Special Issue on ACP-ASIM and Issues in Current Healthcare
“Excellent”

The National Committee for Quality Assurance (NCQA) has designated Health Plan Hawaii’s commercial HMO as one of an elite group of health plans to earn its new “Excellent” accreditation status.

This distinction—shared by only 40 plans nationwide—is awarded on the basis of each plan’s commitment to clinical excellence, customer service and continuous improvement.

Needless to say, we couldn’t have done it without the outstanding efforts of the more than 1,400 physicians participating with Health Plan Hawaii health centers:

**OAHU**
- Central Medical Clinic
- Central Oahu Physician Hospital Organization
- Haleiwa Family Health Center
- Hawaii Filipino HealthCare, Inc.
- Hawaii IPA
- Medical Arts Clinic, Inc.
- Oahu Physicians Group
- Pacific Health Care
- Personal Care Network:
  - Castle Health Group
  - Kuakini Health Network
  - St. Francis Physician Hospital Alliance
- Straub Clinic & Hospital
- The Honolulu Medical Group, Inc.
- Waianae Coast Comprehensive Health Center

**HAWAII**
- Bay/Hamakua Health Center
- East Hawaii IPA
- Hilo Medical Associates, Inc.
- Kona IPA
- North Hawaii Physicians Group, Inc.
- Straub (Hilo & Kailua-Kona)
- West Hawaii Physicians Group

**KAUAI**
- Kauai Medical Associates
- Kauai Medical Clinic

**LANAI**
- Straub

**MAUI**
- Hawaii IPA—Maui Physicians
- The Maui Medical Group, Inc.

At Health Plan Hawaii, quality is at the heart of everything we do. Our heartfelt thanks to the participating health centers and physicians whose commitment to excellence sets the standard for quality care in our island community.
Contents

Editorial
Norman Goldstein MD .......................................................... 40

Medical School Hotline
John S. Melish MD and Richard T. Kasuya MD. ......................... 40

Angioimmunoblastic T-cell Lymphoma (AIL-TCL)
Following Macrolide Administration
Terence Y.J. Sasaki (Medical Student) and Kenneth N.M. Sumida MD ............. 44

Postural Hypertension in Elderly Men- The Honolulu Heart Problem
Kannaviram Alagiakrishnan MD, Kamel Masaki MD, Irwin Schatz MD,
J. David Curb MD, MPH, and Patricia Blanchette MD, MPH ..................... 48

Evaluation of Late Onset Bipolar Illness During Menopause
Takako Vivian Ishimaru-Tseng MD ............................................. 51

Coronary Artery Bypass Grafting Performed With Or Without
A Bypass Pump: Early Results
Jeffrey D. Lee MD, Collin R. Dang MD, Sharyl Taoka (Medical Student IV),
B. Jason Bowles MD, and E. William Johnson MPH .......................... 54

Use of Donepezil in Elderly Patients with Alzheimer’s Disease-
A Hawaii Based Study
Kannaviram Alagiakrishnan MD, Warren Wong MD,
and Patricia Blanchette MD, MPH ............................................ 57

Special Presentation to the State Legislature: Hawaii Coalition
For Health, December 8, 1999 .................................................. 62

Classified Notices .............................................................. 76

Weathervane
Russell T. Stodd MD ........................................................... 78

Hula

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

Depicting the traditional dance of Hawaii known the world over. Shown here is a dancer accompanied by drum.
Editorial

Special Issue: American College of Physicians – American Society of Internal Medicine Hawaii Chapter

Norman Goldstein MD
Editor, Hawaii Medical Journal

This Special Issue features two societies comprised of specialists and internists: The American College of Physicians, and the American Society of Internal Medicine. Many excellent papers and posters were presented at the last Hawaii Chapter meeting on March 19, 1999. Five of these presentations are published in this issue, which will also be distributed to attendees and exhibitors at the ACP-ASIM Hawaii Chapter meeting to be held on March 3 and 4, 2000.

Also within, are presentations made on December 8, 1999 at the informational program for our State legislators sponsored by the Hawaii Coalition for Health. Included are remarks by Coalition founder and president, Arlene Jouxson-Meyers, MD JD, MPH; new Medical School Dean, Edwin Cadman; Dean of the School of Nursing, Dr. Roseanne Harrigan; Associate Dean of Wm. S. Richardson School of Law and Professor of Law, Medicine and Psychiatry at NYU Law School, Sylvia Law; and Regent of the University of Hawaii, A.Q. McElrath.

In addition, this Special Issue contains an insert and membership application for the Hawaii Medical Association. If you are not already a member of the HMA, now is the time to join. We need emerging as well as established physicians in the HMA to maintain and improve the practice of medicine in Hawaii. Our Hawaii medical community values your participation. Join us today.

Norman Goldstein MD, FACP, Editor

Until there’s a cure, there’s the American Diabetes Association.

Medical School Hotline

Clinical Skills Training at John A. Burns School of Medicine (JABSOM): Teaching and Learning the Art, Craft and Science of Clinical Practice

John S. Melish MD and Richard T. Kasuya MD

The medical profession combines a variety of skills, attitudes, and a scientific knowledge base. The capacity of an individual physician to care for an individual patient requires that the physician establishes trust and collects appropriate data in relation to the patient’s concerns, signs, and symptoms. He or she then establishes reasonable diagnostic hypotheses based on that data, and then prescribes evidence-based treatments. This requires the understanding and consent of the patient, making the doctor a teacher and guide. Our student-physicians refine these skills over a lifetime of practice. This process begins at the JABSOM the first week of medical school and continues for the next four years.

As central as these skills have been to the practice of medicine, they have gained even more importance in this day of resource allocation and managed care. Physicians in general, and primary care physicians in particular, have been asked to rely more on their clinical data collection and acumen and less on the non-judicious use of technological tools, in their care of patients. Our goal and commitment is to provide excellent and qualified practitioners to our community.

At the JABSOM, history taking and physical examination skills have been taught in first two years of medical school since its inception in 1970. At that time, JABSOM was a two-year medical school whose graduates finished their training at Mainland schools. Our students appreciated that they were as well or even better prepared than their Mainland counterparts to challenge the third year clinical clerkships.

When the JABSOM became a four-year institution in 1975, this policy of early introduction to patients continued. In the first year, students were instructed in the elements of a standard physical examination that they practiced on each other and learned interviewing skills beginning with a patient profile. The students learned the basic physical exam maneuvers on each other but practiced interviewing skills on volunteer patients in an outpatient setting. In the second year, students learned organ-directed interviewing and physical examination skills in the context of a lecture-based clinical correlation course, Introduction to Clinical Medicine, throughout the second year. (This course ran concurrently with basic science courses in physiology, pharmacology, psychiatry, and pathology, and public health, the familiar medical school curriculum of the time for second year students.) Clinicians lectured on approaches to clinical evaluation of diseases by systems. With each block of lectures, a specific laboratory was held where “extended physical examination skills” were taught. At the same time, individual students were assigned to a tutor who found them patients with problems corresponding to the unit of study. They observed the students during the interview and examination process, giving them
valuable feedback on their skills and their effectiveness in obtaining data and reporting it both orally and in written form. This experience occurred every other week and represented a time commitment of six to eight weeks for members of the clinical faculty. This meant recruiting between 20 and 30 faculty members (sometimes more) every 6 to 8 weeks, a full time job for the coordinator of the Introduction to the Clinical Medicine Course. Again, students generally made an easy transition to the third year clerkships as a result of this patient-related experience.

In both the first and second years, students learned to use the Problem Oriented Medical Record System developed and promoted by Dr. Lawrence Weed. This was adapted to JABSOM and became the standard format for both the students and for the residents in our integrated residency training program. Progress note writing in this format was taught as they entered the third year clerkships. This approach to documentation continues to the present.

Prior to 1989 and the curricular reform of that year, a faculty member evaluated the students’ clinical skills at the end of the medical clerkship. In this exercise, the faculty member observed the student performing a complete history and physical examination on a hospitalized patient, making an oral presentation, and completing a problem oriented medical record. The examiner reviewed a written History and Physical Examination Report, a complete problem list, and an assessment of the three most important clinical problems, along with a diagnostic and treatment plan and plans for patient education. The students’ findings were confirmed at the bedside, with immediate feedback to the student. The student then requested additional data based on his or her plan. This was obtained by the observer from the chart and reported to the student who then wrote a progress note on the three major problems. The observer graded the student based on a standard form, gave feedback as to all of the elements of the exercise, including the professional impression and attitude evinced by the student.

In 1989, the then medical school dean, Christian Gulbrandsen, instituted a wide-ranging curricular change. At that time, problem-based learning (PBL) became JABSOM’s way of integrating appropriate medical information with the data collection and reasoning processes unique to medical diagnosis and management. Clinical skills became an integral part of the curriculum. In this context, students interview and examine patients that fall within the differential diagnosis of the patient problems they study in the classroom setting. This integration provides additional relevance and meaningfulness to all aspects of JABSOM’s students educational experience.

In Unit 1 of the M.D. Program curriculum, students learn basic physical examination skills and clinical anatomy in an integrated course. For example, in one week students will be studying the PBL health care problem of a patient suffering from an acute myocardial infarction. They will spend one morning that week with clinical faculty learning the basic cardiac physical examination and spend that same afternoon with faculty from the Department of Anatomy reviewing the heart and mediastinal anatomic relationships on cadavers and instructional models. Students also spend one afternoon every other week in the community interviewing and examining actual patients under the supervision of practicing physicians.

Patient contact and the learning of the clinical skills relevant to the Health Care Problems under study in the core PBL curriculum continue throughout the remainder of years 1 and 2. Faculty preceptors work with small groups of students, and demonstrate and teach the skills required to collect data by interview and physical examination at the bedside in both ambulatory and hospital settings. These sessions are held for three hours each week, and are supplemented by periodic large group clinical skills demonstration and practice laboratories led by experienced and expert clinical faculty from various disciplines in medicine.

In Unit 6 (the clinical clerkships) and Unit 7 (the senior electives), clinical skills training becomes intertwined with the students’ day-to-day experiences in their required clinical clerkships (Surgery, Obstetrics and Gynecology, Internal Medicine, Family Practice, Pediatrics and Psychiatry), required senior Emergency Medicine rotation and senior clinical electives. Under the guidance and supervision of clinical faculty, students continue to develop their skills in professional communication, history taking, physical examination and physical diagnosis, and medical decision-making.

It is very important to recognize that clinical skills experience relies heavily on the generosity and support of volunteer physicians across all disciplines and located throughout the community. These physicians volunteer their time and expertise to teach medical students the art and science of clinical medicine. This is a tremendous investment in the future quality of medical care in our community.

Evaluation of students’ clinical skills performance is done via a number of methods. Throughout the four years, faculty evaluate each student using a checklist of skills and learning objectives. Students are videotaped performing the physical examination sequence for formative feedback. Students are also evaluated using standardized patients in Objective Structured Clinical Examinations (OSCEs) periodically throughout the four years of medical school training. The JABSOM’s Center for Clinical Skills administers these examinations, and also trains and provides standardized patients for learning experiences throughout the first two years of training. Early in their training, students have the opportunity to interact with these standardized patients to practice skills ranging from counseling an adolescent on the dangers of high risk behaviors, to providing smoking cessation education to a patient at risk for heart disease, to comforting the grieving mother of a child injured in the home. Later in their training, students are expected to obtain satisfactorily complete histories, perform focused physical examinations and demonstrate exemplary professional and communication skills with standardized patients in formal OSCEs. Of note, the United States Medical Licensing Examination (USMLE) Step 2 expects to begin incorporating an OSCE component in the near future. JABSOM’s strong standardized patient program will definitely help its students best prepare for this national requirement.

Clinical skills are a central component of the education of future physicians. The University of Hawaii JABSOM is fully committed to producing outstanding clinicians by providing a clinical skills educational experience that is integrated, innovative, rigorous and progressive.

References
Introducing

the only daily facial moisturizer containing Parsol® 1789.

Cetaphil® Daily Facial Moisturizer with SPF 15

- Filters UVA and UVB rays for maximum sun protection
- Offers gentle moisturization for all skin types
- Can be worn under makeup — lightweight and non-greasy
- Non-comedogenic
- The OTC Skincare line most recommended by dermatologists*

The final word in serious skin care. Cetaphil®.

www.cetaphil.com

* Data on file, Galderma Laboratories, L.P. ©1999 Galderma Laboratories, L.P. GALDERMA is a registered trademark. CET-249-1199 Patents and trademark rights for Parsol® 1789 owned by Givaudon-Roure Corp.
FIVE WAYS TO DIE ON THE GOLF COURSE:

1. Hit by a golf ball.
2. Run over by a golf cart.
3. Whacked by a golf club.
4. Struck by lightning.
5. Forgot your hat.

Surprisingly, one million new cases of skin cancer are detected every year. One person an hour in the U.S. dies from melanoma, the deadliest form of skin cancer. If you spend a lot of time in the sun, you should protect yourself. One out of five Americans develops skin cancer during their lifetime. Don't be one of them. Stay out of the midday sun. Cover up. Wear a hat. Seek shade. And use sunscreen. For more information on how to protect yourself from skin cancer, call 1-888-462-DERM or visit www.aad.org.

AMERICAN ACADEMY OF DERMATOLOGY
Angioimmunoblastic T-cell Lymphoma (AIL-TCL) Following Macrolide Administration

Terence Y.J. Sasaki (Medical Student*) and Kenneth N.M. Sumida MD**

Abstract

Angioimmunoblastic Lymphadenopathy with Dysproteinemia (AILD) is a rare benign reactive process which often follows exposure to certain drugs such as penicillin. Treatment with corticosteroids usually reverses the process; however, there have been reports of 18% of cases evolving into non-Hodgkin's lymphoma. In our case report, we present a relatively healthy woman with a history of various drug hypersensitivities who developed AILD and resultant lymphoma after treatment with azithromycin.

A review of the literature has failed to find reports of AILD following macrolide exposure. Clonality, not present in other forms of hyperplasia, is present in AILD and immunosuppression may account for this difference. It is difficult to say whether the drugs are simply coincidentally associated or actually cause, maintain, or exacerbate clonality in AILD and facilitate malignant transformation.

Introduction

Angioimmunoblastic Lymphadenopathy with Dysproteinemia (AILD) is a rare benign reactive process which often follows exposure to certain drugs such as penicillin. It is characterized by generalized lymphadenopathy, hepatosplenomegaly, and constitutional symptoms. Laboratory abnormalities include derangements in blood counts and a polyclonal gammapathy. Hemolytic anemia and morphologic bone marrow change are sometimes seen. Treatment with corticosteroids is typically successful in reversing the process; however, there have been reports of 18% of cases evolving into non-Hodgkin's lymphoma. Evidence of clonality with subsequent malignant transformation suggests a possible explanation for drug association with AILD. We report a case of angioimmunoblastic lymphadenopathy without dysproteinemia evolving into T-cell lymphoma following macrolide administration.

History of Present Illness:

This 67y/o Japanese woman, with a history of allergic rhinitis and hypothyroidism diagnosed two months prior to admission, was hospitalized one month prior to admission for new onset congestive heart failure and atrial fibrillation with rapid ventricular response. During this hospital stay, bilateral mastitis was noted with associated tender axillary adenopathy and treated with azithromycin. These resolved but follow-up two weeks later revealed generalized lymphadenopathy and biopsies of left anterior cervical and right inguinal nodes were taken. The local pathologist reported an abnormal immune reaction versus Hodgkin's and the specimens were sent to Stanford University for an opinion. Throughout this time the patient continued to suffer nausea, fatigue, appetite loss, and a slight nonproductive cough and on the day of admission felt extreme chills, shakes, and diaphoresis. She denied chest pain, shortness of breath, headache, dizziness, photo- or phonophobia, constipation, diarrhea, or symptoms of urinary tract or upper respiratory infection.

History:

No other medical or surgical history was significant. The patient was allergic to amoxicillin, cepalexin, and donnatal with reactions ranging from rash to difficulty breathing. She was on Synthroid, Lasix, Digoxin, Plavix, and Cardizem. Family history was unremarkable except for her father who died of liver failure. She did not have any tobacco, alcohol, or drug use, and denied travel and exposure to animals or chemicals. She had up-to-date immunizations and had received BCG vaccination, although her PPD was negative. Recent mammogram was negative.

