America needs health insurance reform. But unfair fraud and abuse laws need a second opinion.

Congress is moving now to pass long-needed legislation making health insurance portable and ending coverage exclusions due to preexisting medical conditions.

Congress is also considering ways to end the discrimination in health care by providing a greater range of treatment choices for patients through Medical Savings Accounts and enhanced coverage of mental illness.

The nation—and our patients—need these reforms.

HOWEVER...some proposals in the House and Senate go too far. Despite months of negotiations, legislation is now being considered that could put your doctor in jail or exact grossly excessive fines for unintended paperwork mistakes. These new fraud and abuse laws would set basic principles of due process back a century.

Medicine agrees that fraud and abuse is a serious problem. If doctors willfully and knowingly violate our nation's laws, they should be punished. But honest mistakes should not make physicians—or any other citizens—candidates for incarceration.

America needs health insurance reform...but not unfair laws that will put innocent doctors in jail.

Call the AMA's Grassroots Hotline at 1-800-833-6354 to obtain more information about joining the campaign to strike these onerous provisions from the law.

American Medical Association
Physicians dedicated to the health of America
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Maui the Fisherman

The demi-god Maui is said to have fished the Hawaiian islands out of the sea. He
baited his magic hook with the mud hen or gallinule. Once the islands were out of
the sea Maui tossed his hook up into the sky where it remains to this day as the
constellation Scorpio.

Welcome Wagon Volunteers Needed

The HMA Membership section has implemented a program to call on
new physician members to welcome them into the medical society. If you can volunteer an hour or two a month to accompany a staff member
to the new physician's office, please call HMA at 536-7702.
Editorial

Norman Goldstein MD

Our Lean Issues

Despite the very lean recent issues of the Journal, we have many excellent manuscripts in the hopper just waiting for publication.

The problem: Insufficient ad revenue to pay for the pages of manuscripts.

The solution: We need your help. We are planning a Physician Referral ad page to help our bottom line.

And ask the next few detail men (or women) who come to your office or who exhibit at your hospital to take an ad in the Journal. Full page ads are, of course, desirable, but even half or quarter page ads on a regularly monthly basis would be very helpful.

Call Carol or Becky at the Journal office at 536-7702, Fax 528-2376 or Lori Arizumi 988-6478, Fax 988-2785 for ad info. We need your help!

Letters to the Editor

Brochures on “Successful Strategies For Surviving Managed Care,” the uniformed-like-an-Admiral J. Edward Koop’s seminar on how to hold on to patients, seminars on how to cope with federal guidelines, how to interact with insurance companies, and countless other seminars on what in my opinion is the Beast—Institutional Man—flood in with the mail of medical doctors across the country.

The newspapers inform doctors incomes are down.

In psychiatry, my specialty, most people can’t afford individual psychotherapy of the 45 to 50 minute therapeutic hour, and they certainly can’t afford what actually works: the two to three hour to four hour psychotherapeutic hour—so as reported in the Psychiatric News, there is more group therapy as a substitute, not as the treatment of choice.

The various specialties of the medical field, together and separately, consume huge amounts of time in the battle for adequate dollars to treat.

The chiropractors have taken a severe blow as a result of serious losses in their attempts to lobby the legislature. Some of their homes are on the market now at bargain basement prices. Those among the chiropractors who have survived scramble to get innovatively creative within the institutional funding system, playing an ever-intensifying game of the paper chase. and/or learn to scale down.

The news has it that many medical doctors are going for MBA degrees to enter administrative positions in a desperate attempt to maintain income.

The Institutions, in my opinion, are not in trouble, they’re in rubble. Only the illusion remains—like seeing a dead friend in the chair in which he always sat.

The Institutional Age has ended.

Although terrified, frightened, too damn busy filling out forms, and trying to care for patients with increasing overhead and decreasing income, and almost always perceived as rich, many of my colleagues appear to be clinging to the structures of the past. They may be increasing their own tension, frustration, and anger, firing blind volleys at the insurance industry, which itself has been regulated into a kind of HMO. Even as they win temporary reprieves by decreasing payments, increasing paper hassles, in effect, providing less and less coverage for care, the insurance companies themselves are as doomed at the chiropractors and those of us who rely on them, and those of us who actually expect the various government bureaucracies to provide adequate funding and not strangle the autonomous physician into a hamstrung puppet tugged by increasingly severely, impossibly complicated guidelines that render the actual practice of medicine less and less possible.

Yet, I am optimistic. Everything is okay. The physician who wants to teach by his/her example how to change with the changing times does what he loves to do: teach, advise, and treat patients.

If a patient wants heart-centered care (pun intended), the physician who loves to be a physician is always there. Before third party coverage, medicine thrived, the physician had greater respect, in fact, was generally loved by patients who rarely if ever sued him. The physician did not see patients at 5 to 15 minute clips, a hearty handshake and a generic few words to establish rapport.

Physicians gained their full-of-wonder reputation as caring people with skill by interacting with patients and families, spending blocks of time making “house calls”, and no amount of technology, quick interventions, writing of prescriptions without deep personal communication and interaction with patients can substitute.

Patients who love their doctors, and doctors who love their patients are learning that personal relationships with one another as human beings is primary. Technology secondary. Even science itself becomes useless if it is inhumane.

Blase Harris, MD

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Recent performance of medical students at the John A. Burns School of Medicine (JABSOM) on the United States Medical Licensing Exam (USMLE) has been used frequently to question the quality and effectiveness of the curriculum. This article provides background on the exam itself, clarifies its purpose, and reports accurate aggregate results and trends for JABSOM medical students.

The United States Medical Licensing Exam, a joint program of the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards, provides a common evaluation system for measuring knowledge and cognitive competence of all applicants for medical licensure in the United States. In a transition period which began in 1991 and completed in 1994, the USMLE has replaced the Federation Licensing Examination (FLEX) and the NBME Parts I, II and III, and currently is the only path to licensure in the United States.

