Research Center of Hawaii (CRCH). It was 30 years ago that the CRCH was first conceived by research-oriented scientists from among the University's biomedical academic community who were interested in unraveling the mysteries of cancer. These scientists, under the leadership of the late Dr. Frederick Greenwood, recognized the unique opportunities available to study cancer in Hawaii's multiethnic populations. Through an organized effort, they convinced the UH Board of Regents in 1971 to authorize the establishment of the CRCH, initially as a research component of the Pacific Biomedical Research Center. Not quite coincidentally, 1971 was also the year that then President Richard Nixon signed into law the National Cancer Act, which would fuel the momentum for and funnel millions of dollars to cancer research in the United States.

Dr. Richard K.C. Lee of the UH School of Public Health was named acting director of the CRCH in 1972, while programmatic development of the Center continued with the support of a two-year Exploratory Studies Grant from the National Cancer Institute (NCI). In 1974 Dr. Lawrence Piette, a biochemist, was named the first director of the Cancer Research Center, and the CRCH received the first of three consecutive Cancer Center Support Grants from the NCI. The Center also received a construction grant from the NCI which enabled the planning and construction of the current Cancer Research Center building at 1236 Lauhala Street on the grounds of the Queen's Medical Center, completed in 1979. In 1981 the UH Board of Regents established the Cancer Research Center as a free-standing, permanent, and independent organized research unit of the University to facilitate its mission of understanding cancer and reducing its impact on the people of Hawaii.

Despite successful early development, the Center was unable to sustain further growth. Dr. Piette left the University in 1985, and the Center lost its Cancer Center Support Grant. At the time, the CRCH lacked sufficient appropriations and a critical mass of multidisciplinary research faculty. The situation led to an extensive evaluation of the commitment of the University to cancer research, and resulted in renewed and increased support of the Center in terms of funds and positions from the University under then UH president Dr. Albert Simone.

An international search was initiated for a new director which resulted in the appointment of Dr. Brian Issell in 1988. Under his leadership, the CRCH made great strides in refocusing its research

direction, attracted new research faculty, and succeeded in winning an increasing number of peer-reviewed contracts and grants. During this time, the Natural Products Program, which identifies new anti-cancer agents from marine microorganisms and local plants, was established as well as the first endowed chair at the Center.

During Dr. Issell's tenure, an NCI planning grant was awarded to the Cancer Research Center in 1992 to help it get back on course to achieve its redesignation as an NCI cancer center. Finally, in 1996, the Cancer Research Center succeeded in its bid to once again become an NCI-designated clinical cancer center with the award of a new Cancer Center Support Grant. The CRCH has capitalized on its NCI designation and has continued to grow and prosper in its cancer research activities. Dr. Issell announced his resignation as Center director in 1996, and after an international search, Dr. Carl-Wilhelm Vogel assumed the helm of the CRCH in 1999. Under the new leadership of Dr. Vogel, the Cancer Research Center was rated highly in its NCI review and was awarded a five year extension of its Cancer Center Support Grant in 2000, totaling in excess of \$10 million.

In 1989 the total budget of the Cancer Research Center was \$4 million. Today the Center is one of 60 NCI-designated cancer centers in the U.S. Through the successful efforts of its research faculty and staff, the CRCH currently attracts approximately \$23 million per year in extramural funds, and an increasing amount of philanthropic donations for a total budget of well over \$25 million, of which approximately two million dollars per year are provided by the state for operating costs. This amounts to a 10:1 ratio in extramural funding versus state support, making the Cancer Research Center the most successful and cost-effective UH research institute.

In the past 30 years, the CRCH has achieved a number of important accomplishments. The Epidemiology Section of the Cancer Etiology Program has long served as the cornerstone in the development of the Cancer Research Center. Today its faculty members are recognized worldwide for excellence and their groundbreaking research in a number of key areas.