Physical Examination:

On exam, temperature was 105.2° and blood pressure was 143/63. Left nostril occlusion was present with mucus and serosanguinous drainage but without septal deviation and the oropharynx was moist but erythematous without exudate. Diffuse, mobile, rubbery lymph nodes 1-3 cm which were nontender and non-fluctuant were noted especially in the right submandibular region. Neck was supple without jugular venous distention. Lungs were clear except for slight crackles and decreased fremitus in the right base. Breasts were within normal limits. Heart was tachycardic and an S4 with grade II/V1 systolic ejection murmur was present at the base. Mild hepatosplenomegaly was present. No fecal occult blood was noted. Good distal pulses and no clubbing, cyanosis, or edema were present in the extremities.
Laboratory Findings:
Laboratory investigations showed a white count of 12.1, 28% bands, and 12% monocytes. Hemoglobin and hematocrit were 10.4 and 30.7 respectively and electrolytes were normal except for bicarbonate at 31. Blood urea nitrogen and creatinine were 27 and 1.2. Urinalysis contained 2+ blood and trace protein. Chest films showed diffuse bilateral infiltrates at the bases while electrocardiogram confirmed sinus tachycardia and revealed left atrial enlargement and premature ventricular contractions. A “fever of unknown origin” work-up was performed with negative blood cultures & serologies and thyroid stimulating hormone was within normal limits. C-reactive protein was 6.5.

Hospital Course:
Throughout her course, serologic studies, cultures, and immunoelectrophoresis continued to be unremarkable. Patient’s condition improved slightly with empiric trovifloxacin but then deteriorated into a sepsis-like picture on the third hospital day. The patient needed to be transfused. Marrow aspirate showed only hyperplasia of megakaryocytes. Preliminary node biopsy results from Stanford suggested AILD and prednisone was initiated at 40mg BID and most of her symptoms rapidly diminished. She continued to have residual right submandibular lymphadenopathy. On day 12, routine exam revealed a 3x2cm erythematous mass causing slight nasal septal deviation and head CT and MRI showed an infiltrating left nasal lesion which had biopsy findings consistent with lymphoma. Chemotherapy with Cytoxan and vincristine resulted in regression of the lesion.

Discussion
First recognized by Flandrin and Westerhausen,1,2 angioimmunoblastic lymphadenopathy with dysproteinemia (AILD), a term coined by G. Frizzera in 1974,3 is a rare benign reactive process with a lymphoma-like presentation characterized by generalized lymphadenopathy, nontender hepatosplenomegaly, and constitutional symptoms. It was Lukes et al., however, who proposed that AILD was associated with both benign and malignant forms.4 For the purposes of this discussion, AILD, immunoblastic lymphadenopathy (IBL), and lymphogranulomatous X (LgX) have been considered one entity, AILD (their differences are noted on table II).

Clinical Features
Generalized lymphadenopathy is the sine qua non of AILD and these nodes often rapidly develop into soft, variably tender, moveable, but not matted masses, measuring 2-3cm. Fever occurs in two thirds and chills, night sweats, malaise, anorexia, and weight loss give clue to the systemic nature of this entity. Peak incidence occurs in the seventh and eighth decades. A prodrome of maculopapular rash can be seen, without preferential location, in more than a third of patients.5 It is commonly pruritic and follows administration of drugs such as penicillin.6,8 Men are slightly predisposed, with a 1.2:1 ratio.5

Laboratory Findings
In AILD, normochromic, normocytic anemia, particularly Coombs-positive and hemolytic, can be evident. Leukocytosis and eosinophilia may also complicate the picture. Dysgammaglobulinemia, most often a polyclonal hypergammopathy, is seen in up to three fourths of patients.14 Low CD4 T-cell counts may be discovered during active phases of the disease.15 An elevated lactate dehydrogenase is present in 25-85%, often with accompanying hemolytic anemia.10,14

Peripheral Blood Findings in AILD6,11-13,16

<table>
<thead>
<tr>
<th>Findings</th>
<th>% Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia (autoimmune)</td>
<td>82 (45)</td>
</tr>
<tr>
<td>Lymphopenia/cytosis</td>
<td>37/5</td>
</tr>
<tr>
<td>Leukocytosis</td>
<td>33</td>
</tr>
<tr>
<td>Neutrophilia/penia</td>
<td>28/1</td>
</tr>
<tr>
<td>Plasma cells/immunoblasts</td>
<td>23</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>19</td>
</tr>
<tr>
<td>Eosinophilia</td>
<td>18</td>
</tr>
<tr>
<td>Monocytosis</td>
<td>13</td>
</tr>
</tbody>
</table>

Serological Profile of AILD9,13

<table>
<thead>
<tr>
<th>Findings</th>
<th>% Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysgammaglobulinemia</td>
<td>70</td>
</tr>
<tr>
<td>Polyclonal hypergammopathy</td>
<td>7</td>
</tr>
<tr>
<td>Hypogammaglobulinemia</td>
<td>7</td>
</tr>
<tr>
<td>Monoclonal component</td>
<td>5</td>
</tr>
<tr>
<td>Normal gammaglobulins</td>
<td>23</td>
</tr>
<tr>
<td>Positive Coombs test</td>
<td>39</td>
</tr>
</tbody>
</table>

Histological diagnosis
Marked proliferation of small vessels with hyperplastic endothelium and pleomorphic infiltrate rich in immunoblasts distributed in an uneven pattern typify nodal biopsies. Pronounced and diffuse obliteration of nodal architecture can be seen, with a third of victims having some burnt-out germinal centers scattered across the field. There is often sludgy, eosinophilic material between cells. Serial nodal samples may show actual recovery of nodal architecture or
extensive fibrosis. Reactive morphological changes may be seen in the spleen, bone marrow, liver, and skin but are usually less prominent. The marrow aspirate may show mild plasmacytosis or red cell hyperplasia, particularly in the setting of hemolytic anemia, but will be normal in up to half of patients. AILD is distinguished from neoplasm because peripheral sinuses and remnants of germinal centers are preserved, the angiocellular changes do not occur with any known malignant lymphoma, and the end result in AILD is lymphocytic depletion with perivascular fibrosis not tumoral replacement of organ structures. Surgical staging is not recommended unless progression to lymphoma has occurred.

<table>
<thead>
<tr>
<th>Table 1.— Classification of AIL-TCL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revised European American Lymphoma (REAL) Classification</strong></td>
</tr>
<tr>
<td>Rappaport</td>
</tr>
<tr>
<td>Kiel</td>
</tr>
<tr>
<td>Lukes-Collins</td>
</tr>
<tr>
<td>Working Formulation</td>
</tr>
</tbody>
</table>

Although rare, AIL-TCL account for 4% of all lymphomas (20% of T-cell) by Kiel classification (table I). AILD-like lymphomas are surprisingly similar to IBL-like lymphomas first described in Japan. Virtually all AILD-like lymphomas are peripheral T-cell but rare B-cell lymphomas, often EBV associated, exist. Expanded FDC clusters & CD 21-positive reticulum cells surrounding post-capillary venules have been found to be specific for AILD-like lymphoma.

**Differential diagnosis**

Distinguishing collagen vascular disease, lymphoma, infection, drug reaction, and graft-versus-host disease (GVHD) from AILD is a diagnostic dilemma. Despite their shared constitutional and clinical similarities, the vasculitis, renal assault, and epidermal skin lesions that are prominent in SLE are absent in AILD.

Although malignant transformation is possible, there are several contrasts between lymphomas and pure AILD. Clinically, rarely do non-AILD-type lymphomas consistently display the generalized lymphadenopathy, hepatosplenomegaly, and constitutional symptoms which virtually define AILD. Histologically, lymphomas, with scant vasculature, have monomorphic cellularity and atypia which are features not found in AILD. Another difference are the remnant germinal centers that persist in AILD despite intense cellular proliferation.

Histologically similar, differentiating AILD from reactive processes like infections, such as infectious mononucleosis and postviral adenitis, or autoimmune disorders are important. Infections can coexist with AILD, but nodal biopsy will differentiate the two. Atypical clear cells are present in AIL-TCL, not infections.

Early AILD may have well-preserved germinal centers which may be hard to distinguish from reactive hyperplasia or Castleman’s, making repeated biopsies useful. Molecular genetic analysis, with DNA hybridization, and immunophenotyping are the best techniques available for diagnosis.

In many respects, GVHD is clinically identical to AILD. The generalized lymphadenopathy, hepatosplenomegaly, autoimmune hemolytic anemia, susceptibility to infection, and constitutional symptoms such as weight loss are all familiar to the GVHD picture. Skin and hepatic lesions, however, are not nearly as prominent in AILD and the history of organ transplant is noticeably absent. Histologically, the immunoblast proliferation, the disappearance of follicular structures, eosinophilic deposits, and sometimes granulomatous lesions are all mutually common in the nodes and spleen of patients with both diseases. It is important to note, however, that GVHD pathogenesis is very similar to that of AILD and AILD may simply be an abnormal immune response with pharmaceutical and not tissue triggers.

**Prognosis and Treatment**

A stormy and unpredictable course is standard and, seemingly despite treatment modalities, a period of either rapid progression or remission occurs with fatality in months to years. Death occurs in 75% of those affected with a median survival of 30 months. About one third of patients respond to immunosuppressants. The presence of clear cells, age of onset, type of pharmacotherapy, presence of clonality, and other factors have not been found to be good prognostic indicators for AILD. Complete remission after steroid therapy, which occurs in up to 30%, best correlates with good outcome whereas progression to malignant lymphoma, which occur in 18%-50%, is associated with poor prognosis. Despite its “low-grade” revised Kiel classification, median survival is 16 months in malignant transformation, with drug exposure, elevated lactate dehydrogenase, rash, and lymphocytopenia associated with more rapid progression. Therapy is controversial and can be as conservative as support with steroids or as aggressive as multi-drug combination chemotherapy, utilized particularly in cases with
clonality.10,17,37 Case reports of successful treatment of AIL-TCL by IFN-α, fludarabine, COPBLAM/IMVP-16, and 2-chlorodeoxyadenosine have so far been anecdotal.35,38-40 Infectious complications are the most common cause of mortality, especially pneumonia by CMV, P. carinii, and Aspergillus.13,30,35 TMP-SMX prophylaxis may be considered.

**Conclusion**

In 70-95%, there is evidence of clonality even in early forms of AILD, mostly in the T-cell receptor (TCR) gene.15,24,35,41 IgH rearrangement is also present in 10% of cases.15 Serial biopsies have shown either reduction in clones or malignant transformation.14,23,27 Researchers theorize that the initially benign hyperplasia may simply promote clones with genetic rearrangements due to the numerous rapidly repeating cell divisions.23 Clones, however, are not present in amounts appreciable by Southern blot assay in other forms of hyperplasia.23 Immunosuppression in AILD may account for this difference as T-cell deficiency in regulation is known to result in B-cell proliferation and autoaggression.5,42 The worst prognosis is for those with complex aberrant clones and chromosome 1p structural defects, which is also found in other cancers.36

Allergies and drugs such as aspirin, phenytoin, halothane, L-dopa, and antibiotics such as penicillins, tetracycline, and the sulfonamides have been associated previously to onset of AILD.35,42 A review of the literature has failed to find reports of AILD following macrolide exposure. In our case report, we present a relatively healthy woman of typical age for the onset of the disorder with allergic rhinitis and history of various drug hypersensitivities.

While statistical correlation points to the strong possibility that pharmaceutical exposure may be a risk factor for subsequent development of AILD, the pathophysiologic theory of causation may be more obscure. Some evidence suggests that certain B-cell aberrations are a result of drug hypersensitivity.4 It is difficult to say whether the drugs are simply coincidently associated or actually cause, maintain, or exacerbate clonality in AILD and if drug exposure causes AILD to be more likely to progress to frank lymphoma. Only continuing research will bring light to this query.

**Acknowledgements**

Kuakini Medical Center - Department of Medicine and Pathology, John M. Hardman MD, and Georgette Ulloa

**References**


**Figure 1.**—Prominent blood vessel with extravasated blood in background of proliferation lymphocytic.

**Figure 2.**—High power of endothelial proliferation within lymphoma characteristic of AILD-like T-Cell lymphoma.


continued on p.56
Postural Hypertension in Elderly Men - The Honolulu Heart Program

Kannayiram Alagiakrishnan MD*, Kamel Masaki MD**, Irwin Schatz MD***, J. David Curb MD, MPH****, Patricia Blanchette MD, MPH*****

Abstract
Postural hypertension is a condition in which the blood pressure rises abnormally during standing. The aim of this study is to determine the prevalence of postural hypertension and its association with morbidity and subsequent mortality. In the fourth examination (1991-1993) of the Honolulu Heart Program longitudinal cohort, 3741 Japanese-American men aged 71-93 were examined. Prevalence of postural hypertension in this cohort was 39%. Although there was a high prevalence of postural hypertension in this cohort, its clinical significance is questionable as there were no significant correlations with morbidity and subsequent mortality.

Introduction
Postural hypertension or orthostatic hypertension is a condition in which the blood pressure rises during standing. There are only a few case reports and studies documenting this condition and it is not well recognized. The definition of orthostatic hypertension is not yet standardized. One study defines it as an increase in diastolic blood pressure from below 90 to above 90 mm Hg on standing. Another study defines it as an increase in systolic blood pressure by 10 mm Hg or more by the tilt test, and another by marked hypertension in the upright position with normal pressure in the supine position. Kozo et al define it as an elevation of systolic BP >20mm Hg at 2 minutes after standing.

Postural hypertension was first reported by Schneider et al in 1922, in 4.2% of 2000 apparently healthy airmen examined after World War I. The prevalence of postural hypertension varies. In one study, orthostatic hypertension was found in 71% (15 of 21 patients) of borderline hypertensives, while another study had a prevalence 8.7% (29 of 334). Streten et al showed that as many as 10% of some hypertensive populations may have orthostatic hypertension. Various mechanisms for postural hypertension have been suggested. One study showed that decreased venous return causes decreased cardiac output, increased sympathetic stimulation and excessive arteriolar constriction. Other studies showed that patients have increased vascular adrenergic activity and excessive increase in peripheral vascular resistance during tilting. Therefore, the exact pathogenetic mechanisms of postural hypertension are not clear, even though abnormalities of autonomic nervous system activity may be etiologically related.

Various studies have looked at the clinical significance of postural hypertension. One study demonstrated that neurobehavioral functioning and activities of daily living were significantly lowered in people with postural hypertension. Additionally, more periventricular hyperintensities or advanced leukoaraiosis were seen on MRI of the brain when compared with a normotensive group. In another study, an association with extreme dipping (marked fall in nocturnal blood pressure) and cerebrovascular disease has been demonstrated. The aim of this analysis is to determine the prevalence of postural hypertension in elderly men of the Honolulu Heart Program longitudinal cohort and to study the association with morbidity and subsequent mortality.

Methods
Study Population
The Honolulu Heart Program is a longitudinal cohort study of cardiovascular disease which began in 1965. Participants were men of Japanese ancestry, living on the island of Oahu, Hawaii in 1965, and born between 1900 and 1919. The first examination was performed between 1965–1968 and 8006 men were examined. The entire cohort has undergone 6 examinations so far. At the fourth examination (1991-1993), 3741 men aged 71-93 years were examined, representing 80% of the survivors. For this analysis, all variables of interest were available in 3522 participants. The study was approved by the institutional review board of Kuakini Medical Center, and procedures followed were in accordance with institutional guidelines.
Data Collection
The fourth examination included demographic questions, medical and psychosocial interview assessment of cognitive function, fasting blood and 2 hour GTT, EKG, anthropometry, blood pressures (seated, ankle-arm ratio, orthostatics). Diabetes mellitus was defined by history (as told to the participant by a physician), or by fasting glucose \( \geq 140 \) mg/dl or by 2 hour post prandial glucose \( \geq 200 \) mg/dl. Body mass index (BMI) was calculated as weight (kg)/height (square meter).

Mortality and mortality surveillance by the monitoring of hospital discharge records and death certificates has been performed since the beginning of the study. For this report, mortality data were accumulated through December 1997. Data collection is believed to be essentially complete for all cause mortality. Attrition in this cohort is known to be very small; at the fourth examination, only 5 men were lost to follow-up.

Seated blood pressure was measured twice with a mercury sphygmomanometer using a standardized protocol. Supine measurements taken after at least 15 minutes of supine rest. Standing measurements were taken 3 minutes after standing.

Definition of Postural Hypertension
Normally on standing, there is a fall in systolic BP of 10 mm Hg and a rise in diastolic BP of 2-3 mm Hg. Postural hypertension is syndrome in which the blood pressure (systolic or diastolic) rises by 10 mm Hg or more on standing.