Beginning with the NBME Parts I and II and continuing on with the USMLE, despite consistent disclaimers from the National Board that, "It is important to understand that the examinations have not been developed for the purpose of assessing preparation for postgraduate education," nor for program evaluation, unless the specific objective of the curriculum is to "teach to the test," scores continue to be used for both purposes. In a comprehensive article published in Academic Medicine, Nungenster, et al., emphasize that the general purpose of an examination should be the primary factor in determining how the scores are defined and reported. Since the USMLE is primarily a certifying exam used as part of a licensing process, its main objective is to differentiate between examinees who possess necessary knowledge and skills and those who do not, which is more consistent with a pass/fail classification. The Josiah Macy, Jr. Foundation, concerned with the increased use of scores to evaluate student achievement and to judge the quality of medical school curricula, in their GPEP Report, also called for pass/fail reporting and the elimination of total and subject-specific scores. The report goes on to point out that, “the present, passive system of medical education is based largely on memorization and recall. In over 70% of US medical schools, students are required to take the nationally standardized, multiple-choice examinations...To a limited degree, multiple-choice tests can be used to assess problem-solving abilities, but they largely measure a student’s store of memorized information. They do not assess learning skills that medical students should acquire in order to keep pace with medical progress.”

It is specifically this last skill which is the primary emphasis of JABSOM’s Problem-Based Learning curriculum, and therefore, in the minds of some of the faculty, a more accurate interpretation of students’ scores is that it is more a reflection of their success in acquiring these skills than what they know. In other words, they have learned how to learn.

With this background, JABSOM student performance on the more recent USMLE Step 1 administration (June 1995) closely matches the national norm, including the mean total score (205/207) and passing percentile (92%/93%). Inspite of the lack of discipline-specific courses, none of the mean test scores in the individual subject areas (Behavioral Sciences, Biochemistry, Gross Anatomy & Embryology, Histology & Cell Biology, Microbiology & Immunology, Pathology, Pharmacology, Physiology) were significantly below the national mean. A comparison of the performance of pre-PBL and post-PBL classes is complicated by the fact that the transition from the NBME exams to USMLE exactly coincides with JABSOM’s change in curriculum, and included a change in score scales and discipline categories. However, a rough comparison of passing percentiles revealed that the three pre-PBL classes (83%, 93%, 92%) and most recent three post-PBL classes (86%, 91%, 92%) were fairly comparable.

What has been even more gratifying is that performance of JABSOM students on the USMLE Step II has shown a consistent incline, with the passing percentile (96%/92%) and total mean score (207/202) slightly exceeding the national norms on the most recent administration (August 1995). In addition, scores in the individual discipline areas (Health & Health Maintenance, Understanding Mechanisms of Disease, Diagnosis, Principles of Management, Medicine, Obstetrics & Gynecology, Pediatrics, Preventive Medicine & Public Health, Psychiatry and Surgery) were all consistently above the national mean. The transition from the NBME Part 2 to the USMLE Step 2 took place in 1991 and did provide an opportunity for comparing the performance of one pre-PBL class with post-PBL classes using the same exam format. The analysis revealed that the total mean scores were identical, with a dip in the passing percentile (94% to 87%) between the last pre-PBL class and the first PBL cohort. However, a similar decline was seen nationally, and the overall passing percentile has since been dropped (through the normalization process) from 95% to 92%.

In summary, while the USMLE is designed primarily as a certifying exam, it has been used to evaluate individual students as well as curricula in medical schools. More specifically, critics of JABSOM’s Problem-Based curriculum have cited poor student performance as evidence for the ineffectiveness of the program. Although the caveat mentioned above and limitations inherent therein are recognized, recent results indicate that JABSOM students are performing at or above the national norms on the USMLE.

References
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to Lucy Henriques Medical Center.
We Enjoyed our Partnership with You
and Acknowledge Your Continuing
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to North Hawaii Community Hospital.
We Look Forward to Serving Your Community
Transient Blindness in a Preeclamptic Patient Secondary to Cerebral Edema

Thomas Shieh MD, Thomas S. Kosasa MD, Elbert Tomai MD, Roy T. Nakayama MD

Blindness associated with a cerebral lesion has been described as cortical blindness. This is the first reported case in which computerized tomography has documented cerebral edema to be the cause of cortical blindness in a preeclamptic patient.

Blindness associated with preeclampsia is rare and, in most cases, is a result of ophthalmological changes such as retinal edema, retinal detachment or central retinal artery thrombosis. Grimes et al described the first case of cortical blindness in a preeclamptic patient based on a normal ophthalmological examination, and the presence of bilateral cerebral lesions in the occipitoparietal cortex demonstrated by computed tomographic scan. Due to limitations in the CT scanning equipment of that generation, the lesions were thought to represent either cerebral edema or hemorrhage. Using improved CT scanning equipment, we determined that the lesions in the occipitoparietal cortex in our patient with preeclampsia and transient blindness were found to be from cerebral edema.

Case Report

A 34-year-old primiparous Chinese woman was admitted to the hospital at 32 weeks of gestation with a diagnosis of preeclampsia. She presented with a blood pressure of 155/100 mmHg and 3+ proteinuria. Her highest blood pressure during her prenatal visits was 110/70 mmHg, and urine was negative for protein at every visit. Examination of her eyes revealed normal disks, maculae, and vessels. Her neurologic examination was normal, and there was no evidence of hyperreflexia. Admission hemoglobin was 12.3 g/m100 ml, uric acid 5.5 mg/100 ml, platelet count 197,000 per mm3, creatinine 0.7 mg/100 ml, blood urea nitrogen 9 mg/100 ml, and serum glutamic oxaloacetic transaminase 21 mg/100 ml. A 24-hour urine examination revealed proteinuria of 8 gm. On bedrest, her blood pressure returned to 120/80 mmHg.