- First to recognize and exploit the value in studying the effect of migration on cancer risk.
 - Among the first to emphasize the role of diet in cancer incidence and mortality.
 - Identified diet as one of the key environmental factors that alters risk in succeeding generations.
 - On the cutting edge of research attempting to unravel the multifactorial relationships between diet, genetics, and various susceptibility factors.
 - First to show that a diet rich in fruit and vegetables was more important in reducing lung cancer risk than individual components.
 - First to identify that infection of the stomach by the bacterium *Helicobacter pylori* is an important risk factor for stomach cancer.
- Fundamental laboratory research of the Molecular Carcinogenesis Section of the Cancer Etiology Program has contributed to our understanding of cancer biology.
- First to demonstrate that key dietary molecules such as Vitamin A and β -carotene could enhance cell communication and potentially reduce cancer risk.
 - Identified key biochemical changes that occur in cells such as

Continues on p. 215



Potpourri...

"When I press my forehead with my finger, it really hurts." A patient complained to his doctor..." And when I do the same to my cheek it's also painful. Even if I press my stomach, I suffer...What can it be?" Stumped, the physician sent the patient to a specialist... The man returned to his doctor the following week. "What did the specialist say?" the doctor asked. "I have a broken finger."

Laughter the Best Medicine...

A couple of anthropologists traveled to Indonesia, each going to a different island to study the local culture. Soon, one paddled over to see how his colleagues were doing. "I've made a discovery about the language," the scientist said. "Watch!" He pointed his finger at a palm tree and the locals said, "Umbalogong!" Then he pointed at a rock and they all said "Umbalogong!" "You see?" the anthropologist said, "They use the same word for rock and palm tree. Isn't that amazing?" "You know what's more amazing?" the other scientist replied, "On the island where I work, the same word means index finger!"

The old preacher was dying, so he sent for a lawyer and an IRS agent from his congregation. The lawyer and the agent were puzzled since neither had been a close friend of the preacher. As the two men entered the dying man's room the preacher motioned for them to sit on either side of his bed. He grasped their hands, sighed contentedly and stared at the ceiling. "Why did you ask the two of us to come to your deathbed?" "Jesus died between two thieves," the preacher answered, "And that is how I want to go."

Woman to doctor: "I've been feeling absolutely marvelous with those frolic acid tabs you prescribed."

During a visit to the lady's room, my friend Addy heard the woman in the next stall suddenly ask: "So how are you?" Startled, Addy replied tentatively, "Fine." The woman continued, "So what's new?" Still confused, Addy said, "Not much. What's new with you?" The woman then snapped, "Do you mind? I'm on the phone."

Potpourri...

Nursing Time: It was another busy day in my practice, when coming out of my exam room, I overheard a patient talking to my office nurse. She obviously knew my nurse from high school. She was asking Nurse Gaye if she had gone to nursing school after graduation... Gaye answered, "Yes, of course I did and I have been nursing since 1976." At that, a patient from the waiting room piped up: "Holy smoke, how old is your kid?"

Dr. Linda Ducholke

A Russian cosmonaut crash-landed in the Australian outback and ended up in a small hospital. Regaining consciousness, he saw a nurse approaching his bed. Knowing that he must be in pretty bad shape, he asked, "Did I come here to die today?" "No", the nurse replied, "You came here yesterday."

"Court Jesters" by Peter McDonald, Q.C.

In 1994, a 25 year old chap named Paul Kimbolt was charged with sexual assault in Ogden, Utah. The culprit escaped but was apprehended easily

because he'd left the victim's house minus his pants which contained his wallet and all sort of identification...

Jim Baley was a burglar who no one could ever accuse of being bright... One night in 1968, accompanied as usual by his dog, Turny, he knocked off a Detroit liquor store and lugged the loot home as fast as he could, leaving his Turny behind in the store. When the police officer went to the scene of the crime he shouted to the dog, "Home, boy." The policeman followed the pooch and promptly arrested his master...

Court Jesters...