Statistical Methods
Subjects with postural hypotension were excluded. We compared subjects with and without postural hypertension. We studied cross sectional associations of postural hypertension with age, BMI, smoking status, seated hypertension, abnormal ankle brachial index, diabetes, prevalent CHD, CVA and cognitive impairment, and subsequent 6 year mortality.

Data are expressed as means ± standard deviation (SD) and as percentages. Univariate and multivariate logistic regression models were used to calculate Odds Ratios (OR) and 95% confidence interval (CI) to study cross-sectional associations. Cox proportional hazards models were used to study the association with subsequent 6-year mortality.

Results
Prevalence of postural hypertension in this cohort was 39%. Prevalence of postural hypertension was 38% between 71-74 years of age, 38.9% between 75-79 years of age, 41.5% between 80-84 of age, and 37.5% in persons over 85 years of age. (Fig.1). There was no significant difference in prevalence rates between the 5 year age groups (chi square p= 0.522). The baseline characteristics of variables by postural hypertension status are shown in Table 1. There was a significant difference in prevalence of seated hypertension, 76.8% of those with postural hypertension had seated hypertension compared to 73% in those without postural hypertension. BMI is also significantly associated with postural hypertension. There were no significant differences among those with and without postural hypertension among variables like age, smoking status, abnormal ankle-brachial index (ABI), prevalent diabetes, prevalent CHD, prevalent CVA, and cognitive impairment.

Univariate logistic regression models showed that postural hypertension was significantly associated with seated hypertension (OR 1.23, 95% CI 1.04-1.45) and BMI (OR 1.03, 95% CI 1.002-1.05). There were no significant associations with age, prevalent coronary artery disease, stroke, cognitive impairment, diabetes, abnormal ankle-brachial index and smoking status. (Table 2).

We performed multivariate logistic regression analysis (Table 3) with postural hypertension as a dependent variable and age, BMI and seated hypertension as independent variables. Postural hypertension was significantly associated with BMI (OR 1.025, 95% CI 1.002-1.050) and seated hypertension (OR 1.192, 95% CI 1.011-1.405), but not with age.

Two separate Cox proportional hazards models were performed with 6 year all cause mortality as the end point (Table 4). Postural hypertension showed no significant association with 6 year all cause mortality.
mortality. In the first model, the relative risk (RR) for all cause mortality associated with orthostatic hypotension was 0.95 (95% CI 0.82- 1.10) after adjustment for age alone. Adjustment for other factors like seated hypertension and BMI (model 2) also did not appreciably alter the results (RR=0.97; 95%CI 0.83-1.12).

| Table 2.— Univariate Logistic Regression Analysis, with Postural Hypertension as the dependent variable |
|-----------------------------------|-----------------|-----------------|
| Variables                        | Odds Ratio (95% CI) |
| BMI                              | 1.030 (1.002–1.059)* |
| Smoking                          | 1.018 (0.911–1.159) |
| Seated Hypertension              | 1.230 (1.040–1.450)* |
| Abnormal ABI                     | 0.886 (0.716–1.048) |
| Prevalent Diabetes               | 0.995 (0.878–1.038) |
| Prevalent CHD                    | 1.189 (0.859–1.646) |
| Previous CVA                     | 1.189 (0.859–1.646) |
| Cognitive Impairment             | 0.988 (0.797–1.220) |
| * p < 0.05                       |                  |

| Table 3.— Multivariate Logistic Regression Analysis, with Postural Hypertension as the dependent variable |
|-----------------------------------|-----------------|
| Variables                        | Odds Ratio         |
| Age                              | 1.009 (0.993–1.026) |
| BMI                              | 1.025 (1.002–1.050)* |
| Seated Hypertension              | 1.192 (1.011–1.405)* |
| * p < 0.05                       |                  |

| Table 4.— Cox Proportional Hazards models for association between Postural Hypertension and 6-year all-cause mortality |
|-----------------------------------|-----------------|
| Models                            | Relative Risk 95% CI |
| Model 1 (Postural hypertension adjusted for age) | 0.95 0.82–1.10 |
| Model 2 (Postural hypertension adjusted for age, seated hypertension, and BMI) | 0.97 0.83–1.12 |

**Discussion**

Physiological mechanisms that ensure fairly small oscillations in blood pressure, with changes in posture are well known. Postural or orthostatic hypotension is commonly encountered and its physiology has been well characterised. The opposite, orthostatic or postural hypertension, has received scant attention and only few case reports and studies have been done. Orthostatic hypertension has not been well defined. Sapru et al defined orthostatic hypertension as marked hypertension in the upright position with normal pressures in the supine position. Streeden et al defined orthostatic hypertension as an increase in diastolic BP from below 90 to above 90 mm Hg. Matsubayashi et al defined orthostatic hypertension as an elevation of SBP≥20 mm Hg at 1 or 2 minutes after standing and Kario et al defined it as an increase in systolic BP by 10 mm Hg by tilt test. In our study we defined postural hypertension as change in SBP or DBP≥10 mm Hg on standing after 3 minutes.

Our cross-sectional data showed that the prevalence of postural hypertension in this cohort is 39%. Postural hypertension is significantly associated with seated hypertension and BMI. There were no significant associations with other variables, prevalent diseases and 6 year all-cause mortality.

There are several strengths to this study. It is population-based, and the numbers are large. It is the only large study done in an elderly population, with almost complete follow-up for morbidity and mortality outcomes.

There are some limitations to this study. Seated blood pressure was measured only twice and not multiple times. Orthostatic blood pressure was measured once. Since blood pressure values are known to vary with repeated measurements multiple measures would be preferable. Secondly, morbidity associations that were studied were cross-sectional. Thirdly, there are no data on cause specific mortality in this analysis. Lastly data reported here can only be generalized to an ambulatory male population, since there were no women in the cohort and orthostatics were not measured at home visits or nursing home visits.

In conclusion, even though there is a high prevalence of postural hypertension in this population of elderly Japanese-American men, its clinical significance is questionable as there were no significant correlations with morbidity and subsequent mortality.

**Acknowledgement**

We would like to thank Ms. Kim Siu for her assistance in preparing the manuscript.

**References**

Evaluation of Late Onset Bipolar Illness During Menopause

Takako Vivian Ishimaru-Tseng MD

Abstract

Objective: The purpose of this paper is to review the literature on bipolar illness and to discuss its relevance to the evaluation and treatment of bipolar illness during menopause. The hypothesis is that there is a group of patients who may present with commonly reported symptoms of menopause who are in fact, suffering from an underlying bipolar illness.

Method: The literature pertaining to gender differences in bipolar illness as well as the effect of major life events associated with the onset of bipolar illness is closely examined.

Results: There is enough evidence to support the hypothesis that women in particular are vulnerable to bipolar illness of the rapid cycling type. Exacerbations of a previous existing condition or late-onset bipolar illness may be associated with major stressors and life events such as that experienced during menopause.

Conclusions: Gender differences in the course of bipolar illness and the greater prevalence of rapid cycling among bipolar women may in fact be a major consideration in the evaluation and treatment of symptoms during menopause.

Introduction

Although gender differences in the evaluation and treatment of bipolar illness have been recognized, the impact of this illness on the experience of menopause is a topic that has yet to be explored. Commonly reported symptoms of menopause including irritability, sleep disturbances, and mood changes may in fact, be complicated or worsened by an underlying bipolar disorder. Another consideration is the possibility that there are women who are suffering from the first episode of a late onset bipolar illness. In light of the fact that 40% of the U.S. population is expected to be 45 years and older by the year 2010, this appears to be an area of research that warrants further examination for its clinical relevance.

Table 1.—Type I bipolar disorder (history of at least one manic episode)
From DSM-IV, American Psychiatric Association, 1994 p.332

<table>
<thead>
<tr>
<th>Criteria for manic episode:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (can be less than 1 week if hospitalization required).</td>
</tr>
<tr>
<td>At least three of the following symptoms (four if mood can only be described as irritable):</td>
</tr>
<tr>
<td>Grandiosity</td>
</tr>
<tr>
<td>Decreased need for sleep</td>
</tr>
<tr>
<td>Pressure of speech or more talkative than usual</td>
</tr>
<tr>
<td>Racing thoughts or flight of ideas</td>
</tr>
<tr>
<td>Highly distractible</td>
</tr>
<tr>
<td>Psychomotor agitation or increase in goal-directed activity</td>
</tr>
<tr>
<td>Excessive involvement in pleasurable activities with a high potential for painful consequences</td>
</tr>
<tr>
<td>Mood disturbance severe enough to cause marked impairment in social or occupational functioning. Psychotic features may also be included in this category.</td>
</tr>
</tbody>
</table>

Table 2.—Type II bipolar disorder (recurrent major depressive episodes with hypomanic episodes)
From DSM-IV, American Psychiatric Association, 1994 p.338

<table>
<thead>
<tr>
<th>Criteria for hypomania:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A distinct period of persistently elevated, expansive, or irritable mood lasting at least 4 days.</td>
</tr>
<tr>
<td>During the period of mood disturbance, at least three (four if the mood is only irritable) symptoms of mania have been present to a significant degree.</td>
</tr>
<tr>
<td>The episode is not severe enough to cause a marked impairment in social or occupational functioning. No psychotic features. Hospitalization not necessary to keep the patient safe from self or others.</td>
</tr>
</tbody>
</table>

Review of literature

According to the literature the median age of onset of bipolar disorder in women living in the United States is 34.5 years. The peak incidences, however, occur at ages 20-30 and 40-50 years. The latter peak clearly coincides with the age at which most women in the United States are in menopause. Leibenluft suggests that women may be more likely to experience the onset of bipolar illness at ages 45-49 years.
Currently, the Diagnostic and Statistical Manual of Mental Disorders DSM-IV acknowledges the existence of various subtypes of bipolar illness. The description of the classic type I manic-depressive is the one with which most clinicians are familiar (Table 1). The type II bipolar patient, on the other hand, may present with more subtle clinical features, as they do not present with full blown manic symptoms, but rather attenuated symptoms that are described as hypomania (Table 2). Unfortunately, this latter group can be difficult to identify and to treat, thus often becoming labeled as having borderline personality traits. Symptoms that may lend themselves to this diagnosis include rapid shifts in mood that are attributed to affective instability, intense displays of anger or irritability, impulsivity, recurrent threats of self harm or suicide, and major disruptions in interpersonal relationships.

Bipolar illness can be further classified according to the frequency with which the episodes of depression are intercalated with mania or hypomania. A rapid cycling bipolar illness is defined as the presence of at least four episodes of a mood disturbance in the previous 12 months that meet the criteria for a major depressive, manic, mixed, or hypomanic episode. A mixed episode refers to a mood disturbance that meets the criteria for both a manic episode and a major depressive episode.

Most of the research on gender differences in bipolar illness has focused upon reproductive factors associated with pregnancy and the postpartum period. Out of two studies that included menopause as part of the evaluation of bipolar illness, one group of authors, Kukopulos et al. found that about a third of the bipolar women in their study became what was described as “continuous circular” bipolars around the period of menopause. Wehr et al., however, noted no effect of menopause in bipolar patients who had already been identified as rapid cyclers. What remains to be explored is whether there is a group of women who experience the first episode of a late onset bipolar illness during menopause.

In making an assessment of the factors that lend themselves to the etiology of a late onset bipolar illness, it becomes clear that genetic and biological components alone are not adequate in explaining the heterogeneity observed in the expression of this disorder. In one study conducted by Ellicott et al. it was found that there is a significant association between life events and the relapse or recurrence of bipolar illness. Not only was it reported that bipolar individuals experience increased stress before the onset of their illness, but also prior to subsequent episodes. In another study, Glassner et al. observed that life events appear to play a greater etiological role in late onset bipolar disorder. A treatment plan that attempts to identify and ameliorate potential life stressors may be very important in reducing the likelihood of relapse in bipolar patients. In some cases, it may even prevent or at least delay the onset of bipolar illness during the perimenopausal years.

Although some may argue that menopause is not necessarily experienced by all women as a stressful life event, it is important to keep in mind that the women who present for the treatment of menopausal symptoms are usually in a measurable amount of distress. As of yet, a clear cut syndrome of an affective disorder associated with menopause has not been identified with consistency. However, there appears to be a general consensus in the literature documenting an increase in somatic, mood, and behavioral symptoms. Studies have shown that women in menopause clinics are reported to have elevated symptoms of depression and a reduced quality of life. According to Harlow et al., there may actually be a link to medically treated depression and early menopause. This in itself can be an important consideration in the primary care setting where clinicians can initiate appropriate intervention strategies early in the course of a woman’s reproductive history.

**Differential diagnosis**

Assessing older patients for bipolar illness can present with some difficulties that complicate the clinical picture. Unlike the classic presentation of an agitated, full-blown manic patient with pressure of speech and grandiose delusions, older patients are more likely to present with signs of a mixed episode in which symptoms of both depression and mania are present. In a study by Schulman et al. it was reported that less than 10% of a group of elderly bipolar patients were found to have had their first manic attack before the age of 40. Without a thorough diagnostic evaluation, many older patients may be incorrectly diagnosed as having an agitated depression, a schizoaffective disorder, or borderline personality traits with somatic preoccupation. The danger in this is that these patients may be at increased risk for rapid cycling and worsening of irritability, especially if antidepressant therapy is initiated without a mood stabilizer.

Considering the statistics that indicate that rapid cycling bipolar disorder is three times more common in women than in men, the issue of appropriate mood stabilization and follow-up treatment becomes even more critical in the primary care setting. Not only are these women more likely to present themselves initially to internists and gynecologists during the reproductive years, but also, the likelihood in the recurrence of symptoms in subsequent years is well documented.

**Clinical course**

In order to carefully assess the clinical presentation with accuracy, one must always obtain a detailed history and a description of the clinical course of the menopausal woman’s symptoms. Signs and symptoms associated with menopause tend to develop insidiously and are believed to be linked to a gradual decline in hormone activity. Mood disturbances and irritability that last for at least a week and continue to escalate are suggestive of an affective disorder rather than a worsening of severe menopausal symptoms. A thorough medical work-up to exclude general medical conditions such as thyroid abnormalities can be especially helpful. Several studies in the literature have demonstrated that rapid cycling patients can be successfully treated with high doses of levothyroxine. Other considerations in the differential diagnosis also include substance abuse and drug interactions, especially if a woman is on oral contraceptives, hormone replacement therapy, or antidepressants that can alter the pharmacokinetics of drug metabolism.

**Facilitation of diagnosis**

Sleep disturbances are common during menopause. Hot flashes which are believed to be a symptom of vasomotor instability are especially disruptive to the sleep cycle. Not only does a lack of sleep cause fatigue, but it also has a profound effect on mood, memory, and concentration as measured by cognitive performance tasks, probed memory examinations, and electrodermal-orienting responses.
to assess attentional shift or capture. Sleep deprivation in itself has been known to trigger manic episodes in some bipolar patients. The psychological ramifications of hot flashes has also been noted by Ginsberg and Bakcr in the literature. Once again, a detailed history will reveal clues as to whether there is an underlying mood disorder, or whether it is a symptom that might be ameliorated by hormone replacement therapy.

A patient who reports a sudden decrease in sleep along with an increase in goal-directed activity and irritability is more likely to be suffering from a bipolar disorder than a woman who finds herself feeling constantly fatigued and low in energy because of sleep disturbances related to hot flashes. The difficulty arises, however, when bipolar patients with mixed features present with a combination of symptoms that include lack of sleep, irritability, fatigue, and possibly an increase in goal-directed activities. At this point, it becomes especially critical to evaluate the patient for other supporting evidence such as racing thoughts, grandiosity, excessive involvement in pleasurable activities with a high potential for painful consequences, significant changes in weight, or suicidal ideation, none of which are considered to be a normal part of menopause. When there is a suspicion that an underlying psychiatric illness is present, it is important to ask the patients directly about these symptoms as they usually will not volunteer this information on a routine visit to their primary health care provider.

**References**

11. McDonald W, Neomen C. Practical guidelines for diagnosing and treating mania and bipolar disorder in the elderly. Medscape Mental Health 1998;3(2)
17. Stancer H, Peraudeau E. Treatment of refractory rapid-cycling manic-depressive disorder with levothyroxine: Clinical observations. Arch Gen Psychiatry 1982;39:311-312
Coronary Artery Bypass Grafting Performed With Or Without A Bypass Pump: Early Results

Jeffrey D. Lee MD, Collin R. Dang MD, Sharyl Taoka (Medical Student IV), B. Jason Bowles MD, and E. William Johnson MPH

Abstract

Introduction: Traditionally, heart bypass surgery has required stopping of the heart and the use of cardiopulmonary bypass. Numerous complications have been associated with exposure to this extracorporeal circuit. Newer techniques of local cardiac wall stabilization now enable this operation to be performed safely “Off Pump”. The early clinical results of Off Pump Coronary Artery Bypass (OPCAB) will be compared to a similar group of traditional Coronary Artery Bypass Grafting (CABG) patients.