The second day of admission she began to complain of headaches and her vision acuity was reduced to light perception only. Her blood pressure had risen to 130/90 and she was infused with 4 gm of magnesium sulfate over 20 minutes, followed by continuous infusion of 2 gm per hour.

Both pupils were normal in diameter and reacted fully to light. A repeat fundoscopic examination revealed normal vessels, disks, and maculae in both eyes. Her blood pressure rose to 170/105 mmHg and a cesarean section was performed under general anesthesia. A female infant weighing 338 gm was delivered with Apgar scores of 7 and 9.

A CT scan using a General Electric Advantage Highlight System was obtained following the cesarean section and showed hypodensity in both occipitoparietal lobes. This was diagnosed as cerebral edema (Fig. 1). Magnesium sulfate was continued for the next 48 hours at 2 gm per hour, and her blood pressure fell to 130/80 mmHg. Her vision returned to normal over the next 24 hours although she developed a problem with depth perception. Her vision was completely normal by the third postoperative day, and she was discharged on the fourth postoperative day. A repeat CT scan 6 weeks after delivery was normal (Fig. 2). A neurologic and ophthalmologic examination 6 months following delivery was normal.

Discussion

Antepartum transient blindness with preeclampsia in the presence of normal ophthalmologic findings has been reported in three patients prior to this case (Table 1). Although Grimes et al postulated the etiology as a cerebral lesion by demonstrating hypodensity of the occipitoparietal region of the cortex on CT scan, Nishimura et al failed to demonstrate any abnormalities on CT scan. Anilkuraran et al found the CT scan to be normal in the most recent reported case of cortical blindness. In our case, the CT scan clearly demonstrated hypodensities of the occipitoparietal region of the cortex confirming the etiology of cortical blindness as a cerebral lesion.

Grimes et al postulated that the observed lesions represented cerebral edema or cerebral vascular accident. Beeson et al said cerebral edema was responsible for the findings of hypodensity in the occipital lobes in an eclamptic patient with cortical blindness since these lesions caused symmetric compression of the lateral ventricles and resolved with diuresis. A more recent report by Brown et al suggested that the areas of hypodensity represented petechial hemorrhages accompanied by cerebral edema. Using improved equipment, the CT scan in this case clearly demonstrated that the hypodensities in the occipitoparietal region of the cerebral cortex was due to cerebral edema rather than hemorrhage.

Cortical blindness associated with preeclampsia or eclampsia has
Table 1.—Reported Cases of Antepartum Cortical Blindness in Preeclampsia

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Gestational age (wk)</th>
<th>Preclampsia</th>
<th>Computed Tomographic Scan</th>
<th>Resolution of Blindness Following Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grimes et al</td>
<td>1980</td>
<td>41</td>
<td>Severe</td>
<td>Occipitoparietal lesion</td>
<td>24 hours</td>
</tr>
<tr>
<td>Nishimura et al</td>
<td>1982</td>
<td>36</td>
<td>Mild</td>
<td>Normal</td>
<td>72 hours</td>
</tr>
<tr>
<td>Arulkumaran et al</td>
<td>1985</td>
<td>36</td>
<td>Severe</td>
<td>Normal</td>
<td>4 hours</td>
</tr>
<tr>
<td>Shieh et al</td>
<td>1995</td>
<td>32</td>
<td>Severe</td>
<td>Occipitoparietal</td>
<td>24 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cerebral Edema</td>
<td></td>
</tr>
</tbody>
</table>

been reported in 12 patients in the English literature. Seven of these patients developed blindness prior to delivery and four following delivery. Blindness occurred in seven patients with preeclampsia and in five eclamptic patients. Every case of cortical blindness resolved spontaneously. The results from the CT scan of our patient with cortical blindness corroborates the CT results reported by Grimes et al, who first postulated the etiology as a cerebral lesion. It further confirms the work of Beeson et al, who suggested that the lesion represented cerebral edema.

References
Herpes Zoster at School-Age:  
A Case Presentation and Discussion of the Unique Aspects Within the Pediatric Population

Martin L. Piette MD

This paper is a case presentation and discussion of a 12-year-old boy previously in excellent health who presents with dermatomal herpes zoster. Although not unheard of, the occurrence of herpes zoster in the pediatric population is infrequent. This case provides the opportunity to address many of the aspects of herpes zoster that are unique to the pediatric population including epidemiology, pathophysiology, management and course, and the potential impact of the live attenuated varicella vaccine, recently approved for the prevention of the primary varicella infection, chickenpox.

Case Report
A twelve-year-old Chinese-caucasian male was well and in his usual state of excellent health, when on one Friday morning while at school he complained of a sharp, tingling pain on the back of his neck. The school nurse noticed a small papular, erythematous eruption in the region of the neck from which the patient had complained. The patient was found to have a low grade fever as well. His mother was notified and the patient was sent home. The mother attempted to relieve the symptoms by applying Lanacaine ointment and calamine lotion without much success. The next morning, Saturday, the extent of the eruption had spread following the C3 dermatome down the left side of his neck and up to the back of his hair line. The eruption had become vesicular and more erythematous. The patient also reported some weakness in his left arm. The patient was brought into the clinic and upon further questioning denied any recent outdoor treks, travels, changes in clothes, detergents, or soaps. The mother reported that the patient had had a mild case of chickenpox at a very early age and has otherwise been extremely healthy without any recent increased frequency of illnesses, weight loss, or night sweats.