In Vancouver in 1984, a young bank teller gave the police a vivid description of a real pro at work. She said the man stood in line, patiently waiting his turn, and as soon as he reached her wicket, he growled, "This is a hold up. Give me all your money." She was puzzled, "Where's your gun" she asked. "My friend has it and he'll use it," What's he wearing?" " A brown jacket." The woman scanned the line, then said, "He's gone." "Well give me the money anyway," the flustered fellow demanded... "Wait right here," said the teller, "I have to ask my boss." She vanished into an office, then seconds later returned and told the robber, "You can only have \$150.00" "That'll do," he said quickly and grabbed the meager amount offered and scooted toward the door... He was grabbed by two policemen who escorted him to headquarters... "New at this?" one of the officers asked, "Yes," the man sighed, "It's my first time."

Walking into the local Chamber of Commerce, the stranger looked desperate... He approached the guy at the counter and asked, "Is there a criminal attorney in town?" The fellow behind the counter replied, "Yes, but we can't prove it yet!"

As a dental hygienist, I had a family come in one day for cleaning... By the time I was ready for the father, he informed me I had a lot to live up to... His six year old daughter kept commenting "that's a very smart lady cleaning our teeth today." The father finally asked her why she kept going on about my intelligence... The little girl replied, "I heard people call her "The Dental High Genius."

When a woman in my office became engaged, a colleague offered her some advice..."The first ten years are the hardest," she said..."How long have you've been married?" I asked..."Ten years," she replied...

Medical Tid Bits

Dr. Moti Kashyap of the Long Beach Health care system and colleagues put 800 adults on the following regimen for a year: 1) Niacin (extended release form) b) Vitamin B and c) Lovastatin Results: 41% increase of HDL, 45% decrease of LDL; 42% decrease in triglycerides...

Kids' Antibiotic Use Declines:

A survey of MD's conducted by CDC (Centers for Disease Control & Prevention) shows that the rate of antibiotic prescriptions written by office-based MD's for children under age 15 with respiratory diseases was significantly lower at the end of '97/98...

Sunglasses:

Sunglasses despite the different shades on the market still fail to fully block the two main types of ultraviolet radiation (A & B)...which are linked to everything from wrinkles to sun burn and skin cancer...Water skiers or snow skiers develop photo keratosis...Studies also link UV radiation to cataracts and to macular degeneration...Sunglasses should have official decals indicating that the lens absorbs 99% to 100% of UVA and UVB rays. For a little extra margin of safety, choose lenses that are polarized... (Ian K. Smith, M.D.)

Folic acid:

Two years after folic acid was added to grain products in the U.S., certain birth defects of the brain and spine are down 19%...

Lutein:

A study of 480 healthy men and women with high levels of lutein (a golden hued antioxidant) found in dark green leafy vegetables are less likely to trigger heart attacks, strokes, and blindness....

Coffee Intake

A 10-year study of 61,000 women by Swedish researchers concluded that coffee does not protect against colorectal cancer.

ADHD:

ADHD is usually associated with hyperactive little boys, but these days, millions of adults are also being treated for Attention Deficit/Hyperactive Disorder; and 50% to 60% are adult women...The leading theory is that women now seeking treatment have actually had ADHD since childhood, but went unnoticed.

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"Cancer Research Center Hotline," continued from p. 213

protein phosphorylation leading to cellular proliferation that may be the key to the abnormal functioning of cancer cells.

- First to identify a key dietary component of Vitamin E, γ -tocopherol, as a potential cancer preventive agent.

The Natural Products Program has developed new cancer-fighting drugs from marine organisms.

- Cryptophycin was identified in cyanobacteria and is currently undergoing phase II clinical trials for the treatment of cancer.
- The laulimalides (found in a tropical marine sponge), another class of compounds whose anti-tumor activity was identified by CRCH scientists, is currently undergoing pre-clinical testing.