Methods: A retrospective review of 137 consecutive patients undergoing elective coronary artery bypass grafting was performed, 68 of who underwent traditional CABG and 69 of who underwent OPCAB. Inclusion criteria consisted of first time cardiac surgical procedures with an ejection fraction ≥ 20%, without significant renal failure (creatinine < 2.0).

Results: There was no statistical difference in the age, sex, cardiac function or underlying co-morbidities between those undergoing CABG and OPCAB. CABG patients had slightly more vessels bypassed than those in the OPCAB group (3.0 vs 2.6, p=0.010). Despite similar preoperative characteristics, the OPCAB group experienced a reduction in morbidity without an increase in mortality.

This study was supported by a grant from the Hawaii Community Foundation (grant #961573) and the Pacific Health Research Institute.

correspondence to:
Jeffrey D. Lee MD
1329 Lusitana Street, Suite 709
Honolulu, Hawaii 96813
Tel (808) 531-3311
Fax (808) 550-0279

Table 1

<table>
<thead>
<tr>
<th></th>
<th>OPCAB (n=69)</th>
<th>CABG (n=68)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfusion required</td>
<td>29.0%</td>
<td>45.6%</td>
<td>0.045</td>
</tr>
<tr>
<td>Intubation time (hrs)</td>
<td>3.3 ± 7.3</td>
<td>9.5 ± 8.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ICU LOS (days)</td>
<td>1.5 ± 1.0</td>
<td>2.4 ± 3.1</td>
<td>0.027</td>
</tr>
<tr>
<td>Hospital LOS (days)</td>
<td>4.9 ± 2.2</td>
<td>6.6 ± 4.2</td>
<td>0.005</td>
</tr>
<tr>
<td>CVA 0(0%)</td>
<td>2(3%)</td>
<td>0.150</td>
<td></td>
</tr>
<tr>
<td>Death 0(0%)</td>
<td>2(3%)</td>
<td>0.150</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion: In similar patient populations, OPCAB was associated with significantly reduced transfusion requirements, intubation time, ICU and overall hospital lengths of stay, with no increase in mortality. Further investigation is warranted to ascertain the role of the OPCAB in the general cardiac surgical community.

Introduction

With our aging population, ischemic coronary disease is becoming an increasingly prominent health care problem. Over 800,000 coronary artery bypass grafting operations (CABG) are performed annually worldwide. Traditionally, CABG is performed with cardiopulmonary bypass (CPB) and global cardiac arrest to create a still and bloodless operative field. CPB however, can be associated with significant morbidity and mortality.

Multiple organ systems are deleteriously affected by the systemic inflammatory response, which ensues following exposure of the body to CPB. Organs involved include the heart, lungs, central nervous system, kidneys and gastrointestinal tract. Cardiac damage has been attributed to activated neutrophils, oxygen free radicals and cytotoxins that cause myocardial edema and decreased contractility. Pulmonary dysfunction has been attributed to the degradation of surfactant, activation of complement and neutrophils, and consequent increased capillary permeability, interstitial edema, atelectasis, and decreased compliance. Neurologic complications such as stroke and neurocognitive dysfunction may be related to cerebral microemboli, associated with CPB, aortic cannulation, or surgical manipulation of the aorta. In one prospective multi-institutional study of 2108 patients undergoing CABG with CPB, stroke was seen in 3% overall. Risk factors for a stroke following CABG with CPB included older age (> 70 years old = 6.1% stroke rate), history of a prior stroke (10.1% stroke rate), uncontrolled systolic hypertension (11.0% stroke rate), and chronic obstructive pulmonary disease (6.1% stroke rate). In another prospective trial, neurocognitive dysfunction, which is defined as deterioration in intellectual functioning, confusion, agitation, disorientation, or memory deficit, was seen in 73% of patients following CABG with CPB tested at 8 days postop. Follow-up testing showed initial improvement at 2 months (38% had deficit) that seemed to plateau at one year (35% had deficit).

Interest in minimizing the trauma of heart surgery has spurred investigation into less invasive approaches. The Off Pump Coronary Artery Bypass (OPCAB) utilizes new techniques of local cardiac wall stabilization, which allow accurate suture placement on the beating heart. All coronary vessels are approachable with this
operation and the OPCAB completely avoids the need to place the body on CPB. We will examine the early clinical experience with this new procedure.

Methods
A retrospective review of consecutive patients undergoing elective coronary artery bypass grafting was performed. Inclusion criteria were first time cardiac surgical procedures with ejection fractions ≥ 20%, without significant renal dysfunction (creatinine < 2.0). In order to compare patient populations undergoing a similar number of bypass grafts, all traditional CABG patients who underwent ≤ 3 grafts from January 1998 through May 1999 were included. Patient accrual was from May 1998 through May 1999 (OPCAB), and January 1998 through May 1999 (CABG). These procedures were performed at the St. Francis Medical Center at Liliha, Queens Medical Center, and Kuakini Medical Centers, all located in Honolulu, Hawaii. Informed clinical consent was obtained in all cases. Statistical analysis was performed using SPSS statistical software. Paired t tests were utilized. Differences at the 95% confidence level were considered to be statistically significant.

Results
69 OPCAB and 68 CABG patients were compared. There was no statistical difference in the age (OPCAB 64.8 years, CABG 66.0 years), sex distribution (OPCAB 73% male, CABG 76% male), estimated ejection fraction (OPCAB 55.5% vs CABG 50.9%) or underlying co-morbidities between those undergoing OPCAB and CABG. CABG patients had slightly more vessels bypassed than those in the OPCAB group (3.0 vs 2.6 p = 0.01). In this series, 10/68 (14.7%) CABG patients had more than 3 coronary vessels bypassed (4.4 ± .7 bypass grafts) whereas 11/69 (15.9%) in the OPCAB group had more than 3 bypasses performed (4.0 ± 0.6 bypass grafts). Despite these similar preoperative characteristics, the OPCAB group experienced reduced morbidity compared to those undergoing traditional CABG, with no increase in mortality. Intensive care unit and overall hospital lengths of stay were also reduced. (Table 1)

Discussion
Our early experience with the OPCAB has been encouraging. We have been subjectively impressed with the reduced trauma this operation seems to be associated with in selected patients. This study verifies our impression of a more favorable early clinical result with the OPCAB. The reductions in transfusion requirements, intubation time, ICU and overall hospital lengths of stay are tangible benefits both to the patient directly and to society in general, in terms of reduced medical expenditure and preservation of resources.

Of those patients undergoing traditional CABG, 45.6 % required postoperative blood and blood product transfusions. This compares favorably with the reported 75% transfusion rate in a group of 100 patients undergoing CABG with CPB at a major metropolitan medical center. Unfortunately, this rate of blood and blood product transfusions are not uncommon after coronary bypass surgery and is attributed largely to the damaging effects of CPB on platelet function, and the coagulation cascade. The necessity for high dose heparinization as well as the hypothermia associated with traditional CABG with CPB, are contributing factors as well. In contrast, those patients undergoing the OPCAB are never subjected to the rigors of cardiopulmonary bypass. Platelets and clotting function are preserved. A lower dose of heparin is utilized and the patients are kept warm throughout the procedure. Accordingly, the reduction in transfusion requirements with the OPCAB procedure (29.0%) should not be surprising.

The damaging pulmonary effects of CPB can be profound. Pulmonary interstitial edema is common after CPB and requires vigorous diuresis and prolonged ventilation. Atelectasis and reduction in surfactant levels have been associated with CPB and the lack of ventilation of the lungs during a traditional CABG procedure. In contrast, the OPCAB patients are ventilated throughout the entire procedure and are ready for extubation in many cases almost immediately. In this series, over 50% of the OPCAB patients were successfully extubated on the operating room table, at the end of the procedure.

A significant reduction in ICU and overall hospital lengths of stay was observed with the OPCAB. The earlier extubation in these patients, no doubt, speeds time to recovery and allows earlier ambulation and resumption of normal nutrition. The reduced pulmonary interstitial fluid allows these patients to wean off of oxygen more quickly, which can lead to a quicker recovery and discharge.

Neurologic sequelae of CABG with CPB can be one of the most feared complications of this procedure. Stroke can have devastating effects for the patient, family and society. It is associated with high in-hospital mortality rates (21% with stroke vs 2% without stroke), longer hospital stays (25 days with stroke vs 10 days without stroke), and higher rates of discharge to intermediate care or nursing home facilities (47% with stroke vs 8% without stroke). Neurocognitive dysfunction is a more subtle neurologic deficit commonly seen after CABG with CPB. Development of these neurologic complications have been associated with cerebral microemboli, generated from a diseased atherosclerotic aorta, from the CPB pump circuit, or through surgical manipulation of the heart and aorta. These microemboli can be detected with use of Transcranial Doppler ultrasound probes placed over the bilateral middle cerebral arteries. Since OPCAB avoids CPB entirely; cerebral microemboli may be reduced with reduced neurologic complications. Interestingly, in this series no strokes were observed in the OPCAB group whereas 2 documented clinical strokes (3%) were seen in the traditional CABG group, resulting in one of the two mortalities in this series. While not reaching statistical significance (p=0.150), this trend is supportive of a possible reduction in neurologic complications with the OPCAB.

Clearly there are significant limitations to this study. While consecutive, it is retrospective and subject to significant surgeon selection bias (i.e., perhaps only healthier patients may have had an OPCAB). We hoped to minimize this by using uniform inclusion criteria (elective patients, first time cardiac surgery, ejection fraction ≥ 20 %, no significant renal dysfunction with creatinine < 2.0). We tried to analyze patients with similar numbers of grafts as well. We were fairly successful in our efforts. No significant differences in age, sex or ejection fraction existed between the two groups. Slightly more grafts were performed in the traditional CABG group than in the OPCAB group (3.0 vs 2.6, p=0.01), however, a greater
percentage of OPCAB patients (15.9%) had greater than 3 grafts performed compared to the traditional CABG group (14.7%).

Graft patency is an obvious important endpoint not addressed in this study. Surgeon selection bias (i.e., perhaps only patients with relatively larger target coronary vessels underwent OPCAB) also limits useful analysis. We believe that only a properly performed prospective randomized trial can adequately answer this question. Early angiographic results by others however, have been reported. Jansen et al6 in a favorable clinical report of their first 100 patients who underwent multivesSEL OPCAB documented an angiographic patency rate of 95%. Calafiore and colleagues in 199 consecutive patients and Subramanian in 52 consecutive patients have reported angiographic patency rates of 98.9%, and 96.2%, respectively.

Not all patients can undergo OPCAB. Anatomic and hemodynamic considerations play a role as well as the experience of the surgical team. In this series, 4 patients (5.5%) initially undergoing OPCAB were converted intraoperatively to a traditional CABG. In these patients, hemodynamic instability resulted from either lifting or stabilizing the heart, necessitating conversion. There were no myocardial infarctions or other significant complications in these patients. All were discharged home safely with total hospitalizations ranging from five to nine days (mean 6.5 days). In this study, these patients were included in the traditional CABG group for analysis.

Because of these limitations, definitive conclusions regarding the role of the OPCAB in the general cardiac surgical population cannot be made. Surgeon selection bias can only be overcome with a prospective randomized clinical trial. We believe, however, that these results are interesting and warrant further study. Accordingly, we have now embarked and are actively enrolling patients into a prospective randomized clinical trial comparing the OPCAB to traditional CABG. Funded by a grant from the Hawaii Community Foundation, we are studying the effects of the two procedures on neurologic function, morbidity and cost. Pre and postoperative neurologic and neurocognitive function, brain perfusion and intraoperative Transcranial Doppler analysis of cerebral microemboli, are important facets of this ongoing clinical trial.

We believe that the OPCAB is an exciting new procedure, which may have much potential. As with any new medical procedure however, careful and objective study in the context of a prospective randomized protocol should be encouraged.

References


continued from p. 47


Use of Donepezil in Elderly Patients With Alzheimer’s Disease- A Hawaii Based Study

Kannayiram Alagiakrishnan MD*, Warren Wong MD**, Patricia L. Blanchette MD, MPH***

Abstract
Donepezil (Aricept) is a reversible acetylcholinesterase inhibitor which is indicated for the treatment of mild to moderate dementia of the Alzheimer’s type. We did a retrospective analysis of 41 elderly Alzheimer’s subjects of different ethnic groups including a large number of Asian and Hawaiian patients. Donepezil appears to be clinically effective in patients of different ethnicities with mild to moderate Alzheimer’s disease, even at advanced age.

Introduction
Alzheimer’s disease is the most common disorder causing cognitive decline. It affects approximately 4 million persons in the United States. Some of the cognitive signs and symptoms of Alzheimer’s disease are attributed to a deficiency of cholinergic neurotransmission. Donepezil (Aricept), a reversible acetylcholinesterase inhibitor, is indicated for the treatment of mild to moderate dementia of the Alzheimer’s type.

Published studies have not addressed the effectiveness of donepezil in Asian and Hawaiian populations. This study was done to evaluate the effectiveness of donepezil on cognitive and functional levels in mild to moderate Alzheimer’s disease among the different ethnic groups in Hawaii.

Methods
Subjects
Subjects in this study include male and female elderly of different ethnic backgrounds who were referred to the Geriatrics Consultation Clinic at Kaiser Permanente, Honolulu, Hawaii. Patients who were diagnosed as having Alzheimer’s Disease were classified as mild (>19), moderate (14-19) and severe (<14) based on Folstein Mini Mental Status Examination (MMSE) scores.

Results
Out of 41 subjects who were on donepezil, 13 (32%) were males and 28 (68%) were females. Eight (20%) of subjects were 65-75 years old, 23 (56%) were 76-85 years old and 10 (24%) were >85 years old. The mean age of subjects was 80 years.

Baseline MMSE scores ranged from 14-27, with a mean of 21.5 (Fig 1). 12 subjects (29%) were assessed for at least 9 months, 11 subjects (27%) for at least 6 months, 15 subjects (37%) for at least 3 months and 3 subjects (7%) for 1 month. Three subjects who were assessed for 1 month didn’t have a follow up MMSE at the end of 1 month. MMSE scores improved (>2) in 12 subjects (29%). MMSE scores did not change (+0) from baseline in 15 (37%) of subjects. There were no functional or behavioral declines in the 12 subjects continuing donepezil for ≥9 months. The responses to donepezil in the 3 months, 6 months and 9 months follow up groups, are shown in Table 1. Trends of MMSE scores in the 9 month follow up group is shown in Figure 2.

Among the subjects 9 (22%) were Japanese, 9 (22%) were Chinese, 11 (26%) were Caucasian and 12 (29%) were Hawaiian. Chinese subjects had a mean change in MMSE by +3.73, Caucasian +1.00, Japanese +0.92, and Hawaiian +0.00 at 3 months.

Out of 41 subjects (24%), 10 had side effects. (Table 2). Three subjects had agitation. Two had gross loss in weight (>10 lbs). Fifteen (35%) had clinically insignificant weight loss (<3 lbs).

Nineteen subjects (46%) discontinued donepezil at or within 6 months (Table 3). The reasons for stopping the medication were side effects 8 (19%), family’s wishes not to continue 3 (7%), no cognitive improvement or cognitive decline 4 (10%) and non compliance 1 (2%).

*Fellow in Geriatric Medicine, Division of Geriatric Medicine, John A. Burns School of Medicine, University of Hawaii, Honolulu, Hawaii 96817.

**Kaiser Permanente, Assoc. Professor of Medicine, Division of Geriatric Medicine, John A. Burns School of Medicine, University of Hawaii, Honolulu, Hawaii 96817.

***Professor of Medicine and Public Health, Division of Geriatric Medicine, John A. Burns School of Medicine, University of Hawaii, Honolulu, Hawaii 96817.