On physical exam, the patient was a well developed 12-year-old male, nontoxic appearing but in moderate distress due to the painful lesions on the left side of his neck. Vital signs were within normal limits. The lesions on the left side of his neck had an erythematous, mildly edematous base with superimposed oval-round vesicles. The eruption extended down the left side of the neck to the mid-clavicular region with a few isolated lesions over the acromio-clavicular region. It extended up to his hairline with some scalp involvement. Eyes and ears were not involved. There was a mild degree of weakness on flexion against resistance on his left upper extremity. Sensory and coordination were intact. The remainder of the exam was entirely within normal limits.

A presumptive diagnosis of herpes zoster was made based on the history and physical findings. No confirmatory tests such as a Tzanck preparation, viral culture, biopsy, or immunofluorescence were performed. Based on the patient’s history of excellent health, a workup of the patient’s immunocompetence was deemed unnecessary. The patient was started on oral acyclovir. On follow up five days later, there was marked improvement. The number of lesions had decreased markedly and the existing lesions had dried and crusted over. The patient reported that he had regained his strength in his left arm.

Discussion
The recognition and diagnosis of dermatomal herpes zoster in adults and children is straightforward. Although not unheard of, the occurrence of herpes zoster in the pediatric population is infrequent. This case provides the opportunity to address many of the aspects of herpes zoster that are unique to the pediatric population.

Epidemiology
With an estimated 3 million cases of chickenpox a year in the U.S., greater than 95% occurring in children and adolescents, the prevalence of primary varicella zoster virus (VZV) exposure is nearly universal within the pediatric population. In contrast, the incidence of herpes zoster, which is the manifestation of the reactivation of latent varicella zoster virus from within the dorsal root ganglia, is very low in childhood. In individuals less than 10 years of age, there is an estimated incidence of 0.74/1000 patients versus an estimated annual rate of 3.4/1000 for the general population.
There are several conditions or circumstances in children that have a higher incidence of herpes zoster than the general pediatric population (See Table 1). Acute lymphocytic leukemia (ALL) patients or children receiving immunosuppressive therapy, have the highest incidence of herpes zoster within the pediatric population. It has been estimated that herpes zoster occurs in 22-25% of children with ALL and a prior history of chickenpox. Immunocompromised children are at greater risk for disseminated herpes zoster with visceral involvement, particularly VZV pneumonia, and a 20% mortality. Children with HIV are commonly afflicted with herpes zoster but it rarely becomes disseminated. Herpes zoster occurring in infants is strongly associated with in-utero exposure to VZV. Children afflicted with chickenpox, the primary infection of VZV, at less than 1 year of age, have a greater predisposition for developing herpes zoster later on in their childhood, particularly before the age of 7.

<table>
<thead>
<tr>
<th>Table 1.—Risk Factors for Herpes zoster in children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ALL and other malignancies.</td>
</tr>
<tr>
<td>2) Immunocompromised (treatments, HIV).</td>
</tr>
<tr>
<td>3) In-Utero varicella exposure.</td>
</tr>
<tr>
<td>4) Chicken Pox at age &lt; 1 yr.</td>
</tr>
</tbody>
</table>

The dermatomal distribution of the cases of herpes zoster within the general pediatric population is similar to adults with the preponderance of cases occurring between T2-L2. However, Terada et al. found some interesting variations in dermatomal distribution when the pediatric population was broken down by age. In children less than 7 years of age, the involvement of cervical and cranial nerve dermatomes was 41.7% and 25%, respectively. In children greater than 7 years of age, 78.9% involved the thoracic dermatomes. Terada et al. hypothesized that these findings may reflect the changing body proportions of growing children. If this is the case, Terada further hypothesized that the dermatomal site of herpes zoster may be a reflection of the region of highest preponderance of exanthems during the primary infection with VZV, chickenpox.

**Pathophysiology**

It is firmly established that following primary infection, VZV remains in a latent state within the dorsal root ganglia. Herpes zoster represents the reactivation of this latent virus from within a particular ganglion. The epidemiology of herpes zoster indicates that latency and reactivation is dependent on both host and viral factors. Attempts to elicit the pathogenesis of herpes zoster have been confounded by the fact that human beings are the only known harborers of
The high incidence of herpes zoster in immunocompromised indicates that the immune system plays a role in maintaining latency, particularly cellular immunity. The higher incidence of Herpes zoster in adults, it is believed, may reflect a natural decline in cellular immunity with age.

The occurrence of herpes zoster in children is even more puzzling. In some cases, it may be the result of an immunocompromising illness or therapy, but in healthy children, it remains a mystery. Analysis of blood drawn from healthy children with herpes zoster often resembles that of a primary infection with high titers of Natural Killer Cells and IgM antibodies despite having been previously exposed to the virus. It has been hypothesized that this apparent loss of immunologic memory may be due to an incomplete or immature immunologic response at the time of primary exposure to the VZV. An immature immune response has been the long-held belief for the mechanism behind the higher frequencies of herpes zoster in infants exposed to VZV in-utero and in children who had a primary VZV infection at less than 1 year of age. In other children, the occurrence of herpes zoster may reflect an incomplete immune response to perhaps a mild primary VZV infection. However, a relationship between herpes zoster and the severity of primary VZV infection has not been established.

Studies of immunologic memory status have revealed that VZV specific cellular immunity is enhanced by frequent exposure to VZV. It is hypothesized that multiple exogenous exposures to, or subclinical endogenous reactivation of, the VZV may serve as a booster to the immunologic system and may aid in maintaining the virus in their latent state within the ganglia.

Management and Treatment

In the management and treatment of herpes zoster in children, the pediatrician may be faced with several questions that are unique to the pediatric population.

- Should anti-viral medications such as acyclovir (Zovirax), famcyclovir (Famvir), or valacyclovir hydrochloride (Valtrex) be employed? Or are there toxicities or precautions unique to the pediatric population that one should be aware of?
- Should a healthy child with herpes zoster be further evaluated for other immunocompromising illnesses?
- Is herpes zoster a precursor to a malignancy?
- Will there be any persistent neuralgias as may occur in adults?
- And the inevitable question of all parents of school age children, is the child contagious, should he stay home from school?