The Prevention and Control Program has focused on reducing the incidence and severity of cancer and spans the continuum from primary prevention and early detection to treatment and long-term survivorship. The program has been instrumental in leading initiatives to reduce cancer-causing behaviors in Hawaii's multiethnic populations including smoking, underage drinking, and excessive sun exposure. This program has also been instrumental in conducting clinical trials seeking to reduce cancer mortality and morbidity. These trials include new treatment studies as well as interventions to improve psychosocial well-being. Presently, through its Clinical Trials Unit, the program makes approximately 150 clinical trials from NCI-supported clinical research groups available to cancer patients in Hawaii in cooperation with community oncologists and hospitals. Researchers in this program also conduct prevention intervention trials to test the effects of dietary change on cancer incidence as an instrumental component in translating fundamental knowledge generated by CRCH research into practical use.

In recognizing the growing importance and growth of both, the study of risk behavior in healthy populations as it relates to the incidence of cancer as well as the need for more patient-oriented clinical research, the Prevention and Control Program was dissolved this July with the creation of two new programs, the Social and Behavioral Sciences Program and the Clinical Sciences Program at the CRCH.

In its early years the CRCH also pioneered the provision of state-of-the-art diagnostic and treatment equipment when the technology was not available through our community medical centers. Examples of these include the first cell separator or pheresis machine and the first radiation dosimetry machine. The cell separator provided blood support to patients, who were rendered vulnerable to life-threatening infection and bleeding as a result of their treatment with chemotherapy and radiation. The radiation dosimetry machine provided greater accuracy in measuring a patient's dosage and pinpointing the perimeters of the site to be radiated.

Since 1982 the Cancer Information Service (CIS) of Hawaii, which is a part of the Clinical Sciences Program, has made outstanding contributions in helping cancer patients and their families and health care professionals by providing general cancer and disease- and stage-specific information, including available treatment options. Up through mid-October 1999, the CIS of Hawaii provided this information through a locally available phone service, which is now provided to Hawaii residents by information specialists located

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"Cancer Research Center Hotline." continued from p. 215

at a CIS call center in Seattle. However, the CIS is now focusing its efforts in cancer outreach by building and supporting partnerships with community organizations whose constituencies are comprised of minorities and hard to reach populations.

The Cancer Center also operates the Hawaii Tumor Registry which maintains a database on virtually all cases of cancer diagnosed in the State of Hawaii. It provides complete cancer reporting for the entire state and serves as an important resource for nearly all epidemiological cancer research and cancer control studies at the Center. It is in its 41st year of operation and represents one of the most successful tumor registries in the nation. Support for the Hawaii Tumor Registry is primarily derived from the NCI through its Surveillance, Epidemiology, and End Results (SEER) program with additional funding from the State of Hawaii Department of Health.

On September 22, 2001, the Center will celebrate its 30th anniversary with a signature event called "The Mauka Makai... Voyage of Discovery" on the parking lot of the Center's neighbor, the Board of Water Supply. It will be a friendraiser and fundraiser for the Center which is planned to develop into an annual event. At "The Mauka Makai" event, Ms. Loyal Garner will be honored with the first Mauka Makai Award for serving as a spokesperson on cancer and for her courage in sharing her personal experiences as a cancer survivor.

At the time of celebrating past accomplishments, it is also important to look to the future. The Cancer Center faces significant challenges and opportunities. As a result of its growing research programs, the Cancer Center building on Lauhala Street has become too small to house all investigators. The Center is currently going through a phase of establishing satellite facilities on the UH Manoa campus and elsewhere in Honolulu. However, the vision is for a new Cancer Center building, which will reunite all cancer research activities under one roof and will provide the necessary space to meet the needs of the growing research programs. Furthermore, to achieve designation from the NCI as a "comprehensive cancer center", the Cancer Research Center has been charged with developing a state-of-the-art outpatient facility which will significantly enhance the clinical research opportunities of its faculty. Such a facility will simultaneously allow us to make innovative cancer treatments available in Hawaii and will result in better and coordinated care for Hawaii's cancer patients. Such an outpatient component of the Cancer Center would ideally be operated in partnership with community oncologists and hospitals.