Correspondence to:
Kannayiram Alagiakrishnan MD
347 N. Kuakini Street, HPW 9th Floor,
Honolulu, Hawaii 96817
Phone: 808-523-8461
Fax: 808-528-1897
Figure 1.— Baseline MMSE score ranges in the subjects on the study

![Baseline MMSE Score](image)

Table 1.— Responses to Donepezil

<table>
<thead>
<tr>
<th>Duration of donepezil therapy</th>
<th>Mean Baseline MMSE score</th>
<th>Post intervention MMSE score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months- All subjects (15)</td>
<td>20.4 ± 3.6</td>
<td>21.7 ± 4.1</td>
</tr>
<tr>
<td>Responders (11)</td>
<td>20.8 ± 3.0</td>
<td>23.2 ± 3.5</td>
</tr>
<tr>
<td>Non responders (4)</td>
<td>19.0 ± 4.5</td>
<td>16.0 ± 3.7</td>
</tr>
<tr>
<td>6 months- All subjects (11)</td>
<td>22.3 ± 1.9</td>
<td>22.7 ± 4.1</td>
</tr>
<tr>
<td>Responders (8)</td>
<td>22.0 ± 2.1</td>
<td>24.5 ± 3.7</td>
</tr>
<tr>
<td>Non responders (3)</td>
<td>22.7 ± 1.2</td>
<td>19.0 ± 0.8</td>
</tr>
<tr>
<td>9 months- All subjects (12)</td>
<td>22.3 ± 2.9</td>
<td>22.2 ± 4.09</td>
</tr>
<tr>
<td>Responders (8)</td>
<td>22.5 ± 2.2</td>
<td>24.4 ± 2.5</td>
</tr>
<tr>
<td>Non responders (4)</td>
<td>22.0 ± 3.9</td>
<td>17.8 ± 2.9</td>
</tr>
</tbody>
</table>

Table 2.— Side effects of Donepezil in this study

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agitation</td>
<td>3</td>
</tr>
<tr>
<td>Gross Weight Loss</td>
<td>2</td>
</tr>
<tr>
<td>Visual Hallucination</td>
<td>1</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>1</td>
</tr>
<tr>
<td>Severe Depression</td>
<td>1</td>
</tr>
<tr>
<td>Insomnia</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3.— Reasons for discontinuation of Donepezil treatment

<table>
<thead>
<tr>
<th>Reasons</th>
<th>1 mo</th>
<th>3 mo</th>
<th>6 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to side effects</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Family’s wishes</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No Cogn Improvement</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Cognitive Decline</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>
Discussion
To our knowledge, this is the first study which assesses and compares the effectiveness of donepezil in different ethnic groups. The results presented herein, demonstrate that donepezil appears to be clinically effective in patients of different ethnicities with mild to moderate Alzheimer’s disease, even at advanced age. MMSE scores improved (> +2) or did not change (±2) from baseline in 66% of subjects in this study. Donepezil was well tolerated and continued for at least 6 months in 56% of subjects in this study. Previously published trials utilized ADAS-cog, CIBIC plus, MMSE, CDS-SB, and IDDD to measure efficacy of donepezil. However, the Folstein Mini Mental Status Examination is the most commonly used tool in clinical practice. This paper suggests the likely impact of donepezil on Folstein scores in patients with mild to moderate Alzheimer’s disease. Age does not appear to be a factor in its effectiveness.

The limitations of this study includes its retrospective nature, different periods of follow up and the lack of a control group of untreated subjects.

Acknowledgement
The authors thank Judie Suzuki Ching, R.N. Geriatric Care Nurse, Kaiser Permanente, for her help in this study.

References

People know Pueblo for its...

Snazzy Web Site
(www.pueblo.gsa.gov)

Cool Consumer Information Catalog?

Easy-To-Remember Phone Number?
(1-888-8 PUEBLO)

Famous Hot Salsa?

It’s not just the salsa. In Pueblo, the free information is also hot. You can get it by dipping into the Consumer Information Center web site, www.pueblo.gsa.gov. Or calling toll-free 1-888-8 PUEBLO (1-888-878-3256) to order the free Catalog. Either way, you can spice up your life with ready-to-use government information on topics like investing for retirement, getting federal benefits, raising healthy children and buying surplus government property.

So remember, if you want information, mild, chunky or otherwise, Pueblo is all you need to know. Sorry, salsa not available through the Consumer Information Catalog or web site.

A public service of this publication and the Consumer Information Center of the U.S. General Services Administration.
The Second Annual Queen’s Conference
Monday, Tuesday, Wednesday
February 28, 29, March 1, 2000
Hilton Hawaiian Village, Honolulu

Conference Chair
R. Michael Blaese, MD, PhD
Clinical Gene Therapy, NIH (retired)
President Chief Scientific Officer, Kimeragen Pharmaceuticals

Topics include discoveries and applications in cardiology, oncology, and neurosciences as well as clinical implications of the Human Genome Project, ethical issues, and gene therapy. Confirmed speakers are from some of the most prestigious research and clinical centers across the United States.

If you wish to be mailed a brochure, call (808) 537-7009 or visit our web site at www.d2p.queens.org

Sponsored by The Queen’s Medical Center, Honolulu
First Hawaiian Bank has the prescription for HMA members. It includes free and discounted personal and business banking services, discounted mortgage loan fees, reduced rates on business loans, free consultation and reduced fees on financial planning, and a Business Banker to help you with it all. It's exactly what you need to keep your finances in excellent health. If you're an HMA member, sign up by calling 525-6262 (or call collect from the neighbor islands).
When it comes to health care, the future is best seen not by adopting a global perspective, but rather by focusing on what is purely local. An island community like Hawaii cannot depend on a phone or fax line, or the next airplane or ship, to bring dedicated, experienced, and qualified health care professionals to its shore. Hawaii must preserve within its own community the sensitive hands and intuitive minds of experienced specialists; the nurses and doctors attuned to the needs of a multiethnic and multicultural community; and the rural and primary hospitals that are accessible to all.

The Hawaii Coalition for Health is a consumer health advocacy organization that seeks to remind decisionmakers and the public that providing optimum care for patients depends on preserving the health of all components of our health care industry, from institutional providers to individual providers, from health plans to the professional schools. Since its inception in 1996, the Coalition has provided balance to a health care industry where health plan management felt free to diminish the quality and quantity of patients’ medical care at will.

The health of Hawaii’s health care industry impacts not only consumers and current practitioners, it impacts the future of the University of Hawaii professional health schools and their graduates as well. The Schools of Medicine, Nursing, and Public Health contribute enormously not only to the quantity of health care in our community, but also to the high quality of health care in this State. The symbiotic relationship between our professional health schools and providers throughout the State needs to be considered and nurtured by policymakers.

Informed policymakers can formulate and implement policies that will preserve and support all facets of Hawaii’s health care industry. In 1998 and 1999, our Legislature enacted statutory protections for patients that helped to level the playing field for both patients and providers. However, the Coalition is now concerned that the imbalance of bargaining power between managed care organizations and providers will undermine those protections. On December 8, 1999, the Coalition convened a panel of experts to share their concerns about the current state and future prospects of health care in Hawaii. The following articles represent those experts’ viewpoint in their primary areas of concern.

**Special Presentation to the State Legislature: Hawaii Coalition for Health December 8, 1999**

Arleen Jouxsom-Meyers Esq., MD, JD, MPH, President, Hawaii Coalition For Health

The Hawaii Coalition For Health, for those who don’t know about the organization, is a 3-year old 501(c)(3), non-profit corporation established to advocate for consumers in any matters which affect health. The organization, presently with a membership of about 1,200, comprising 400 physicians and other professionals, and 800 general public, provides a forum for consumers to become involved and to participate in policy making regarding how their health care is delivered. The Coalition believes that it is time for all of us to take our heads out of the sand and to bring the problems that exist into the sunshine, and to end the downward trend in the quality and availability of health care delivered in Hawaii, before we totally lose the fruits of many years of hard work.

The Coalition hosted a meeting at the legislature on December 8, 1999 with a purpose of raising awareness of the serious problems that exist and hopefully to spur our legislators to create a forum in which we can, as a community, explore solutions. I would like to thank Senator Suzanne Chun-Oakland and her staff for assisting us in setting up the meeting. Unfortunately, due to some mis-communication that occurred, many of our key legislators were unable to attend, but I hope that by their staff carrying back information to them, we can still accomplish our objectives. I would also like to thank Professor Sylvia Law, a visiting law professor from New York University, for permitting me to use data which have resulted from research she is conducting.

In some respects Hawaii stands out as a leader in our nation: Firstly, because only 8.8% of our population is uninsured, whereas, 16.3% of Americans nationwide were uninsured in 1999, substantially more than when managed care took hold in the late 1980’s and we were promised that more Americans could be insured out of savings generated by more efficiently managing health care costs. Secondly, Hawaii’s health care costs are lower than the rest of the nation. We spend roughly 11% of Gross State Product on health care versus 15% nationally. In light of the fact that Hawaii’s life expectancy is 79, four years longer than the U.S. average, our low expenditures on health care is even more remarkable. In other respects, perhaps, Hawaii has cut too close to the bone and, similar to the federal government recently re-evaluating Medicare reimbursements, we should reconsider whether we too have gone too far.

Numerous problems are emerging in Hawaii: Firstly, our hospitals are facing serious financial difficulties. We recently heard that Wahiawa General Hospital had defaulted on its State bonds. Kahuku Hospital has been considering closure for quite a while. The hospital CEO’s and Rich Meiers from the Healthcare Association of Hawaii were not present at the legislative meeting because they were meeting with Governor Cayetano at the time and were holding a press conference to inform law makers and Hawaii’s people of the critical problems faced by our hospitals. I have personal knowledge from my participation on the medical staff of certain hospitals, and as a patient, that the safety and quality of care has been dangerously
eroded over recent years. I chose not to single out any one hospital in a public meeting, because as victims of virulent health insurance reimbursement practices, they are all engaging in similar cost-cutting measures which have led to less availability of unprofitable services, demoralization of our nursing profession, and unsafe and poor quality care being delivered. Some have tried to diversify their revenue sources by starting health insurance plans, but have not had the economic power to compete in the insurance market place and have been consumed by our more powerful health insurer. Secondly, the medical school and other health professional schools are no longer adequately supported by the State or by the hospitals. We well know that the presence of health professional schools in a community not only facilitates provision of culturally sensitive care, but plays a direct role in the safety and quality of care delivered. By being able to rub shoulders, on a day-by-day basis, with academicians, practicing professionals are able to maintain a very high standard of knowledge and current expertise which in turn relates to a greater degree of safety and quality for our patients. For goodness sake, we live on an island unable to drive to the next tertiary care center in a neighboring state. If we cannot meet our own needs, we are dead in the water. Sadly, we have already lost our School of Public Health, and we have no assurance that we can get a program of public health accredited. Thirdly, Hawai’i’s physician population has been depersonalized and is struggling to survive. A notable number of my physician colleagues have difficulty paying the rent, and some, especially the more senior and more experienced are leaving Hawai’i, leaving more of our health care to newly graduated and inexperienced physicians. They too cut costs by reducing the number of qualified nurses they employ and by providing a lower quality of care than before. Furthermore, the way physicians practice medicine and what they can do for their patients is controlled by health insurers through enforcement of one-sided and unfair contracts. Doctors in Hawai’i, because of the monopolistic power of one health insurer, the Hawai’i Medical Service Association, to whom physicians must sell their services or go out of business, are therefore powerless to advocate for their patients’ rights. Fourthly, Hawai’i has a far greater percentage of uninsured children than in the United States as a whole. In 1997, 9.8% of all children in Hawai’i had no health insurance, and 13.1% of children were under six years of age. Even in light of these statistics, Hawai’i has not claimed the $8.9 million federal dollars available to cover children under the CHIP program. Lastly, Hawai’i’s community health centers play an essential role in providing care to uninsured and in keeping the cost of health care low, yet we are threatening the viability of these centers by permitting unreasonably low capitation payments which prevent them from adequately caring for the uninsured and for patients with multiple medical needs.

It can be easily seen that these complex problems cry out for a collaborative approach to problem solving, not the heavy-handed and one-sided mechanisms that are often presently used. Each and every one of us can count on one fact: we will need health care at some time in our lives. Let us guard against further erosion of our access to high quality and safe health care.

Edwin C. Cadman MD,
Dean, John A. Bums School of Medicine
Interim-Dean, School of Public Health
University of Hawaii at Maona
Honolulu, Hawaii

It is a pleasure for me to be here today and share with you my vision for our medical school. I am delighted to be the Dean of the John A. Bums School of Medicine. There is nothing I would rather do than be the Dean of this medical school. I share your concerns, aspirations and dreams for the school. I chose to come to Hawaii because I believe that the Governor, the Legislature, the University, the community, the hospitals, the faculty, the physicians of Hawaii and the students want to be a part of an excellent medical school.

To achieve our goals of excellence will require all of us to rethink what it is we wish our medical school to become. Some of the faculty will need to redirect their energies and talents in different directions to accomplish these objectives.

A Medical School’s success is measured many ways. For a community the yardstick of success is often related to the positive influence it has on the well-being of the health of the citizens in the region and state, and the impact it has on the advancement of medical science. For a single individual, it may be how effective someone was at the school in helping you or a friend resolve a personal illness or identify an appropriate referral to a competent physician. For you, the state legislature, it may be the return on investment that you have made in the medical school.

People have always had a great interest in medicine and health. Most communities in which a medical school is located, take great pride in their medical school, and enjoy, in fact, take great pride in the success of the students and faculty.

There are many clinical settings in which medical schools are expected to be leaders. These include the study and evaluation of human health and disease, not only in the health of populations, the purpose of which is to improve the health of groups of people; but, also in the basic science investigation of the molecular biology of disease. Most medical schools provide the clinical leadership in selected areas where innovation and clinical research are required to advance and improve our diagnostic capabilities and treatment options.

My vision is that our medical school should become more involved in the research that is critical to the future understanding of disease. And from this research become recognized leaders in the new biomedical revolution.

My vision includes programs devoted to how to measure and document the difference between good patient care and outstanding patient care. And then communicate these findings effectively to patients and physicians. As a profession, we can do a lot better in the defining the quality aspects of patient care. We must be the paragons of excellence in medical care, and learn how to communicate more effectively to our patients and their families. We must teach them what excellent medical care is, so that they can become more involved in the decision process regarding their diagnosis and treatment.

Medical schools traditionally have had the responsibility for the leadership in continuing medical education of the faculty and local physicians and other health care professionals within the region.
Some schools have also assumed the leadership in the use of information technology to assist physicians and patients achieve access to medical knowledge and care options.

My vision is that we enhance our efforts in continuing medical education, so that we can become a site of choice for continuing medical education for mainland physicians. A mature continuing medical education program could attract thousands of physicians and their families to Hawaii annually. These programs would be a few days to a week in length, with multiple different topics covered over the year. And, of course, medical schools have the sustaining reputation of being the crucible of new knowledge that affects and advances our understanding of health and disease from which improved patient care comes.

The foundation on which all medical schools are built is their commitment to education. The original purpose of a school was to educate, and in so doing, make certain the future generations of physicians are better than we are. Therefore, a significant measure of success can be determined by the quality of our students and their future successes in whatever it is they chose to do. Our students are indistinguishable in their academic accomplishments from those students of the best medical schools in the country, including Harvard and Yale. We standout as a leader in our commitment to accepting the student of a different cultural background. We have the most diverse student body of any medical school. And, we have proven to others that diversity is an asset.

We graduated our first four-year class in 1975, since then our medical school has graduated 1554 students. Sixty percent of Hawaii’s physicians are graduates of the John A. Burns School of Medicine or trained in our residency programs. There are 1100 applicants for a class of 62, 25% of whom are graduates of the University of Hawaii. Six to ten are out of state residents. Ten years ago, our medical school began what is called Problem Based Learning, or PBL. This was a radical departure at the time from the traditional training process, which was two years of lectures followed by two years of practical experience in a hospital. PBL is focused on specific patient diagnosis or set of clinical problems. The learning is done in small groups of 5 to 6 students, referred to as tutorials, supervised by faculty. The focus of these tutorials is to stimulate the student into thinking about information and analyzing data. There are lectures, but they are related to the clinical problem under discussion. Our medical school has received national recognition for this program, and many students apply here because of it.

My vision is to build on the successes of this innovative educational program, and use the new electronic technology to enhance the educational process. In so doing we can consider exporting segments of our programs to other schools and medical students. We have plans to work more closely with the neighboring islands of Hawaii in our educational programs.

In addition to doing so well in student education, to achieve a national reputation of excellence, a medical school must demonstrate excellence in research—both clinical research and basic research. Fortunately, there are funds available from federal and private sources for which we can compete to support our research endeavors. Great medical schools are not dependent on state funds for all of their support, but generate substantial dollars from these national funding sources.