In most cases, herpes zoster in otherwise healthy children runs a benign course, requiring only supportive treatment with non-aspirin analgesics and local wound care. The exceptions to this are herpes zoster involving the first branch of the trigeminal nerve or within the ear canal. Forty percent of patients with initial zoster lesions occurring on the forehead and eighty percent with initial lesions on the tip of the nose, will develop ocular involvement. Because ocular and auditory involvement may lead to significant permanent impairment, more aggressive therapy may be warranted.

The indications for and usage of antiviral agents in the management of pediatric herpes zoster is still quite controversial. The safety and efficacy in children has not been established for famcyclovir and valacyclovir hydrochloride. There has been considerably more experience with the use of acyclovir. However, it still has not been adequately studied for the use on children less than 2 years of age.

In 1992, the FDA approved the use of oral acyclovir for the treatment of varicella infections in otherwise healthy children. In 1993, the American Academy of Pediatricians (AAP) released the following recommendations for the use of oral acyclovir in varicella infections:

<table>
<thead>
<tr>
<th>American Academy of Pediatrics Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Oral acyclovir is not recommended routinely for uncomplicated varicella in otherwise healthy children</td>
</tr>
<tr>
<td>2) for children at increased risk of severe varicella or its complications (older than 13 yrs., those receiving chronic corticosteroids or aspirin therapy, those with chronic cutaneous or pulmonary disease), oral acyclovir should be considered, if it can be initiated within 24 hours of the rash.</td>
</tr>
<tr>
<td>3) When given, oral acyclovir should be administered for 5 days. The patient must maintain adequate fluid intake.</td>
</tr>
<tr>
<td>4) Primary varicella or recurrent zoster in immunocompromised and virus mediated complications of varicella in normal hosts should be treated with intravenous acyclovir.</td>
</tr>
<tr>
<td>5) Oral treatment is not recommended in pregnant adolescents with uncomplicated disease.</td>
</tr>
<tr>
<td>6) Oral acyclovir may be considered for household contacts because they usually have more severe illness.</td>
</tr>
</tbody>
</table>

In children, acyclovir appears to be better tolerated than adults. Possible side effects are nausea and vomiting which occurs in less than 8 % and 3 % of the pediatric population, respectively. There is even lower incidence of diarrhea, headaches, and cutaneous eruptions. Dehydration and over-dosage may lead to renal precipitation. Renal function should be closely monitored in the neonate population.

Herpes zoster eruptions are contagious to individuals not previously exposed to the varicella virus. However, it is estimated to be only one third as contagious as primary varicella infection. Transmission by direct contact with the lesions has been established. Respiratory transmission, the main mode of transmission in primary varicella infection, has not been conclusively excluded as a mode of transmission to susceptible individuals.

Although there is a higher incidence of herpes zoster in childhood malignancies, the reverse has not been found to be true. No association between herpes zoster and subsequent cancer has been found. Prospective studies of individuals with herpes zoster have shown the same incidence of malignancies as the general population. From this information, it appears that further evaluation on an otherwise healthy child is unnecessary unless dictated by their history.

The occurrence of post-herpetic neuralgia in children is still questioned. In general, it can be said that herpes zoster has a much
milder course in children than adults with a minimal risk of post-herpetic neuralgia, the incidence of which is as high as 43% in some adult studies. In their study of childhood zoster over a 20 year period, Guess et al found no incidence of post-herpetic neuralgia.5

**Live Attenuated Varicella Vaccine**

With the recent AAP recommendation of the live attenuated varicella vaccine for the prevention of primary varicella infection (chickenpox), there has been much discussion on its potential impact on the incidence of herpes zoster. It was initially hoped that with the eradication of primary varicella infection by the vaccine, there would be a similar impact upon herpes zoster. However, further studies of the attenuated vaccine virus have shown that it, too, can cause latent infection within the ganglia and dermatomal zoster eruptions upon reactivation. As a result, there has been a growing concern that there may possibly be an increase in the incidence of herpes zoster as a result of the new vaccination policies.

Current U.S. studies show no increased incidence of herpes zoster in healthy immunized children. A 4 year follow-up study of 548 children with ALL immunized against varicella actually showed a decrease in the incidence of herpes zoster. This finding was significant in that these patients are normally considered at highest risk for varicella reactivation.

There may be several explanations for the decreased incidence of zoster after vaccination. One is the virus is attenuated. Another is that the exanthem of primary varicella may be necessary for the virus to gain access to the sensory nerves and reside within the dorsal ganglion region.

The varicella vaccine may play another role in the prevention of herpes zoster. Immunologic studies of adults receiving vaccination have shown higher levels of VZV specific T-cell levels. These findings imply that the varicella vaccine may have the potential of being used as an immunologic booster with the hope of preventing herpes zoster in adult populations as well.

**References**

Council Highlights

June 7, 1996
Roger Kimura MD, Secretary

The meeting was called to order by Dr. Carl Lehman, President at 5:30 pm.

Those present were J. Spangler, President-elect, R. Kimura, Secretary; L. Howard, Treasurer; F. Holschuh, Immediate Past-President; AMA Delegates: C. Kam, R. Stodd; Alternate AMA Delegate: A. Kunimoto; Speaker: H.K.W. Chinn; Component Society Presidents: L. Sonoda-Fogel for Dr. Bade, Hawaii; T. Crane, Kauai; T. Smith, West Hawaii; Councilors: P. Chinn, W. Dang, P. DeMure, M. Shirasu, J. Betwee, C. Kadooka, A. Bairois; Past Presidents: W. Dang, G. Goto, J. McDonnell, S. Wallach, N. Winn; Young Physician Delegates: C. Goto; HMA Alliance: C. Gutteling.