For more information on the Cancer Research Center of Hawaii and "The Mauka Makai... Voyage of Discovery", please visit the Cancer Center's website at www.crch.org.



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Assistant Professor

ASSISTANT PROFESSOR— Position Nos.88885T, 85755T and 85754T, M3, Geriatric Medicine Program, John A. Burns School of Medicine, F/T, to begin approx. August/September for one year, non-tenurable. **DU-TIES:** Incorporate geriatric teaching in medical school curriculum, all residency programs, and continuing medical education. Curriculum development, clinical and didactic teaching, clinical teaching services research publications and community service commensurate with academic rank. **MQS:** M.D. or D.O. degree; board eligible or board certified, fellowship in Geriatric Medicine, Certified (or eligible for certification) in Geriatric Medicine, eligible for Hawaii license and demonstrated ability in teaching. **DQS Min. Annual Sal** \$78,924. Send updated C.V., bibliography, and 5 names of reference to: Patricia Lanoie blanchette, M.D., MPH, Geriatric Medicine Program, John A. Burns School of Medicine, University of Hawaii, 347 No. Kuakini St., HPM-9, Honolulu, HI 96817. Closing Date: Aug. 13, 2001. An EEO/AA Institution.



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Shooting Up Once Is Alright - Twice Is Too Much - Three Is Not Enough.

A not rare event occurred recently involving a Hawaii physician with an addiction problem. A fellow physician learned of his colleague's disorder and was torn with whether to "rat" on his friend, or keep quiet about the whole thing, since the doctor seemed to have no difficulty with his medical practice. Fortunately, in our state we have an active *physician's health committee* in the Hawaii Medical Association which serves to confront the addicted physician. If caught in time, the committee can deter his prosecution, and steer him on a path for survival. It can save his professional career and perhaps his life. It isn't ratting on a friend when you help him into a rehab program. Furthermore, if a fellow physician is aware of an impaired doctor and fails to seek help for the errant physician, both are in a vulnerable liability position.

It Takes A Lot Of Suits To Keep A Lawyer Well Dressed.

One of the first cases involving a lawsuit against an HMO (cardiology group) occurred in Texas when a 46 year old woman died of congestive heart failure three days after a physician had prescribed a drug for symptoms of heart valve disease. When the patient called his office because her symptoms were worsening, a nurse advised her to double the dose of the medication. The family brought a lawsuit claiming that the patient was unable to get an appointment because the HMO referral from her primary care physician had expired. It was alleged that the HMO withheld 10% of its payments to providers until the end of the year as an incentive to reduce costs. Ultimately, the suit was settled before trial in order to avoid a jury verdict. The general counsel for the Texas Medical Association believes the HMO liability law is serving its purpose since the cardiology group would have been liable for the total amount without the statute.

Congress In Session - Nothing Ado About Much.

Any type of tort reform is rare from the U.S. Senate. But, this May 9, 2001, the Senate passed the Teacher Liability Protection Act of 2001 which included an amendment shielding teachers from liability for conduct that conforms to laws or school rules. Moreover, it abolishes punitive damages and joint and several liability in actions against teachers. The House of Representatives will act upon parallel legislation shortly. It does not directly impact the adjudication of medical malpractice claims, but any Senate tort reform is a step. This process will probably stay alive until the trial lawyers lobby does their usual number of annihilating any medical malpractice tort reform.

If You Remember The Sixties, You Weren't There. - Part 2

In a May decision, the Supreme Court of the United States unanimously ruled against the Oakland Cooperative in regard to the medical use of marijuana. While the therapeutic issue is one of ongoing debate, the legalities are fairly straightforward. Congress has defined marijuana as a class one drug without any medical use. The question was one of whether the Court would overrule medical use, and by unanimous decision, the Court decided not to do that. If, as proponents claim, there are appropriate medical uses of the drug, presentations should be made to Congress. Scientific research based upon established therapeutic principals, must be presented. Anecdotes and testimonials will not suffice to convince Congress to decriminalize a substance which many still view as the gateway to cocaine and heroin addiction.