The National Institutes of Health, best known as the NIH, is a federal agency whose only purpose is to support biomedical research, mainly through a competitive grant process. It has a budget of 15.7 billion dollars; and both the republicans and democrats are committed to doubling this funding over 5 years. In this year’s 2000 budget there is an additional 2.3 billion dollars earmarked for the NIH, which will bring the total NIH spending authority to 18 billion dollars. Private foundations, such as the American Cancer Society, American Heart Association, American Diabetes Association, the Howard Hughes Medical Institute and pharmaceutical companies contribute in excess of 50 billion dollars toward the nation’s biomedical research efforts.

Another vision I have is to recruit physician-scientists as well as basic science investigators who can compete successfully for these dollars. Faculty will be recruited whose research will influence the future of our thinking about the normal and abnormal condition, improve the diagnoses or treatment of human disease, or help us understand why there are different rates of illness in people of different ethnic origins.

Biomedical and clinical research is an industry that can become an economic engine. Successful investigators bring new dollars into a region and state through their grants and contracts. In many instances, these can average 1 to 2 million dollars per year for each research team. An average faculty member has 2 to 3 grants that total half a million to a million dollars. These research teams hire support staff, including research technicians, administrative personnel, and provide the training ground for young scientists and physicians who will be the future faculty and practitioners. In addition to these immediate benefits, discoveries made in these laboratories are often the genesis of new small biotech companies that develop in the surrounding communities.

Many of our faculty are considered leaders in their chosen fields of investigation, but we need more of them. I hope to provide the infrastructure that will help the current faculty become even better at what they do.

With a long-range strategic plan that establishes the areas in which we wish to excel, we can recruit additional faculty to join those who are here. We will create an office of research at the Medical School that will assist the medical school faculty in writing grants and the required reports. This office will also work closely with those who do clinical research to make certain that patient data is collected in a timely and accurate fashion; and that all of the federal and state mandates related to clinical research are followed.

The reputation of a medical school cannot be made on education alone, there needs to be the appropriate mix of education, which must be done in an exemplary fashion, AND innovative, well respected and recognized research.

A successful medical school will be an asset to the city of Honolulu and the state of Hawaii. It will be an economic engine that brings in new dollars, it will become nationally recognized for excellence in education and research, it will be a school that outstanding faculty will want to join. We can develop a reputation that parallels those of the Mayo Clinic, Yale, Harvard, Johns Hopkins, Stanford, and the Cleveland Clinic. We must think big and believe. We have an asset that no one else has—we have Hawaii! A destination on everyone’s list; the most culturally diverse population of any state; and, a geographical location that provides us the great responsibility to help others in the Pacific region.
I do believe that the state should be the sole or even the major source of funds for the medical school. I expect the state to be a partner with the federal government and private foundations. The state currently contributes 15 million dollars to our 60 million-dollar budget. These figures do not include the time that the private physicians donate to the education of our students and young physicians in training, the 250 residents. Already your support is being leveraged at a rate of 4 to 1.

I wish to comment briefly on the School of Public Health. First I welcome this school into the medical school. I consider public health an important discipline. A measure of personal success for me in five years will be the success of the school of public health. I will do what is necessary to build the school, not dismantle it further. For you to be blamed for the deterioration of the school of public health is inappropriate. The real issue was that the school did not have balanced portfolio of funded research to sustain the academic mission.

I wish to lead both the Medical School and the School of Public Health into a situation where funding is from a variety of sources, so that we will be less vulnerable when any one funding agency sets different priorities.

I view the State as our KEY partner, AND you have demonstrated your wisdom and leadership over the years by constructing buildings and providing the operating dollars to sustain the administration and essential faculty of the school. The Institute for Biogenesis Research is just the most recent example.

I am meeting with community leaders, you, the state legislature, the University administration, the faculty, the students, our State senators, Inouye and Akaka and congressman Abercrombie and congresswoman Mink. From their input we will develop a strategic plan. I will share this plan with you. A partner needs to be involved in the thinking and creation of the plan. I promise that I will never surprise you with a request. I will never blame you for our shortcomings. All I ask is that you become an involved partner.

Before I close, I want you to know just how outstanding the hospitals are in Honolulu. These hospitals compare favorably with the best in the country. These hospitals offer a strength that most medical schools do not have. As you know, medical students’ major patient-directed education occurs within the hospital or clinic setting. The private physicians and clinical faculty are equally impressive, and also compare with the very best in the country.

If we set our standards high and look beyond the nearest horizon, we can become a medical school with a national reputation for excellence in all areas. I want the John A. Burns School of Medicine to be a school of which our faculty, our community, and our State can be most proud. An excellent medical school sets the standards of health care expectations. I want our school to set the highest standards; I want to prove to our community the value of having a medical school. I never want there ever to be even the whisper of closure. It is my responsibility as dean to communicate effectively with you and others in the community so that over time we can all understand the extraordinary value that a medical school can have in a community.

I am honored to be included in this illustrious group. I am Sylvia A. Law, the Elizabeth Dollard Professor of Law, Medicine and Psychiatry at New York University Law School. Since 1970, I have studied health care financing, written many books and articles, and done legal work to improve access, costs and quality for all people. I came to Hawaii to learn from you.

You have many reasons to be proud of your health care system. You do better than any state in assuring the benefits of health insurance coverage. Your network of community health centers is the best in the Nation. Your commitment to public health, exemplified by your clean needle law, is unparalleled.

There is so much to admire in Hawaii health care that it seems ungracious to talk about problems. Nonetheless, that is what I will do. In the short time available to me, I want to address two problems: first, the need for more probing Insurance Department scrutiny of HMSA, and second, child health care.

Dr. Meyers and Professor Miller have made a strong argument that HMSA does not treat physicians in a way that it is fair and reasonable, and that patients suffer as a consequence. I do not know enough to evaluate the substantive merits of these claims. But I do believe that they deserve to be taken seriously.

HMSA exercises a market power in Hawaii that is greater than any single insurer in any other state. HMSA wields monopoly power as a seller of health insurance and monopoly power as a purchaser of the services of health care providers. It has enormous capacity to exercise control. Functionally, Hawaii has a “single payer” health insurance system. Progressive people often favor a single payer form of health insurance, recognizing that a powerful payer can do sensible planning and negotiate with providers on behalf of patients. But here the single payer is not the government, but a private organization, HMSA. My early impression is that HMSA does a pretty good job in many ways. Because HMSA exercises such great power, it should be held to high standards of fairness in both process and substance. The Insurance Commissioner is the most likely candidate for the job.

In short, Hawaii is unique in that HMSA has so much power. Because it has so much power, the people—consumers, patients, employers, tax payers, hospital, doctors, and other providers—have a special interest in knowing that it is acting fairly and reasonably.

Hawaii seems to be unique in another respect. In most states, all insurers are required to file rates with the Insurance Commissioner, and he or she is required to approve them as “fair, reasonable and non-discriminatory.” Frankly, in most times and places, insurance commissioners rubber stamp the rates submitted. But they have the general statutory power to probe and to disapprove rates that are not fair and reasonable. Insurance commissioners in other states have used such general regulatory authority to oversee contracts between health insurance companies and health care providers. In Hawaii, the Insurance Commissioner plainly has this power in relation to casualty, surety, property, marine and transportation insurance.

I understand that the Commissioner has used this power to review auto insurance and return money to insured people. Beginning in
2000, health insurers are required to pay the Insurance Commission $10,000 per 70,000 non-governmental members, “to defray any administrative costs, including personnel costs, associated with health insurance regulation.”2 The mandatory fund plainly implies significant insurance department regulation of health insurance. In addition, the Insurance Commissioner has broad subpoena power.4 The Hawaii Insurance Code is not a model of clarity.

HMSA should be subject to scrutiny and regulation by the Insurance Commissioner. The Commissioner should assure all the people that rates paid are fair, reasonable and non discriminatory. He or she may have that authority under current law. If this is not clear, the legislature should affirm that the Insurance Commissioner should assure that rates to both consumers and providers are fair, reasonable and nondiscriminatory.

I would like to briefly address another issue: child health. While Hawaii generally does a better job than most other states in providing health insurance coverage and care, children in the Islands are less likely to have insurance coverage, either public or private, than the population as a whole.5 In 1999, estimates of the number of Medicaid and QUEST eligible children who were not enrolled ranged from 4,500 to 13,000.6 Several factors contribute to high rates of uninsured children. The Prepaid Health Care Act mandates coverage for full time employers, but not for dependents.7 The QUEST application process is extraordinarily complex and slow.

The lack of health insurance for children has many adverse consequences. Despite the state’s generally good health statistics, the rates of measles, mumps and rubella — classic childhood diseases that can be prevented by immunization — are higher in Hawaii than in the rest of the United States.8

In 1997, Congress created the Children’s Health Insurance Program (CHIP) to provide federal funds to states to “enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.”9 Under the CHIP program, Hawaii is entitled to $8.9 million in federal dollars a year from 1998 to 2003.10 When CHIP went into effect in 1998, many states were ready with programs to claim the maximum amount of federal funds available to provide health insurance to low income children not eligible for Medicaid.11 Most states are now in the second or third phase of their CHIP programs.12 In fiscal year 1998, Hawaii failed to claim $9 million in federal dollars available to it to provide health services to low income children. The state passed up the additional $9 million federal dollars available to it in 1999. On Oct. 22, 1998, Hawaii filed an application to participate in CHIP in 2000. The state requested $602,566 to serve 440 children in the year 2000, and an additional $581,045 to serve an additional 440 children in the year 2001. Hawaii’s proposal was quickly approved by the federal Health Care Financing Administration. But the state legislature has appropriated no funds to implement CHIP. Rather, the state Senate passed a resolution promising to devote 35% of a possible settlement in national tobacco litigation to “the department of health for health related programs, including the children’s health insurance program.” Hawaii may be the only state in the U.S. that has failed to claim federal CHIP money.

Why would Hawaii, the Health State, leave eighteen million dollars to care for low income children in Washington in 1998 and 1999, and then claim only a half million of those dollars for the year 2000? The answer is not that the children of Hawaii are already well served. The 1990s were economically difficult for Hawaii, but tourism has now again reached record levels. Other poorer states have picked up their CHIP money. Hawaii spends a smaller proportion of its budget on Medicaid than most states. In many contexts, Hawaii understands that you need to spend money to make money. In the case of CHIP, the federal government guarantees 65 cents for every 35 cents that the state invests. This is a secure investment. Further, Hawaii accurately can tell prospective investors that health care costs are low and workers are healthy. Finally, health care is Hawaii’s second biggest industry, behind tourism, and growing the health care sector also grows the economy.

Some suggest that any effort to enroll children in CHIP is likely to find additional children who are eligible for Medicaid. There is a widespread belief among health policy makers in Hawaii that the state is prohibited from spending any more on health care services for low income people than it was spending when QUEST was adopted. This fixed pie constraint is often attributed to the federal government. But, the federal budget neutrality requirements allow adjustments both for inflation and for an increase in the numbers of people qualified for AFDC/RAFT, and children eligible for GA and SHIP. Further, administrative costs for QUEST are not subject to the federal budget limit and the federal government pays a 90% match for the development of the QUEST information system. Alternatively, the fixed pie assumption is attributed to poor economic conditions. But as the economy improves, it becomes more obvious that the decision to cap state spending for health care for poor children is a political choice, not compelled by any external or legal force.

In sum, I have two suggestions. The Insurance Commissioner should scrutinize relations between HMSA and providers and insist that rates and payment procedures be fair and reasonable. Hawaii should pick up its federal CHIP money for health services for low income kids.

References
1. See e.g. In re Ras Filing of Blue Cross Hosp. Serv., Inc., 214 S.E.2d 339 (W.Va.1975)(commissioner’s statutory duty to determine that subscriber premiums were reasonable created an implied authority to determine that payment rates to hospitals were reasonable).
5. In 1997, 9.8% of all children in Hawaii lacked health insurance, and 13.1% of children under age six had no insurance coverage; “the percentage of the uninsured who are children is higher in Hawaii than in the U.S. overall.” HEALTH TRENDS IN HAWAII, 1999, 104-105.
6. The low estimate is provided by the state Health Department, based on a telephone survey. The higher estimate is provided by the State’s Chief Health Care Association. Helen Attron, Groups Seek Kids With No Insurance: A Campaign Triesto Enroll Children Eligible for Health Care Assistance, HONOLULU STAR-BULLETIN, A-1, July 15, 1999.
Health Education Needs in Hawaii: Social Work, Dental Hygiene and Nursing

Rosanne C. Harrigan EdD, APRN-Rx, FAAN and Barbara Molina Kooker DrPH, APRN, RNC

Abstract
In this article, the need for selected health education programs in Hawaii will be discussed. Changes in the health care system, population and provider population impacting supply are identified. Health trends in Hawaii are highlighted and strategies needed to assure that Hawaii’s demand for health professionals in social work, dental hygiene and nursing are suggested.

Introduction
Health trends, current and projected health care system changes, population and provider factors, and supply and demand issues driving the need for education of selected health professionals in the State will be discussed in this article. In addition, the difficulties associated with recruiting qualified health professionals are presented. Economic leverage and research and service contributions are offered as strategies undertaken by the University of Hawaii at Manoa School of Nursing to address workforce supply and demand issues.

Social Work
The School of Social Work at the University of Hawaii at Manoa has the only MSW and PhD programs in social work in the Pacific. It also has the largest B.S. program. Social work is among the fastest growing profession for the next ten years and the School provides graduates to meet the need. These graduates are educated to understand the specific concerns and values of Hawaii’s multicultural population. They are prepared for the workforce needs of the State, for example in child welfare, mental health, and services to older people.

In addition, the School is a leader nationally in producing research on Asian Americans and Pacific Islanders. The research generates knowledge needed to develop policies and programs within our State. The School brings in an annual amount larger than its general fund budget in training and research funds. The MSW program is ranked 29th out of 150 by US News.1

Dental Hygiene
Statistics indicate a continued need to provide oral health care, prevention and education services to the people of the State of Hawaii. The Department of Health reports that on screening of 70,000 public school children, the dental health of Hawaii’s school children is poor and among the worst in the nation. Some ethnic groups and island communities in Hawaii have disproportionately high rates of dental disease. Ninety-four percent of 6-year-olds nationally are caries-free compared to 18% of 6-year-olds in Hawaii. Five percent of mainland 5-year-olds have “baby bottle tooth decay” compared to 15% of 5-year-olds in Hawaii. The highest rates of this type of tooth decay are among Native Hawaiians (21%), Filipinos (32%) and residents of Molokai (33%).

Several areas of the neighbor islands are designated as “dentally underserved.” In 1992, 71% of dentists surveyed indicated there was a shortage of dental hygienists in the State. A large percentage of dental offices have no dental hygienist due to the chronic low supply of hygienists. Hygienists are needed on the neighbor islands and Oahu.

The Dental Hygiene program at University of Hawaii at Manoa is the only dental hygiene education program in the State of Hawaii. The program parallels the entry-level educational goal (baccalaureate) of the national professional organization, the American Dental Hygienists’ Association. The program is accredited by the American Dental Association and 100% of graduates pass National and State Board Dental Hygiene Examinations on their first attempt. The program ranks 47 of 212 or in the top 25% of national performance ranking by the National Board of Dental Hygiene Examiners. This program is attended primarily by women who are often heads of households and have a need to access educational opportunities on island.

The Program also operates a clinic that provides low-cost oral care as well as dental health education to students and residents (elementary schools, skilled nursing facilities, community rehabilitation programs, Special Olympics, etc.) of Hawaii. Casts are also made for University of Hawaii athletes in order to fabricate their mouthguards. Career education is also provided at various high schools and University of Hawaii affiliates to recruit students from diverse backgrounds.

Nursing
In order to meet the health care needs of the citizens of the State of Hawaii, adequate numbers of nurses are essential. Demographic and educational characteristics of nurses in the nation and Hawaii have an influence on the supply of practicing nurses as well as the supply of nursing faculty. This section describes these characteristics and addresses the approach used by the University of Hawaii School of Nursing to address these issues.