Minutes: The minutes of the April 12, 1996 meeting were approved as circulated.

Hawaii Health Information Corp. (HHIC): Dr. Sharon Vitousek, HMA’s representative, gave an update on what HHIC is doing and where it is going. The goal is to give patients better care and to cut the cost of health care delivery.

- Dr. Lehman reported: 1) he appeared on “Dialog” in a discussion of health care issues in Hawaii; 2) the Distinguished Medical Reporting Awards Banquet and talent show was outstanding; 3) he appeared on KGMB news to discuss the Hawaii State Employee’s Retirement Fund, including investments in tobacco industries; 4) as a member of the Hawaii Health Council he met with the President of the Hawaii State Bar Association to discuss decreasing the cost of medicine by utilizing alternative dispute resolution methods to circumvent expensive court proceedings; 5) the HMA held two evening seminars on “Coding Reimbursements.” There is also a waiting list for another seminar; 6) the contract for Central Verification Services has been signed and marketing will begin within two months; 7) the Membership Task Force has met and is working on recruiting and retaining members. Dr. Spangler, Chair of the Task Force is considering three subcommittees to carry out appropriate membership functions; 8) that the request to Chairs and Commissioners for their annual reports will be going out early July. The annual reports should state the goals of the committee, accomplishments and suggested goals for next year. The deadline for budget requests is August 16, Annual Reports August 26 and Resolutions September 17; 9) HMA acted on behalf of physicians regarding Medicaid delinquent payments; 10) Contact was made regarding the addendum to insurance contracts where physicians would assume liability. After HMA’s immediate action, the clause was rescinded; 11) a No-Fault meeting will be held in preparation for a special session of the legislature.

- Dr. Spangler, President-elect reported that on July 22 at 5:30 p.m. there will be a meeting to go over the HMA Committee/Commission Structure with the Chairs and Commissioners.

- The HMA Alliance gave an extensive report from October 1995 - July 1996 on all the functions and fundraisers they have participated in.

For Action

The HMA Council approved the following:

- The Tobacco Task Force’s recommendation that HMA urge Governor Cayetano to have Hawaii join a class action suit against tobacco companies.
- The Tobacco Task Force’s recommendation that the committee write a letter to Aloha Medical Mission, bringing to their attention that one of these sponsors, a tobacco company, contributes to public health problems.
- The Executive Committee’s recommendation that Drs. Ed Montell, Frederick C. Holschuh, Deen Wong, Donna McCleary, Ron Kwon and Steven Moser will be nominated for the Board of Directors, Hawaii Health Systems Corp.

Component Society Reports

Honoalu.—Dr. P. Chinn reported that the HCMS Finance Committee will be meeting soon to look at a mid-year budget revision. The HCMS is also planning a retreat at Kualoa Ranch which will be in August. Dr. McDonnell reported that last month’s Mini-Internship program was a success.

Kauai.—Dr. F. Holschuh reported for Dr. T. Crane that the physician/patient complaints Dr. Crane discussed at the last Council meeting regarding various physicians were successfully resolved on the County level on an informal basis.

West Hawaii.—Dr. T. Smith reported that North Hawaii Community Hospital is open and already at full capacity. The West Hawaii County Membership meeting will be scheduled in the near future.

Hawaii.—Dr. L. Sonoda-Fogel reported for Dr. E. Bade. Their county will be having a picnic and will invite new physicians. The Family Practice Program residents and students will also be invited.

Maui.—Dr. Betwee reported on recent experiences with the DEA and Medicaid. Problems need to be reported to the HMA as other physicians may have similar experiences.

For Information

Colorado AMA Resolution.—HMA is in support of this resolution that the AMA prepare a model state legislative resolution concerning the equitable tax treatment of expenditures made for health care purposes and provide it to all members of the Federation for consideration to be introduced into their next state legislative sessions.

HMA Resident Physician Section.—A group of residents are interested in forming a resident section of HMA. HMA is hosting a party for them on July 11 at Pizza Bob’s. Clinical Laboratories made a generous contribution towards the establishment of the resident’s section.

Long Range Planning Committee.—Dr. Cynthia Goto will chair a focus group inviting young member and nonmember physicians. The purpose of the group is to get feedback from them on how HMA is relevant to them and how the organization can best serve them. This will be reported back to the Long Range Planning Committee.

Staff was excused and Council proceeded into Executive Session at 7:50 p.m.
Life in These Parts
Directory Numbers Speak for Themselves
(by Robert Kraus)
Nuggets from the 1996 edition Yellow Pages
Attorneys 72 pages; Physicians 58 pages; Automobiles 51 pages; Dentists 27 pages; Contractors 17 pages and Computers 16 pages.

Leading Families
Lees, 25 columns; Wongs, 20-1/2 columns, Kims, 14 columns; Youngs, 12-2/3 columns; Chars, 12-1/4 columns; Chans and Smiths, 10-1/2 columns; Chings, 9 columns; Laus, 8 w/3 columns; Lums and Nakamuras, 8 columns each.

New Isle Health Plans on the Horizon
Robert Nickel, HMSA VP for Integrated Delivery Systems, announced that the following health plans are being developed: (viz HMO’s formed by hospital systems with HMSA as insurer)
• The Kapiolani Health Hawaii Network (Kapiolani hospital & HMSA)
• Kuakini Medical Center, the two St. Francis hospitals, Castle hospital & HMSA
• Queens Medical Center, the Queen Physicians group & HMSA
• Straub Clinic & Hospital

Fred Fortin; HMSA assistant VP for community relations comments; “Whether all the new groups will be able to compete effectively remains to be seen. Within the flurry of networks being formed, employers will have a wide selection of health plans.”
Bob Nickel explains, “Kaiser, the grandfather of HMO’s is a fully integrated service. The other organizations may be one step up from fee for service programs or somewhere in the middle.”