Utah Winter Olympic Event - Downhill Polygamy!

In Iron County, Utah, two men pleaded guilty to drilling holes in a woman's skull (with her permission). The District Attorney prosecuted them for practicing medicine without a license. Some *New Age* followers claim the procedure, called "trepanation," promotes higher consciousness and relieves depression. Does this fall under the definition of alternative medical care to be used when St. John's wort fails? Of course, some doubters might assume that the whole crowd is playing with about half a deck.

Survival Of The Effetest.

Pamela Gardiner, deputy inspector general for tax affairs, wanted to learn how IRS employees used their government computers. Over a period of

months, her staff evaluated 16,000 workers. The results are amusing, but not very funny. Out of 16,275 hours online, 8,250 (that's over half, friends) were devoted to trading stocks, gambling and downloading erotica. 23% were using their IRS computers to blab in Internet chat rooms, 20% were searching for job opportunities, and 7% went shopping. The report summed up, "the IRS is losing productivity, creating unnecessary demand on its telecommunications system, and could be fostering a hostile work environment by allowing sexually explicit material into the workplace via the Internet." I am shocked! Senate Finance Committee chairman, Charles Grassley (before the switcheroo), was not amused either and said, "some IRS employees are clearly goofing off." These are the same people who are auditing our tax returns, and according to the report, 37% of phone calls are not even answered. Those are the lucky phone calls, because the IG also found that the IRS gave incorrect answers to taxpayers' questions 49% of the time! Flat tax, anyone?

Only In Paradise Does Cancer, Heart Disease, Stroke, et seq, Add 4.17%.

The American Medical News ran a story telling of the only states with a sick tax, Minnesota's 1.5% and West Virginia's 2%, but somehow the writer overlooked Hawaii's 4.17%. A bill offered in the last legislative session would have removed the "disease tax" which is part of the nefarious Hawaii tax code called *general excise tax*. The GET, which allows compounding of virtually all transactions, is so much a part of our porky state government budget, that the politicians just can't find a way to stop penalizing sick people in Hawaii, including those suffering terminal illness. Joe Souki, speaker emeritus, stated that the issue is not dead and can be reconsidered at the next session. May I suggest that you not suspend respiration.

Another Thing Stranger Than Fiction Is Woman.

The Supreme Court of the United States recently ruled 6-3 in favor of 10 women who filed a lawsuit against the Medical University of South Carolina. In 1989 the medical facility established policy whereby it tested pregnant women for drugs without their consent. The fear was that cocaine use among pregnant women was increasing. The policy was run in conjunction with law-enforcement authorities, and users were thereby liable for prosecution. Justice John Paul Stevens, writing for the majority, said the program violated the Fourth Amendment rights against unreasonable searches. Dissenting Justices Rehnquist, Scalia and Thomas said doctors are supposed to have patients' welfare in mind, and if they happen to provide evidence for the police, that "should make no difference." Thank goodness the other 2/3 of the Court disagreed.

The Shape Of Things To Come.

Only in California, the land of almonds, oranges, and other fruits and nuts, comes the latest fad in baby shower parties. The expectant mother, at eight plus months of gestation, strips bare while her friends lay plaster over her anterior torso. After about 10 minutes, the cast of her abdomen and breasts is removed, still thin enough to reveal graphic contours of her stretched full frontal bod. Some mothers save the cast to hang on the wall as a proud memento. Others have turned them into planters, candy bowls, cradles for the newborn, or even center pieces for the dining room table. Some viewers have been shocked at the detail revealed in plaster, while some others don't recognize what it is. Belly casters claim the practice dates back to an ancient African ritual, and was only revived in California in the 1980s. Whatever. The shower practice is now sweeping the nation, and there are websites for do-it-yourself kits. Pregbelly dot orgy?

ADDENDA

- ❖ The fire-bellied toad has a heart-shaped pupil.
- ❖ Perhaps war is God's way of teaching us geography.
- ❖ My parakeet died. We were playing badminton.
- ❖ Just remember, if the world didn't suck, we would all fall off.