Demand
Despite a wave of managed care changes such as mergers, consolidations, and briefer lengths of stay that saw hospitals trim their ranks of inpatient RNs by 6% between 1992-1996, the number of employed RNs nationwide grew by its highest annual rate ever — an average of more than 3% a year, to 2.1 million in the same period, according to the latest figures from the Division of Nursing, U.S. Department of Health and Human Services.2 Even as many hospitals cut their inpatient RN staff, nursing employment boomed in other hospital areas between 1992 and 1996, up 25% in outpatient and labor and delivery units, up more than 15% in emergency rooms, and rising nearly 10% in surgical facilities, federal figures show. In the same period, the number of RNs in community health centers rose 42%, nearly triple the growth in the previous four years, and climbed by 32% in long term care facilities.2

The increased hiring of RNs has spurred multiple factors including: (1) the mounting health care needs of increased numbers of elderly; (2) a growing population of hospitalized patients who are older, more acutely ill, and in need of more skilled RNs per patient; (3) the rapid expansion of front-line primary care to many sites throughout the community; and (4) technological advances requiring more highly skilled nursing care. A related factor in hiring trends is the aging of RNs. In 1996, the average age of RNs in the U.S. was
44, up from 40 in 1980. Only nine percent of RNs were under 30 years of age. In 1997, the mean age of RNs in Hawaii was 44.9. Since high levels of retirement are projected in the next 10-15 years for the majority of the RN workforce, the significance of preparing replacements for them in the face of increasing demand is staggering.

Federal figures project that if current trends continue rising, demand will outstrip the supply of RNs beginning approximately 2010. By 2015, says the Federal Division of Nursing, 114,000 jobs for full-time equivalent RNs are expected to go unfilled nationwide. Presently, in an expanding number of markets, hospitals and other employers are struggling to meet a rising need for RN care and have stepped up recruitment.

Supply
The majority of RNs in the U.S. hold associate degrees or diplomas in nursing. Although 31% of RNs in the United States in 1996 held baccalaureate degrees (41% in Hawaii), 32% held two-year associate degrees (31% in Hawaii), 27% held diplomas (18% in Hawaii), 9% had a master of science in nursing (10% in Hawaii), and fewer than 1% had obtained the doctoral degree (less than 1% in Hawaii as well). This disproportionate supply of nurses with associate degrees and hospital diplomas has led many policymakers to call for the closure of significant numbers of these programs in favor of accelerated production of baccalaureate and graduate prepared nurses. The National Advisory Council on Nurse Education and Practice, an advisory panel to the federal Division of Nursing, has recommended, as a policy target, that at least two-thirds of the basic nurse workforce hold a B.S. or higher degree by 2010. A recent report by the Pew Health Professions Commission (1995) urged the closing of up to 20% of associate degree and hospital diploma programs and more concentrated production of nurses from baccalaureate and graduate programs. The nurse supply in Hawaii is described in Figure 1. A steady decline over the past five years can be noted.

The health care system’s complexity requires nurses who (1) are capable of more independent clinical decision making in less structured environments, (2) are prepared broadly in basic as well as behavioral and social sciences and management, (3) can communicate effectively, and (4) are oriented more to health promotion, maintenance, and cost-effective coordinated care. The B.S. in nursing curriculum provides such preparation, including education and training in community based primary care, not typically a part of associate degree or diploma programs, and gives nurses a foundation to enter graduate education for advanced practice and management roles.

At increasing numbers of health systems nationwide, B.S. prepared nurses are practicing in ways that recognize their different educational preparation and competencies from other entry-level RNs. In these differentiated practice models, B.S. nurses not only provide more complex types of patient care but also design and coordinate a comprehensive plan of care for the entire length of a patient’s stay—from pre-admission to post-discharge, supervise nurses aides and other unlicensed assistive personnel, design teaching plans for patients, and collaborate with physicians, family members, and other hospital departments and research staff. Associate degree prepared nurses function primarily at the bedside in less complex situations and provide additional care such as teaching patients how to maintain care after discharge.

Faculty Shortage
Faculty recruitment problems are emerging nationally and in Hawaii. As the demand for nurses increases, the professors simply will not be there to educate the workforce on which the state and nation depend. We are facing serious barriers to attracting the faculty we need.

Tight budgets have allowed only modest increases in nursing faculty earnings. Full-time nursing professors at four-year colleges and universities earned $66,132 in the 1998-99 academic year, up 2.7% over 1997-98. The salary of a middle range full professor at the University of Hawaii is $64,872. Average salaries for UH Manoa Nursing faculty are $35,160 for instructors, $41,768 for assistant professors, $58,186 for associate professors, and $74,300 for professors. According to College and University Personnel Committees, assistant and associate level faculty pay tallied fairly even with other disciplines while full professors trailed, especially at private institutions. This makes recruitment very difficult in light of the fact that cost of living in Hawaii is about 30% more.

The American Association of Colleges of Nursing reports many faculty are opting for early retirement packages or resigning for greener clinical or administrative positions. Some schools are supplementing faculty practice plans or share salaries throughout appointments with clinical agencies. In 1998, 411 people graduated from doctoral programs in nursing. Only 43% had an employment commitment to serve as nursing school faculty. Seventeen percent accepted non-academic positions. Filling faculty posts has become a problem. Many candidates do not have a program of research defined or they lack teaching skills. Others know research is the name of the game and do not want to teach.

Faculty life presents a harder road than private practice or administration. Clinical faculty in particular have long arduous working
hours. Increased patient acuity has decreased the number of nursing students that can be safely accommodated in a clinical setting. Faculty may be responsible for 10-14 patients as well as their 8 - 10 students in a complex clinical area.

Quality and accreditation requires faculty have at least a degree higher than their students. The new PhD in Nursing Program, now funded by the Division of Nursing, is a substantive, coordinated effort to increase the number of doctorally prepared nurses who also are prepared for an academic career.

Strategies Used by the University of Hawaii School of Nursing

Economic Leverage
The School of Nursing has generated more than $2.4 million in research and training grants. The amount of extramural funds generated by the School have increased by more than 600% over the past three years. All graduates get jobs and pay taxes supporting the economy of the State. Most graduates remain in the state. Nurses in primary care roles have demonstrated the ability to achieve quality primary care outcomes at lower cost. Advanced practice nurses are the least expensive primary care provider to educate.

Research Contribution
Nurses in PhD programs are the only health discipline specifically educated to do clinical research with human subjects. Nurses have the potential to develop evidence-based practices and reduce waste in the delivery system. Nurses also monitor quality of health care services.

Service Contribution
Numerous activities occur within the School of Nursing that provide service to the community. Health outreach education is provided for example through Dr. Wang’s clinic in China Town for diabetic patients. Care is also provided for the elderly through special programs, clinics and partnerships. Complementary care is offered through the Healing Center at the School of Nursing. Community-based education is the basis of the curriculum and all students learn within community sites addressing the needs of the diverse population in the State. Diabetes management is provided through numerous service and research projects. Dr. Kadohiro has a leadership role in the American Association of Diabetes Educators. Faculty also serve as Pro Bono primary care providers in community health centers. Faculty and students provide health education for students and the community. Health screening is also provided for children through the Keiki Gold project. All levels of programs are delivered using distance delivery methods to neighbor islands. Faculty are funded through the Community Initiative on Nursing to conduct nursing workforce analysis and forecasting studies for the entire State.

Conclusion
Numerous challenges remain to assure that the State’s demand for social work, dental hygiene, and nursing professionals is met. As health care needs of our residents and health care systems change, it is imperative that the State’s educational systems are ready to meet the challenge. Economic resources are well invested in these programs which assure health and safety of the public and maintain our quality of life.

References

Why We Need Laws to Protect Patients from Their Health Plan

Richard S. Miller
Professor of Law Emeritus,
The William S. Richardson School of Law,
University of Hawaii at Manoa
Legal Consultant to Hawaii Coalition For Health

The Hawaii Coalition for Health knows that members of the health industry are continuously interacting with members of the Legislature, building good will, and putting forth their views of what the world of regulation should or should not include. Unfortunately, few on the consumer side have the resources or bodies to put forth such time and effort, and most of what we do in the Hawaii Coalition for Health is either unpaid or poorly paid. We are essentially volunteers. Furthermore, while we share wide agreement with health care providers about the problems of managed care, our loyalty is to the health care consumer and not to the physician. The vast majority of our members are patients, not professionals, and the dues of these ordinary people are negligible. They, however, are the Legislature’s primary constituents.

Here is why patient-protective legislation is important:

1. Several years ago, the Legislative Reference Bureau studied the status of Hawai‘i’s health care system and reported that competition was healthy. Unfortunately, the situation has changed dramatically since then. Today, competition is not working in Hawai‘i to provide the best choices of health insurance for health care consumers. For all practical purposes, the competition that does exist is only between HMSA and Kaiser, and it manifests itself in efforts by HMSA to reduce the “bottom line” in order to reduce premiums to employers. If HMSA is successful in this competition, it could force Kaiser out of business. Then HMSA will really have a monopoly of health care business as well as a “monopsony” - the only buyer of providers’ services left in Hawaii — and HMSA will
HMSA has become, for all practical purposes, the only buyer of physicians’ services in Hawaii because Kaiser employs its physicians on a full-time basis. If a non-Kaiser physician cannot work for HMSA, she or he cannot make a living in Hawaii. HMSA is therefore free to, and in fact does, dictate terms to its participating providers. Hawaii’s physicians, in return, are coerced into accepting HMSA’s terms even though, in large measure, HMSA seeks to substitute, in cases that matter, its own treatment decisions for the participating physician’s, and even though reimbursements for important services are all too often wholly inadequate. For the most part, HMSA’s participating physicians don’t speak out because they are intimidated to remain silent.

3. Health plans employ various means to ration health care by creating disincentives for physicians to treat patients. Inadequate reimbursements, for example, for certain vaccines or for lengthy and complex office visits is one form of disincentive. A more insidious form of disincentive is a gainsharing program. Under gainsharing, health plans maintain treatment profiles of physicians and reward physicians with cash for treating patients less and for limiting advocacy on behalf of the physician’s own patients. HMSA claims its gainsharing programs merely reward good physician practices.

4. The Board of Directors of HMSA, a tax-exempt mutual benefit society, has already demonstrated its disdain for its membership. Last year, on short notice, and with full knowledge that many Hawaii physicians were attending a conference on Kaua’i, the Board called a special meeting to be held the day before Election Day. The Board loaded the meeting with HMSA employees and HMSA members who worked for firms friendly to HMSA. At the meeting, those present voted to change the number of member signatures necessary to call a special meeting from 100 to 3% of the membership, about 18,000 signatures! They also significantly reduced the power of members to name directors.

Hawaii’s consumers are thus faced with:

1. An all-powerful, tax-exempt, so-called mutual benefit society
2. that virtually monopolizes the Preferred Provider Organizations (PPOs) and is almost the only buyer of physicians’ PPO services in this State;
3. whose board is insulated from member action because of changes made to its bylaws;
4. that cannot, by virtue of ERISA, be sued by its members in ways that the normal insurer can be sued by its policyholders or third parties, i.e. for bad faith refusal to settle or pay, or for general or punitive damages;
5. that by statute sets the criteria for other health plans under Hawaii’s Prepaid Health Insurance Act
6. that is subject to only the most minimal of scrutiny and supervision by the Department of Labor; and
7. That has intimidated its participating physicians into abject silence and acceptance of inadequate compensation, with no right to appeal maximum allowable charges, and a contract that places ultimate power to determine what is appropriate treatment in the hands of HMSA directors whose primary duties are to the health plan and not to the patients.

If this situation does not require active state supervision and regulation, I don’t know what does.

**Universal Single Payer Health Plan — Answer to our Dilemma?**

Ah Quon McElrath
Member, University of Hawaii Board of Regents

The irony of being the richest industrial nation is that the United States is without a coherent, comprehensive, universal health care plan for its 275 million residents. The result is 44.3 million residents without health care and over six million underinsured despite a still strong economy and low unemployment, inflation, and interest rates.

The increasing numbers of individuals without health care occur with the downsizing and merging of companies which result in huge layoffs of workers and the changing nature of work which has increased the numbers of part-time, contractual, and consulting workers who generally do not receive the benefits that regular full-time workers receive. Furthermore, there has been a decrease of unionized workers whose collective bargaining agreements usually provide health care.

For laid-off workers and those with pre-existing conditions, the 1985 Consolidated Omnibus budget Reconciliation Act (COBRA) and the 1996 Health Insurance Portability and Accountability Act (Kennedy/Kassebaum), respectively, have not been effectively helpful in the continuation of health care because premiums have been prohibitively high and include provisions that present difficulties with compliance and administration. For recipients of public payments and new immigrants, the effect of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform) on continued Medicaid eligibility is murky.

Congress has skirted around the issue of providing health care for all Americans. What has been provided has been incremental and accretional and targeted towards specific population groups—the aged, disabled, and poor; ethnic groups such as the American Indians and Hawaiians; the military and veterans; individuals with named health conditions; and often only as a response to strong pressure from affected groups.

When the Social Security Act was promulgated in 1935, health care was not seriously considered since the effects of the depression were perceived primarily as an economic problem with its 16 million unemployed, closure of factories, breadlines, and massive dislocation of families who could not meet rental or mortgage payments. Policy makers did not think that congressional support for health care could be galvanized.
Following World War II, an attempt was made by the Truman administration to pass a national health insurance program. However, the organized resistance of the medical profession and hospitals with cries of “socialized medicine” doomed the attempt.

Discussion about health care lay dormant until the “great society” period of President Johnson. In 1965 amendments to the Social Security Act resulted in Medicare (Title XVIII) and Medicaid (title XIX). Medicare provides health care for the aged and the disabled and is funded through an employee/employer payroll tax (Part A—hospitalization) and a monthly premium and general revenues (Part B—medical services). Benefits do not include out-patient prescription drugs (with a few exceptions) or long-term institutional care (except after a 3-day hospital episode), both of which account for huge expenditures by the elderly themselves. Medicaid, for public assistance recipients and other income eligible individuals, is funded by states and the federal government under a federal matching device known as the Federal Medical Assistance Percentage (FMAP). FAMP is determined annually on a comparison between a state’s average per capita income and the national average with a federal match not lower than 50 per cent nor higher than 83 per cent for every dollar spent for benefits. (Hawaii now receives 52 percent in FMAP, although it was 50 per cent for many years.)

Medicaid is a complex and complicated program with its system of basic and optional benefits and varying eligibility requirements.

In 1972 Congress combined the public assistance titles of the Social Security Act-Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Permanently and Totally Disabled (APTD – into the supplemental Security Income Act (SSI), with complete federal funding. One of the options under this program was automatic eligibility for Medicaid, for which most of the states opted. Hawaii was not one of those states, citing its generous public assistance and Medicaid program as the reason for not so choosing.

In the early 1970s a bill to promote the formation of health maintenance organizations (HMOs) was enacted under the Nixon administration and largely prompted by Minnesota adherents of the idea, which already had its reality in the Kaiser plan, HIP of New York City, and the Group Health Plan of Puget Sound. The concept was not embraced wholeheartedly until the 80s, when insurance companies, under the rubric of “managed care,” saw HMOs as a way by which money could be made. Thereafter, these companies purchased clinics, hospitals, laboratory facilities, and even mortuaries and cemetery plots. They promoted their for-profit HMOs as a good investment for investors and their highly paid CEOs.

“Managed care” took the medical profession and patients out of making health care decisions, especially those which affected the profit margin of HMOs.

Interestingly, market economics or making a profit, has affected the behavior of the traditional “blues” as well as the not-for-profit HMOs in the way they run their operations.

For a short period, “managed care” for government programs like Medicare & Medicaid and Private industry plans kept health care costs fairly stable, but there are signs that costs are beginning to rise. In 1999, over 4,000,000 Medical beneficiaries lost “managed care” coverage when insurance companies began “losing” money. Employer groups, now faced with the rising costs of providing care for their employees, have begun the cycle of increasing employee premium contributions, instituting caps, cutting benefits, and eliminating dependent coverage.

In 1975 legislation for national health planning and resources included the issuance of certificates of need for the acquisition of technology, changes in services, and the building and renovation of facilities such as hospitals and nursing homes. Certificates of Need were thought to be the answer to rising costs, promoting quality, and improving access to care.

In 1994 the Clinton administration attempted to increase coverage and community participation in health care. The attempt failed, despite leaving insurance companies as the principal player in health care, in the morass of an over 1,000 page bill which few took the time to read, let alone understand.

Thus, the health care landscape is littered with many make-shift attempts to contain costs, increase accessibility, and insure quality. There are the likes of Certificates of Need, Diagnosis Related Groups (DRGs), participating physicians (PARs), Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBs), Children’s Health Insurance Program (CHIP), and other acronyms long forgotten.

There are hundreds of health care plans for public and private workers and their families sold by large and small insurance companies. Health care exists in Workers’ Compensation, automobile insurance, homeowners comprehensive insurance, and individually purchased plans. Cost of these plans are usually borne by premiums paid by employers, employees, government entities, or by the individuals.