Kim Thorburn’s Departure
“We are sorry to hear that Dr Kim Thorburn, Hawaii’s chief prison doctor, will be stepping down. With Thorburn’s departure, the need for vigilance in inmate health care will, if anything, increase. We hope the department is committed to finding a replacement who is as dedicated to inmate health care.”
(From Advertiser editorial April 9)

Kim was forthright: “I have been extremely troubled to be associated with a department whose administration condoned abusive treatment that was tantamount to torture.”

Medical Missionary
(Abstracts from Honolulu Magazine Mar ‘96)
Likeable Dick Frankel is medical director of Queen Emma Clinic and professor of medicine, John Burns Medical School. He is also consultant to WHO on Hansen’s disease and tuberculosis, which requires traveling to China, the Philippines, Malaysia, Tonga, New Guinea, the Solomon Islands and more.
“The traveling is arduous. Endless kidney jostling truck trips into areas plagued by gunfire as by tuberculosis, this seasoned traveler has learned all the tricks, even to maintaining a vegetarian life style in places where getting meat for meal is cause for celebration. Says Dr Frankel with a grin, “I always carry jars of peanut butter and jelly.”

Outcry from the Inferno (Shura Kyokan)
Physician-author Jiro Nakano scores again with an anthology (translations of 100 agonizing Tanka written by survivors of the Hiroshima holocaust) Jiro, former Hilo-UH Med School physician is currently director of the International Division of...
Kobe Kaisei Hospital and personally witnessed these Hibakusha. $(10—Bamboo Publishers)

Potpourri

“Have you ever had any accidents?” the insurance agent asked the cowboy.

“Nope,” the Wrangler replied, “though a bronco kicked in two of my ribs last year, a bull gorged me awhile back and I sprained my shoulder when my horse threw me.”

“Wouldn’t you call those accidents?”

“Naw. They did it on purpose.”

Playboy Party Jokes (May ’96)

Conference Notes

Male Erectile Dysfunction

Lecture by Robert Kessler Stanford Professor of Urology at QMC-UH Friday morning March 31, 1995.

What is impotence?

“Inability to achieve and maintain an erection adequate for vaginal penetration for mutual satisfaction.”

Prevalence

1.9% at age 40; 25% at age 60; much higher in certain diseases. “Let’s have a show of hands: How many of you are impotent? Can’t get your hands up either?.”

Neurotransmitters

- Acetylcholine
- Catecholamines
- VIP
- Prostaglandins
- Endothelial derived substance

Neurogenic

Psychogenic: T12-L1
- Sympathetic
- Olfactory
Reflexogenic: S2-S4
- Parasympathetic
- Direct stimulation: penis, bladder, rectum

Hemodynamics: 6 phases

Frequency of Sex

20s—tri weekly
40s—try weekly
60s—try weakly
70s—try anything

Categories of Impotence

- Psychogenic
- Organic
- Mixed

Evaluation of Impotent Male

- History: definition; progression; other factors during progression; present level

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Endocrine Disorders

5% of total
- Hyperprolactanemia
- Hyperthyroidism
- Hypothyroidism
- Cushing’s Syndrome
- Uremia
- Diabetes: 2-5 times greater; 30% Type I by age 30 (due to vascular rather than neurogenic cause)

No hormonal changes
- Medications: Antihypertensive drugs (but not ACE and calcium channel blockers)

Treatment Options

- Sexual counseling
- Hormonal Therapy
- PEP (Pharmacologic Erection Programs)
- Vascular surgery
- Vacuum Devices

Vascular Devices

Very successful; simple, non-invasive; reversible
58% satisfied patients; 57% satisfied partners

Advantages

Increases size of erections; some improve vascular circulation.

Problem

Numbness in 19%

*PEP

Papaverine: PGE1; Phentolamine

*Penile Implants

1936; rib stent; 70’s silicone inflatable

Retaim Plans

Investment Management Consulting

- Life and Disability Insurance
- Charitable Remainder Trusts

derand capital management group

Registered Investment Advisor, mel r. hertz is a registered principal of IFG and an associated person of its affiliate AFP, both of which are otherwise unaffiliated with derand.

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**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 non-member form. Rates are $1.50 a word with a minimum of 20 words or $30. Not commissionable. Payment must accompany written order.

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**Position Wanted**

**Ophthalmologist.**—Canadian-trained/American Board certified, wishes to do locum in Hawaii. Contact Michael Myles MD, FRCSC, 211-1 Centrepointe Dr., Nepean, Ontario, Canada, K2G 6E2. Tel (613) 226-8872, Fax (613) 226-2903.

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**Position Available**

**Lahaina, Maui.**—BC/BE FP.—Well-established multispecialty group. Ambulatory care, minimal call. Position available summer 1996. Send CV to Dr Gilbert, 130 Prison St, Lahaina, HI 96761.

**Help Wanted**—Health Care Division Administrator for Department of Public Safety (PSD), State of Hawaii, responsible for planning, budgeting, organizing, implementing, and operating health services for individuals detained and incarcerated by the PSD. Major duties include supervision of health professionals and paraprofessionals who provide health services to the detained and incarcerated; management and administration for development and implementation of health services policies for all State correctional institutions; clinical duties which include quality assurance programs, medical consultation, medical oversight of clinical issues including pharmacy and therapeutics, disease prevention, investigation of communicable disease outbreaks. Reports to Deputy Director for Corrections, PSD. Must have current Hawaii medical license and completion of an accredited residency at a recognized institution. Three years experience in correctional medicine with two years in correctional health services administration.

Applicants should submit letter of interest to HMA Correctional Health Committee, 1360 S. Beretania Street, Honolulu, HI 96814 or FAX to (808) 528-2376.

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**Office Space**

**Medical Arts Bldg.**—250 sq. ft. to 997 sq. ft. office space avail. Pharmacy, x-ray lab; Clinical Laboratories of Hawaii on-site. Call Chrissy Young (S), 524-2666.