Aloha and keep the faith —rts■

Contents of this column do not necessarily reflect the opinion or position of the Hawaii Ophthalmological Society. Editorial comment is strictly that of the writer.



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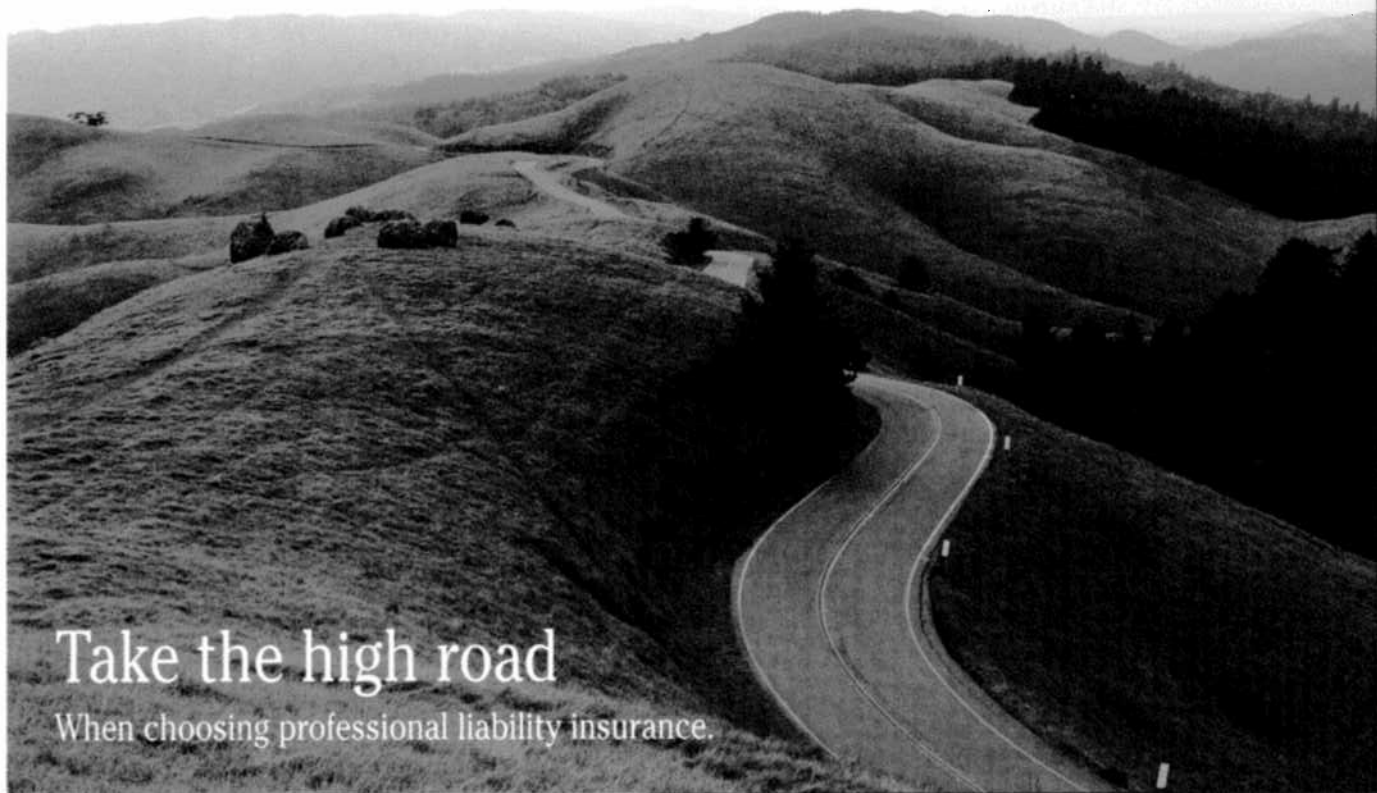
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