Coverage is spotty. Some plans provide coverage for the entire family, others only the employed member, others cover dependent at an employee’s sole cost, such as Hawaii’s 1974 Prepaid Health Care Act. Hawaii, the only state to have such a plan, is exempted from the preemption clause of the Employee Retirement Security Income Act (Erisa) by a congressional act after a successful court challenge by a local oil company. Benefits range from the adequate to the inadequate, with or without caps, deductibles, or co-payments. Most of the plans provide curative care, but few provide preventive care.

It is unlikely that Congress will soon enact a universal health plan to cover all residents of the United States, even though it would be a relatively easy conversion of either Medicare or Medicaid with the federal government’s being the single payer.

Under this circumstance, individual states can become truly innovative about how they provide health care for all of their residents.

States can use the age-old concept of states’ right, or devolution, as it is euphemistically called, to create their own universal single payer program.

There would be no difficulty in devising a universal single payer plan. There are many models already in existence, including that of the Canadian government whose experience, by and large, has resulted in a high degree of patient satisfaction.

The benefits of a universal single payer program have motivated a number of states and organizations to consider seriously legislation for such a program. Prominent among these are California, Maryland, Massachusetts, and Ohio and Physicians for a National Health Plan, Universal Health Care in Ohio.

The advantages of a universal Health plan are many. They include:
Coverage of all residents of a state, without the need to administer the fine points of eligibility as for example, in Medicaid.

- Elimination of unnecessary paper work by placing administration in a single agency.

- Uniformity of benefits to insure equality of treatment.

- Uniformity of payments to all health care providers, either on a fee-for-service or capitation basis, with geographic and practice variations.

- Creation of review bodies to assess payment structures, quality of service, distribution of care, acquisition of technology, changes in services, capital investment and improvements, etc.

- Assessment of financing mechanisms which could include payments by the federal government based on past expenditures in Medicare and Medicaid with increases according to the medical practice index; inclusion of health care provisions under workers compensation, auto insurance, homeowners insurance as incentives to business and industry to get out of the health care business; revisions of the tax code to finance health care, with consolidation of the numerous business taxes into one amount to take care of lost wages under workers compensation, temporary disability, and unemployment insurance.

Hawaii cannot continue to temporize. Our population is growing older and living longer; we have 4,000 to 10,000 new immigrants who come to this state every year; we have populations that need care, particularly the Hawaiians whose statistics on health care represent a shame of negligence. There are new methods of treatment presaged by discoveries in genetic manipulation and technology.

We cannot leave health care to market economics and its cover of profit making via competition. Health care for all residents does not belong in the competitive arena. It belongs in the area of providing equal care to all who need care.

Let the discussions begin on the merits of a universal single payer health plan to achieve this equality.

---

**POISON CENTER TIPS**

- Keep the number of the Hawaii Poison Center on or near your telephone.
- If you suspect a poisoning, do not wait for signs and symptoms to develop. Call the Hawaii Poison Center immediately.
- Always keep Ipecac Syrup in your home. (This is used to make a person vomit in certain types of poisoning.) Do not use Ipecac Syrup unless advised by the Hawaii Poison Center.
- Store all medicines, chemicals, and household products out of reach and out of sight, preferably locked up.
- A good rule to teach children is to “always ask first” before eating or drinking anything—don’t touch, don’t smell, don’t taste.

**Donate to help us save lives.**

Mail checks, payable to:

Hawaii Poison Center
1319 Punahou Street, Honolulu, HI 96826
Mammograms

Not just once, but for a lifetime

The National Cancer Institute has free booklets about breast cancer screening. To order these publications, call NCI’s Cancer Information Service at 1-800-4-CANCER (1-800-422-6237). Persons with TTY equipment, dial 1-800-332-8615.

http://rex.nci.nih.gov

Janssen Pharmaceutica

Is proud to support the Hawaii Medical Journal

World leader in antimycotic research

JANSSEN

Titusville, NJ 08560-0200

©1998 Janssen Pharmaceutica

Aloha Laboratories

...when results counts

A CAP accredited laboratory specializing in Anatomic Pathology
Quality and Service

- Surgical Pathology
- Dermatopathology
- Cytopathology
- Gynecologic Pathology
- Frozen Sections

David M. Amberger, M.D.
Laboratory Director
2036 Hau Street, Honolulu, HI 96819
Phone (808)842-6600
Fax (808)848-0663
ALOHALABS@WORLDNET.ATT.NET

Arleen D. Jouxson, Esq.
Attorney at Law

A.K.A. Arlene Meyers, MD, MPH

- Wahiawa pediatrician since 1979
- Associate Clinical Professor, JABSOM
- 1998 Roscoe Pound award winner in health care law
- President & founder of the Hawaii Coalition For Health

NEED HELP?

CALL 621-8806 (Oahu) for more information or for a free initial consultation at your place of business.

302 California Ave., #209, Wahiawa, HI 96786, Ph: 621-8806; Fax: 622-5599
What Do A Life Preserver And A Flu Shot Have In Common?

If You Have Diabetes, Ask Your Doctor.

If you live with diabetes, you're more likely to die with the flu. Just ask the families of the 30,000 people with diabetes who died of flu or pneumonia complications. Then ask your doctor for a life-saving flu shot for you and those closest to you, and about the other risks you face when you face diabetes. Because with diabetes, prevention is control, and control is your life line.

This message is brought to you by CDC and your health department.
If you think your chance of getting breast cancer is one in a million, the fact is, it's one in nine.

Over their lifetimes, one out of every nine women will be faced with breast cancer. That's one out of nine friends. One out of nine sisters, mothers, daughters. It's a statistic you can't afford to ignore. And mammography is a weapon you can't afford to be without. A mammogram can detect breast cancer in its earliest stages, when it's most curable. It's not enough to simply know the statistics. You have to fight back. Get a mammogram.

**Mammography. Your most powerful weapon.**

© 1991 American Cancer Society

---

**Classified Notices**

To place a classified notice:

- **HMA members.**—Please send a signed and typed written ad to the HMA office. As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMJ as space is available.
- **Nonmembers.**—Please call 536-7702 for a nonmember form. Rates are $1.50 a word with a minimum of 20 words or $30. Not commissionable. Payment must accompany written order.

---

**Office Space**

**Ala Moana Bldg.—** PHYSICIANS WANTED to share space and support services. Interest in physical rehab preferred. We have flexible rental arrangements starting at one half-day per week. Run your practice with no fixed overhead. Contact Dr. Speers, REHABILITATION ASSOCIATES, 955-7244.

---

**Locum Tenens**

**BOARD CERTIFIED FAMILY PRACTICE.**—15+ years caring clinical experience in Hawaii. Office coverage for 1/2 days, own MIEC Policy, fee flexible, call anytime Deborah C. Love MD: Home Oahu: (808) 637-8611; Cell Ph: 295-2770.

---

**Physician Wanted**

**PRIMARY CARE INTERNIST FOR KAUA'I.**—SEEKING A BC/BE PRIMARY CARE INTERNIST; interests in rheumatology, infectious diseases and geriatrics are welcome. Kauai Medical Clinic is a 60-physician multispecialty medical group affiliated with Wilcox Health System’s 185-bed community hospital. Excellent quality of life in a safe, beautiful, family oriented rural community. Competitive salary, benefits and relocation package. Send/fax CV to: M. Keyes-Saiki, Kauai Medical Clinic, 3-3420 Kuhio Highway, Suite B, Lihue, HI 96766-1098. Fax (808) 246-1625. E-mail: mkeyes-saiki@wilcoxhealth.org

---

**For Sale/Rent**

**HILO, BIG ISLAND.**—FOR SALE OR RENT for doctors or dentists. Renovated doctor's office. Ponahawai Medical Center (Ka Wena Lapu Au), 670 Ponahawai, #207 (806 sq. ft.) or 207 & 205 (1600 sq. ft.). Call 935-4533 or 959-7575.
Join us in the quest for continued medical excellence.

Join your Straub colleagues as we strive for continuing medical excellence.

Straub Clinic & Hospital, Inc. is accredited by the Hawaii Medical Association to sponsor continuing medical education for physicians.

Straub designates this educational activity for a maximum of one credit hour in Category 1 of the Physician’s Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

You are invited to attend...

– Friday Noon Conference –
Vision for a “New” Medical School
Edwin C. Cadman, MD

March 3, 2000
12:30 – 1:30 p.m.
Doctor’s Dining Room

Learning Objectives
At the conclusion, participants will be able to:
• Describe the restructuring plans for the medical school.
• Gain knowledge about the vision of the medical school.
• Summarize the goals and objectives of the “new” medical school.

– Friday Noon Conference –
Luncheon
Antithrombotic Therapy Update and Review of the 1998 ACCP Consensus Conference
James E. Dalen, MD, MPH

March 10, 2000
12:30 - 1:30 p.m.
Doctors Dining Room

Learning Objectives
At the conclusion, participants will be able to:
• Describe the process by which the American College of Chest Physicians develops consensus statements.
• Identify evolving indications for low molecular weight heparin in coronary disease states.
• Discuss new developments in antiplatelet therapy – agents and dosing.

We would like to acknowledge the Educational Grant from DuPont Pharmaceuticals Company.

Please call Fran Smith at 522-4471 for more information.
Life is Tough. Three Out Of Three People Die, So Shut Up And Deal.

Despite the atrocious and abusive power of the Health Care Financing Administration, and despite the obstructive and manipulative mechanisms of Hawaii’s Blues organization (“members” my Aunt Fanny - it’s a money-making insurance company in every sense), and despite the weevils in our own ranks who cozy up to medical pretenders for personal gain, the Hawaii Ophthalmological Society remains a strong and vibrant organization to carry into the next century. Yes, of course the actual new century doesn’t begin until next year, but writing triple zeros automatically makes us all think of the 21st century.

Nobody Wants To Be A Snitch.

In a turnabout from the previous AMA House of Delegates, at the December interim session the House decided to make policy that doctors are to be policemen. The Council on Ethical and Judicial Affairs was supported in their recommendation that doctors report patients with medical problems to the motor vehicle authority if the physician feels that driver is unsafe on the road. Without doubt, the doctor has a duty to do advise the patient, and perhaps also the next of kin, but to reveal privileged medical information to any third party without the patient’s knowledge and consent goes beyond the practice of medicine. Additionally, there are already many unlicensed drivers on the road (frequently driving under the influence), so simply removing the license will hardly deter anyone who fails to respond to the doctor’s direct advice.

In Any Given Set Of Circumstances, The Proper Course Is Determined By Subsequent Events.

Blame it on previous contact lens use for disrupting corneal epithelium, or perhaps hormonal changes with menopause, or possibly use of birth control pills or use of topical medications, whatever, the point is that the LASIK (laser in situ keratomileusis) parade is being rained on by the postoperative dry eye problem. Other theories include damage to the cilia and an affect on mucous layer of the tear film, or cutting the nerves of the central cornea with loss of corneal sensation affecting the tear secretion. The problem of the dry eye is emerging with increasing frequency following LASIK and making patients very unhappy. Vigorous treatment is often necessary with punctal plugs and non-preserved artificial tears.

Just Because Your Doctor Has A Name For Your Condition Doesn’t Mean He Knows What It Is.

Senator John McCain of Arizona is running for the Republican nomination for president in the fall of 2000. He suffered nearly fatal injuries and disease during the Viet Nam war, when he endured six years of incarceration as a POW. Now there is a whispering campaign saying he is mentally unfit for the office. To refute the gossip-mongers, Senator McCain has released his entire medical record. Claire Dixon-Lee of the American Health Information Management Assn. has stated that that should not be necessary, and candidates for presidency should not be expected to provide information beyond what is pertinent for the office. “The American public needs to understand the importance of maintaining an individual’s right to privacy, and of protecting the confidentiality of his or her health information.” Well, yes, that was the rule in days gone by, but the media of today believes it is their duty to poke through every candidate’s underwear on the road to Pennsylvania Avenue.

Knowledge Of The World Is Acquired In The World, Not In The Closet.

Congress established a sustainable growth rate (SGR) to determine the Medicare conversion factor based upon projected rather than actual data. Then, it is up to the Secretary of Health and Human Services, Donna Shalala, to exercise her authority to correct the factor when the real data comes in. Now the American Medical Association has filed a lawsuit charging Ms. Shalala with failing to use actual values and this has cost physicians $3 billion a year for 1998 and 1999. In October 1997, HCFA indicated that it would correct the SGR for 1998 and future years, updating with actual data rather than projections. Subsequently, without seeking public comments, HCFA reversed its decision! Meanwhile, many medical practices are failing, management companies are going broke, and hospitals are struggling for survival. The sad part is that a law suit must be brought in to make the government fulfill what is fair and what has been promised.

Eagles May Soar, But Weasels Don’t Get Sucked Into Jet Engines.

What was once a rare event, has become a hazard for air travelers and airlines. In the air and on the ground, unruly passengers are a growing problem. The number of cases of passengers interfering with flight crews in 1997 was double the number in 1991, according to the Federal Aviation Administration. The Association of Flight Attendants, which represents more than 44,000 attendants at 24 airlines, claims those cases are probably only the tip of the iceberg because many incidents are not prosecuted. With the crowded cabin seating, the increase in sold out flights, bumping and rescheduling, plus so many passengers carrying bags into the airplane rather than checking luggage, passengers are often short tempered, frustrated, impatient and angry. On July 22, a 50 year old Continental Airlines gate agent, suffered a broken neck after being thrown head first to the floor by a 29 year old man, who was trying to board the jetway without a gate pass. Continental is pushing for aggressive prosecution. Senators Bill Frist (R. Tenn.) and Harry Reid (D. Nev.) introduced a bill that would raise the civil penalty for assaulting airline crew members or interfering with duties to $25,000 from $1,100.

Looking For Fraud In All The Wrong Places.

As was described on this page recently, the American Association of Retired People and Medicare have recruited volunteers to establish “senior patrols” to recoup the ostensible zillions of dollars of fraud lost to those cheating doctors. Now we are informed that this fruitless effort has resulted in a 30% increase in the number of complaints about Medicare bills in just the past six months. However, according to the same report, so far those complaints have not led to any increase in recouped Medicare funds! Come on, Donna Shalala, stop looking for sharks in the wading pool.

Managed Care Sucks - But It’s A Great Export!

Like tobacco, managed care has become an ugly commodity in the USA, but many foreign medical leaders are finding it works in their countries. Some major U.S. insurers are investing in health companies around the world, and American consultants are pitching the managed care concept for various government systems. Managed care is already well established in Israel, Brazil, Switzerland and the Philippines, and is growing fast in Indonesia, Mexico, South Africa, Poland, India and Chile. Hossam Badrawi, who founded Egypt’s first HMO nine years ago, claimed he looked worldwide for models, and found the U.S. managed care model the best. Interestingly, the phrase managed care is never applied. Wherever the system is introduced euphemisms are used - “evidence-based medicine” or “sickness funds” or “clinical guidelines.” The news media have beamed stories about America’s growing hostility with the system, so the phrase is a no-no.

In Our Play We Reveal What Kind Of People We Are.

A research ecologist at the Department of the Interior said that the practice of “toad licking” as a means of achieving an hallucinogenic “high” is on the decline. Users (lickers) found the presence of poisonous chemical compounds in the toad venom. However, it was reported that “toad smoking,” on the other hand, seems to be less risky and is on the rise. Come on, baby, light my toad.

ADDENDA

†Horses can look backward with one eye and forward with the other eye at the same time.

†The most powerful laser devised is at the Lawrence Livermore Lab in California. A single pulse has been measured at 1.3 quadrillion watts.

†Number of cars in New York City 1.7 million; number of handguns 1.7 million!

†Rock music is against the law in Venetian gondolas.

†Crooked judges live on fixed income.

Aloha and keep the faith —risen
At MIEC, we know what it means to stand out in the crowd. Twenty-five years ago, we started the West's first doctor-owned, not-for-profit malpractice insurance company. The idea quickly caught on, and now there are dozens of "doctor-owned" companies throughout the country.

But there is only one MIEC. Our rate and dividend history is unparalleled. Guess that's why we don't need a large sales or marketing staff. Our track record speaks for itself.

The original is still the best. Call us.

Medical Insurance Exchange of California
6250 Claremont Avenue, Oakland, California 94618
Telephone 800-227-4527  www.miec.com
HAWAII CLAIMS OFFICE: 1360 South Beretania Street, Honolulu, Hawaii 96814

Our 25th Anniversary, 1975–2000
Sponsored by Hawaii Medical Association