**Office to rent.**—In town. Fully furnished turnkey operation. Rental $2.50 sq. ft. Pager 361-5164.

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**Locum Tenens**

**Locum Tenens.**—For family practice, no OB or PEDS. GP, FP, IM are OK. Location Hilo, for two weeks, mid to end of July. Compensation negotiable. Contact Richard Lee-Ching MD, 780 Laukapu St, Hilo, (808) 961-6922.

**The Pacific Center for Dermatology and Phototherapy** is now receiving referrals for dermatology consultations and/or phototherapy. Lois Y. Matsuoka, MD, FAAD, FACP, (former faculty mem., Jefferson Med. College.). Ala Moana bldg., Suite 911, 1441 Kapiolani Blvd., Honolulu, HI 96814. (808) 941-5506.

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The Weathervane

A politician will plan to build a bridge even when there is no river.

Despite the failure of HCFA’s own pilot study, and irrefutable testimony from other sources such as the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgery, the Clinton administration persists in resurrecting the cataract “Centers of Excellence” plan for discounted medical care. In 1994, the Clinton health reform plan predicted a savings of $110 million/year with the “centers”, but now the figure has dropped to $29 million with this Wall-Mart care. However, even that dust-budget figure will certainly fail to be reached with the projected cuts in Medicare reimbursement.

Where there’s a will, there’s a won’t.

Police brought a rape suspect to a hospital emergency room to obtain a blood sample for evaluation. He was not a patient and did not request any medical service. Furthermore, the suspect refused to give his consent and stated he would actively resist. The doctor and other hospital personnel refused to draw a blood specimen, but then were prosecuted for “obstruction of, or interference with, the conduct of a law enforcement investigation.” The charges were dismissed when a Superior Court judge ruled that hospitals have no legal duty to obtain bodily samples from unwilling police suspects. Still, irremediable professional damage can result from the media attention when a criminal action is brought against a physician, even when all charges are subsequently dismissed. Although he was arrested, to date no charges have been brought against the Hilo ophthalmologist who wrote a legitimate prescription, but the damage inflicted to his reputation is done.

Neurosis is a communicable disease.

For decades, researchers have tried and failed to incriminate coffee drinking with increased morbidity for heart disease, cancer, and other less common ailments. However, a new study reported in the Archives of Internal Medicine involving 86,626 nurses over a 10 year period, found that coffee drinkers (two or more cups/day) had less hypertension, diabetes, and hypercholesterolemia, and were 66% less likely to commit suicide than the baseline group. Moreover, they were less likely to take tranquilizers, and reported improvement in mood and less irritability following coffee consumption.

Any event, once it has occurred, can be made to appear necessary by a competent public relations man

Historically, the Cleveland Clinic has depended upon its tax-exempt status as an academic institution for tertiary eye care. Now, the Cleveland Clinic has entered into an exclusive ophthalmology contract with Emerald Health Network Inc. Apparently, without application or with credentialing, invitation was extended to those ophthalmologists who agreed to refer specialty eye care cases to the clinic. Other subspecialists in the community and general ophthalmologists who do not refer to the clinic, are out of the network and understandably irate. Record another victory for the managed care nabobs in their abiding design to turn doctors against one another, while they seek the lowest common denominator.

About that mysterious whooshing on Haleakala with the Playboy photo shoot

Dr James Bachman, reporting in the New England Journal of Medicine, has seen more than a dozen women with surgically enhanced breasts who experienced swishing bosom noises while at altitudes above 9,000 feet. Apparently air in the implants expands enough to allow implanted saline to slosh around. The breasts become silent at sea level, and whistling originates from other sources.

You too can be a rank insider

If you happen to have Allergan Inc. stock in your portfolio, you should be pleased at its recent rise and potential. Pharmacia-Upjohn Inc. has developed a new anti-glaucoma drug called Latanoprost which in clinical trials appeared to be more effective than Merck’s Timoptic (numero uno glaucoma drug seller). Moreover, the new drug does not have the cardiac risk inherent in the beta-blockers. Because Pharmacia needs to develop a bigger, specialized sales force to make the most of Latanoprost’s marketing potential, the word is that they want to buy Allergan, the Irvine, California, company said to be worth about $2.5 billion. Neither company is talking, but the Allergan acquisition would place Pharmacia second only to Alcon Laboratories, Inc. in global market share.

There is always someone who can make it a little worse and sell it a little cheaper

Valujet was the envy of other airlines, because of its high profit margin and $120 million in ready cash. However, at least one federal investigator had refused to fly on the airline, “primarily because they were flying old aircraft, their pilots were below grade and had limited access to training,” and the management staff was thin and has not kept up with growth. Obviously, this is an airline which functions “on the cheap.” Following the crash and while denying any oversight failure, the FAA hired 91 new safety inspectors. Meanwhile, in medical managed care, quality has also gone “on the cheap” with restrictive contracts, limited formularies, staff reductions, use of allied health practitioners, and other penny-pinching practices. We may not see 120 people in a 27 year old airliner decimated in a swamp, but the degradation is there, no less.

You can’t make up anything any more. The world itself is a satire.

A national survey of 350 department chairs and service chiefs at various centers of academe was conducted by American Health magazine. From this meaningless exercise 1,000 “best doctors in America” were named and published. How comforting!

Addenda

◆ 50% of baby boomers say they smoked pot, but now 74% of that group say they would be upset if their children even tried marijuana.

◆ Americans spend $2 billion/year on “organic” foods.

◆ Marlon Brando’s new sitcom—My Three Chins.

Aloha and keep the faith—rts.
Hawai‘i Medical Association
140th Annual Meeting
Primary Care Update

October 17-20, 1996

Kauai Marriott Resort
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